Little Hoover Commission
Public Hearing on Long-Term Care
March 25, 2010
Outline of Testimony
Leslie Hendrickson, PhD.

Thank you for the invitation to present comments today. Bob Mollica and I are pleased by the Commission's interest in our Long-Term Care Financing Report. The Commission has a long history of publishing influential reports and has an outstanding reputation. Commission staff have asked me to address four matters.

In terms of content, we would appreciate an overview of the findings and recommendations in your report, with an emphasis on what is missing in California's continuum of care for our aging and disabled,

The overview is given in the Executive Summary which Commission staff have distributed to you.

How the different long-term services can fit together more seamlessly,

The Long-Term Care Financing report and its recommendations are consistent with those described in the 1996 Little Hoover Commission report on LTC. The 1996 report, the Commission's excellent 2004 Real Lives Real Reforms report, and ours contain recommendations of a similar spirit. In 2006, the ten-year review of the 1996 recommendations by California Healthcare Foundation said "limited" progress had been made. It is a mixed picture, for example, some progress such as establishment of public authorities for IHSS and single points of entry. Recommendation for consolidation/reorganization has not occurred.

Discussions of LTC reorganization, like discussions at the Mad Hatter's Tea Party, are informative but have not actually resulted in Alice finding her way out of Wonderland. IMHO, if reorganization was feasible it would have happened by now.

No consensus among persons interviewed as to how reorganization could happen.
Advocates are wary of changes that might reduce the visibility of their priorities and prefer the devil they know.
Departments are of unequal sizes so authority or program priority after merger is uncertain

Instead state might think of other methods of organizing LTC

1. Senator Liu's SB 998 is an excellent bill. Its emphasis on assessment and case management goes directly to the heart of fitting things together more seamlessly.

2. LTC needs to be organized by persons not by Departments.

    a. Need single database on persons who use LTC regardless of what programs they receive. Database must span all departments and programs and collect similar assessment information on all purpose and contain information on services received and their costs. A state whose garages gave birth to Hewlett Packard and whose schools gave birth to Google deserves better technology.

    b. Also need person-based reimbursement systems such as case mix in nursing homes. Reimbursement should be based on characteristics of the person not provider lobbying power, or cost, or across the board budget cuts.

3. You can creatively build organizations that span Departments. Example of PA Office of Long Term Living. When created the head was appointed as Deputy Secretary in two departments and supervised programs in both departments. Offices within Departments are only building blocks. You can arrange the building blocks anyway you want.

4. Single points of entry would help a lot. Also a recommendation of LHC's 1996 report. ADRC work done by Community Choices Project should be expanded. States that have good long term care programs and better control typically focus on assessment and case management through single points of entry.

Whether all of the state's existing programs should continue as they are,

1. State policymakers are in a position where it is difficult to cut programs because of the reaction of advocates and legal challenges.

2. Nor can they add programs since the state has a few budget problems.

3. What is reasonable to do now about long-term living programs? We can focus on administrative actions that would be cost effective and look like they might have good payoff. What the state can do is to become more efficient at what it does

    a. More rigorous job of maximizing federal revenue
    b. Figuring out how to control costs better such as ventilator expenses

c. Figuring out how to reshape incentive programs e.g. labor driven operating allocation, for nursing homes
d. More transition and diversion work so higher cost cases are better managed and lower cost services are used instead.
e. Can get administrative efficiencies and make small program changes like adding TBI services from consolidating waivers. Feds now permitting consolidated waivers e.g. New Jersey's. Federal requirements over last ten years on use of waivers have imposed considerable administrative burden on state.
f. Licensing issues like the need for three adult day health care licenses should be dealt with.
g. Single database would be more efficient. One database for nursing home treatment authorization requests (TARs) is unusable. Cannot be searched cannot be linked
h. Need to settle fraud and abuse claims about IHSS program. Is it a pot of gold at end of rainbow or simply a leprechaun tale

4. Report contains recommended policy changes such as increasing size of home maintenance deduction

and how a state strategic plan – as your report recommends – might look.

a. Not sure what to say about a strategic plan that isn't already in the report. Report states that a plan must cover all agencies involved in long-term living. Use cross agency perspective. Recent, illustrative RFP from North Carolina for business process redesign of its LTC programs.

   A plan outlines specific steps that will be taken, who will undertake them, when the steps will be taken, and what outcomes should be expected.

   Programs need to be managed as one program. A strategic plan can help make that happen. For example, see attached report from North Carolina. It shows all programs that provide case management and counts how much duplicate case management exists across all programs. Each number in the table represents persons where the state is paying for case management in two separate programs. What we learn from North Carolina is that you can't manage well if you don't know what you are not managing.

Duplication of Case Management Services by DOS, FY 2009, 10/01/2008-12/31/2008
Recipients, Total Paid Amounts, & Total Service Units
60-Day Search Window for Duplicate Services

MID Counts (Cell numbers are counts of recipients receiving services from programs in intersecting Rows and Columns)

ClaimDetailTableColumn	CAP/C15	CAP/Cpm	CAP/DA	CAP/CH	C/MRDD	DD	AT RISK	HIV	CSC	MCC	MOW	EI	HC	SAIOP	ACTT	CST	IIHS	MST	SACOTP	CSI-Ch	CSI-AD	CS-GP
ProcRevCodePaid	T1016	T2022	T1016	T2041	T1017	T1017	T1017	T1017	T1016	T1017	S9445	T1017	W8017	H0015	H0040	H2015	H2022	H2033	H2035	H0036	H0036	H0036
ProcCodeModifierAdj					HI	HI						HI				HT				HA	HB	HQ
Provider Type/Specialty	082/ 094	082/ 094	082/ 094	082/ 094	074/ 113	074/ 113	099/ 060	040/ 060	020/ ***	020/ ***	020/ ***	038/ 115	001, 054/ ***									
" " "	082/104					112/ 116			022/ ***	022/ ***	022/ ***	055/ 060	022, 055/ ***									
" " "						112/126			055/ ***	055/ ***	055/ ***	066/ 060	066, 093/ ***									
" " "									111/ 060	111/ 060			102/ 100									
CAP Indicator Code	HC,SC,IC	HC,SC,IC	CS,CI	SD,ID	CM, C2	*not* CM,C2																
Recipient Age									0-5			0-3										
CAP/C CM (per 15 min)		1	2		2	3			4			10	18									
CAP/C CM (per month)			1									1	5									
CAP/DA Case Mgmt					1	10	20	11		1			6	1	6	8				1	67	
CAP/Choice Care Adv							1						2								1	
CAP/MRDD Waiver TCM						130	12		1	2			60			1				3	1	
DD Targeted CM							40	2	27	17	1	8	2,090			2	6	1		44	33	
At Risk Case Mgmt								16	20	9	3	7	588	1	44	42	13			103	137	3
HIV Case Mgmt									1	8	1	2	39	7	6	46			11	4	83	1
Child Svcs Coord										2	575	429	6,675				8			32		
Maternal Care Coord											618	2	1,908	10	5	24	5	2	27	109	105	
MaternalOutreachWrkr												10	449	2		3			9	6	14	
Early Intervention													3,893									
Health Check Coordi														51	21	147	1,506	179	5	24,672	11	81
SubAbuseIntervOutpat															2	9	1		10	34	67	2
Assertive Comm Tx Tm																15			3	2	24	
Comm Support Team																			5	22	249	1
Intensive InHome Svcs																		2		543		4
Multi-Systemic Therapy																				66		
SA CompOutpat Tx																				4	72	2
CommSupp-Child																					16	84
CommSupp-Adult																						112
CommSupp-Gp																						