NYL NEXT WAVE

"We Understand Health Care"

April 2, 1996

Barbara A. DeBuono, M.D., M.P.H.
Commissioner of Heath
c/o Long Term Care Financing Comments
NYS Department of Health
Corning Tower Room 1602
Empire State Plaza
Albany, New York 12237-0053

Dear Commissioner DeBuono:

I presented testimony at the Task Force on Long Term Care Financing Public Hearing last Friday after many of my colleagues, and was therefore able to deviate from prepared remarks and build upon their testimony in my oral presentation. Brian Ellsworth asked me after the hearing if I would expand on these oral remarks in writing, particularly my recommendations to:

> Establish Long Term Care Case Management as a Public Good/Entitlement, and
>
> "Unbundle" Major Service Components (Case Management, Housing, Personal Care, and Medical Care) as a framework for understanding and dealing with the complexities of resident/client need, eligibility, targeting public funds, public/private financing, service delivery models, and public education.

The core of my oral remarks was that I agreed with ALL of the testimony I had heard throughout the day - as partial views of the larger picture. What I offered to both the Task Force and the Staff was a structure to fit all of the testimony into this larger picture.

LTC Case Management as a Public Good

Case Management is a critical factor in LTC reform discussions, an issue recognized by the Task Force as evidenced by the extensive time spent on questions during Michele Berry's testimony .

Case Management in Long Term Care is similar in concept to the "Medical Home" for Managed Health Care - a gatekeeper function which is focused on meeting the needs of the individual resident/client in the most cost effective and least restrictive means available. Models for this "LTC Home" are key components to PACE and CCRC, but are somewhat less developed in a mixed provider or non-network setting. Evaluation of the case management process under the MR/DD Medicaid Waiver, and specifics of the various CASA approaches, combined with review of computer tools to assist in this process which are currently in use in a number of counties can provide the needed insights for development of a comprehensive model.

As presented in other testimony, Unit Costs within any current service provider are about as low as they can go since much care provided at close to minimum wage and previous budget constraints have squeezed out most of any inefficiencies in a given provider. The only material cost saving potential is to address SYSTEM efficiency (placement and flow) vs. component efficiency (unit costs at a particular level of care). This is the focus of LTC Case Management.

Addressing the Complexity Dilemma - "Unbundle" Major Service Components

One thing I have observed in attending Task Force meetings is that the sheer complexity of LTC financing and service delivery slows down discussion and inhibits consensus. This was also noted in testimony by Carl Young, who quoted from H.L. Menken - "For any complex problem, there are a number of simple solutions - all of them wrong." I recommended that the Task Force and Staff consider breaking the total system into its major service components (housing, personal care, medical care) and adding case management as indicated above. I have found this useful as a tool in conceptualizing the overall process. See the enclosed chart as an example.

Abandon (to the extent possible and as soon as possible) - the "all or nothing" threshold for eligibility for public funding (Medicaid or otherwise). This will then allow the flexibility to "target" only those services needed by a resident/client in the least restrictive setting.

Defining case management as one of four major components acknowledges its importance in coordinating and targeting the other three.

Formally separating out the medical care component will help avoid "over medicalization" by clearly showing it is only one of three major service components in LTC.

I hope that these comments are useful. If you, Task Force members, or staff have any questions regarding this material, please contact me at 452-3351.

Sincerely,

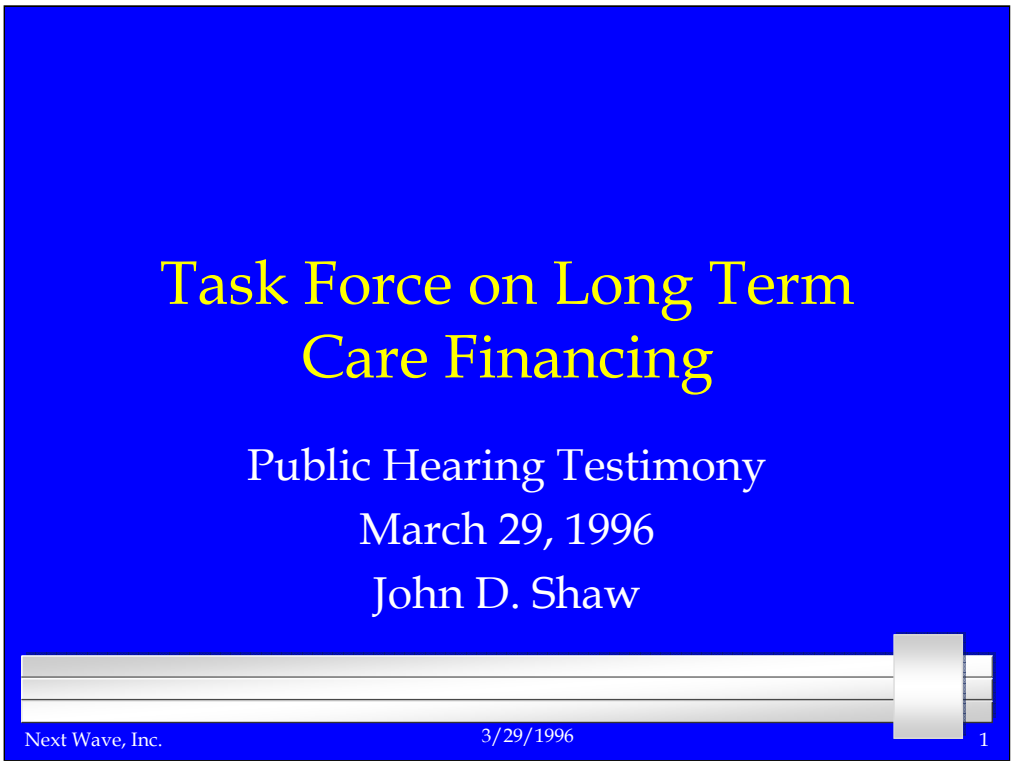
John D. Shaw
President

Enc.

cc. Brian Ellsworth

Conceptual Framework - Long Term Care Financing and Delivery

Service Component	Model	Target Public Funds	Public/Private Financing	Service Models	Consumer Perceptions	Public Education
Case Management	Public Good	Coordinate and "Invest" in a uniform, unbiased system for all	"Prevention" is the most cost effective in the long term, but no one wants to pay now. Pay for everyone: MAKE A PUBLIC GOOD	Consumer (or advocate) Choice and Marketplace Directed	Existing case management biased (i.e. employee of provider instead of customer advocate)	Teach concept of Customer Advocate - "LTC Home". How/where to access
Housing	Use Existing Resources First	Align incentives with co-pay on housing	If housing available - private responsibility (on housing only), if not - public responsibility	Builds Inherent Flexibility into System	Most Sensitive Asset to protect - Expectation to pass along to children	Educate BOTH consumers and providers on available programs.
Personal Care	Maintain Least Restrictive	Allow and encourage client and family to assume a greater level of risk	If family/friend available to provide care - encourage it (and build respite credit). Identify and "target" partial public funding to support and maintain private care. Protect BOTH income & assets.	Competition Decides Most Cost Effective Model(s) at any given point of time for a client	"Too risky to keep mom/dad at home - s/he may fall again." "I want to stay at home but need <u>some</u> help." "I do NOT want to be a burden."	"Elderly caring for the Elderly" and family responsibility Educate providers on available programs. Personal Responsibility
Medical Care	Health Insurance	Traditional Medicaid plus "catastrophic" access for all New Yorkers	Encourage traditional health insurance model (with Partnership OR Self Insurance/Private offering the SAME income and asset protections) after time or $ spend-down.	Focus on resident or client NEED vs. Site of Delivery	Impersonal and intrusive. Perception that many services "can only be done in a Nursing Home - too risky for home."	Educate consumers - realistic expectations. Educate consumers AND providers on cost effectiveness and quality measures.

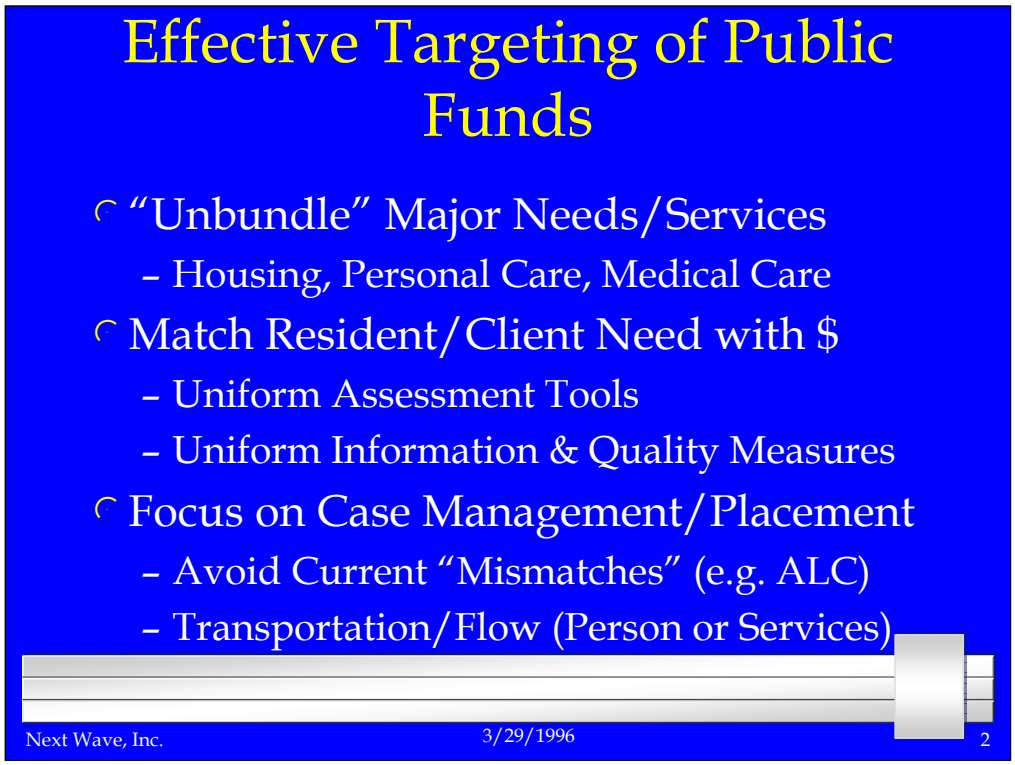


Good afternoon, I'm John Shaw and I'm the president of Next Wave, Inc.

Next Wave is a health care consulting, evaluation, research, and education company based in Albany. We are currently the trainers for the State of NY on the long term care assessment forms: the PRI, the Screen, and the MDS+. We were the technical consultants to the legislature on design of the NYPHRM System. We've performed evaluation projects in the past on the impacts of DRGs on NY's hospitals for HANYS and on HMO's for the NYS HMO Conference. We developed a joint cost profiling system for NY nursing homes for HANYS, NYAHSA, and NYSHFA.

We also perform management studies for individual hospitals, nursing homes, and insurance companies, looking at costs, payments, and case mix adjustments. I've also served on the Technical Advisory Group to develop case mix measures for nursing homes (RUG II and RUG III+) and on the Professional Advisory Group to develop long term care quality measures under NY's NYQAS Experiment. We recently completed an evaluation project to look at the impact of NY's RUG II case mix payment system on nursing home management practices over the past ten years which should be released shortly.

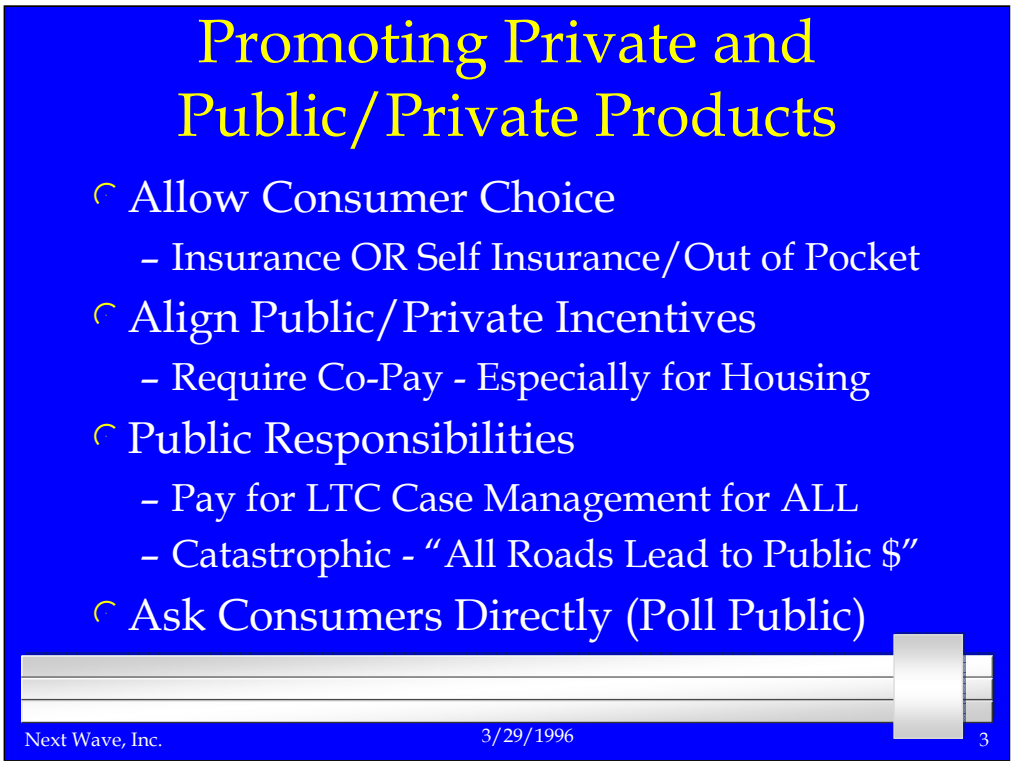
I hope this broad perspective from the payor, provider, and research side will assist the Task Force to formulate their recommendations for restructuring the long term care financing process in NYS. I am here today representing myself.



We have a tendency to focus on the site of delivery rather than resident/client need. There are widely different consumer expectations, costs , and public policy perspectives for housing, personal care, and medical care. For effective targeting of public funds and services, we support Task Force efforts to focus on these areas separately. Defining separate benefits in each of these areas could also assist in subsequent discussions on how to structure a rational delivery continuum.

We now have uniform ways of assessing resident/client needs across the continuum - the nursing home MDS/RAI is used in 16 different countries with versions now available for home care and adult homes. There are quality outcome measures which can be used for regulatory oversight as well as internally in a facility. Community Health Information Networks are being developed to disseminate this information to providers, consumers, and regulatory agencies.

Another way to target public funds is focus on case management and placement. We recommend that the Task Force also consider unbundling this function. This is targeting at the most local level - the individual person. Total financing needed will ultimately depend on cost effective delivery. Defining a case management benefit would implicitly address this **for each person in the system**. Case managers could be held to performance measures focused on cost effective placement of the resident/client. An unbundled transportation benefit (moving either the resident/client or services needed) could enhance cost effectiveness.

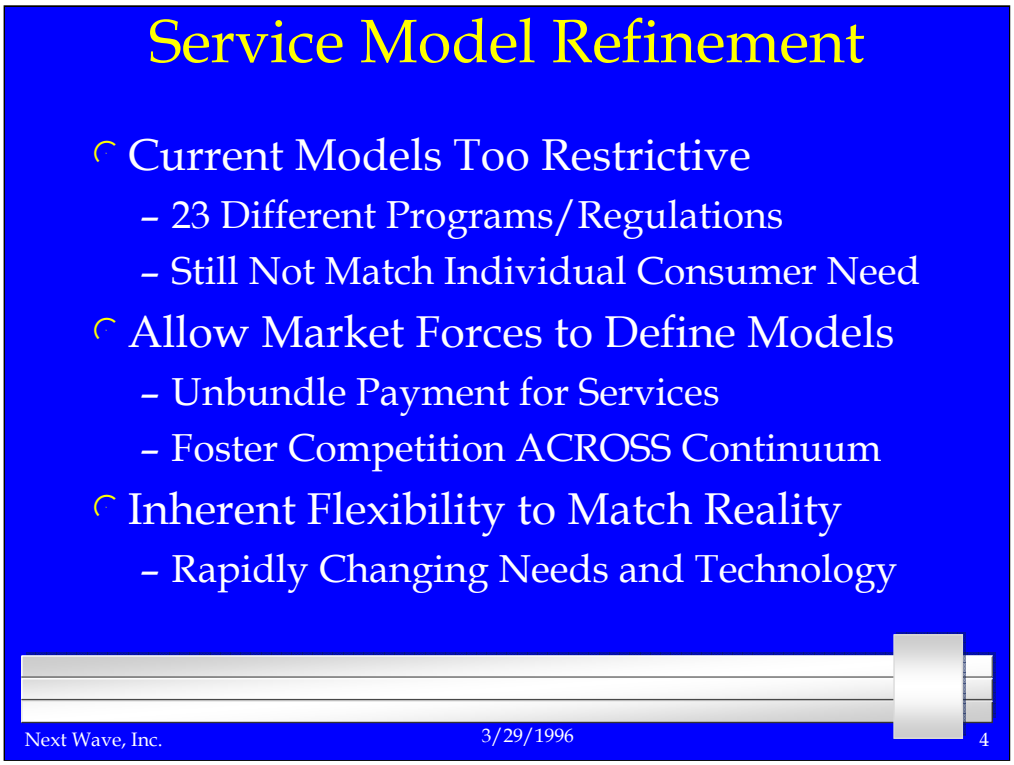


The basic tenet of encouraging more private involvement in health care payment and decision-making is to promote responsibility and the ability to make informed choices. Consumer choice is a major factor in our market-driven economy, the customer ultimately demands a say in how their personal funds will be spent. We strongly recommend the consumer be allowed a choice in providing for their care either to purchase insurance or to choose self-insurance/out of pocket in order to gain the same protections of assets and income as insurance.

Another way of promoting private or public private products is to align the public and private incentives. To this end we strongly support the concept of co-pay by the consumer, particularly for the housing component of their care.

We wish to make a strong recommendation that the Task Force consider paying for case management function for all New Yorkers, yes even Donald Trump. System efficiencies in use of standard case management tools more than offsets the costs of covering all. The other area of public responsibility is catastrophic coverage for all consumers. Disenfranchising an group of consumers from access to public services is contrary to equal protection and ultimately will be unstable. We do not deny access to other public services such as roads. We pay for everyone.

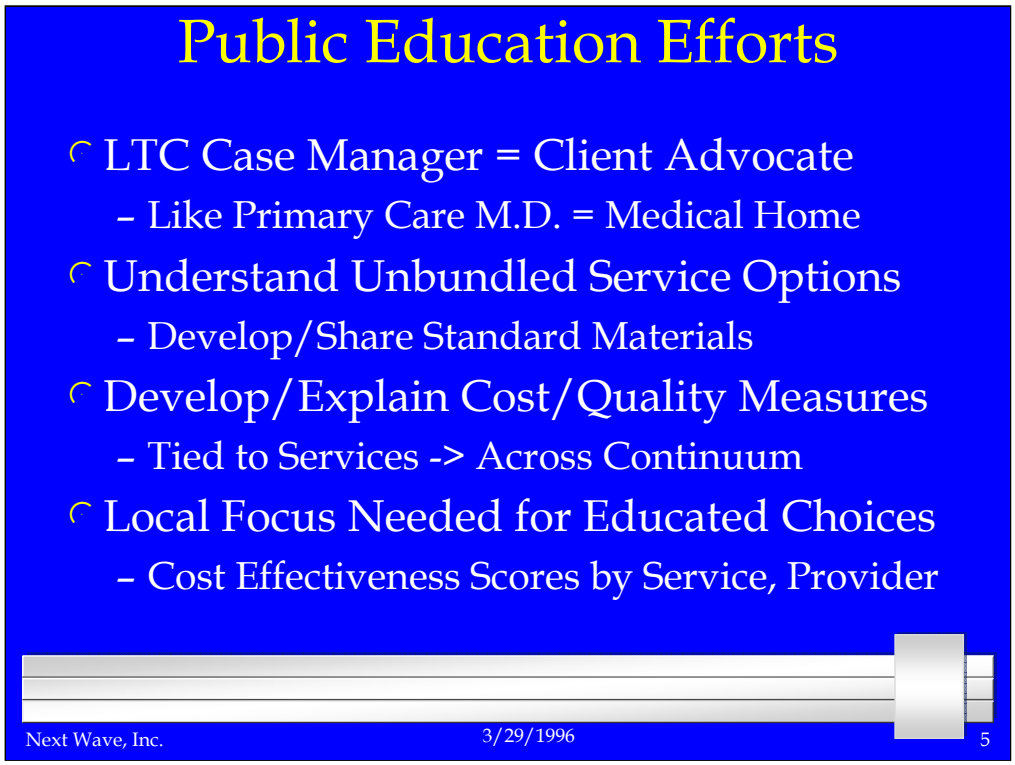
The last thing we would recommend to promote private and public private products, is to consider polling the consumers directly. As professionals in a very complicated industry we have a tendency to think we know what the public wants; however, I also know from much of our evaluation and research work that what we think may be widely different from what the consumer actually wants. Let's not repeat Medicare Catastrophic Coverage.



I thought it was quite interesting that in the first set of handouts to the Task Force there was a chart of the 23 different programs that are in existence in NYS currently to provide long term care. Even with this diversity of programs, there's a difficulty in being able to match a particular individual with an appropriate program. ALC still exists. At least part of the difficulty is the barriers between these levels of care and just the time and paperwork to move the individual to the setting that best meets their needs.

We would therefore recommend that **market forces define the models** rather than trying to anticipate what those models "should" be. Our previous recommendation to support unbundling of payment for service will help facilitate this and will help foster competition across the continuum so that the marketplace will assist in the process of placing an individual in the most cost-effective setting.

Our final recommendation for service model refinement is to inherently build into the process a strong flexibility in order to match the reality of our rapidly-changing long term care resident/client population and the technology to better define and meet resident/client needs for the population. Our current regulatory process almost mandates that any system we put in place today will be obsolete by the time that it is actually implemented. We strongly applaud the direction this Task Force is taking to set the guiding principles and let the details be taken care of in the marketplace.



The last area where the task force has asked for input is public education. This industry is extremely complicated and much information needs to be provided to the consumers to make it work in a market-driven scenario. To this end we would recommend promoting the long term care case manager as the advocate for the client. This is similar to the concept and vision of the medical home for an individual.

To implement unbundling, it will be necessary to educate the public that long term care is no longer just nursing homes or home care but rather services to meet their particular needs in the dimensions of housing, personal care, and medical care. We recommend sharing standard materials developed centrally but disseminated on a local basis to be reworked into materials that fit particular needs of an urban or rural or suburban population.

We must balance the value of letting the marketplace define the costs and services that are most appropriate with public accountability to ensure the consumer interests are truly being met for a significant public investment. We need to develop and be able to explain cost-effectiveness measures to consumers. We recommend that these measures be tied to services and not to particular provider groups. This will allow comparisons across the continuum and to allow the consumers to make more informed choices.

One way to accomplish this is to put together cost-effectiveness scores looking at cost and quality by service and by provider at a local level. These tools could then be used by the case managers in that area as well consumers.