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NEW YORK STATE ADVISOTY COMMITTEE TO THE U.S. COMMISSION ON CIVIL RIGHTS

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26 Federal Plaza

New York, New York

December 4, 1991

2:35 P.M.

B E F O R E: Dr. Setusuko M. Nishi, Chairperson

A P P E A R A N C E S:

TINO CALABIA
PAULA CIPRICH
RICHARD COX
ARNSTEIN MURRAY
JUAN PADILLA
JEFFERY AMBERS

P R E S E N T E R S

JOSEPH KENNEDY - U.S. Department of Health and Human Services
MICHAEL R. CARTER - OCR Investigations Division
DR. LAUREN PETE - New York Hospital Association
CARMEN V. CUNNINGHAM - President, Affirmative Action Programs
MARIO TAPIA - President, Latino Gerontological Center
SARA VIDAL - Office of Andrew Stein

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DR. NISHI: We will now open the meeting with regard to nursing homes with regard to older minorities.

Good afternoon, my name Setsuko M. Nishi. I am a professor of sociology in the graduate center of the City University of New York and at Brooklyn College, and I chair the New York State Advisory Committee to the U.S. Commission on Civil Rights.

To my left is Paula Ciprich; professor Richard Cox from Buffalo; Mr. Arnstein Murray from Albany and Mr. Juan Padilla from Rochester and to my immediate right is Mr. Tino Calabia who is the staff community and staffs the northeast -- the five states of the northeast.

The members of each of the Commission's State Advisory committees are residents of different areas of their respective states and they serve as 'the local eyes and ears' of the eight Commissioners in Washington, D.C. who appointed them.

The Commissioners and their 51 state advisory committees inquire into issues pertaining to discrimination or the denial of equal

protection based on race, color, religion, gender, age, disability or national origin, or in the administration of justice.

Let me welcome our speakers and other guest, two of whom who have offices in this building, while others have come from as far away as Albany. They have been invited to share information and their views on long-term shelter and nursing care for the minority aging. We are looking at the older population in the New York State's minority communities and to what extent these residents may or may not enjoy equal access to long-term shelter, such as in nursing homes. As some have you know, litigation on behalf of minority group members seeking nursing home admittance has occurred in Tennessee and Pennsylvania.

Because of your work with older New Yorkers, our committee is gratified that you have volunteered to provide information and offer your views today. This forum was organized to complete work begun last year, when several of the agencies invited then could not get to Buffalo where the original forum took place. I should add that, as

before, the press was informed of today's forum, and any members of the audience will have a reasonable opportunity to offer comments as well.

The procedures are being tracscribed and the transcript will be maintained in the offices of our Washington staff in accordance with the Privacy Act. Let me explain that for access to information provided by you and stored in Washington, you may contact the Commission's solicitor at the address shown on the agenda.

Federal law also requires that all persons refrain from degrading or defaming any individuals when providing information. At the same time, all persons presenting information have the right not to be reported or photographed by the media. Should you wish to exercise this right, please let us know so that your request can be accommodated.

We plan to issue a summary report of the two forums. It will be based on the transcript, supplementary interviews, and any other relevant information now in our staff's files or obtained in the coming weeks. Having stated these requirements and our plan, let me introduce the

first of our guests. Mr. Joseph Kennedy and Mr. Michael Carter of the U.S. Department of Health and services. Thank you for being with us.

MR. KENNEDY: Good afternoon, my name is Joe Kennedy. I am acting regional manager of New York and Michael Carter is the branch chief of the investigator division.

As manager of the New York region, I represent the national director of the office for Civil Rights, Edward Mercado. On behalf of the staff herein, Region II, I welcome the opportunity to speak before you today on nursing home care and civil rights for minority elderly. I find it gratcifying that in the time of economic stress that we're not so consumed with the problems of the economy of minority care and their need for adequate nursing care.

Unfortunately, the problems of economic downturn and the problems associated with elder care are not free of the dynamics that affect all segments of our society. These dynamics include the ever present influence of discrimination in its many forms. The network of human and social services programs is extensive. Yet, a common and

redundant theme continues to rear its ugly heed. If you are poor African American or poor Hispanic; if you are not of the same native land; if you do not practice the same religion, your request for benefits of being an American and your Civil Rights may be denied. The office for Civil Rights in the agency within the Department of Health and Human Services is charged with the responsibility of monitoring the performance of recipients of federal financial assistance to determine whether they are complying with the applicable Civil Rights laws.

In the case of the Nursing Home Act, of 1964, Section 504 of the Rehabilitation Act of 1973, the community service assurance of the Leo Burton Act, Omnibus Reconciliation Act of 1982. While each of these provisions provided specific coverage in areas relating to the handicapped community residents and the aged OCR through Title VI protects the rights of minorities in the application, admission receipt and other aspects of Nursing Home Services. Title VI read in part no person of the United States shall, on the ground of race, color or national origin be

excluded from participation in, be denied the benefits of, or otherwise subjected to discrimination under any program..."

These words, as written, are succinct and direct, yet the absence of a deterant influence can render the clearest and forceful of laws ineffective.

Accordingly, the Office of Civil Rights maintains a presence in ten Regional offices in the continental United States and it provides coverage through a staff of 325. In the New York Region, it is authorized a staff of 19. This is hardly sufficient to adequately monitor all of the nursing homes in the region on a one to one basis. However, we do have programs in place that allow us to examine targeted areas of concern and respond to complaints that may be filed by the public.

When I came to the New York region in October of this year, I was impressed in the resiclience and the drive that New Yorkers displayed. Nonetheless, Region II shares the same lament as the other regions; to many facilities and not enough staff. The staff here in New York

have conducted more than 2100 compliance actions in the last five years. A number of these were self-generated acts that we commonly refer to as pre-grant reviews.

Pre-grants present an opportunity for the office of Civil Rights to provide instructions, technical assistance and to obtain commitments prior to a recipient obtaining a grant or clearance to participate in the Medicaid or Medicare programs. Typically, it assists in the development of policies, examines procedures and practices and secures corrective action to determine if a recipient and applicant will be able to comply before funds are let.

Despite having conducted more pre-grant reviews in fiscal year '91, the level of compliance review activity is less than enough to have a deterrant influence on the more than 585 nursing homes we did not contact during the year.

Despite the level of self generating activity in the effectiveness in the office is in part control led by the general public. Their willingness to communicate with us, to file complaints of instances of noncompliance and

become aware of their rights if a long way to determine the shape and strategy of the office of Civil Rights. Routine statistics on the number of nursing home residents and ethnicities are not available.

As a general rule, the Department of Health and Human Services does not collect these data. State agencies may have information concerning the number of inhabitants by race in nursing homes. Such information may be available by a request to the nursing home itself.

As a condition of receiving Medicaid certification, many homes have agreed to maintain such data. Much of the federal activity serves as a deterant issue of compliance monitoring and in any of its forms should be sufficient to those who are victims. However, without an aggressive outreach program and a vigorous enforcement program, the public cannot resolve the shield that is there to protect them.

A number of Title VI complaints filed against nursing homes and health related agencies in the last five years is less than 10. We do not believe the numbers reflect the levels of the

discrimination.

In contrast, there may be more than 1,000 filed in other jurisdictions. Particularly Section 504 of the Rehabilitation Act of 1973. Were it not for self-generated activity, Title VI monitoring would be virtually absent. We have known for some time that disproportionately fewer minorities are admitted to nursing homes. Why is this so? Fewer apply disproportionately to their presence for admission because of economic disadvantage impacts the availability of Medicaid among working poor such as those who earn too much money and would be classified as self paid. There is a lack of general attention to health care which means less contact with counselors an social service administrators. There is a general lack of health care professionals and facilities in poor communities.

The sector shows fiscal responsibility to the extent that they show effective management. The inclusive or improvement of private pay profile reflects success African Americans and Hispanics do not resort to institutional care. Medicaid is seen as a last

resort. If a facility is predominantly Medicaid, it is less able to complete for top quality professional services and they are less likely to attract staple employees. Self-selection is a mirage when more generic questions are asked regarding adequate diet, hygiene, safety and security.

African Americans, Hispanics and whites all opt for better conditions when there are choices. Access to family and convenience is critical; however, the location of a nursing home can influence its ability to employ stable and competent staff. Minorities are all too often victims of discriminatory practices of nursing homes. Increasingly, nursing homes have not maintained applicant flow data. Without applicants or complainants, discrimination is hard to prove. Ethnic identification and religion restricts the application by those other than one belonging to a specific group.

While the nursing home that receives Federal financial assistance, it prohibited from restricting admission an uninformed Protestant is less less likely to attend a home identified as a

Catholic institution. Moreover, a Jewish home for the elderly will more likely attract Jewish residents than a Catholic or Hispanic black who may not be of Jewish faith. When charges of denial of the admission are verified the remedies are to rectify the individual harm and take such action to preclude from discrimination from happening again. The remedy may be developed as a result of an OCR compliance review or the result of a Complaint Investigation.

In either events, OCR monitors the performance until it is assured compliance has been achieved.

What are some of the concerns beyond admissions? Services for specific handicaps such as oxygen therapy, HIV individuals, renal dialysis, tracheotomy and tube feedings and those generally thought of as needing heavy care.

The concerns of the handicap magnifies the impact of discriminatory policies ancd practices. If anything, nursing homes may use these as pretext to discrimination. OCR provides technical assistance, monitors performance after grantees through compliance reviews and

complaints.

If it is to be more effective and impact the care of the elderly, it must continue public notices, seminars and workshops; increase the number of compliance activities in the nursing homes; improve internal processing times; improve and maintain dialogue with the community; develop referral networks with State agencies to increase federal involvement.

A common myth that minorities, that is African and Hispanics, take care of their own is a behavior pattern. The notion of self-care is more than altruistic undertaking.

African Americans and Hispanics are two groups that represent poor and as a consequence they have not been a part of the elder care network. For the African American, one would have to divest himself or sign over his assets to gain entry to a nursing home is a replusive thought. African Americans have laws interpreted or had those laws available so that they can benefit. They simply are unaware of the strategies that the wealthy use to avoid giving everything they own to a nursing home.

Also alarming are the practices of hospitals and the referral sources. Their yielding behavior reinforces the perception that minorities have that they are relegated to less durable homes. The result is a system that bars minority consumers from the better facilities and an understanding that they will end up in substandard care.

The truth is minorities have no choices. Seeing a homeless elderly person is a stark reminder that many of those needing nursing care are not self-sufficient and they are not being taken care of by their own. Bring together the forces of the beneficiaries, the recipients and the private sector and the forces of the government. Each must make a contribution to the unending battle for repudiating discrimination. The scourge of apathy dispair and discontent tear at the underpinnings of Civil Rights policy, particularly for those who because of discrimination feel that the system does not work for them. The components that will make a difference are education, outreach government and enforcement component. Yes, we are here to

discuss the plight of the minority elderly in seeking nursing home accomodation.

We are concerned that nursing homes seek profit over principle and quality may lie in our ability to pay the cost of care for those who cannot care for themselves. It is not as simple without examining the problems of yesterday. Our views on discrimination in housing, employment transportation and public accommodations influence our values when it comes to the concerns or lack of concerns for minority elderly.

Currently, the Office for Civil Rights is rising to meet the challenge through a number of actions. We're expanding our outreach efforts to better educate the public. We are developing more efficient strategies. We are developing a training institute to better staff, improve staff skills. We are restructuring the organization to improve the ratio of investigations to the number of staff numbers. We're increasing the volume of nursing home compliance reviews.

The present challenges as we face are not insurmountable but the road to the correct level of vigilance is not easily traveled. So

that when Secretary Sullivan's realization of a long time life span is obtained, the vestiges of discrimination will have been eliminated.

I brought with me Mr. Michael Carter because Mr. Carter has a longer history working in the region and some of the specific questions you may have to answer, I'll have to defer to him.

DR. PETE: Doctor Lauren Pete, New York Hospital Association. The association represents hospitals and nursing facilities in the New York City area and the surrounding community including Nassau County and Westchester.

As I said, we represent over 17,000 beds in the metropolitan area, non-profit facilities. It is not a proof of discrimination of nursing facilites and we do not have a policy of discriminating against minorities. However, in response to Mr. Kennedy's comments, I must say that I would like to see some of the statistics or some of the figures upon which you base your generalizations. Perhaps you have them available but not at this time. We're prepared to give the details because I have a problem with dealing with some of your comments when you start off by saying

that nursing homes don't have statistics on the racial breakdown on residents and their facilities.

If that's true, how can we determine one reason why we don't determine whether or not discrimination is actually going on. Is it based on the statistics we have? If we don't have statistics, how are we jumping to the generalizations you are making? That was my first and major comment. If we don't know who is in the homes, how do we know someone is being discriminated against? Talking about discrimination against any group, age, ethnicities, it's difficult to make because it's one--

MR. KENNEDY: I think you may have misunderstood. I did not say that nursing homes don't keep statistics. I said that in many instances, they are not maintaining applicant flow statistics, which is the number of people who actually apply for services or entry to the nursing home.

DR. PETE: I still would need that too.

MR. KENNEDY: It's only after they have

contact with your office, for example, that many of them are required to do so. In terms of the representation in the nursing homes, they do maintain the actual number of individuals by race and sex within the facility itself.

DR. PETE: That doesn't answer my question because you said you had only less than ten complainces over the last five years.

MR. KENNEDY: Less than ten complaints.

DR. PETE: I still don't see how we are determining a discrimination is going on. It may be true what you are saying -- I don't know where -- I don't know where you found out that nursing homes have been told by their attorneys not to keep these numbers. I assume you can back that up with documentation. I don't know. I have never encountered that. I simply don't know. I'm concerned that we don't learn from generalizations without making some kind of attempt to be a little more specific; otherwise, how can the industry look at themselves, for one thing, and if something is indeed wrong, correct it, when we're dealing with big generalizations. For instance, some of the things you mentioned afterward, you

said that nursing homes were using other things like the kind of services that minorities may need, like deventilators.

DR. NISHI: If you have other question, you have to be brief.

DR. PETE: I have a number of points that Mr. Kennedy had made that I would like to have some kind of documentation or support or I wondered where he got the generalizations from.

DR. NISHI: If you wish to communicate further though, we'd we happy to receive communication to be included.

DR. PETE: Are your comments going to be given to the committee?

DR. NISHI: Your comments have been transcribed. The members of the panel, of course, do have some questions.

MS. CIPRICH: I'll pass.

MR. COX: I'll pass too for now.

DR. NISHI: I have a question. Of course, it was rather sounding to hear there were ten complaints and were you speaking in the period of a year.

MR. CARTER: That's within five years.

DR. NISHI: A five-year period. I understand. What were the outcomes of these ten complaints?

MR. CARTER: First, let me clarify the fact that the ten complaints Mr. Kennedy speaks of, they are services. Admissions, alleged admissions. We have, over that same five-year period received and processed, oh, I would have to say at least several dozens of complaints in the area of employment that relates to nursing homes but in the area of services, the complaints have been ten. The outcomes in those cases have been resolved.

DR. NISHI: What was the nature of the resolutions?

MR. CARTER: The nature of the resolutions varied. In some case, it addressed policies reflected based on race, color or handicap. In other cases, it may have been a series of procedural violations, such as several areas under Section V or IV of the Rehabilitation Act which requires certain kinds of services to the sensory impaired.

DR. NISHI: They came under compliance.

MR. CARTER: OCR, in most cases, prior to the completion enters into a compliance agreement with most of these facilities. One of the things we attempt to do is really to bring them into compliance and if that means through their volunteer effort to agree to a particular corrective action plan, that's what we're concerned with about.

In most cases, it is getting resolution regarding the individual particular complaints as well as making sure that any policies or practices need to be modified or changed or implemented are, in fact, put in place.

DR. NISHI: I would like to pursue another area. The number of complaints filed is not indicative of the extent as it is perceived that there are more instances of unequal treatment. Would you care to comment as to what factors are at work here which keep down the number of actual complaints filed?

MR. CARTER: I would have to say that, Number 1, I think, in many cases, it's an absence of knowledge in terms of the whole beneficiary population that we tend to serve throughout New

York/New Jersey and the Virgin Islands. We have, through the period 1983 to 1987, conducted a number of workshops and conferences and seminars, both addressing the beneficiary population as well as the recipient population. Our attempt there was to try to increase the knowledge on both sides of both rights and responsibilities.

Yet, at the same time, you would think almost that there might result from that same additional kind of complaints. Yes, complaints did come back to us but, as I mentioned earlier, most of those complaints were in the area of employment as opposed to services. So, I would go further to say that the absence of a body of what the roles are of many individuals, I think in many more cases than not, played a major part in the absence of numbers of complaints that you would think we would normally receive.

MR. COX: When you talk about complaints, you are talking about a particular legal procedure, filing of documents of some kind?

MR. CARTER: Well, it doesn't -- I really wouldn't necessarily say it constitutes a

legal procedure in the sense of documents. We receive, Number 1, it can be a phone call that is subsequently turned into a letter basically identifying certain things we need to constitute a complaint but it doesn't really get into the full realm of a real document as it may.

MR. COX: At some point it may?

MR. CARTER: Yes.

MR. COX: And gives rise to litigation maybe?

MR. CARTER: Yes. For example, both OCR as well as other state agencies may be involved jointly in investigations. Several of those have resulted in formal agreements between a recipient institution and both respective parties.

MR. PADILLA: I wonder if you will be able to provide the committee with more statistics filed about the situation so we could then analyze better and make some judgments?

MR. KENNEDY: What would be the nature of the statistics you are seeking?

DR. NISHI: In terms of the breakdown; in terms of protective categories of participation and various kinds -- various classes or categories

or types of nursing home facilities. Data with regard to the complaint and their resolutions.

I'm sure that the complaint process, in the case of violation, if the perceived violation of civil rights resulted in a language and painful process and that for so many, there is a perception that the process does not produce what they had hoped might occur. So that it is of interest to us to know what the outcomes were of the complaints that were filed.

MR. MURRAY: I'd like to know what area of the state those complaints come from.

MR. CARTER: The ten complaints that I mentioned would cover the entire Region II area. That would be New York/New Jersey, Puerto Rico and the Virgin Islands.

MR. COX: All of New York State?

MR. CARTER: Yes.

MR. COX: Was there any particular concentration?

MR. CARTER: No. To the best of my knowledge, we're talking about a five year period but to the best of my knowledge, at this point, I do not believe there was any concentrated area.

DR. NISHI: We'll appreciate any data you can provide to us.

MR. MURRAY: I was a little bit concerned about your comment that if a nursing home were to rely on Medicaid or any governmental reimbursement that that degree of reimbursement would be perhaps less than they might get from private insurance and therefore, the quality of service that might be provided might be less good. That may very well be true.

I'm concerned that if that's the case, whether there is any effort being made to try to provide endorsements for people to provide services in areas where they are likely to be dealing more with poor people than with wealthy.

In New York City, at least, poor people tend to be more colored than Caucasians. Just and as example and this isn't a successful one but the idea was good. In New York City, the City hospitals have affiliations, for the most part, with university training centers for medical students and doctors that allows what we hope are good quality doctors to practice medicine in settings where poor people are being taken care of

and I'm wondering whether the government has done anything to encourage comparable kind of arguments where the care for elderly people, which is obviously going to be more and more of an issue when people are living longer and longer, where the care for them is -- the quality of the care for them is encouraged to be at a higher level by this kind of an affiliation agreement. Has anything been done to encourage that sort of approach?

MR. KENNEDY: I can't speak for the department in that area. There may be programs in the department that address the particular points you are making. Our office is directly concerned with the enforcements of the civil rights laws to the extent they would be a broad base program we can be responsive to. I can't. I might also add the one point that I think I was trying to make there was, that, in many instances, the nursing homes themselves talk about the difficulty they have in attracting professional staff and also in paying a salary commesseriate at the lower levels to an array of workers on board.

MR. MURRAY: In essence, you respond to

complaints that are perceptions of poor service or poor something or discrimination by individuals approaching a nursing home? My concern is that perhaps the level of care, in general, is not as good in certain homes or certain areas as it could be and that perhaps this kind of arrangement might proactively say bad care.

MR. KENNEDY: I can't answer that.

MR. COX: The State pays a lot of money every year which is done through the area offices. I was wondering whether it disturbs you and Mr. Carter that, based upon these annual inspections of nursing homes in the State, the State has never once conducted a thorough investigation of civil rights violations, has never once conducted enforcement action and has never once in history actually found any New York State nursing home for noncompliance with the '64 Civil Rights Act despite the fact that you are paying them millions of dollars over these years to conduct these annual surveillance reports?

MR. KENNEDY: I think and I can speak from my experience of having worked in other regions, I think it is a concern and one of the

ways in which we try to address that concern is to begin to share the responsibilities of the civil rights responsibility with the State agencies.

Quite frankly, the performance of the states have not been that good and for that reason, we have to rely upon the third component which is the beneficiaries themselves coming to us to tell us because for all the surveys that are done, I have not had anything that referred to me and I have worked in several regions.

MR. CARTER: I would like to add one comment; while the numbers of actual complaints have been low in this region, again, for the past five years and perhaps for a longer period of time, one of the things that we've attempted to do quite successfully during the same period of time is to conduct what we call project reviews whereby we identify maybe 25 or 35 nursing homes around the region, primarily in New York and New Jersey, and we target those nursing homes for what we call single issue reviews where we have found patterns and problems.

In most recent years, most of those problems have been in the section of 504. We have

conducted numerous reviews and I can provide the data to that, that in over ninety percent of the project reviews we have taken action.

DR. NISHI: Thank you, Mr. Carter. We thank you very much, Mr. Kennedy and Mr. Carter for being here.

We will now hear from Carmen Cunningham who is the president of the Affirmative Action New York State.

MR. CARTER: Good afternoon, Madam Chair, members of the advisory committee, fellow presenters and guests. My name is Carmen Vinales Cunningham. I am the Director of Affirmative Action Programs for the State Office for the Aging which is located in Albany. On behalf of Ms. Jane Gould, the State Office Director, we welcome this opportunity to speak to you today on problems relating to access to longterm care, particularly nursing home care experience of older minority residents of New York.

I would like to begin my comments by distinguishing the role of the State office for the Aging in relation to the focus of your study on longterm shelter and nursing care for the

minority aged. As the designated State Unit on aging by the Administration on Aging, the State Office is charged with advocating for the development, coordination and administration of a comprehensive delivery system for the over 300 million elderly New Yorkers. With primary Federal funding under Under the Older Americans Act, as well as the State and local funding, the State Office advocates for and serves elderly New Yorkers through program, policy and legislative initiatives. The State Office oversees 59 local offices for the aging which includes two that are on Indian reservations. One is the St. Regis Mohawk Reservation and the others is Seneca Nation of Indians; both of upstate. An important role of the State Office through the aging network, is to promote and advocate for longterm care services. The escalating demand for longterm care services coupled with government's increased desire to expand and improve community based services - places the State Office for the Aging in a challenging and new dawn. Over the past few years, our mission has expanded to include not only those elderly that are in need but

acknowledge and address the needs of their caregivers as well. The State Office is committed to expand community and home based longterm care services which are designed to avoid or prolong the institutionalization of an elderly person. To this end, our Office has limited programmatic or policy authority in nursing homes or other custodial longterm shelters. Our Office does however, administer an ombudsman program through through local sponsorship for licensed Long Term Care facilities. The longterm care ombudsman program provides opportunities for residents of longterm care facilities and their families to voice problems and develop solutions. The State Office and the 39 local ombudsman program sponsors, advocate for nursing home residents. Ombudsman receive, investigate and resolve a wide range of concerns and complaints about the conditions in longterm care facilities. A future possible policy area for the State Office to consider is the development of an appeals mechanism for nursing home denials to work in close cooperation with ombudsman programs.

As I mentioned to Mr. Calabia,

statistics regarding the composition of New York nursing home population by ethnicity is the information that is not compiled by our Office- as we are charged with advocating for and bringing services to the noninstitutionalized elderly, with the exception of the aforementioned Ombudsman program. However, that data can be obtained by the Department of Health and I was told that a person of the Bureau of Health Facilities Coordination has appeared before you regarding that data. The lack of constant data hampers policy development for the longterm care system.

It is my understanding that the Department of Health nasa patient review instrument for nursing facility residents which was developed as a tool for determining nursing home case my reimbursements. This is the only document to provide a computerized profile of recipient characterization.

This document has been examined by the State Division of Human Rights regarding the legality of ethnic data collection. And I was hoping that the presenters that were scheduled before me would be able to speak about the status

of that.

The issues of economic and racial discrimination in accessing aging services, parrticularly longterm services which can be more costly and needed for many minority elderly have major policy implications for government agencies.

In New York, there are a variety of cross cutting policy and administrative issues among agencies regarding the development and delivery of longterm care services to the elderly. As I mentioned earlier, the State Department of Health has the primary regulatory authority over the administration of hospitals and nursing homes, including the admission process.

The State Department of Social Services has the responsibility of overseeing the implementation of the Medicaid program which covers a significant portion of the total patient health care expenses incurred in our hospital and nursing homes. Out of necessity, the Medicaid program has become and remains the primary vehicle to meet longterm care needs. As the recipient of federal Medicaid funds, the Department of Social Services has the definitive civil rights

enforcement obligations required by Title VI of the Civil Rights Act of 1964.

The targeting of services to those elderly in greatest social and economic need with particular attention to low income minorities is a mandated regulation pursuant to the Older Americans Act and is a priority at all levels of the aging network, national, state and local.

It is our targeting initiative that strives to increase the participation and representation rates of minority elderly in aging service programs. Among the many steps taken to increase access and information from the minority elderly, the State Office has established a Statewide Committee on Minority Participation. This 15 member committee has representatives from committees across the State, of differing cultural and ethnic backgrounds and with affiliations as retirees, academicians, lawyers, service providers and minority agent advocates organizations. It is the charge of this committee to assist Director Gould in identifying barriers and formulating strategies to address the situations which we restrict equal access to minority elderly and

their families including access to nursing homes.

For example, one of the members of the Statewide committee is a senior citizen who is a native American and she has brought to the attention of the committee the unique health problems of Indians, whereby Indians age 45 and over exhibit many health related characteristics of the white population 65 and over and she would like the committee to have Indian access to nursing home care and explore the necessary requirements for the development of a nursing home on her reservation in upstate New York.

The State Office for Aging was actively involved in the New York State Nursing Home Task Force which issued a report in June of 1986 and I feel that that report has a lot of valuable information so that if you don't have it, I'll be sure forward you a copy of it.

That report included specific recommendations regarding discharge planning and admissions to nursing homes. Also recommended was the establishment of a data base on referrals and admissions to document if, in fact, systematic discrimination based on race for nursing home

admissions exist. The Task Force, consisting of representatives from the Department of Health, Office for the Aging, Division of Human Rights and friends and relatives of the institutionalized aged was a result of a report which was released in 1984 by an advocacy agency named Friends and Relatives of the Institutionalized Aged which alleged racial discrimination by hospital discharge workers and hospital personnel resulting in segregation in nursing homes in New York City. The task force report revealed low minority resident representation in nursing care facilities.

Based upon subsequent documentation and research on minority elderly matters such as that from the Minority Elderly Report which was forwarded to this committee in October of this year, we know that minority persons have a higher prevalence rate for chronic disease and a higher level of impairment or frality than same age whites. Therefore, the likelihood for the need for longterm care services may be higher as well.

As a member of the Task Force, the State Office became aware that representation of

minority elderly in nursing homes was disproportionately low and has supported departmental bills from Health and legislative proposals that have been designed to address this problem.

For aging services and nursing home care, the reasons for problems with access by minority elderly and their families are varied and well documented. In the interest of time, I will not attempt to list all the barriers that research and common sense have identified as impediments to minority use of certain services. However, I feel it is important to note that in the absence of hard core data on discrimination complaints regarding access to nursing homes, which may be available to you by the Division of Human Rights, there are systemic problems regarding access. These apparent problems or barriers do not apply to access to nursing homes but to health and social services for the elderly. These include categorical situations that have, to some extent, been institutionalized into potentially discriminatory practices by the nature that they have the effect of creating adverse impact on

minority utilization patterns.

These access and coordination issues include the perception of health care providers that all minority families tend to or prefer to take care of their own, even in the neediest of cases, without regard to individual circumstances, the lack of awareness by many minority older persons of existing long term care services and how to navigate through bureaucracies and entitlement programs to obtain the needed services and the uncomfortable and inadequate or lack of communication between minority elderly or persons acting on their behalf and health care providers.

In these situations, oftentimes cultural differences or socioeconomic differences relating to communication and expression, exclusive of language barrier, may include such things as tone of voice, use of hands when speaking, lack of eye contact on the part of minorities and lack of cultural sensitivity on the part of the health care provider contribute to inadequate access to services when the best care plan is not the end result.

Also, it cannot be overstated that many

elderly minorities have experience or have memories of discrimination with government agencies in the past and have culturally based fees regarding divulging personal information. This, of course, impacts on access as it is presently structured. Issues of racial disparities and medical coverage are presently being examined by the National Senior Citizens Law centers and other advocate groups across the country.

As you know, the lawsuits in Tennessee and Pennsylvania have sparked a reaction throughout all states to determine what extent, if any, state policies that allow Medicaid discrimination violate the civil rights law as well as the Medicaid statute. The major significance of the Linton verus Tennessee case is the finding that discrimination by health care providers against Medicaid patients has a disparate impact on minorities. What we hear from these cases is that there is a definite correlation between poverty levels, ethnicity and Medicaid status. Unlike Tennessee, New York State does not allow limited bed certification which was the catalyst of the Linton case. The Office for

the Aging as an advocate for the elderly population will follow developments in data analysis regarding New York State and whether and these issues.

The State Office for the Aging has expanded its advocacy role over the years to better address the program implementation needs of the elderly that tend to get lost in the larger human services agencies. Recognizing the personal and characteristic needs of the elderly, including socioeconomic and ethnic differences, has given us an advantage to strategize on age discrimination problems faced by the elderly in accessing services. The mounting costs for nursing home care and the commitment to helping older persons stay at home has encouraged state government and public agencies to reconsider the design of long term care services and how they are accessed.

Governor Cuomo, in his 1991 State of the State message, directed our office to examine the feasability of implementing a program known as Managed Access to Aging Services or MAAS. This program would establish to a single point of entry to longterm care for the elderly in New York

State. The key features of MAAS include the consolidation of responsibility and authority for managing the elderly's access to longterm care services within the State Office for the Aging and the designation of local longterm care case management agencies with the responsibility for assessing the elderly's need for longterm care, determining the most cost effective method for responding to those needs, authorizing last resort public payment for needed services and providing ongoing case management to monitor the provision of services and make adjustments in care plans as appropriate.

In its totally the MAAS proposal embodies a basic change in longterm care responsibilities. There will be, for the first time, a visible point of accountability for all longterm care access issues for older New Yorkers. The implication for increasing access too longterm care for minorities will be factored into the MAAS program. As newly developed agencies - cultural diversity issues will be an integral part of program planning and training for MAAS entities. The proposal will also provide for

a data base regarding referrals to nursing home facilities. It is clear from the cases that are surfacing regarding discrimination in accessing nursing home care - that the components of a longterm system must address the complex issues of potential Medicaid discrimination and any other discrimination which violates their rights of low income and minority elderly.

As the designated State Agency for elderly New Yorkers, the State office commends the work of this committee in examining these issues relating to minority elderly and longterm care access.

DR. NISHI: We thank you very much. I have a question. With regard to ethnic data collection, I know that this has often been a problem in terms of admissions. Other than without data, it's extremely difficult to monitor whether access is there. Now, it's my understanding that that is not available but that the ethnic characteristics of the nursing home, longterm sheltered care population is available; is that correct?

MS. CUNNINGHAM: Not through our

sources.

DR. NISHI: Was is not?

MR. AMBERS: A recommendation of the State Nursing Home Task Force in 1976 that was adopted by the State Hospital of Human Planning Counseling was that nursing homes would be required to keep there -- as part of their application process, the PRI which is a form that comes with an application to a nursing home that has racial and ethnic data on the PRI, to keep those applications in a chronological order so that within the nursing home would be a record, you know, that was compilible of PRI data that had the race of ethnicity of every applicant.

DR. NISHI: What happened to that recommendation?

MR. AMBERS: That was passed by the State Hospital for Planning. Do the nursing homes maintain such records.

MR. MURRAY: I don't know if it's important.

MS. CUNNINGHAM: Concerning the PRI that is still being used by the Department of Health; however, the Division of Human Rights is seeing

the legality of that document being used prior to the nursing home person actually showing up for a bed. They don't want that document which identifies ethnicity to be at the nursing home before the person shows up.

MR. AMBERS: That's the only thing that would indicate, though that is available. That's why it is an important document.

DR. NISHI: Explain to me what the difference is in this data keeping issue as it pertains to race, ethnicity as employment data, like the EO required reports do require that the person's gender, ethnicity, etcetera and that it be maintained and reported? EO reports do require that. What I'm saying is that nonetheless in the application procedure such data, as well as a large number of other characteristics, cannot be accessed such as family, state. Why cannot the same principle be applied here?

MS. CUNNINGHAM: Because the nursing home is considered a housing provider and so in terms of the State, law prohibits in housing discrimination, in housing and so that's the distinction between employment.

DR. NISHI: Have there ever been used testers as in housing discrimination cases? Testers in terms of nursing home applications?

MS. CUNNINGHAM: We've not used testers. In fact, we had discussions this last calendar year about that very approach in some of the investigations.

DR. NISHI: As far as you know, it has not been used since there has been that data collection problem. Of course, in other institutional areas, some other processes have been used to seek to documents. That is a widely held perception of inequity. Thank you. Are there any other questions for members of the panel?

MR. AMBERS: I want to know if you are aware of the fact that in the Department of Health there are six areas that have the responsibility of monitoring Title VI compliance and there are supposed to be six Civil Rights compliance offices. Three of those positions are currently vacant and been vacant for a long time and the State is threatening to do away with the other three positions. Are you aware of that?

MS. CUNNINGHAM: I mentioned that in terms -- I know I mentioned DSS has the responsibility. But I think what Mr. Kennedy spoke of earlier was in terms of the vacancy and having personnel in those positions. We're all feeling the crunch of the budget crunch and it doesn't surprise me that the positions are vacant.

MR. MURRAY: I was going to ask it sounds like your agency is doing a commendable job in trying to protect the rights of elderly people of whatever ethnic group. On the other hand, we have a record of ten complaints in the last five years in this whole region. Has anything happened via your agency to prevent complaints from getting beyond the agency? That is a big success, that may be that it is why so few get into the Federal Government.

MS. CUNNINGHAM: I think personally elderly people tend not want to complain and not file complaints. That is very realistic of the low numbers. In terms of complaints handled by our office, the omnibus program handles complaints of residents in the facilities. I don't think that's the same nature of complaint that was

referred to earlier.

DR. NISHI: I have a question here. If they receive federal funds and my assumption is that all of these agencies, if they get Medicaid they get federal funds so they must be in compliance with the requirements of law; if this be so, do private nursing care facilities, for example, under sectarian auspices, are they permitted to give preference to their own sect?

MS. CUNNINGHAM: Yes.

DR. NISHI: Even in foster care, because it uses public money, even though foster care is under sectarian auspices, they are not allowed to give preference to their own religious group. What is the division here?

MR. YOUNG: I'm Carl Young.

DR. NISHI: Do you plan to speak to this point?

MR. YOUNG: Not at length.

DR. NISHI: Perhaps we can ask you again.

MR. AMBERS: The 1964 Civil Rights Act the section of what we're talking about. Section VII doesn't deal with discrimination based upon

religion. So that religious based nursing homes are free to discriminate and give preference but part -- the problem that Freia (phonetic) pointed out in the '64 report is that a lot of religious based nursing homes use this aren't truly religious based nursing homes but they will accept white applicants from other religions and exclude minority people. Then we alleged that they waived their exception as religious based organizations. They went away from the group that they purported to represent.

MS. CUNNINGHAM: That was offered as part of a justification in the Pennsylvania case, that many of the segregating nursing homes are, in fact, religious.

DR. PETE: Just to comment on that point, I think some times there are many factors that are considered when someone comes into a nursing home and when you line up the important criteria part, religion and ethnicities are way at the bottom because nursing homes in the New York City and surrounding areas have more of a problem in trying to maintain a high quality of care for their residents based upon the reimbursement

figure and that is the major issue for nursing homes. I'm not saying there is no discrimination in New York City or State but in terms of the discharge, focusing is on level of the care that New York has for that particular resident and when you look at the PRI, there are many categories that help make that determination.

When I talk to these people, that's what comes out; that's the problem in getting them in. Otherwise, you have minority residents backed up in hospitals, which you don't have; you have patients backed up in hospitals where the reimbursement system simply cannot operate and that's where you are getting people backed up. If you can show me the hospitals are full of minority patients who cannot get into nursing homes simply because of their race, that's one thing. That's not what you're going to find. There are people and alternate levels of care and waiting for different kinds of longterm services because of the nature of the care that they can't meet at the nursing facilities. It's a matter of reimbursements. With the Governor's new reductions to Medicaid, it's going to get worse.

I think it's aiming to take focus on religion or ethnicity in terms of what is in the nursing home as a factor; who is going to have access to a nursing home without understanding the many factors that go into a decision.

DR. NISHI: We understand that. It is our charge to examine.

DR. PETE: You have to examine that amongst other issues.

DR. NISHI: That's why we have invited you to be present and advise us with regard to this. You are indicating to us that if there is inequity in availability of nursing home care, that it is an issue related to differences in reimbursement availibility.

MR. YOUNG: That's a major factor.

DR. NISHI: Are there institutionalized racial ethnic task forces that are associated with this difference in the reimbursement factor which obviously must be related as well as to their socioeconomic accumulated resources?

MR. YOUNG: I think the short answer is probably not.

DR. NISHI: There is not an economic

factor associated to reimbursements?

MR. YOUNG: No.

DR. NISHI: Reimbursement is based on the kind of insurance people have, etcetera.

MR. YOUNG: Two sources of payment in New York State. Private pay or Medicaid. Medicare is such an unsignificant player in New York that we need not consider it. In fact, as confirmed by a study that the State authorized in 1990, it was done in '89 using 1988 data, 70 percent of the nursing homes in the State are losing money on their Medicaid patients. This is State sponsored survey. Since 1988, the State has taken $144 million out of the system through adjustments. The picture that this study act documented in 1988 has gotten worse and you, as a provider, a Medicaid patient who is presented to you is automatically a financial loss for you. So the only way you can stay in business, whether you are a priority facility or for a profit, is to take a person and charge higher.

MR. AMBERS: That's in dispute.

MR. MURRAY: I was going to suggest that if there is an implication that Medicaid patients

or people of minority ethnic groups that have more complex medical conditions and require more complex services. If that's the case, then the State's system discriminates by not allowing appropriate reimbursements for nursing homes.

MR. YOUNG: The reimbursement system is at least intended in its structure to address severity of need. There are 16 categories; they are called resource utilization groups and they identify 16 levels of patient needs and your reimbursement is tied to that need. The higher the patient need, the more you're reimbursed for that patient. What this has done is make the more needy patient more attractive to the provider.

An interesting phenomena occurred since RUGS went into place. Public run facilities used to have the most severe patients because the system was a perdium rate of reimbursements. The sicker patients were less attractive because they required more care and the providers of last resort, historically, have been the public facilities. The public facilities generally had a higher level of patient intensity. When the RUGS system came in place, giving greater financial

regard for them, what you've seen happen is the public facilities continued to lose money because they can't get the really sick patients. They are still the provider of last resort and the "least desirable" and I use those word in quotation marks, patient is that that lower level of care patient for whom you'll get less reimbursements.

Now, there are, I think all the providers would argue and many advocates as well that the RUG system is not perfect for that very reason. It directs some disinsentives for people who have need but they are no longer attractive as residents and secondly, the criteria on which the categories were based aren't necessarily valid today.

For instance, the Alzheimer's patient has a low RUG score and they are labor insentive.

DR. NISHI: I wonder whether we should have your presentation now or should we continue with the questions.

Do we have any further questions to Ms. Cunningham?

DR. PETE: You mentioned the MAAS proposal. I got the impression that your

interpretation of how this proposal may go forward is that you might be considering using the MAAS proposal as a way of rectifying what may be perceived as discrimination in terms of this single access point if, let's say, in access point or longterm services, would you also be using race as a determination? For instance, there is the Medicaid access before the State hospital and Urban Planning Council that would provide for patients do have access to nursing homes, would this be the kind of MAAS single entry point you would also use race to say, well, we have three or four minority residents here who need nursing facilities; we know you have a certain number of beds, take them.

MS. CUNNINGHAM: No. The proposal at its stage, those kinds of processing questions have not been fine tuned. When I referred to a determination of cultural diversity and race in the MAAS entity is basically as a new -- I don't want to use the word -- as a new agency. The potential there is to build into the training and the plank of the MAAS, to build into cultural sensitivity in terms of staff not in terms of

saying we have three minority elderly that need care.

DR. NISHI: Are there any other questions? I regret to have to announce that Dr. Nadia Martinez, the executive assistant to the commissioner in the New York State Division of Human Rights, who has been involved in the major research on minority elderly and hursing home care, regretably she is ill so she is not going to be able to appear.

Judge Albert Kostelney has been called to an emergency meeting and will not be able to attend. I'm sorry to have to announce this. They will, however, be communicating with us in writing so that we will have their testimony as well as their documents which will be incorporated into the record. I think we will proceed to Mr. Carl S. Young who is the president of the New York Association of Homes and Services for the Aging.

MR. YOUNG: By way of introduction, our association represents the not for profit and public providers for longterm care. We represent approximately 400 institutions statewide, about 250 to 260 nursing homes.

MR. COX: Not for private, meaning?

MR. YOUNG: 70 percent of our members are religious based, 20 percent of the public and the balance are community based. We make the distinction between not for profit and non-profit. Not for profit, we believe, is the term. The purpose of your members is that if there is black ink at the end of the year, the money goes back into the institution. While our primary mission is the elderly, longterm care is expanding and our members include providers who, for instance, have AIDS or are AIDS positive. There are people with disabilities who are elderly but are receiving care. We have decided -- In fact, we went through a process, does this change our mission with this changing population and we have decided that not really, not the word aging; it is all encompassing and we all begin that process at birth. The issue of minority access to health care services is interesting in the sense that in nursing homes themselves, the percentage of admits, as a part of the total admissions, is just about equal to the minority percent of the population statewide.

According to the Civil Rights survey, the Department of Health in 1990, a little over 13 percent of the nursing home admissions were to minorities.

DR. NISHI: This is in New York State?

MR. YOUNG: Right. Were to minority citizens. A point that was made earlier, the often --

DR. NISHI: Can you give us the full cite on that because we want to make sure we have that?

MR. YOUNG: Department of Health and Civil Rights Survey for 1990 and it's slightly more than 13 percent of the admissions. The point that was made here earlier among the minority population may have overall likely, do have lower overall health conditions and the need may be higher is something you have to weigh in when you take that figure into account.

Also, it's interesting, 13 percent of the over 65 population is minority in New York at this juncture. I'd like to talk about access issues from two perspective, one, is it for minorities to become providers? Our organization

has been working about a Baptist church in Buffalo which is in the process of buying -- it's a Jewish facility that is rebuilding a new facility and the old one, they are willing to sell. They are up against very severe problems, the least of which is a State requirement for 10 percent equity just to get your service need in the door. Generally speaking around the state and particularly the urban areas, cost of the land is virtually prohibited.

Again, for minority based organizations, the procurement of the necessary capital to get under way is a real problem. Back in 1987, there was a Baptist congregation in Brooklyn who had their C of O denied by the State of the because of the inequity. It is especially bad for minority providers. Historically too, there has been a low level involvement in longterm care from the management perspective by minorities, for a variety of historical reasons.

At the labor level, of course, particularly in urban areas, you have a high participation which is made orderly and so forth. In terms of access to services, there are a

variety of factors and I think we touched on this in the earlier session. One is bed availability. Access is a problem in some parts of the State for anyone and for minority people, that is depending on where they are. The second thing I was going to mention was geography. Access to a facility is often very much a problem. Another condition factor is the level of care needed.

As we mentioned earlier, the more severe the need, the more attractive they are as a potential resident. The method of payment is a critical condition and again, as Dr. Pete alluded to earlier, many of the proposals that are on the table today to reduce Medicaid funding have the net affect of making the Medicaid recipient who is disappropriately a minority a less attractive patient and, you know, even though our members are church based and not for profit, not for profit does not mean suicidal. You have to have a bottom line or you are not able to carry on your charitable purpose. You have to at least break even.

I think I mentioned the Lewen (phonetic) Study which was the State study -- it was either

published in '90 or '89. I know they used 1988 data and they concluded that 70 percent of the facilities of the providers are statewide. Now that figure is even more difficult, more not for profits, 85 percent of the not for profit lost money on their Medicaid patients and 96 percent of the public lost money on their not for profit patients.

Obviously, on the priority side, there was a better balance sheet on the Medicaid but even though statewide, you have a 70 percent figure of losing money on Medicaid. As we said, if a Medicaid patient becomes less attractive, you have to fill the gap with private paying patients or more vigorous fund-raising by your foundations or the other entities that people rely on or they branch off to other services, like home care and/or another level of service that might operate to the blacks to subsidize though services.

There is a secondary issue. A good many of the religious, there are also fraternal organizations. The facilities reason for being is to make sure the member of that religion or benefits of that order, whatever it may be, will

have access to long term care. And the Attorney General ruled back in the mid- '80's, whenever that study --

DR. NISHI: Is this State?

MR. YOUNG: State Attorney General, that as long as the religious preference was indeed a religious preference and not a tool to discriminate on the basis of race, that it was not law. I know at least a couple of our members where this mandate from their charter actually creates administrative difficulties. I won't specify but it's one of your Jewish facilities, not only charged to take primarily Jewish people first but people of a particular sect and for the administrator, this is a tremendous headache. He said to me this practically means I'm going to mandate; that means I lose. If I can't raise $200 million a year on outside fund-raising, if you narrow your focus, you can't see what else makes that attractive.

In some aspect, this ties the hands of the administrator. These institutions were formed with a primary, race care for a particular religious order. I think it's important that in

this discussion to that, the Commission look beyond just nursing homes and when I talked with Tino, we discussed this a little bit, not only this commission but longterm care has to address the needs of the well elderly as well. We can't afford the continued dependent care. New York State is adding 5,000 bed this year. 6,000 beds are scheduled to go on the system next year.

If you use the current rate, which is 83 percent patient beds for those eleven now beds, if you don't raise reimbursements; if you keep a flat for those two-year periods, the State is incurring a $120 million State shared expense at a time when the State is already -- they are not looking to spend more money, they are looking to cut it back. If we don't develop other non-institutional type things for the elderly, we're going to create more unattractive medication and minority is grossly disappropriate in that population and they are going to have more access difficulties to them.

New York State did adopt a program this year. They still are waiting on regulations and part of my soapbox has been they structured it by

failing to putting its administration in two separate departments. That does not disparage either department. You have two corporate facilities and I know of no management principle that leaves the buck two places to stop, which means it will never stop.

New York State adopted Life Care Law two years ago and tied it up with regulations and there has been one applicant to do it and secondly, the revenue requirements are so high that the only people who will be able to use these are the well to do. We're not really addressing minority needs under the structure. Met these types.

Again, I want to understand there is a need to look beyond. We represent housing for many of our members, provide senior citizens housing. I think these are areas, if you provide the housing, bring services in, relieve pressures on the nursing home. To the extent you are relieving, you're making access available for more people. I know that this body is, I guess, going to write a report with recommendations. I would recommend for inclusion in the recommendations a

philosophical approach to the extent you can recommend incentives for providers and for committees as distinct from regulations to punish bad behavior. If you create sentence for good behavior, the response will be that much more successful. I spent 16 years in government, in county government and I know the impulse to regulate.

DR. NISHI: What are the incentives you are talking about?

MR. YOUNG: Inspection incentives. New York State, I believe we could relieve a lot of pressure on Medicaid if we have available in New York State affordable viable longterm medical insurance. What is happening is Medicaid is being used by the middle class and well to do. The phenomenon of asset divesture is recently getting much attention but the fact is law firms whose sole practice is enabling middle class and well to do people to divest their assets.

I know a case where a resident died as a Medicaid patient and he had, in his estate, $8 million. That means the taxpayer got to subsidize the private inheritance of $8 million. If we had

a meaningful system of longterm care insurance with incentive to buy it. For instance, tax credits for people to buy longterm medical insurance so that you could -- you wouldn't have to shelter your assets. If you had this money you can pass the assets onto the -- there is a Robert Woods Johnson proposal which will move in this direction but those kind of incentives. I'm not suggesting regulation has no place in it but New York State is probably the most regulated State. New York State officials never met a regulation they didn't like.

MR. AMBERS: Or enforced.

MR. YOUNG: Or enhanced if they got the opportunities. There is a simplicity that if you pass a regulation against this perceived wrong, that somehow you will fix it. I know Macon is a well deserved repute. He said that for every complex problem, there is a number of simple solutions and they are all wrong. Often, it's the simple sounding solution.

DR. NISHI: I think any other suggestions you may have with regard to incentives that you think might work, as it often occurs, as

you gave an example with regard to changing the reimbursement which meant that still, that the inner-city house rules were not being -- I wonder with regard to these institutions whose purpose for establishment are to pay for a specific population. To what extent are they subsidized?

MR. YOUNG: Depends basically to the extent to which they rely on Medicaid as a payer.

DR. NISHI: Medicaid is the primary source of the public assistance?

MR. YOUNG: Yes. Medicare is not really a player in New York State.

MR. COX: I wonder if you have any further comments on the issue that was raised earlier about the -- what some might regard as an astonishing low level of actual complaints entered in this large area over a five-year period; that is the experience of the association and particular places you work with, is there-- let me put it in this way, a large residual body of complainants who are barred from articulating them from these issues.

MR. YOUNG: I came in just after or during that. What type of complaints are we

talking about?

MR. COX: About admission, for example,.

MR. YOUNG: Minority access type?

MR. COX: Yes.

MR. YOUNG: I've been with our association for two and a half years and I have not heard of this discussed as an issue, either as a fear that they are going to be required to take minorities because I think the overwhelming majority of your members, particularly the urban areas, have populations in their facilities that are reflected in the general population. It truly is not, whether you are sitting around at a social function or in a community meeting, this has never been raised as an issue in the two and a half years that I've been there.

MS. CIPRICH: One of your recommendations was that a problem is the law that allows middle class and wealthy people to divert their assets when they go into a long term facility in Medicaid. Why it is that wealthy and middle class can get into facilities on Medicaid and minorities can't? If that's true, something is happening.

MR. YOUNG: I think you put a twist on the phenomenon that isn't there. I don't know minorities can't get in first. Secondly, the other factors that I mentioned are equally important. I had a very prominent political person ask if I could help them get into a specific facility. And the administrator said, I can't afford to take them in because of what they will to do my case mix and my reimbursement will follow my case mix down.

MR. COX: What I'm saying is--

MS. CIPRICH: Something is happening here. The wealthy and middle class can get it and the minorities can't. I'm asking anybody who is present to address this. What is happening?

MR. YOUNG: A, there is geography. B, is case mix. Both of those are far more important to a payer. Geography is important to the person who is using the facility. We're not talking about rich white people being accepted as Medicaid patients while the minority can't get in. The distinction, if I'm the provider, I have the two Medicaid patients come in. I want to know what there RUG category is. Are they a physical A, or

are they complex? If they are complex, I want them. If they are a physical A, I really rather not, if I can avoid it.

MR. COX: That is the first criterion that people in your operation really look at?

MR. YOUNG: Yes.

MR. AMBERS: Can I expand on this?

MR. MURRAY: Along the same line, I believe that you implied that you'd expect minority populations being poorer, in general, than Caucasian populations to have more illness and presumably more complex conditions and if anything, should, on that basis, be over represented in nursing care facilities because they would be desirable because they should have a higher reimbursement rate.

MR. YOUNG: If they are -- geography is not to be dismissed.

MR. MURRAY: I understand but you are saying Statewide, the minority population is roughly 13 percent and that's pretty close to what you have as a nursing home population. You would anticipate if, in fact, the illness complex medical problem relationship to profit exists

that, in fact, there ought to be more than 13 percent of minority patients in nursing homes by a substantial amount.

MR. YOUNG: Another way in which it works is a person comes in and a Private Way and have sheltered most of their assets. They stayed for two months as a private payee and go on to Medicaid or a relatively short length of stay as a private payee.

Frankly, if you are really conniving about this as a family, you keep enough of the assets available so that they will have that private pay access and pay the private rate for three months, six months. Your assets are gone because -- proper utilized to the law and then you are Medicaid patient.

MS. CIPRICH: What ability to the nursing homes have to request a financial information from the perspective?

MR. YOUNG: I am not sure how extensive that is.

MS. CIPRICH: Can a nursing home say I want to see your balance sheet?

DR. PETE: They want to know they are

coming. Most people who go to nursing homes come directly from hospitals and when they were in the hospital, a lot of them were on Medicare or Medicaid anyway. There is information asked for them to pay in the hospital. The information is transferred to the PRI and the nursing home wants to know are you Medicaid eligible in New York State. That's the financial question so you can get paid. The question is are you Medicaid eligible.

MS. CIPRICH: What is being said here is people go in as private pay patients and then switch to Medicaid. If a nursing home can tell what a person's income is, it wouldn't make sense for a nursing home to do that.

MR. YOUNG: Not in a reasonable case level; all the reason to take them. You are going to get them private pay two months and then you are going to have a mix.

MR. AMBERS: We assist 4,000 people anually through the placement process as information referral nursing homes. In New York City, virtually are 80 percent are subsidized by Medicaid; virtually 100 percent choose over who to

admit or who not to admit and they ask for and receive all of the financial data they need to make a choice, you know, to make the choice they want to make in terms of bank books.

In terms of tax records, everything they ask for and get it for people who want to be admitted and if the people won't produce it, they won't process the application. Cutting back to something else that you asked, in terms of, you know, in determination of equal Medicaid applicants, two years ago, an investigation that Freia started with the New York office, the special prosecutor's office in New York City, two of the most prominent and well respected nursing homes in New York's City, two, maybe three years ago pleaded guilty or nolo contendere to shaking down families of Medicaid applicants so that the Medicaid applicants could get in for asking for legal contribution which is against the state law of Medicaid applicant to get in.

I'm not saying that this is widespread, I'm saying that this existed in two facilities that pled no contest to it and this was two of the most prominent facilities in New York City.

Also in terms of the facilities that are not for profit, they, you know, and they do a lot of fund-raising in addition to the Medicaid funding. If a white family shows up with a Medicaid applicant to a nursing home, they can say legally we recognize our responsibilities, we want our loved one to get in; we recognize our responsibilities to maintain your institution, too, you know, to your expanion program and building program. This is not illegal.

This is something that exists and this also exists when you have a wealthy middle class family whose relative has spent down their assets and are on Medicaid, this gives them a chance to get in over a minority applicant. There are many different factors that go with it and I think what we're going to see in New York is what we're seeing in Tennessee and what we're seeing in Pennsylvania.

There is going to be Court cases that are equating Medicaid discrimination against minority people with racial discrimination because the effect is that they are one in the same and I think we're spending as a civil right -- as an

organization concerned with civil rights, we're spending too much time looking at the balance sheet of nursing homes. No nursing homes in New York City are going out of business. Everybody wants to be in the nursing home industry and none of them are going into Chapter XI. If they are sold, they are sold within families or sold within the industry but as long as I've been in Freia in the last two and a half, I don't know of one nursing home that has gone out of business or gone into Chapter XI because of the Medicaid reimbursements. It's one of the highest reimbursements in the country.

MR. YOUNG: It is the highest in the country; the labor costs and capital costs are the highest.

DR. NISHI: Are there any other questions for Mr. Young?

MS. CIPRICH: I would like to ask if there are any statistics on case mix. Is there a study or statistics you can give us; something in writing. We've heard a general discussion about this is the way it is and Freia is saying that while you know, for instance, if we can get the

two cases you are referring to, that would be great but on this side, if we can get statistics that a nursing home is interested in case mix and the RUG category.

MR. YOUNG: You should come to the Hospital Review and Planning Counsel meeting Thursday where the State is intent on recalibrating reimbursements because facilities have increased their case mix over the last five years and the State is convinced that they did that not by increasing the level of care to patient but rather by manipulating the company. We have documented the direct cost to patients and have striped the State's increases in care. You are asking for a broad thing. If you can refine what you want, I can fill this room with data.

DR. NISHI: If I can articulate. I think what we are interested in is the trends with regard to the case mix. You've indicated to us -- you've testified to us that is a case mix to the crucial factor; it would be helpful to us.

MR. YOUNG: Ability to pay.

DR. NISHI: With what you identified as a crucial factor and to indicate to us what the

trends are in the crucial factor with regard to.

MR. YOUNG: If I had with me the State's data on case mix.

DR. NISHI: Or even a summary of that. We don't need a large room full. What we need are those crucial points that indicate what you are contending that this is the crucial factor in differences. We have Mario Tapia, president of the Latino Gerontological Center.

MR. TAPIA: Distinguished Commissioners, my name is Mario Tapia, president of the Latino Gerontological Center. On behalf of our Board of Directors, I express our deep appreciation for inviting us to participate in this forum. I will be presenting information about the surmounting difficulties faced by the Latino elderly in accessing services in general and longterm and nursing care, in particular.

The Latino Gerontological Center is a recently established organization that addresses the alarming situation faced by Hispanic elderly in the country, particularly in the northeast, in this case, New York State. The purpose of the center is to promote way to improve the quality of

life for Hispanic seniors through advocacy. Our Board of Directors is comprised of outstanding and a National Board of Advisors with diverse ethnic backgrounds, from Puerto Rico to Los Angeles. We are working in conjunction with a number of public and private agencies in addressing the needs of the elderly.

Our members have and will continue to use their diverse range of expertise when conducting conferences and special events on behalf of our aging community. This year we have presented at the American Society on Aging Annual Meeting and at the first conference of the "Sodiedad De Gerontologia De Puerto Rico." We are consultants to a national demonstration project, titled: INNOVATIVE EDUCATIONAL MATERIALS: ALZHEIMER'S DISEASE AND PUERTO RICAN ELDERLY. Presently, we are working in collaboration with other organizations from the region, in the development of the first northeastern conference on Hispanic elderly, planned for March of 1992.

This presentation is significant because of the dramatic change in demographics experienced throughtout the State, particularly in the City of

New York, and because of the growing, difficult and complicated obstacles faced by this population.

In 1980, the City of New York was the home of 101,000 persons of Hispanic origin 60 and over. This figure increased to 163,000 in 1990. During this ten year period, the Hispanic elderly population of the City grew 61 percent. In 25 more years, statistical projections bring that number to well over half a million. Implications for adequate longterm and nursing care plans for the latino elderly are obvious.

To be old and Hispanic in the country implies that there will be a significant differnce between the opportunities available to most older persons and those accessible to the Latinos. This discrepancy stems from a life-long discrimination experience, which channelled both male and female Hispanics into the hardest and most poorly paid jobs. Consequently, depriving them of the ability to make choices in terms of housing, education and health services, among other things.

CLose to 90 percent of the Latino elderly are Spanish monolingual. Ninety percent.

46 percent live alone, a result of the difficult circumstances experienced by Latino families and their communities. Two out of three Latino older persons are living below or near the proverty level.

Hispanic seniors, as well as their families, often lack basic information on how to access economic benefits available to older persons. For example, 65 percent of Hispanic elderly residing in the northeast who were eligible for supplemental security income (SSI) did not know it existed.

A broken window in New York during the winter when the temperature is 10 degrees below zero is a life threatening situation when you do not know the language nor have information about where to call for service.

For a Latino older person, attempting to enter the health care system is an uncomfortable, and for some, a frightening experience. Medical staff are often unable to communicate because they do not know the language nor do they possess the cultural sensitivity needed to relate to the patient.

Discussions with older persons reveal that "they avoid going to a health care facility when sick because they are convinced that they will get sicker."

In 1991, the lack of assessability to basic services remains unfair and a grave violation of the Civil Rights of Hispanic persons is the lack of assessability to nursing home care.

In reviewing the 1990 reports on nursing homes prepared by the United Hospital Fund, we observed that the nursing home population is composed of 80 percent whites, 13 percent Afro-Americans and 40 percent Hispanics. In the 1990 census Hispanics over 65 years are 11 percent of the total number of the City's elderly, revealing that they are disproportionately represented in nursing home facilities.

Is not uncommon for seniors who receive home care to report that they do not understand the language of the care giver. This typically causes frustration and anger which ultimately affects the individual's sense of well-being. A few years ago, as part of a national study and

longterm care for the Hispanic elderly, I visited a centrally located nursing home in New York City. Of the 700 residents, 500 were Hispanics. At the time of the visit, there were no bilingual professional on the staff, nor were cultural provisions observed. This matter was brought to the attention of several administrators, who later informed us that the menu would now include... Chili con carne.

We are entering the third decade of this country's ongoing discussion on the needs of Hispanic elderly. Unfortunately, programs have been minimal.

Governmental, private corporations and foundation resources have not been fairly distributed according to the growing needs of the Latino community, including the elderly, despite the growing population.

The annual report of a major New York based foundation reported that out of $50 million allocated in 1989, less than one percent was directed to Hispanic organizations. Hispanics are 25 percent of the City's population. In the year 2030, it will be 47 percent.

Experts at the last World Congress on Aging in Mexico unanimously recommended that services to the ethnic elderly populations be implemented as an extension of their own communities. This included longterm care services.

It is necessary at the present time to present and implement programs for that half million Latino seniors. Our professionals, as well as our community based organizations, know how to plan and provide services that are ethnically and culturally appropriate. However, it is a difficult task when we lack the resources which are systemically denied to our community-based organizations from public and private sources.

We are submitting the following recommendations for you to consider as you propose to address the needs of the fast growing and underserved communities.

1. Develop community based research by Latino researchers for the purpose of systematically assessing the needs of this population.

2. Identify and provide funding to

Latino advocacy organizations.

3. Engage in the formulation of public policy and analysis which will positively impact on the present and future Latino elderly population.

4. Design and promote effective model's of service delivery for the Latino elderly population, including participation in the development of longterm care programs and policies, and the provision of technical assistance to community groups in terms of grantsmanship, organizing, etcetera for program development and.

5. Training gerontologicl specialists that will work with the Latino elderly population and its diverse groups.

Social change requires a lot of courage, social courage. It also requires very special people to implement this change. This hearing is an important step in the right direction. Thank you.

As a welcome to the Commission, I wrote an article of the Spanish article and it came out Friday.

DR. NISHI: For those of you who have written transcripts--

MR. PADILLA: I would like to really ask a question to Mr. Calabia. Since I am Hispanic and as an Hispanic, I claim that we prefer to have our elderly staying at home with their family and sometimes that is a problem because that discourages all. How you say that, the issue, cultural issue pertaining to Hispanic elderly at home and within the family other than to put them in a nursing home because sometimes that is not good.

MR. YOUNG: I think that goes to the point that I was trying to make earlier, the development of other programs. Whether it's an assistant living program or the expansion of the home care attendant service to enable families to stay together. To provide options and to reduce the dependents on uninstitutionalized care, I think in everyones behalf.

MR. TAPIA: I think that's one of the key questions and it's good you brought it up because there is a myth there used very much by the majority of organizations to keep minority

groups outside of resources. This is a matter of resources, existing resources. We're not going to go to another place to get assistance. It's the money we have right in my State, City and Federal government.

If we have a chance, first, we did our own survey trying to, you know, because we got the feeling, we like to be with family. We are family oriented people. But somehow the economics in renting half a room of studios, how do you see taking care of your grandparents?

DR. NISHI: Could you provide a copy of that survey for your study?

MR. TAPIA: Yes. And we found that 46 percent of people live alone. I made another point, the Commonwealth Fund started, I reported 22 percent of Hispanics. There was a national wide study and in my recommendations, I also asked for research done by Hispanic researchers. My point is that the Commonwealth Fund started was that over the phone they told 2,200 people from the marketing points of view and now their survey is that in the other area, 38 percent of Hispanic their households do not have phones.

Just to answer your question in my 15 years as a professional on aging, I believe the City is close to 35 percent of the people are living alone and the family has this very difficult decision where to go because they are not welcome everywhere. That's the other problem. When I told you the experience of going to this particular nursing home, there was no nurse. There was no social worker that will speak the language of the Hispanic person in that place. It has changed. I think it has changed. Maybe 30 years ago, we were all young and we never saw ourselves growing old. Right now we see our elderly population growing so fast.

MR. AMBERS: We were surprised to see that the Catholic sponsored nursing homes had very few Hispanics and virtually no West Indians Blacks that are also members of the Catholic faith. This was a case where, you know, there so-called religious based nursing homes might have been religious based but for white religious and not for the black and Hispanics religious. That was quite disturbing to see.

MR. TAPIA: These are statistics, the

annual statistics from the State Department when you look at the survey breakdown.

DR. NISHI: We appreciate that.

MS. CUNNINGHAM: I just a had a comment. I think also that the changing demographics show that a lot of families now don't necessarily live together.

For example, my mother lives in the Bronx and I live in Albany so that as she gets older and she has long term needs, it would mean, either her moving to Albany, which she'll never move or dependency on community based or other long term care shelter so that even though the cultural closeness of the family is there, the system has to be responsive to the reality of the situation.

MR. PADILLA: I believe that but it is still in the Hispanic community that will have to be a cultural change because when we go to interface with other institutions, we claim that we don't want to see our parents in nursing homes. So there has to be an approach in your community.

MS. VIDAL: Thank you, Madam chair, and

members of the committee for inviting us to participate and for the distinguished panel that is here. My name is Sara Vidal, I am here representing Andrew Stein who is not able to attend today because of prior commitments.

Recently, Mr. Stein held a public hearing on problems facing the Hispanic elderly in New York. Mr. Tapia was part of our panel. The number of Hispanic elderly has increased dramatically. The 1990 census reported more than 150,000 persons of Hispanic origin 60 years and over in New York City. This figure represents approximately 12 percent of the total elderly population.

Actually, the Hispanic elderly is the fastest growing segment in the City of New York and is expected to quadruple by the year 2000. I'm going to add a little paragraph here.

Andrew Stein is synonomous with elderly issues in the City. As Council President, as assemblyman, etcetera, he was at the forfront of the nursing home crisis here in the City and, therefore, many elderly people come to our offices for services.

Our approach with regard to the last hearing that we held was to dig in deeper into the needs, specifically of the Hispanic elderly; very little documentation exists nationwide, less so in the Spanish community. We were able to bring together many agencies, many advocacy groups, specialists, and we came up with a very good document which you have on the table there for your records.

Speaker after speaker at the hearing illustrated the horrendous living conditions of the older Hispanic New Yorkers. They confirmed at that time major barriers afecting the Hspanic elderly resolve around language, cultural awareness and lack of services.

Despite the many governmental policies and regulations requiring bilingual workers in many agencies and non for profit organizations, older Hispanics are still unable to access services because of the lack of or insufficient number of bilingual workers. Older Hispanics are usually Spanish and poorly educated and therefore illiterate in both Spanish and English. Many are intimidated by the forms and paperwork that are

required to be completed by agencies before they provide services to the elderly.

Further, many speakers at the hearing identified that lack of information is in itself a barrier that prevents older Hispanics from taking advantage of services for which they qualify.

Traditionally, elderly Hispanics rely on information delivered to them by word-of-mouth. Therefore, the conventional outreach methods are not successful with this constituency.

Lack of the access information prevents Hispanics from using available entitlements. The 1989 Commonwealth Fund Study states that 44 percent of the Hispanics who are eligible for SSI are enrolled and that more than a quarter of those potentially eligible said they had never heard of SSI before. SSI benefits are crucial for the Hispanic elderly because they have earned low incomes and most retired their health insurance benefits.

At the hearing, witnesses stated that Hispanic elderly live in substandard housing and are concentrated in poverty stricken areas of New York City. These areas are replete with

dilapidated buildings and buildingd that violate the housing code. Added to the stressful situation is a fact that many elderly tend to live with family members. A study done by the Partnership for the Homeless in 1989 estimated that between 45,600 and 52,500 Hispanic families live in doubled and tripled-up situations in New York City. Housing in New York City has become even more scarce and substandard as Federal funding as decreased. Hispanic elderly are uninformed about what is available in housing for them although most Hispanic elderly are eligible for some kind of housing: Section 202 Senior Citizens Housing or Senior Citizen Rent Increase Exemption, the complex rules and regulations governing these programs coupled with the lack of publicity prevent the Hispanic elderly whom might prefer living alone from taking advantage of them.

To insure better quality of life information and language policy of the Hispanic elderly must be addressed. I will continue to examine the issues and recommendations that surfaced during the course of testimony presented

at the public hearing. A copy of said testimony is being provided to the U.S. Commission on Civil Rights for the record. Thank you for this opportunity.

DR. NISHI: We appreciate that very much. Thank you. Our regards to Council President. Are there any questions? Are there any questions from the floor?

MR. YOUNG: To what extent does the pervue of this go beyond the issues?

DR. NISHI: They are--

MR. YOUNG: They are becoming an increasing part of our clients.

DR. NISHA: We were leaning specifically with minority elderly. If you have supplemental testimony, we'll take that.

We thank you all for participating in the informational hearing. We received a great deal of information. We expect to sift through the data and to present a report which you will have an opportunity to report. We thank you.

MR. CALABIA: Before it is published, you will have a chance to look at the draft and update any information. Also, when we do release

it in a public press conference, you'll be invited to participate with us.

DR. NISHI: We thank you very much. We believe we've dealt with an extremely important issue and appreciate your compliance in initiating it and understanding it.

(TIME NOTED: 4:45 P.M.)

C E R T I F I C A T E

STATE OF NEW YORK

COUNTY OF KINGS

I, JOANNE SIMONE, a Shorthand Reporter and Notary Public within and for the State of New York, do hereby certify:

That the foregoing record of proceedings is a full and correct transcript of the stenographic notes taken by me therein.

IN WITNESS WHEREOF, I have hereunto set my hand this 15 day of January, 1992.

Joanne Simone

JOANNE SIMONE

Good afternoon Madam Chair, members of the advisory committee, fellow presenters and guests. My name is Carmen Vinales Cunningham. I am the Director of Affirmative Action Programs for the New York State Office for the Aging in Albany. On behalf of Ms. Jane Gould, the State Office Director, I welcome this opportunity to speak before you today on the problems of access to long term care services - particularly nursing home care, experienced by older minority residents of New York.

I would like to begin my comments by distinguishing the role of the State Office for the Aging in relation to the focus of your study on long term shelter and nursing care for the minority aged. As the designated State Unit on Aging by the Administration on Aging, the State Office is charged with advocating for the development, coordination and administration of a comprehensive service delivery system for the over three million elderly New Yorkers. With primary Federal funding under the Older Americans Act, as well as State and local funding, the State Office advocates for and serves elderly New Yorkers through program, policy and legislative initiatives. The State Office oversees 59 local offices for the aging which includes two that are on Indian reservations, the St. Regis Mohawk Reservation and the

consider is the development of an appeals mechanism for nursing home denials to work in close cooperation with ombudsman programs.

The issues of economic and racial discrimination in accessing aging services, particularly long term services which can be more costly and needed for many minority elderly have major policy implications for government agencies. The targeting of services to those elderly in greatest social and economic need with particular attention to low income minorities is a mandated regulation pursuant to the Older Americans Act and is a priority at all levels of the aging network, national, state and local.

It is our targeting initiative that strives to increase the participation rates of minority elderly in aging service programs. Among the steps taken to increase access and information for minority elderly, the State Office has established a Statewide Committee on Minority Participation. This 15 member committee has representatives from communities across the State, of differing cultural and ethnic backgrounds and with affiliations as retirees, academicians, lawyers, service providers and minority aging advocates organizations. It is the charge of this committee to assist Director Gould in

long term care data hampers policy development for the long term care system. It is my understanding that the Department of Health has a patient review instrument (known as the PRI) for nursing facility residents which was developed as a tool for determining nursing home case mix reimbursement. This is the only document which provides a computerized profile of recipient characteristics. Recently this document has been examined by the Division of Human Rights regarding the legality and use of ethnic data collection. I was hoping to hear an update on this issue from Mr. Kostelney, Administrative Law Judge from Human Rights, who was scheduled to present here today. The PRI was an outcome of a 1986 report on Nursing Home Care which noted the need for ethnic data of nursing home residents to be able to determine if discrimination exists. However a recent review of the PRI instrument by the counsel at Human Rights suggests that the document should not be forwarded to the nursing homes until the patient actually shows up to occupy a bed. In New York State, there are restrictive laws regarding ethnic data collection that are designed to hinder discrimination on applications to nursing home facilities and other long term care services. This regulation has a restrictive impact on our data collection efforts regarding newly implemented caregiver programs as well. However

The State Office staff was actively involved in the New York State Nursing Home Task Force which issued the report referenced earlier in June of 1986 that included specific recommendations regarding discharge planning and admissions to nursing homes. Also recommended was the establishment of a data base on referrals and admissions to document if in fact systematic discrimination based on race for nursing home admissions exists. The task force consisting representatives from the Department of Health, Office for the Aging, Division of Human Rights and friends and relatives of the institutionalized aged was a result of a report which was released in 1984 by the advocacy agency Friends and Relatives of the Institutionalized Aged which alleged racial discrimination by hospital discharge workers and hospital personnel resulting in segregation in nursing homes in NYC. The task force report revealed low minority resident representation in nursing care facilities. Based on subsequent documentation and research on minority elderly such as that from the Minority Elderly Report which was published by our Office and forwarded to you last October, data supports that minority older persons have a higher prevalence rate for chronic disease and a higher level of impairment or frailty than same age whites. Therefore the likelihood for the need for long term care services may be higher as well. As a

providers that all minority families tend to or prefer to take care of their own even in the most neediest of cases without regard to individual circumstances, the lack of awareness by many minority older persons of existing long term care services and how to navigate through bureaucracies and entitlement programs to obtain needed services and the uncomfortable and inadequate communication or lack of communication between minority elderly or persons acting on their behalf and health care providers. In these situations, often times cultural differences or socioeconomic differences relating to communication and expression, exclusive of language, such as tone of voice, use of hands when speaking, lack of eye contact on the part of minorities and lack of cultural sensitivity on the part of the health care provider contribute to inadequate access to services when the best case plan is not the end result. Also it cannot be overstated that many elderly minorities have experienced or have memories of discrimination with government agencies in the past and have culturally based fears regarding divulging personal information. This of course impacts on access as it is presently structured. Issues of racial disparities in medicaid coverage for nursing care are presently being examined by the National Senior Citizens Law centers and other advocate groups across the country.

persons stay at home have encouraged state governments and public agencies to reconsider the design of long term care services and how they are accessed.

Governor Cuomo in his 1991 State of the State message, directed the State Office for the Aging to examine the feasibility of implementing a program known as Managed Access to Aging Services (MAAS). This program would establish a single point of entry to long term care for the elderly in New York State. The key features of MAAS include the consolidation of responsibility and authority for managing the elderly's access to long term care services within the State Office for the Aging and the designation of local long term care case management agencies with responsibility for assessing the elderly's need for long term care, determining the most cost effective method for responding to those needs, authorizing last resort public payment for needed services, and providing on-going case management to monitor the provision of services and make adjustments in care plan as appropriate. In its totality, the MAAS proposal embodies a basic change in long term care responsibilities: there will be for the first time, a visible point of accountability for all long term care access issues for older New Yorkers. The implications