

LONG TERM CARE COMMISSION

Public Hearing, January 6, 2012
Conference Room 229, State Capitol
415 S. Beretania St.

OFFICIAL

Written Testimonies Received

Stanley, Patrick - Kupuna Caucus of Democratic Party of Hawaii

Hirada, Nancy

Jaycox, Kathleen

Lenzer, Anthony

Stanton, Barbara Kim - AARP Hawaii

Young, Jackie - American Cancer Society

Ribbentrop, Keith

Pratt, Dave

Takamura, Jeanette

Kelliipio, Josephine

LONG TERM CARE COMMISSION

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415 S. Beretania St.

Additional Oral Testimony - January 6, 2012

sign up sheet (please print clearly)

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To: David Nixon, LTC Commission

From: Patrick Stanley*, Caucus Co-Chair

Re: LTC Commission Report

The DPH Kupuna Caucus represents only an interest group within the membership of the DPH, it does not officially represent the DPH as such. The caucus met on December 21, 2011 to consider your recommendations and find the following in general, specifics may be missing:

ES Exhibit 1:

- A. Life Insurance option – We view LTC to be a health issue not a death issue; it is unlikely that death benefits are distributed equitably; most death benefits are confined to meager funeral expenses:

^ Kupuna Caucus Position #1 - The KC-DPH opposes life insurance as an alternative to mandatory health insurance benefit coverage.

- B. Mandatory LTC insurance – LTC contributions must be shared equally with employer; current Hawaii PHC covers 90% of full time workers and government costs are minimal since only standards need pre-approval by a small staff, it is “industry driven”; self-employed are not included because of instability of work record and their contributions would be double the employed; work record should be adjusted for spousal contributions; 10 year eligibility clause needs flexible point swap provision; 365 day penultimate life estimate is rash and needs humane input; HPHC uses only 2 part time employees to certify eligible plans:

^ Kupuna Caucus Position #2 - The KC-DPH endorses the LTC Commission recommendations on mandatory LTC coverage with our stated exceptions.

- C. Regulatory Reform: the Caucus recognizes that many kupuna needs are met by ohana and undocumented community support but we also recognize that opacity of information about senior care facilities is the major crime and scandal of the current era; family members must make immediate selections for

placement without any transparent information about the safety and honorability of facilities; the State House Health Committee has steadfastly refused to allow inspection information to be transparent and online:

^ Kupuna Caucus Position #3 - The KC-DPH endorses the LTC Commission recommendations on regulatory, information transparency and centralization of access reform for all kupuna care related facilities.

D. Aging and Disability Centers: the Caucus is unsure about lumping aging with disabilities, the range seems too immense.

*/Full Disclosure: I, Patrick Stanley, in 1967, crafted the first draft of a Bill for an Act to establish the Hawaii mandatory PrePaid Health Care law while a Legislative Research Bureau researcher at the request of Senator Nadao Yoshinaga. The bill, as submitted, was converted into a Resolution to study the matter. Professor Stefan Rheisenfeld, University of Chicago, was consulted and produced a revised version three years later. His revised draft became an Act signed into law by Governor Ariyoshi in 1971. Years later I was also an unrelated employee of the Hi Dept of Labor which had been entrusted to administer the law. The following comments reflect this experience and have been acknowledged by the Caucus./

end

Subject	Long term care
From	kikuo harada <kandn@hawaiiintel.net>
Date	Wednesday, January 4, 2012 5:59 pm
To	dnixon@hawaii.edu

This has been an on-going concern for many years. I believe the commission has made comprehensive recommendations. I think everyone should be responsible in some part for their future need, like Social Security. Education is a must first step. Thank you for your hard work. Aloha, Nancy

*Kathleen M. Jaycox
559 Pauku St.
Kailua, HI 96734*

January 6, 2012

To the Members of the Hawai'i Long-Term Care Commission:

I am writing in support of the actions proposed in your final report to the Legislature.

Thank you very much for the time and energy you devoted to researching the key issues discussed in your report. I must admit, as a senior citizen who is able to pay my own monthly premiums for long-term care insurance, I was initially surprised by your second recommendation, discouraging tax incentives for the purchase of such insurance. But as I read your report, the arguments you presented soon led me to agree with you. It is important for the future of our state that we think about the needs of an aging population across all income levels.

I also appreciate the fact that you have addressed the need for balance between institutional care and other care options, especially home-based care. Clearly, more and more community- and home-based options will be needed to deal with the increasing percentage of the population who will need long-term care.

In your report, you have identified the very tricky "tightrope issue" of keeping long-term health care affordable both for the individual and for government. I think that your recommendations provide some very concrete starting points which can address this balance. In particular, you note the need to streamline the diversity of agencies with whom individuals must work as they move through long-term care. I definitely support this idea!

Again, many thanks to all the commission members for your hard work.

Sincerely,

Kathleen M. Jaycox
jaycox@hawaii.edu
261-7846

Subject	LTCC Report - Public LTC Insurance Program
From	Anthony Lenzer <Tlenzer@hawaii.rr.com>
Date	Wednesday, January 4, 2012 3:11 pm
To	dnixon@hawaii.edu

Dave:

A few things come to mind: (1) given the extensive actuarial and other work that went into designing the 2003 Care Plus Program, I'm curious why this couldn't have been updated to produce an estimated premium cost, especially since the currently proposed program is much more strictly defined and limited; (2) the Commission seems to be convinced that this is the way to go, yet is very hesitant in coming right out and saying so; is this primarily out of fear that people seem unwilling to pay for it and legislators are averse to adding new taxes? In short, that it might be politically unfeasible? If so, shouldn't a one major focus of the proposed public Education campaign be educating the public about the value of a mandatory insurance program?; (3) one of the recognized disadvantages of the insurance program is that it leaves a lot of people out; true, but, so what? It brings a lot more people IN, most of whom will never have private LTC insurance or will figure out how to use their life insurance for this purpose, and therefore will be stuck with paying out of pocket (I assume it will be increasingly difficult to qualify for Medicaid, even if people are willing to apply); and (4) finally, I'm wondering if the Commission or its staff was concerned about the legal challenges to the mandatory insurance provisions or the Federal Affordable Care Act, and whether a similar challenge might be brought against this program.

Anthony (Tony) Lenzer
Professor Emeritus of Public Health
University of Hawaii at Manoa



To: Long Term Care Commission
Mr. Stuart Ho, Chair
c/o David Nixon

Date: January 6, 2012

Re: **Report of the Hawaii Long-Term Care Commission, Draft Final Report**

Chair Ho and Commission Members:

My name is Barbara Kim Stanton, State Director of AARP Hawaii. AARP is a membership organization of people 50 and older with nearly 150,000 members in Hawaii. We are committed to championing access to affordable, quality health care for all generations, providing the tools needed to save for retirement, and serving as a reliable information source on issues critical to Americans age 50+.

AARP commends the commitment and careful deliberations that resulted in the Long-Term Care (LTC) Commission's Draft Final Report.

As the Draft Final Report clearly outlines, Hawaii's system of LTC has serious problems. According to the Commission's Report, the cost of a private pay nursing home in Hawaii exceeds \$132,000 annually. That is a staggering \$11,000, on a monthly basis, and well beyond the financial reach of most Hawaii residents. As a result, most seniors will opt to live in their home as long as possible. Family caregivers are shouldering the burden of caring for their loved ones, and on any given day in Hawaii, nearly one out of 5 people provide caregiving services. Caregiving is a 24-hour job, and the resulting caregiver burnout may force seniors into nursing homes which will result in higher long-term care costs for individuals and the State.

Ironically, instead of home and community based LTC services, the Hawaii LTC system is skewed heavily in favor of institutional services. Hawaii faces serious challenges in encouraging more private funding into the LTC system and making better use of public funding, especially Medicaid. We note that the 65 and older population is expected to increase by 71% from 2010 to 2030 and that the State is not prepared to adequately address the LTC challenges at our doorstep. Thus, we believe the Commission's focus in the Draft Report should be on concrete steps that Hawaii can take now to reform LTC.

In that spirit, the following are our comments on the stated recommendations in the Draft Report and recommended revisions to the Draft Report. Our comments address the recommendations in the order that they appear in the Draft Report and do not reflect AARP's position about their relative importance.

Comments on the Commission's Draft Recommendations

1) Conduct a long-term care education and awareness campaign

AARP agrees with the Commission that “there is little evidence that long-term care public education campaigns have much impact on behavior.”¹ In fact, AARP membership surveys showed that approximately 29% of those surveyed were misinformed and thought that LTC services would be paid by Medicare, when in most cases it does not. Despite the low impact of LTC education and awareness campaigns in other states, nonetheless, there is no question that that elevated public awareness of LTC is essential to solving the LTC problem. Meaningful reform would be difficult without a public that is better informed about LTC risks, costs and availability to themselves and their families.

AARP generally believes that a public awareness campaign should be but one of a number of elements of LTC reform in Hawaii. Further we believe that the private and non-profit sectors have a critical and in fact, necessary role for any public education and awareness campaign.

2) Do not enact tax incentives for the purchase of private long-term care insurance

AARP does not universally support or reject state tax incentives designed to encourage the purchase of private LTC insurance, but encourages policymakers to consider both the impact on tax revenues and who the incentives will likely benefit. As the Commission notes, tax incentives “may or may not induce very many people to change their behavior and purchase private insurance” and tend to benefit largely those people who would have bought policies without the tax incentives.² In such cases, the government cost per additional policy sold may be high. AARP also recognizes that these state tax incentives are often regressive – providing greater benefit to higher income individuals.

3) Encourage life insurance as a source of private long-term care funding

The Commission is encouraging the development of life insurance options as a source of private LTC funding which is an intriguing idea. This concept has been previously considered, but has not come to fruition due to many challenges. The proposed accelerated death benefit options for LTC first arose in the 1990’s, but there has been little growth in this sector with many insurers abandoning the options altogether.³ The recommendation to mandate the offer of accelerated death benefits may impact the prevalence of employer-sponsored life insurance policies, and the legality of such a mandate under state and/or federal law needs to be determined.

AARP’s policy is that states that do allow this funding mechanism should “regulate accelerated death, life settlement, and viatical settlement benefits to ensure full disclosure of information to consumers on the effect of accelerating benefits and should ensure that consumers receive fair actuarial compensation for the value of their life insurance.”

4) Support funding for Kupuna Care

¹ Draft Report page 20.

² Draft Report page 37.

³ Can 1 + 1 = 3? A Look at Hybrid Insurance Products with Long-Term Care Insurance, page 7, AARP PPI, 2007

AARP strongly supports the continued maintenance and growth of Kupuna Care, and expansion of vitally needed long-term services and supports. This program provides funding for services to populations who are not eligible for Medicaid, but cannot afford services or insurance on their own. While the recommended sliding fee schedule could be a method to generate additional revenue and expand LTC, we believe that any such scale should be set at levels to protect low income beneficiaries and to not exclude individuals who cannot afford to pay fees.

5) Establish a limited, mandatory public long-term care insurance program in Hawaii

This recommendation raises many political and practical challenges. While not opposed to such a program in principle, indeed AARP actively supported the CLASS Act as part of the Patient Protection and Affordable Care Act (ACA), further study is needed as to the feasibility of a state public long-term care insurance program, given the current political and economic environment.

6) Reform the regulation of domiciliary care facilities, including Adult Residential Care Homes, Extended Care Adult Residential Care Homes, Community Care Foster Homes, and Assisted Living Facilities, and nursing homes

Given the evidence of poor quality of care in certain residential care facilities in Hawaii,⁴ we agree that regulatory reform is necessary. AARP supports strong oversight and state funding to ensure the quality of all residential care facilities and supports regulatory programs that reduce complexity in the LTC system. The State should:

- provide ongoing monitoring and independent evaluation of state LTC systems with meaningful consumer input;
- focus monitoring efforts on improving resident outcomes;
- provide sufficient oversight infrastructure, resources, expertise, and commitment to LTC quality; and
- set licensing standards that address quality-of-care issues, including requirements for an adequate number of well-trained workers and a range of services to meet consumers' needs, safety, and sanitation.

7) Consolidate Hawaii state departments responsible for long-term care into a single agency or department to improve accountability, efficiency, and policy coordination

This recommendation represents a potentially promising approach to streamlining the LTC system in Hawaii, achieving more consistent policymaking and enhanced economies of scale, and simplifying the consumer's experience. This recommendation to consolidate operations allows for increased flexibility, particularly when the consolidated agency has budgeting authority to shift funds among LTC services, to increase spending on HCBS, and to improve consumer access to those services. Consolidation, including global budgeting, by giving responsibility for the budget of all LTC programs to a single administrative unit would allow the financing to follow consumers through the system as their needs and preferences change over time.

8) Strengthen Aging and Disability Resource Centers and expand their role

⁴ See Draft Report page 61.

Hawaii's ADRC program needs improvement. AARP's recently published State Long-Term Services and Supports Scorecard (the "Scorecard") ranks Hawaii 41st in ability to access LTC through an ADRC or other single entry point.⁵ The ADRC program provides states with an opportunity to effectively integrate the full range of LTC into a single, coordinated system. The expanded responsibilities of the ADRC contemplated by the Commission here, specifically serving as the single point of entry for the new public long-term care insurance program (if established) and Kupuna Care, raise questions on whether federal funding would be available for these services and whether the ADRC will be tailored to qualify for additional funding under the ACA. Even with any such proposed expansion, it is important not to lose sight of the broader, core purposes of the ADRC and the goal to use the ADRC to help people access home and community based services (HCBS) where possible.

Recommended Additions to the Draft Report

In reviewing the Draft Report, two areas should be more fully addressed by the Commission.

Establishing Clear Steps Towards Rebalancing

As noted by the Commission, Hawaii's Medicaid Quest Expanded Access program's "financing and delivery system is highly skewed toward institutional care," even though Hawaii residents have indicated a strong preference for receiving care in their homes.⁶ The Commission states a clear goal to "Change the balance of institutional and home and community-based care,"⁷ and increased emphasis by the State is needed to address the HCBS supply deficiency and financing imbalance in Hawaii.

Rebalancing should be a main focus of LTC reform in Hawaii. The recent AARP Scorecard gives Hawaii low marks on rebalancing efforts.⁸ States across the country are realizing that rebalancing is a proven strategy that can be pursued immediately to slow Medicaid cost growth in the future. Although the new Quest Expanded Access program in Hawaii has shown some promise in promoting HCBS, rebalancing still stands out as an area for improvement and warrants more direct attention by the State.

Pursuing Appropriate Federal Funding Opportunities

The State should also take advantage of the significant federal funding opportunities and incentives available to the state under the ACA to help promote a better balance between HCBS and institutional services. For example, as Hawaii currently spends less than 50% of its Medicaid LTC dollars on HCBS, Hawaii is eligible for a 2% increase in its federal match rate for LTC by

⁵ Hawaii: 2011 State Long-Term Services and Support Scorecard Results. AARP, the Commonwealth Fund, and the SCAN Foundation. September 2011.

⁶ Draft Report page 1.

⁷ Draft Report page 2.

⁸ The Scorecard ranks the state 42nd in percentage of Medicaid and state-funded spending going to HCBS options compared to institutional care for older people and adults with physical disabilities, 33rd in percentage of new Medicaid LTC users first receiving services in the community, and 2nd in percentage of nursing home residents with low care needs.

implementing structural changes to its Medicaid program.⁹ Hawaii can also choose to take advantage of the Community First Choice Option – a new Medicaid state plan option that covers attendant care services and supports for Medicaid-eligible individuals with institutional level of care need. Using this option, Hawaii would receive a 6% increase in Medicaid federal match rate for expenditures related to this option.

It is a federal Medicaid priority to improve the LTC sector in ways that will slow Medicaid spending and the ACA provides a time-limited opportunity for states to access funding to accomplish this goal. The Draft Report should encourage Hawaii to carefully explore these and other funding options and aggressively pursue opportunities that will assist the state in meeting its LTC rebalancing goals.

In summary, we urge the Commission to focus on recommending major concrete steps to accelerate LTC reform to address the needs of Hawaii's rapidly aging population.

Thank you for the opportunity to provide comments.

⁹ State Balancing Incentive Payments Program - Initial Announcement, available at <https://www.cms.gov/smdl/downloads/Final-BIPP-Application.pdf>.



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January 6, 2012

Hawaii Long Term Care Commission
Public Hearing
State Capitol Room 229
415 S. Beretania Street
Honolulu, Hawaii 96813

Comments provided by the American Cancer Society regarding Long Term Care in Hawaii
Jackie Young, Chief Staff Officer
Cory Chun, Government Relations Director

Thank you for the opportunity to share comments regarding long term care in Hawaii. The American Cancer Society (ACS) is the nationwide, community-based, voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer, through research, education, advocacy, and service.

ACS would like to thank the Commission for their work in providing viable solutions to solve our long term care crisis. Here in Hawaii we continue to see a strong correlation between the age and cancer incidences. As the age of our population rises, so too will the state's cancer incidence rates. The findings of the Governor's Blue Ribbon Panel on Cancer Care in Hawaii, established in 1999, found that:

“Overall, Hawaii’s world standard, age adjusted incidence rates for cancer exceed the world average. In Hawaii, for virtually every cancer site, one observes considerable ethnic variation in both incidence and mortality. Cancer incidence increases quite dramatically with age. Based on Hawaii’s aging population, the number of Hawaii citizens with cancer is expected to double over the next 30 years.”¹

Long-term care is a serious health concern for not only cancer patients, but for the entire population. As the population ages, however, we are concerned with the rise in cancer incidences and the care required for the treatment of cancer. The American Cancer Society will continue to work with community health providers and stakeholders to address this pressing issue. Thank you for the opportunity to provide comments.

¹ The Governor’s Panel on Cancer Care in Hawaii, 2002 Final Report, Appendix I.

UNIVERSITY of HAWAII
MANOA

Hawaii Long-Term Care Commission
Mr. David Nixon, Administrator

RELATING TO LONG – TERM CARE REFORM IN HAWAII: REPORT OF THE HAWAII
LONG- TERM CARE COMMISSION, DRAFT FINAL REPORT, 13 DECEMBER 2011

LONG TERM CARE COMMISSION

Public Hearing – 6 January 2012

2:00 p.m., State Capitol, Conference Room 229

By Keith T. Ribbentrop, United States Air Force (Ret)

Having read the Long-Term Care Commission Report, I am surprised to see little mention of long term-care programs available to our state's military veterans including their implications to other state programs. Our veterans have made valuable contributions to our country by protecting our Nation's ideals. Today the state veteran population is in excess of 120,587 representing approximately ten percent of Hawaii's total population. Roughly speaking, Hawaii's veteran population aged 45 and older is 88,000, 44,000 of which are over the age of 65. The veteran population is relatively stable and, by the year 2030, veterans aged 65 or older is projected to exceed 38,000.

There are three primary entities that offer care and finance to Hawaii veterans. They within Hawaii, the State Veterans Home program (SVH), under the Dept. of Veterans Affairs (VA), the Veterans Health Care Administration (VHA) and the Veterans Benefits Administration (VBA). Identifying who is best suited to provide services can be a daunting task.

Currently, the Yukio Okutsu State Veterans Home – Hilo is the only SVH. It is a 95 bed SNF/ICF facility that also offers an Adult Day Health Care Program. This facility is managed by contract and there is no operational or maintenance cost to the State. Eligibility for the SVH is determined by the state and includes veterans who are disabled by age, disease or those incapable of earning a living due to disability as well as spouses who have not remarried and Gold Star parents. Services available include domiciliary, nursing home and adult day health care. VA standards for the SVH program mandate facility and quality of care that exceeds Medicare/Medicaid standards.

The VA carries out funding for the SVH program by way of two grant-in-aid programs. It may participate in up to 65 percent of the cost of construction or acquisition of State nursing homes or domiciliary or for renovations to existing State homes. When a State accepts VA SVH construction grant assistance, at least 75 percent of the bed occupants at any one time at the facility must be veterans. Twenty five percent may be spouses of veterans who have not remarried. The second part of the grant-in-aid program is per diem payments for the care of eligible veterans in State homes. There are two types of per diem: the Basic Rate and an Enhanced Rate. Paid monthly for each veteran in residence, the Basic Rate is paid in addition to any Medicaid reimbursement. Public Law 109-461 established an Enhanced Rate per diem. The Enhanced Rate reimburses the SVH for the actual cost of care for each veteran with a Service Connected Disability

rated 70 percent or greater. Currently there are 3,100 veterans in the state eligible for Enhanced Rate per diems IF there were SVH facilities available.

It is not reasonable to expect that people, who spend their entire lives in a location, abandon their community and family ties for the sake of long-term care. Hawaii's unique geography poses challenges. The VA has allotted a total of 216 SVH beds to the State of Hawaii. Of the allocated beds, 95 are at the Yukio Okutsu State Veterans Home – Hilo. The remaining balance does not appear to be sufficient to meet the needs of Kauai's 6,300 veterans (2,600 older than 65), Maui's 11,751 (4,900 older than 65), or Oahu's 80,969 (29,000 older than 65).

Federal VA benefits provide a wide range of long-term care services including nursing home care, domiciliary care, adult day health care, geriatric evaluation and respite care. Nursing home benefits may be provided if specific qualifications are met. Those are: a veteran must be in need of such care and seeking nursing home care for a service-connected (SC) disability, a veteran is rated at a 60% SC disability and is unemployable, a veteran is rated at a 60% SC disability and is permanently and totally disabled (P&T) OR for any condition if the veteran has a combined SC disability rating of 70% or more. The care will be provided in a VA nursing home or contract nursing home. Non Service Connected (NSC) and non-compensable zero percent SC veterans can apply for long term care in the VA but could be subject to long term care co-payments. Veterans with a compensable service-connected disability are exempt from long term care co-payments in Federal facilities. NSC veterans applying for extended care or nursing home care may be a subject to determination of the family's current income and assets. Veterans requiring nursing home care for a service-connected condition or a veteran rated at a 70% or greater SC have mandatory eligibility for admission to Extended Care Services; and, those veterans are eligible to have indefinite care provided to them in the VA or in a VA contracted nursing home.

It is important to note that the VA is composed of several administrations; and as just as important to know that the VA has no real means of effective of internal communication about a veteran or their status.

Following is a very brief and limited summary of the plethora of programs offered under the Veterans Health Care Administration; Geriatrics' and Extended Care Unit (long-term care). Please note that each of options offered by the VA has different eligibility and admission requirements and may not be available because of lack of qualified service providers:

- VA Community Living Centers - Provide short-stay and long-stay nursing home care to Veterans on or near a VA medical center property.
- Community Nursing Homes - Provide care for Veterans in community nursing homes that have a contract with a VA medical center.

- Respite Care - Provides Veterans with short-term institutional and non-institutional services in order to give the Veteran's caregiver a period of relief from the demands of providing daily care.
- Residential Care - Community Residential Care and Medical Foster Homes provide room, board, and personal assistance for Veterans who do not need nursing home care but are unable to live on their own.
- Adult Day Health Care – Therapeutic day program
- Home Based Primary Care - Provides long-term primary care to chronically ill Veterans in their own home.
- Homemaker and Home Health Aide - Provides home and community based services to Veterans needing nursing home care.
- Purchased Skilled Home Care - A professional home care service that VA medical centers purchase from private-sector providers.
- Community Residential Care and Medical Foster Homes - Provide room, board, and personal assistance for Veterans who do not need nursing home care but are unable to live on their own. Medical Foster Homes Programs match a Veteran with a community caregiver who takes the Veteran into their home and provide 24-hr supervision and assistance.
- Hospice and Palliative Care - Provides comfort-oriented and supportive services for Veterans with advanced life-limiting disease.

Additional Benefits monetary benefits from the VA Benefits Administration include Aid and Attendance and Housebound benefits:

Aid and Attendance (A&A) is a benefit paid in addition to monthly pension. This benefit may not be paid without eligibility to pension. A veteran may be eligible for A&A when:

The veteran requires the aid of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting himself/herself from the hazards of his/her daily environment, OR,

- The veteran is bedridden, in that his/her disability or disabilities requires that he/she remain in bed apart from any prescribed course of convalescence or treatment, OR,
- The veteran is a patient in a nursing home due to mental or physical incapacity (note: income derived from VA Pension, Aid and Attendance is subject to Medicaid recovery it allows the Veteran to retain a greater monthly stipend.)

Housebound is paid in addition to monthly pension. Like A&A, Housebound benefits may not be paid without eligibility to pension. A veteran may be eligible for Housebound benefits when:

- The veteran has a single permanent disability evaluated as 100-percent disabling AND, due to such disability, he/she is permanently and substantially confined to his/her immediate premises, OR,
- The veteran has a single permanent disability evaluated as 100-percent disabling AND, another disability, or disabilities, evaluated as 60 percent or more disabling.

Award of a non service connected disability pension by the VBA and/or Aid and Attendance and Housebound programs allow veterans greater access to VHA Health Care Administrations Long Term Care programs.

Recently, AARP conducted a long-term care awareness workshop in Hilo. The workshop was very well attended largely due to curiosity and concern about potential long-term care issues. I believe that continuing public education is necessary spotlighting individual programs and their specific benefit limitations and requirements. Additional funding is needed for the Hawaii State Office of Veteran's Services to provide outreach, education, and claims assistance to veterans with service connected disabilities as well as non-service connected disability pensions to veterans, spouses and spouses who have not remarried after the death of a veteran. Beginning with service to the 89,000 veterans on Oahu, a State Veterans Home and its programs need to be established on each Island. These Homes provide high quality long – term care at little or no cost to the State or the individual. Further, SVH program expansion could potentially increase the overall availability of long-term care beds and could significantly reduce or eliminate certain State costs paid to programs cited in the Commission's Report.

Thank you for the opportunity to comment on the Commission's report.

Post Office Box 29, Volcano HI 96785-0029

Telephone: (808)967-7563

Email: keith.ribbentrop@gmail.com

Subject	Senior Long term care report
From	Dave Pratt <davepratt00@yahoo.com>
Date	Friday, December 30, 2011 9:00 am
To	"dnixon@hawaii.edu" <dnixon@hawaii.edu>

Sir,

I fully admit that I haven't read the report and have only read the article in West Hawaii today. So, if you choose to discount my opinions, fine. That being said, as a recent retiree and having just moved to the Big Island, I feel that I have a say in the matter at hand. From the article and other reports like it, the answer always seems to be abdication of personal / familial responsibility in favor of another government program with the associated organizational infrastructure, taxes, and laws. Nobody is forcing us to live in a state that has the "4th highest cost of in the nation". That is our choice and not all choices are good ones. If I can't cant afford to live here, I should move to some place or in with some one where I can. So, that being said, I am opposed to another government program to cover for people who don't want to plan at the expense of those who have.

Dave Pratt
From the home / personal account

Testimony
Submitted to
The Hawaii Long Term Care Commission

by
Jeanette C. Takamura, MSW, PhD

Chairman Ho and Members of the Long Term Care Commission:

My name is Jeanette Takamura. I am Dean of the School of Social Work at Columbia University. From 1987 to 1994, I served as Director of the Executive Office on Aging and from 1995 to late 1997 I was Deputy Director of the Hawaii State Department of Health. Subsequently, I served as Assistant Secretary for Aging in the U.S. Department of Health and Human Services. My testimony is submitted as a private citizen and resident of Hawaii.

I learned recently of the Commission's engagement in the development of a comprehensive assessment of Hawaii's existing long term care system and of recommendations to address the state's long term care needs. Arguably, these are needs that will grow ever more dramatically in the future, particularly with the aging of the baby boom population. The Commission is to be commended for its efforts and in particular Chairperson Stuart Ho should be acknowledged for giving voice to very real, persistent issues that require courageous, responsive action by policymakers. At the urging of Barbara Kim Stanton, Executive Director of AARP in Hawaii, I am submitting this hastily drafted expression of concern and support. Please note that I received a copy of the Commission's report yesterday afternoon and have not had an opportunity to peruse it in full. Nonetheless, hopefully the historical context provided in this testimony and lessons that have been learned in preceding decades will help to illuminate the necessity for bold action. If the past is instructive, it is entirely possible that inaction will continue to be the course taken once again. Unfortunately, policy inaction will mean that many will continue to suffer now and in the decades ahead – not just older persons, but their family members of all ages.

Since the 1970's, long term care has been an issue on the state's aging policy agenda. Two decades later -- at the start of 1991, the Executive Office on Aging (EOA) presented Financing Long Term Care: A Report to the Hawaii State Legislature to review the dimensions of the long term care financing challenge before the state. The report conveyed findings in one of three areas examined by the EOA and three public-private sector committees. The other areas were: the long term care service system and the quality of long term care services, all in the State of Hawaii. This tri-prong effort was itself part of a larger state-funded endeavor which included an extensive multi-year public awareness campaign, programs to improve quality of care, and an effort to increase the supply of long term care services for-fee through a business development initiative.

To be more specific, for example, the EOA conducted a comprehensive multiyear public awareness campaign that included:

- Two years of a state-funded, EOA produced television series called *LTC: Let's Take Charge!* that aired on Hawaii PBS weekly. The series offered information to familiarize the public with long term care, chronic conditions, and care techniques, assistive devices, and services that could be utilized by caregivers and individuals needing care.
- A multilingual telephone access-line (called SAGEline) that provided a menu of recorded information about aging and long term care services to callers in Chinese, Japanese, Ilocano, Samoan, and other languages.
- Community information sessions on long term care that were conducted on all islands, that involved the area agencies on aging, and were often facilitated by public sector retiree organizations.
- Multilingual *LTC: Let's Take Charge!* informational materials that were available throughout the state.
- Caregiver training programs through the community colleges throughout the state.

Concomitantly, EOA received funds from the Legislature to establish a LTC Business Development Fund that awarded start-up monies to private sector organizations and individuals who had developed an acceptable business plan

for long term care services for-fee. A business development training program was contracted through Kapiolani Community College and interested parties were enrolled and provided assistance with the formulation of long term care business plans.

While the foregoing were conducted, the Family Hope Program proposal to address the knotty long term care financing issue was placed before the Legislature. The proposal was developed by EOA staff and a team of consultants that included two individuals in Hawaii along with the Actuarial Research Corporation, Lewin-ICF, Dr. Judith Feder of Georgetown University, Edward Howard who was General Counsel of the U./S. Bipartisan Commission on Comprehensive Health Care, and others. EOA and its consultants recalibrated the 22,000 person sample used in the Lewin-ICF simulation model to resemble a randomly selected profile of Hawaii's population and ran a number of long term care financing options through to assess the outcomes of each option in relation to the sample population.

The Family Hope Program proposal called for a mandatory state long term care financing program which included opportunities for supplemental private long term care insurance for either the front or back end of coverage. It was supported by many aging service, advocacy, retiree, professional, and other organizations and opposed by business and insurance lobbies. Had the proposal been enacted as late as 1995, those who had paid into the program would now have been insured for many years. They would already have access to coverage for home and community based as well as institutional care.

Versions of the Family Hope Program were reintroduced year after year. And since 1991, there have been a number of commissions and long term care studies produced under the aegis of the state. Bold leadership was provided by former First Lady Vicki Cayetano in an attempt yet again to address the financing conundrum. A long term care financing measure was passed by the Legislature several years ago and was later vetoed by then Governor Linda Lingle.

An aging agenda that has included long term care as a component for nearly 40 years and commissions, studies, and public education conducted for more than two decades have not persuaded policy makers. What we learned in the process of designing the Family Hope Program remains germane today: benefits cannot be expected at no cost. The cost of long term care is inescapable. Long term care services and the “system” that still needs to be built to meet Hawaii’s people’s needs cannot depend upon legislative funding on a year-to-year basis. Government line-item funding is not reliable, and family resources are typically inadequate to shoulder the expenses entailed in long term care.

There simply are no easy answers and no right time. Likely the only way to pay for the protection of Hawaii’s individuals and families is through a mandatory, tax-based program that links payments by individuals to their earned benefits. But this takes courage.

Let me add my appreciation to the Commission for its work. Let us hope that it has not been in vain.

Thank you for permitting me to submit this testimony on an issue that will only grow in magnitude with the aging of the Baby Boomers

Subject	Report of the Hawaii Long-Term Care Commission Draft Final Report (Comments from Josephine Keliipio)
From	"J.Lilinoe" <j.lilinoe@gmail.com>
Date	Friday, January 6, 2012 8:10 am
To	David Nixon <dnixon@hawaii.edu>

Aloha,

As a 58 year-old senior taxpayer, voter and an advocate for elderly independent living, the following are my comments on the HLTCC Draft Final Report:

1) According to the landmark Starfield Study (JAMA, 2000), the US medical system is the THIRD leading cause of death behind cancer and heart disease. In addition, more than 100,000 patients die each year due to taking drugs as prescribed to them by their own doctors. The reason why this information is important to me is because if the medical system and doctors are responsible for KILLING these many people, can you imagine how many people are INJURED and become unable to care for themselves because of the US medical system? I wonder how many of these sick and disabled people are ending up as long-term care patients due to medical system induced disabilities and sicknesses?

2) While I don't have any studies about the food that we are eating I do know that much of the food that the average person eats is either highly processed and filled with poisonous and carcinogenic additives (like aspartame, high fructose corn syrup, MSG, fluoride, etc.) or seriously lacking in vital nutrients that our bodies must have in order to keep us well. When we eat enough of these bad foods, we usually end up having some serious health problems like diabetes, obesity, cancer, etc. and become sicker sooner in our lives and for longer periods of time. I wonder how many of these sick and disabled people are ending up as long-term care patients due to a food system that makes us sick and keeps us sick?

Bottom line is that while the HLTCC Draft Final Report speaks the lack of adequate long-term care facilities and financing for them it fails to address ways in which we can keep our aging population healthier so that they DON'T need to use these facilities at all or so early in their lives. I know it is a sensitive subject to admit that the medical system and our food system might be the primary culprits in causing so much illness and disability but I don't see how we can discuss long-term care w/o addressing these factors.

Mahalo,

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