Response to the Supplemental Expert Report of Samuel S. Flint, Ph.D. June 8, 2007

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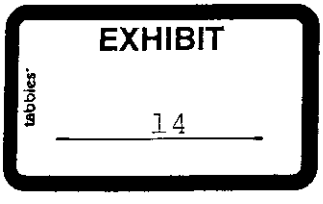
Radaszewski v. Maram
United States District Court for the Northern District of Illinois
Civil No. 01-CV-9551



Response to Flint's June 8, 2007 Supplemental Report

The purpose of this report is to respond to the June 8, 2007 supplemental report of Samuel S. Flint, which is a critique of my analysis provided in the case of Radaszewski v. Maram. Mr. Flint's report is broken into two distinct sections, "Critique of the Werner Cost Projection" and "Critique of the Werner Anticipated Health Care System Impacts". I will respond in the same manner to simplify references to Mr. Flint's report.

Response to section titled "Critique of the Werner Cost Projection"

Medical Necessity

Mr. Flint's first issue concerns medical necessity. He describes it as, "the most fundamental methodological processes required for a reasonable health care cost projection." He then states that the cost projection from my report "completely ignores medical necessity" because of the assumption made that participants could shift from a nursing home setting to a community-based setting.

The comparison of nursing home residents to 24 hours of registered nurse (RN) care is made because that is the amount of care being requested for Eric Radaszewski, which is beyond what has been authorized under the federally approved waiver program commonly referred to as the Home Services Program (HSP). The premise of my analysis is that Eric Radszewski is requesting services not only beyond the current program but also that 24 hours of RN care is not medical necessary. Mr. Flint's premise is that the request of Eric Radaszweski is medically necessary.

Part of the dispute between the plaintiffs and defendants in this case is whether or not 24 hours of RN care for Eric Radaszweski is medically necessary. That is an issue of fact that is in the Court's purview and beyond the scope of my expertise or Mr. Flint's. Until the Court rules on this disputed fact, it is completely appropriate for my analysis to be based on the premise held by the State, that Eric Radaszewski is requesting care not only beyond the scope of the federally approved HSP but also beyond medical necessity.

Under the premise that Eric Radaszewski is seeking care that is not medically necessary then the logical conclusion is that granting his request to receive such care sets a precedent for other beneficiaries to request and receive non-medically necessary care also. Mr. Flint's criticism that my analysis "completely ignores medical necessity" is based solely on a point of disputed fact on which the Court has not ruled. Therefore, it cannot be considered either a valid or relevant criticism of my analysis.

Neither Mr. Flint nor I are qualified to determine the medical needs of Eric Radaszewski. Mr. Flint is appropriately allowed to consider the premise put forward by the plaintiffs as true, just as I am allowed to consider the defendaut's premise as being true. It is simply inappropriate for Mr. Flint to use a disputed fact, on which he lacks the expertise to opine, to discredit an analysis.

Even though Mr. Flint's criticism on the matter is neither valid nor relevant because of his use of disputed fact as the basis of his criticism, The analysis still holds strong even if one considers the premise of the plaintiffs to be true, that Eric Radszewski is requesting care that is medically necessary.

For the sake of argument the question becomes; would other individuals be able to receive increased services if Eric Radaszewski received 24 hours of RN care daily and that care was determined to be medically necessary for him? Mr. Flint assumes that answer is no, however, I think it is answered yes.

Medical need of 24 hours of daily RN care does not mean that the nurse is performing medical duties every single second of every minute during the 24 hour period. The patient simply needs to have immediate access to a nurse at all times for their medical needs to be met. Patients in nursing homes have access to nursing care 24 hours a day even though each patient needs direct medical care to a varying degree. Home and Community Based Service (HCBS) waivers like the HSP are required under federal law to demonstrate cost-neutrality. In other words, the services provided by HSP cannot exceed the cost of providing institutional care.

Even if 24 hours of RN care is medically necessary for Eric Radaszewski, that amount would exceed the cost-neutrality test for the HSP program. In the analysis it shows that the daily cost of care for Eric is $672 per day which far exceeds the average of $74 per day for nursing home care and the average of $255 per day for an individual in the exceptional care program on a ventilator, the highest cost group under the exceptional care program. Just 3 hours of nursing care at $28 per hour ($672 / 24 hours) would exceed the cost-neutrality based on a nursing home setting. The limit would be 9 hours for the exceptional care person on a ventilator.

If medical need is determined to override the cost-neutrality limits established under the federally approved waiver for the HSP, then it would clearly necessitate a State only program serving individuals with medical needs that can be met in the community with a service package that exceeds federal cost-neutrality requirements. The new program limit would be based on the highest level of care offered, in this case 24 hours of RN care, which is effectively no limit. Without a cost-neutrality limit in place, then every single person in a nursing home would be eligible for home and community based services. The limiting factors become the availability of community support, financial support for non-medical needs, and adequate housing.

Nursing home residents have varying degrees of need for nursing care. All of them may not need access for a full 24 hours but without cost-neutrality as a limit and medical need having a limit set at 24 hours a day, every nursing home resident could receive nursing care in a community setting. It is more than reasonable to think that many individuals might be interested in such a program if offered. Even if they didn't need a full 24 hours, many probably would need in excess of the 3 or 9 hours currently limiting the program via cost-neutrality.

As stated in my analysis, my purpose was to identify the potential maximum impact of such a change. A true maximum without any other considerations would be 100% of the nursing home residents. At no point do I ever suggest that 100% of nursing home residents will seek such services. Instead I attempt to put a more practical perspective on the analysis by estimating the number of individuals that would transition to the community if limits on cost-neutrality were eliminated.

The 10% Estimate and Data Critique

Mr. Flint states in the second paragraph of his report that my report "provides extremely misleading data", however Mr. Flint never in any part of his critique challenges the validity of the numerical data used for the calculation. Instead Mr. Flint challenges the assumptions used in the calculations, most notably the assumption of a 10% shift of nursing home residents to the community and a 10% shift of HSP participants to a higher level of care.

Mr. Flint states, "The Werner estimate makes no pretense of actuarial sophistication." The word pretense is defined as, "insincere or feigned behavior: something done or a way of behaving that is not genuine, but is intended to deceive somebody"[1] I agree. At no point do I pretend that my analysis is meant to be a highly technical actuarial model. Although I have used actuarial techniques in the past, the analysis for this case was a simple mathematical approach to identify the potential maximum impact, which could also be characterized as a worst-case scenario. A complex analysis is not necessarily more accurate than a simple analysis nor is a simple analysis invalid because of its simplicity. Mr. Flint's report appears to imply such but does not provide support for that point.

The one assumption that Mr. Flint refers to repeatedly is what he calls the "arbitrary 10%". Again, the purpose of my analysis was to simply identify the potential maximum impact. The maximum population is 100% since everyone's medical needs could be met within the maximum amount allowed, which would be 24 hours a day. Because of the multiple variables that affect such a shift: number of hours each individual needs, does the person have someplace to live, is there family support, does the person have adequate finances, et cetera; it is reasonable and logical that not everyone will be able to shift and not everyone will need the maximum amount of hours.

For the maximum impact to be reasonable, it needed to be adjusted. I calculated four possible percents of population shift, 1%, 10%, 20%, and 30%. The value of 1% gave the analysis the flexibility to calculate various population shift levels by simply taking the value for 1% and multiplying it by the chosen level. I used my professional judgment and experience to decide that it was highly unlikely for more than 30% of the population to shift. In general, a small number of people generate a large portion of the healthcare costs, frequently referred to as the 80-20 rule. Therefore a small portion of the nursing

[1] Definition #1 from MSN Encarta online dictionary
http://encarta.msn.com/encnet/features/dictionary/dictionaryhome.aspx

home population is likely to need nursing care in amounts greater than the 3 or 9 hours daily that exceed cost-neutrality. For discussion purposes it was reasonable to use a value of 10% to illustrate how a very small number of people could generate a significant amount of increased costs.

At no point do I assert in my analysis that 10% of the population would shift to receiving 24 hours of RN care in the community. I never used such absolute terms because the analysis was not meant to determine an absolute conclusion. It was only intended to give a reasonable estimate of the maximum impact that could potentially occur to provide understanding as to how it does not take a very large population shift to become very expensive. I acknowledge that further analysis would need to be completed to arrive at a more precise number.

Mr. Flint criticizes the 10% but never opines on what number is appropriate to establish the maximum impact. Mr. Flint does offer the suggestion of using the Minimum Data Set (MDS) to make the number more precise. The MDS does have data that could be used to further define a population but it does not give a complete picture. The State and nursing home providers did agree to a reimbursement system based on the MDS but data appropriate to setting reimbursement is still incomplete. Again, the purpose of my analysis was to identify the potential maximum impact and that could be reasonably accomplished without a detailed review of MDS records. That approach is consistent with the types of quick legislative and policy analyses performed when complete data is not readily accessible or unavailable. Mr. Flint does identify the MDS as a data source but fails to offer a suggestion how that data could be used in performing an analysis.

Mr. Flint's other approach to criticizing my analysis is to compare it to the analysis of Mr. Menenburg. Specifically, Mr. Flint compares the results of our two analyses and comments on the variance between our two conclusions. Basically the argument of Mr. Flint is that since my numerical conclusion is so much higher than Mr. Menenburg's it can't possible be reasonable. Clearly since my analysis is intended to represent the upper bound of costs, my analysis has to be higher than Mr. Menenburg's attempt to more precisely identify the costs. Mr. Flint simply uses the significant variance in these two analyses to use shock rather than fact to dispute the results of the analysis.

Mr. Flint concludes this section of his analysis by stating, "In my opinion this potential exposure to the state flies in the face of common sense, which is not too surprising give(n) its complete lack of scientific rigor" It appears that he is arguing that scientific rigor is necessary for common sense. The definition of common sense alone is sufficient to show the invalidity of this concluding statement. Common sense is defined as, "good judgment: sound practical judgment derived *from experience rather than study*"(emphasis added). My eleven years of experience performing analyses concerning policy and fiscal issues affecting the State of Illinois Medicaid program has provided me with a great deal of experience and knowledge. Such experience and knowledge is invaluable in performing analyses like this one and provides a practical approach rather than a theoretical one. The lack of validity in Mr. Flint's concluding statement is appropriate for a critique that is heavy on negative words and arguments based on

disputed facts. The cost projection in this analysis was intended to be a simple yet valid approach to identify a maximum impact. Mr. Flint never challenges the calculations, only the assumptions, and still doesn't offer the Court any opinion as to what the assumptions should be or why. Mr. Flint fails to provide anything indicating that the "arbitrary 10%" is grossly unreasonable or impossible. Instead he substitutes pontifications of academic arrogance.

Response to section titled "Critique of the Werner Anticipated Health System Impacts"

Impacts on the Illinois Nursing Labor Force

Mr. Flint cites the quadrennial report from the U.S. Department of Health and Human Services (DHHS) Health Resources and Services Administration (HRSA), *The Registered Nurse Population: National Sample Survey of Registered Nurses, March 2004.*[2] Contrary to Mr. Flint's statement I did not ignore this information. I used other documents to illustrate the commonly held opinion that there is a shortage of nurses. Mr. Flint uses this preliminary report to challenge that view but the final report is much more comprehensive.

Mr. Flint first refers to the increase in wages as reported in Chart 7 of the preliminary report he utilized. The report does show that salary increase for RN's once adjusted for inflation increased less than 1% for the period between 1992 and 2000.[3] However, I find no reference or statement in that section to support Mr. Flint's assertion that there was a nursing shortage in that period. The final report does state that there was a, "perceived nursing shortage from 1988 to 1992."[4] In that time frame inflation-adjusted salaries for nursing increased by 11.2 percent and the report states that it indicates a, "significant economic demand for RNs over this period."[5] Neither version of the report supports Mr. Flint's characterization that the 14% increase in inflation-adjusted wages from 2000 to 2004 was "a 'catch up' from the eight year period of stagnant compensation growth."

Mr. Flint argues that Illinois is better off than other states and implies that there is not a shortage or a need to be concerned about wage inflation. HRSA however, published another report that is very useful titled, *What is Behind HRSA's Projected Supply, Demand, and Shortage of Registered Nurses.* This report details the design of a model to project the supply of nurses and another to project the demand for nurses. This report indicates that in 2005 that the supply of nurses only met 90% of the demand with a projection that if the current trends do not change then only 64% of demand will be met

[2] For clarification it should be noted that the Preliminary Findings of that report where actually provided with Mr. Flint's analysis. I will also be referring to the final report that was issued March 2006.
[3] HRSA Preliminary Findings, page 10
[4] HRSA Final Report, page 21
[5] Ibid.

by 2020.[6] Illinois is better off than the nation as a whole with 98% of demand met in 2005 and 71% of demand met in 2020[7], however, that assumes current trends so an increase in demand of any magnitude will only exacerbate the problem. The report further indicates that an annual increase in RN salaries of 3% would be necessary to keep pace with the growth in demand but demand would still be in excess of supply.[8]

Mr. Flint states that, "Illinois has 24,313 licensed RNs who are currently not employed", however, he should have completed the sentence by adding "in nursing".[9] Without those words it incorrectly implies that Illinois has a lot of unemployed nurses looking for work. Instead only 4.1% of nurses not employed in nursing listed "Difficult to find a Nursing job" as a reason they aren't working in nursing.[10] The report indicates that the implication of Mr. Flint's statement is false.

Mr. Flint then reviews the number of employed nurses per 100,000 populations to illustrate that Illinois is better off than other states. I agree with his comparison that Illinois has more employed nurses per 100,000 people than the national average. However, having more employed nurses than the national average does not mean Illinois has enough nurses. As discussed above, Illinois has a smaller shortage of nurses now than the national average and is projected to be better off than the national average in 2020, but a shortage is still a shortage.

In short, the reports from HRSA indicate that there is a current shortage of nurses in Illinois and nationwide that is projected to get worse if there are no changes made in the factors driving supply and demand. Moving individuals from congregate care setting into individual settings will increase the demand for nurses in Illinois. Wage inflation is likely in an environment where demand exceeds supply.

Potential Shortage of SNF beds

I agree with Mr. Flint that Illinois in aggregate has more nursing home beds than currently needed. My analysis never asserted that there would be a statewide shortage of nursing home beds. Instead my point was that in some areas of the state which may only have one nursing home might find it difficult to offer services if occupancy drops due to individuals moving out. No matter what there will always be some individuals who will need to reside in a nursing home. In remote areas access could become an issue if small nursing homes no longer are able to maintain a minimum number of residents. In those cases people may be forced to relocate from their local areas to larger areas to find the care they need. Large urban areas can easily handle such pressures and likely do a better job of serving patients but more rural areas will see their choices disappear. Mr. Flint's critique only addresses this issue on a macro level, which hides the problem that could occur in smaller communities.

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[6] HRSA Projections, page 27 exhibit 24.
[7] HRSA Projections, page 32-33 exhibit A-3.
[8] HRSA Projections, page 11.
[9] HRSA Preliminary Findings, page 19; HRSA Final Report, Table 51 page A-53
[10] HRSA Final Report, Table 40 page A-41

Unaddressed Impacts

Mr. Flint concludes his report by indicating that savings from increased home-based care should be also considered. Savings can be attained if the rules in the current HSP are adhered to and individuals receive service plans that are cost-neutral compare to an institutional level of care. Right now that is achieved by mixing care from RNs with less expensive personal assistants. Anything in excess of 3 hours of RN care for a non-exceptional care nursing home resident or 9 hours for someone comparable to an exceptional level of care would exceed the cost-neutrality limits. Without those limits the HSP program cannot save money. Since individuals with needs below the cost-neutrality level already have access to the HSP program it is unlikely many will move into the HSP. Mr. Flint's critique fails to offer any type of data or estimates as to how savings can be achieved by providing services in excess of the current cost-neutrality limits in the federally approved HSP.

Conclusion

Mr. Flint's report uses inflammatory language to cast aspersions on the analysis performed rather than provide valid criticism or data to contradict the numeric results of the analysis. His critique fails to provide more than a superficial review. My analysis provides a simply, logical, and reasonable estimate of the potential maximum impact to the State if the current program limits of the HSP are effectively removed by providing a service package to Eric Radaszewski in excess of the cost-neutrality constraints as required under the waiver approved by the federal government.

Reports Referenced

Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (DHHS) *The Registered Nurse Population: National Sample Survey of Registered Nurses, March 2004 Preliminary Findings*

---. *The Registered Nurse Population: National Sample Survey of Registered Nurses, March 2004 Preliminary Findings (Final Report)* (March 2007) as accessed on June 25, 2007 http://bhpr.hrsa.gov/healthworkforce/rnsurvey04/

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