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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

ESTHER DARLING; RONALD BELL by his guardian ad litem Rozene Dilworth; GILDA GARCIA; WENDY HELFRICH by her guardian ad litem Dennis Arnett; JESSIE JONES; RAIF NASYROV by his guardian ad litem Sofiya Nasyrova; ALLIE JO WOODARD, by her guardian ad litem Linda Gaspard-Berry; individually and on behalf of all others similarly situated,

Plaintiffs,

v.

TOBY DOUGLAS, Director of the Department of Health Care Services, State of California, DEPARTMENT OF HEALTH CARE SERVICES,

Defendants.

Case No.: C-09-03798 SBA

CLASS ACTION

DECLARATION OF LESLIE HENDRICKSON, Ph.D., IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

Hearing Date: July 26, 2011
Time: 1:00 p.m.
Judge: Hon. Saundra B. Armstrong
Address: 1301 Clay Street
Oakland, CA 94612
Courtroom: 1, 4th Floor

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DECLARATION OF LESLIE HENDRICKSON, Ph.D.

I, LESLIE HENDRICKSON, do hereby declare:

1. I make this declaration in support of Plaintiffs' Motion for Preliminary Injunction. The opinions set forth herein are based on my professional expertise, my review of materials provided to me by counsel, and other data sources.

2. I have been retained by Plaintiffs' counsel to, among other things, offer my opinions about the following: (1) the adequacy of any transition planning for recipients done by Defendants because of the elimination of Adult Day Health Care (ADHC) as an optional Medicaid benefit; and (2) potential costs associated with the elimination of ADHC as a Medi-Cal benefit pursuant to AB 97, including the impact on other Medi-Cal services, and specifically the costs associated with increased placement in nursing facilities. I am being compensated by Plaintiffs at my customary hourly rate for similar services.

BACKGROUND AND EMPLOYMENT HISTORY

3. I have 25 years of Medicaid experience including management positions in two state Medicaid programs. In Oregon, I was the only Senior Budget Analyst in the Medicaid Budget Office for six years and performed hundreds of fiscal impacts on the Medicaid program. I then became a manager in the Division now known as the Division of Seniors and Persons with Disabilities. In that capacity, I supervised long-term care eligibility, General Assistance, Aid to the Blind and Disabled, the Medicaid Personal Care option, the criminal background check unit and participated in budget analysis and in-home policy work. From 1997-2002, I served as an Assistant Commissioner in the New Jersey Medicaid program and was responsible for Medicaid and non-Medicaid home and community-based services, nursing facility reimbursement, eight field offices with support staff and nurses and social workers that conducted preadmission screening for nursing home admissions, a nursing home transition program that helped 3,000 persons leave nursing homes, and a large pharmaceutical program for persons over Medicaid income levels.

4. Upon retiring from New Jersey Medicaid, I accepted the position of Revenue Services Director for Maximus, Inc., a large, national consulting company, that had revenue maximization contracts with states. During the next two years I worked in ten states on financial analyses to improve the amount of Medicaid and Medicare reimbursement received by those states.

5. Since leaving Maximus, Inc. in 2004, I have been an independent consultant and have worked on studies of state long-term care and behavioral health programs. For example, this work includes statewide reviews of long-term care in California, Alaska, and West Virginia, statewide reviews of mental health and substance abuse in Oregon and West Virginia, studies of specific Medicaid programs, such as Ohio's home and community-based waiver programs, the Texas Medicaid non-emergency medical transportation program, the Texas early intervention program, Colorado pay-for-performance nursing home programs, and Florida programs for the visually impaired.

6. I co-authored a 300-page report on California long-term care programs entitled, Home and Community-Based Long-Term Care: Recommendations to Improve Access for Californians, prepared for the California Health and Human Services Agency and published in November, 2009. My California-related presentations include appearances before the Little Hoover Commission and State's *Olmstead* Committee, and I was asked by California Assembly and Senate subcommittees responsible for aging and long-term care to make presentations to them as well.

7. During the period 2007-2008, when I was a Visiting Professor at Rutgers University, Center for the Study of State Health Policy, I supervised a technical assistance center for state programs that had received Real Choice System Change grants from the Center for Medicare and Medicaid Services (CMS). I currently am on the technical assistance panel of national experts used by CMS to provide services to states that have received Money Follows the Person grants.

8. I have conducted research, visited at, interviewed staff, and prepared reports on adult foster homes, Area Agencies on Aging, assisted living programs, community mental health centers, hospitals, independent living centers, neighborhood health centers, nursing homes, private intermediate care facilities for the mentally retarded (ICFs/MR), programs for the visually impaired, state developmental centers, and state mental health hospitals.

9. My educational background includes a Bachelor of Arts degree in Sociology from San Francisco State College, and Master's and Doctorate degrees in Sociology from the University of Oregon.

10. A true and accurate copy of my resume is attached hereto as Exhibit A to this Declaration, and a true and accurate list of my publications and presentations is attached hereto as Exhibit B.

SUMMARY OF OPINIONS

11. I have read the Plaintiffs' Notice of Motion and Motion for Preliminary Injunction and supporting declarations, the Defendants' Opposition to Plaintiffs' Motion for Preliminary Injunction and supporting declarations, and State Plan Amendment (SPA) material submitted to the Centers for Medicare and Medicaid Services (CMS) by the Defendants. Based on my review of these documents, conversations with Lydia Missaelides of CAADS, national research literature, and publicly available material on transition planning prepared by Defendants and available on its website, I have come to the following conclusions: (1) while some preliminary transition planning has been done by Defendants, they have not taken adequate steps to ensure that alternative services are available and in place for ADHC recipients when their ADHC services are discontinued on September 1, 2011; and, (2) the elimination of ADHC will likely result in increased costs to the State, specifically due to the likelihood of nursing facility placement of thousands of ADHC recipients.

TRANSITION PLANNING FOR THE ELIMINATION OF ADHC SERVICES

12. I have been asked to comment on the transition planning for recipients done by Defendants because of the elimination of adult day health care as an optional Medicaid benefit.

Based on the information available to me, the Defendants' transition planning appears to rely on undocumented assumptions of availability of categories of community-based services, and reliance on other agencies and providers to ensure that ADHC recipients receive those services. For example, one such assumption is the speculation in the Defendants' Opposition and supporting declarations that entities such as the ADHC centers that are closing, managed care organizations, county In-Home Supportive Services programs, and targeted case management (TCM) programs will provide case management to link individuals to community-based services. Without detailed planning by, instructions from, and accountability of DHCS, there is no assurance that their assumptions will be borne out. Moreover, Defendants have not indicated any ability or intention to monitor what happens to recipients once they are discharged from ADHC.

13. In my opinion, the state's current plan lacks specificity regarding what services are actually available to ADHC recipients and how these services will be provided in time for the September 1, 2011 termination date. First and foremost, the Defendants have the opportunity and should conduct the necessary planning and analysis, set forth below, that would enable them to: (1) identify recipients who need alternative, replacement services and where these individuals reside; (2) evaluate the availability of services, including the location and capacity of providers and whether such services fit recipients' needs; and, (3) identify and plan for gaps in services in order to avoid worsening physical and mental conditions and the unnecessary use of hospitals, other health care providers, and nursing homes.

ANALYSIS OF AGGREGATE PROGRAM CAPACITY

15. An essential element of transition planning is ensuring adequate, available, and appropriate capacity of alternative services. Defendants have not provided any analysis of aggregate program capacity to determine the level of capacity that alternative services have for absorbing the demand for services that will occur when ADHC is eliminated as an optional benefit.

14. The Defendants' response in their Opposition to Plaintiffs' Motion for Preliminary Injunction did not rebut evidence in the Plaintiffs' declarations that the programs which Defendants suggest are alternatives to ADHC services:

- have been threatened with closure in the past year;
- have had recent budget cuts;
- do not provide the services they are said to provide;
- do not or are reluctant to take Medicaid clients;
- have waiting lists;
- are not in all geographical areas of the state; and,
- do not provide the mix of services provided by the ADHC programs.

See [Docket No. 229] Behr Decl. ¶¶ 30-35; [Docket No. 232] Davis Decl. ¶¶ 30-35; [Docket No. 240] Hafkenschiel Decl. ¶¶ 12-31; [Docket No. 245] Missaelides Decl. ¶¶ 69-76**;** [Docket No. 246] Myers-Purkey Decl. ¶¶ 20-24; [Docket No. 252] Regalia Decl. ¶¶ 20-28; [Docket No. 254] Steinke Decl. ¶ 25; [Docket No. 256] Toth Decl. ¶¶ 30-41; [Docket No. 257] Wilber Decl. ¶¶ 11-19.

16. In the face of multiple years of budget cuts to home and community-based programs in the state, Defendants should conduct an accurate and comprehensive analysis of program capacity to address these concerns.

17. **Step One**: The first step in creating such an analysis is to determine the size of the population affected. According to data from the California Department of Aging, the monthly average number of Medi-Cal persons using ADHC services during the period July 2010 through December 2010 ranged from a low of 36,824 in July 2010 to 37,597 in September 2010. *See* [Docket No. 245-13] Missaelides Decl., Ex. M at PL00940, PL00947. For ease of discussion, I will assume approximately 37,000 persons used ADHC services any given month in FY 2010-11. The monthly number is important for understanding the magnitude of the population for whom transition planning must be completed and alternative services must be located before September 1, 2011. However, the unduplicated count of persons who receive

services throughout the year is a more appropriate number to use in analyzing the impact of the elimination of ADHC services and the demand for alternative services.

18. Department of Health Care Services (DHCS) budget documents of November, 2009 state that, "There are approximately 55,400 unduplicated ADHC users per year." California Dept. of Health Care Services November, 2009 Medi-Cal Estimate, Medical Acuity Eligibility Criteria for ADHC Services, p. 50, a true and correct copy of which is attached hereto as Exhibit C to this Declaration. While 37,000 persons need to have transition plans implemented and effective by September 1 2011, it is the 55,400 persons that the State has to be sure to have services for.

19. **Step Two:** The next step is to understand the type of population to be served. Eighty-three percent of ADHC participants are what are called "dual eligibles." [Docket No. 245-9] Missaelides Decl. Ex. I at 3, 13-15.

> "Dual eligibles" are persons who are eligible for both Medicaid and Medicare. According to the Federal Medicaid agency, dual eligibles are among the most chronically ill and costly individuals enrolled in both the Medicare and Medicaid programs, with many having multiple chronic conditions and/or long-term care needs. "More than half have incomes below the poverty line... Forty-three percent "have at least one mental or cognitive impairment, while 60 percent have multiple chronic conditions. Nineteen percent live in institutional settings compared to only 3 percent of Medicare beneficiaries who are not also eligible for Medicaid … [they] account for a disproportionately large share of expenditures in both [programs]."

Dual Eligibility Factsheet, People Enrolled in Medicare and Medicaid, a true and accurate copy of which is attached hereto as Exhibit D to this declaration; Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending, July, 2010, a true and accurate copy of which is attached hereto as Exhibit E to this declaration.

20. **Step Three:** Having defined the population of persons needing services, the third step in the analysis of program capacity is to identify where the person who uses ADHC services lives. Defendants' eligibility files can identify the address of the 55,400 persons who used ADHC services in the last 12 months and summarize this information by county.

21. **Step Four:** Defendants should identify the addresses of all providers of Medicaid services by county and summarize the number of providers and the volume and type of their Medicaid business by county. This will assist in identifying the pool of providers potentially available to provide services.

22. **Step Five:** Defendants should conduct a county-by-county analysis of actual availability of services of the programs they say are available. For example, this could include calling providers that might provide respite care or skilled nursing services and asking them if they can provide a certain volume of additional services. Another example would be talking with an MSSP program and helping it deal with its waiting lists so it can provide additional care management services to ADHC persons losing their ADHC services. Such an effort is necessary to ensure there is a match between alternative services available and the location of ADHC recipients who need services.

23. **Step Six:** Relying on the data collected, Defendants would be able to identify where they need to recruit providers and build additional capacity. The Defendants should engage in a proactive effort to build capacity where needed. Such capacity building could entail recruiting new assisted living providers for the Assisted Living Waiver, using former ADHC programs to provide case management and care coordination, recruiting home health agencies and nursing homes to take more Medicaid clients, rescinding recently-enacted across-the-board IHSS cuts, and providing additional funds to county IHSS programs to lower the case loads of their case management staff to provide more timely assessments. Where there is insufficient capacity to meet the need, expansion of services through a HCBS waiver or retention of ADHC-type services may be necessary to serve recipients.

INDIVIDUAL TRANSITION PLANNING

24. In addition to aggregate planning, the State should ensure that information about service capacity and availability is communicated, and implemented at the individual ADHC recipient level. This includes meeting with each ADHC user and their families and/or persons taking care of them to develop and review a new proposed care plan, securing their agreement to

the plan, and then arranging for provision of alternative services. Arranging services goes beyond the passive requirement to refer someone. What needs to be done is to actually get service providers to agree to provide the services, schedule service delivery, and provide follow up to be sure the right services were performed in a timely way. *See* [Docket No. 257] Wilber Decl. ¶ 21.

INADEQUACY OF ALTERNATIVE SERVICES IDENTIFIED

25. Declarations submitted by Defendants are filled with references to programs, but the blithe mention of program names and categories of programs is not a substitute for understanding where 55,400 poor, aged, and chronically ill persons will obtain services, or ensuring that each of them receives services in September, 2011, and the following months.

26. Defendants' declarations are replete with the names of programs that have been suggested as possible alternatives to ADHC services. *See* [Docket No. 274] Ogle Decl.; [Docket No. 271] Kokkos-Gonzales Decl.; [Docket No. 270] Ferreria Decl.; [Docket No. 277] Portela Decl.; [Docket No. 276] Owen Decl. Defendants rely on case management provided by managed care organizations or programs such as the Multipurpose Senior Services Program (MSSP) or Targeted Case Management (TCM) that do not actually provide services to persons. Rather, these programs refer persons to potential service providers. Other references are to generic services such as senior centers and mental health programs; others are to administrative entities such as the Departments of Aging and Developmental Services; while still others are to small obscure waivers such as the IHO waiver which has 143 persons on it and the DD/CNC which has 45 persons on it. [Docket No. 276] Owen Decl. ¶ 7.

27. The County-Based Administrative Activities program (CMAA) is a federal revenue maximization program in which the county can receive federal funds for eligible county expenditure. CMAA is not a service program; rather, it is an administrative procedure for capturing federal match on services that counties are already providing. Targeted Case Management (TCM) is a similar federal matching program whose major administrative activities

are ensuring that time allocations are correctly captured by county staff so federal match can be obtained for them.

28. The Defendants' declarations contain references to the state's new 1115 demonstration waiver, a Bridge to Reform, as providing alternative services. However, dual eligibles are not included in the mandatory expansion of Medicaid recipients into this waiver; some dual eligibles are to be included in four pilot projects the second year of the 1115 demonstration, and others in the third year. California Section 1115 Comprehensive Demonstration Project Waiver Vision, pp. 2 and 3, a true and correct copy of which is attached hereto as Exhibit F to this declaration. There is no immediate usefulness of this waiver for the dual eligibles, who will no longer have ADHC services in September, 2011.

29. Instead, the Defendants need to provide a realistic appraisal of the alternative services that are actually available and are appropriate to meet the needs of individuals receiving ADHC. This can be obtained by identifying potential service providers, going county by county, and actually collecting information on service availability. For example, the assisted living waiver is only available in seven counties and waiver programs have capped caseloads and can have waiting lists. Defendants would need to collect additional information about actual capacity, location of that capacity, whether services offered are a good fit with the needs of ADHC recipients, and whether services could be expanded to meet ADHC recipients' needs. These kind of questions need to be asked for each potential program that could be used during the year by ADHC participants who will be losing their services.

30. Notably, Defendants have not included nursing homes in their references to alternative sources of services despite the fact that persons who have lost their ADHC benefits are already going to nursing homes. [Docket No. 241] Houghton Decl. ¶¶ 13-15, 24. Unlike nursing homes, California's home and community-based care programs have had permanent cuts to provider reimbursement rates. Moreover, beneficiary costs in the form of co-pays have gone up for Medi-Cal services, but not for beneficiaries in nursing facilities. These shifts in funding

incentives paired with the lack of availability of alternative community services will make nursing facilities a likely placement for dual-eligible recipients.

31. To complete an adequate capacity analysis, Defendants can combine data on how many of the 55,400 ADHC recipients are in each county, how many and what kind of Medicaid providers are in each county, what utilization levels these providers provided to Medicaid, and what other state and local programs in those counties can actually provide services to dual eligibles. Defendants have the data to conduct such analysis and from that can organize an orderly transition of services and plan for any gap in services. An aggregate program capacity analysis is a necessary foundation for substantive transition planning.

32. In sum, Defendants have taken embryonic steps towards the beginning of planning, but there is little documentation proffered in the Defendants' Motion to show they have an understanding of how many persons need what services where and how the services can be obtained. There is a significant underestimation of the persons impacted by the closure of the ADHC program and there is little, if any, evidence in the Defendants' declarations showing the actual availability of alternative services. Defendants need to move beyond the continued vague references to potential programs and establish the factual availability of services on a county-by-county basis and match the availability of services against the need for services of this very physically and mentally compromised dual-eligible population. Unless this planning is done, the likely results are multi-month gaps in services or persons simply never receiving alternative care.

OTHER TRANSITIONAL PLANNING CONSIDERATIONS

33. The Defendants should provide assurances that no one will lose ADHC services until any needed alternative services are in place. Given the gap between Defendants' plans and the steps that would actually need to be completed, it is unlikely that replacement services will be scheduled by September 1, 2011. The Defendants have not proposed any contingency planning to deal with this gap. One option would be the use of a phased-in approach so that services could be systematically shut down, for example, over a six- or nine-month period, and alternatives secured. In situations where a total shutdown is done, the first wave of persons to

seek services will use up the scarce local resources identified and actually available, in this case, resources available to ADHC participants. Succeeding persons will not have the same services available to them until providers gradually add capacity and there is a turnover of clients. A phased-in approach allows for an orderly, rolling program closure that helps ensure successful transition planning.

34. What is conspicuously absent in the Defendants' declarations is any discussion of groups of current ADHC recipients, if any, who have in fact been successfully transitioned to alternative community services identified by Defendants. Centers have started to close. Analyzing the data available regarding these closures would be helpful in designing and implementing a successful transition plan.

DISCUSSION OF THE LEWIN REPORT

35. I have been asked to comment on the potential costs associated with the elimination of Adult Day Health Care (ADHC) as a Medi-Cal benefit pursuant to AB 97, including the impact on other Medi-Cal services, and specifically the costs associated with increased placement in nursing facilities.

36. I have read the Declaration of the Plaintiffs' expert witness, Roger Auerbach, and Auerbach's Exhibit B, the Lewin analysis of ADHC costs. I have also read Defendants' Opposition to Plaintiffs' Motion for Preliminary Injunction and its comments about the Lewin Report.

37. Based on my experience, the Lewin Group is an experienced company that has frequently worked for state governments analyzing their long-term care programs, providing them with actuarial services, and modeling financial long-term care statistics. I first encountered Lewin staff in the mid-1980's when they were studying Oregon's home and community-based services, know that Lewin frequently works on CMS Medicaid contracts, and currently runs the Technical Assistance Center for Aging and Disability Resource Centers (ADRCs) nationwide.

38. Notably, while Defendants criticized the Lewin report as being biased, they did not offer any alternative analysis regarding the link between ADHC and institutionalization, and

shifting of costs to Medi-Cal and other programs upon elimination of ADHC. Although, in critiquing Lewin by saying that "most patients would not go to nursing homes . . ." if they lost home and community based services, the Defendants admit that some will. [Docket No. 273] Muchmore Decl. ¶ 5. Federal Medicaid statistics show, "Dual-eligible beneficiaries are more than six times more likely to be living in an institution, with 19 percent living in one compared with 3 percent of other beneficiaries." 2010 MEDPAC Report, Chapter 5, Coordinating the Care of Dual Eligible Beneficiaries," June 2010, pp. 133, a true and correct copy of which is attached hereto as Exhibit G to this declaration. Given that 83% of the ADHC population are dual eligibles, these federal Medicaid statistics would suggest there is high linkage between ADHC and institutionalization.

39. While Defendants assert that estimates of potentially fraudulent or erroneously paid claims in 2007 should have been taken into account by the Lewin analysis, in my opinion, Lewin is correct in basing its analysis on costs that were actually paid rather than making speculative assumptions that some costs should not have been paid.

COSTS AND SAVINGS ASSOCIATED WITH ELIMINATION OF ADHC

40. I concur with the Plaintiffs' other expert declarants that persons using ADHC services will use other services when ADHC services are no longer available, including hospitals, nursing facilities, emergency services, and community-based Medi-Cal services. *See* [Docket No. 228] Auerbach Decl.; [Docket No. 238] Gardner Decl.; [Docket No. 257] Wilber Decl. As discussed above, Defendants list many broad categories of publicly-funded services that they claim can replace ADHC, including IHSS, other Medi-Cal services, Medi-Cal Waivers, etc. They have not, however, provided any cost analysis of the expense of providing any of these services.

41. The projected total budget in state and federal funds for ADHC services in FY 2011-2012 is $423,474,000. [Docket No. 245-4] Missaelides Decl., Ex. D at PL00870.

42. On June 30, 2011, the Governor approved an additional $60 million in State funds to the $25 million in state funds that had been approved before to bring the total to $85 million in

State funds for "Adult Day Health Care (ADHC) Transition." These $85 million in state funds (or $170 million in State and Federal funds, assuming 50% federal match) are to provide funding for ADHC transition assistance and other long-term care services. In his veto message of June 30, 2011, the Governor deleted the provision that would have used this money for a new waiver and specified the following uses: (1) to transition current beneficiaries of the Adult Day Health Care program to other appropriate services, and, (2) to assess the needs of the population to determine to what extent additional services are needed during and after the transition -- including seeking federal waiver services and developing alternative funding arrangements to preserve services at ADHC centers. Governor's Objections to Appropriations contained in Senate Bill 87, a true and correct copy of which is attached hereto as Exhibit H to this declaration.

43. The budget language further provides that any additional ongoing services after the transition take into account other existing home and community based services, not be duplicative, and provide a coordinated and integrated approach to providing services that reduce Medi-Cal beneficiaries' risk of institutionalization. Ex. H., 3-4.

44. The Governor's June 30, 2011 veto message thus envisions a possible savings of $126,737,000 in State general funds from the elimination of ADHC services. This is calculated by $423,474,000 (total State and federal funds estimated for ADHC in 2011-2012) - $170,000,000 (State and federal funds appropriated for transition services, assuming $85 million described above is eligible for full federal match) = $253,474,000 (State and federal funds) ÷ 2 = $126,737,000 (State general funds). This savings estimate assumes that the State will spend no more than $170 million in State and federal funds for all publicly funded services that replace ADHC — including transition assistance, Medi-Cal services (such as nursing facility placement, IHSS, physician and hospital visits, and home health), and other state-funded services.

45. AB 97 included a 10% Medi-Cal rate cut to nursing facilities. [Docket No. 278] Watkins Decl. ¶ 8. In the final enacted 2011-2012 budget, however, the 10 percent payment reduction was terminated on August 1, 2012. Senate Subcommittee #3, Health and Human

Services Agenda, May 26, 2011 at 44, a true and accurate copy of which is attached as Exhibit I to this declaration. A provision for a one-time supplemental payment in the 2012-13 rate year was provided that is equivalent to the 10 percent reduction that was applied from June 1, 2011 to July 31, 2012. *Id.* In other words, while AB 97 imposed a 10 percent rate reduction to nursing facilities, that reduction is to be restored next year. This action will cost the state approximately $155 million. Medi-Cal May 2011, Local Assistance Estimate Policy Changes 2011-2012 at 213-214, a true and correct copy of which is attached as Exhibit J to this declaration. In addition, the final 2011-2012 budget also provided for a two-year rate increase for nursing facilities of 3.93 percent in 2010-11 and up to 2.4 percent in 2011-12. Ex. I at 46. These State budget documents clearly show that while massive cuts were made to community-based Medi-Cal services, the State increased its expenditures for institutional services.

46. To conduct a cost analysis of the projected savings from elimination of ADHC, and offsets based on increased costs in other service categories, the State should use available data showing the last twelve months of Medi-Cal expenditures by provider type for persons using ADHC services. How many unduplicated persons used services from each provider and how many services were used? This information would enable budgeting analyses to occur since it would show a comprehensive listing of expenditures, users, and utilization of all Medi-Cal services by ADHC users. The State would then be able to perform analyses such as zeroing out ADHC services and making assumptions, such as assuming certain percentage increases in IHSS, physician office visits, and home health. The State could then calculate the total impact of changing unduplicated counts and utilization assumptions by provider type. With this information, it would be possible to perform fiscal impacts of changes in services in the absence of ADHC services and the increase of costs in alternative services.

47. In addition, the State would need to analyze the number of former ADHC users who would seek nursing home services. The Defendants have not released information about their assumptions regarding nursing facility use.

48. A conservative percentage would be that ten percent of the persons currently receiving ADHC services could be placed in a nursing home.[1]

49. The loss of services that maintain persons in the community increases the probability that some persons in the population losing services will see the necessity of using nursing home services. The ADHC program provides the following services that maintain stable community placement and the loss of these service will increase the probability that persons will be channeled into institutional care:

- Respite care for up to five days a week so that the families of persons served can maintain their economic livelihood and can continue to provide unpaid caregiving;
- A de facto medical home where skilled medical staff look at the ADHC participant every week and can monitor changes in their health conditions;
- Physical and occupational therapy that strengthens the physical capability of persons attending the ADHC program;
- Socialization opportunities that reduce the level of depression in a dual-eligible population that is characterized by high rates of mental illness and depression, and
- Medication management in which medically trained staff actively reviews medication compliance and the effects of medication.

50. There are higher estimates than 10% of what the percentage of nursing home utilization might be on the part of persons losing ADHC services, which are plausible based on the consistent data available. The CMS data cited above indicates that 19% of dual eligibles are institutionalized. Ex. G. The Defendants' witness says that the correct percentage that Lewin

[1] I base this on facts in the Defendants' records that show that in July 2007 there were 1,153,021 dual eligibles and persons over the age of 65 in California. Medi-Cal/Medicare Dual Eligibility by Age by County as of January July 2007, a true and correct copy of which is attached hereto as Exhibit K to this declaration. I obtained the sum of 1,153,021 by adding the number of dual eligibles and Medi-Cal persons over the age of 65 as shown in the table for July 2007. In calendar year 2007, the Defendants' records show that there were 116,035 unduplicated users of Medi-Cal paid nursing home services. Home and Community-Based Long-Term Care: Recommendations to Improve Access for Californians, November 2009, pp. 113-114, a true and correct copy of which is attached hereto as Exhibit L to this declaration. The ratio of Medi-Cal recipients in nursing homes in 2007 to the number of dual-eligibles and persons over the age of 65 is 10%. I am assuming that the percentage of nursing home utilization for the dual eligibles that are losing ADHC services will equal the percentage of dual eligibles and aged persons who are using nursing homes now.

should have used is 18%. [Docket No. 273] Muchmore Decl. ¶ 7. I have also reviewed a June 2011 survey by the California Association for Adult Day Services (CAADS) which is based on a 22% sample of their membership. Information about the survey and results is set forth in Supp. Missaelides Supp. Decl.¶¶ 9-16 Ex. G. The CAADS provider survey found that if ADHC programs closed their doors on September 1, 2011, 11 percent of ADHC recipients would be discharged to a nursing facility immediately, an additional 12.3 percent within the first 30 days and another 10.9 percent within two months.

51. A Plaintiffs' declaration describes an ADHC center that closed because of the impending loss of Medi-Cal revenue and states that 3 of the 60 persons, 5 percent, went into nursing homes immediately and another 2 persons will need to enter "in the very near future" and another 13 will enter within six months. [Docket No. 241] Houghton Decl. ¶ 24. This is a potential percentage admission rate of 25 percent.

52. These other sources of information contain estimates ranging from 18% to over 30%. However, a conservative estimation is 10 percent.

53. In addition to this analysis of population utilization and the specific services being lost with the elimination of ADHC, I also base my 10 percent assumption on the likelihood that IHSS services can be used to replace the services lost by the ADHC recipients. Given that 63 percent of the ADHC population already has IHSS services, the Defendants regard adding more IHSS services as "low hanging fruit." [Docket No. 245-9] Missaelides Decl., Ex I at 3, 21-25. However, IHSS service hours are allocated by formula and it cannot be assumed that more hours would now generally be authorized to the same persons. Moreover, the IHSS program does not provide the services outlined above. So both the quantity and quality of services available from IHSS is questionable, and the Defendants have neither raised nor addressed these issues in their transition planning.

54. I also analyzed the point at which nursing home utilization rates would become so great that the State's expenditures on the ADHC population would exceed its original budget for ADHC before cuts were made to it, assuming the State had all of the $423,474,000 as estimated

for the ADHC budget in fiscal year 2011-2012. [Docket No. 245-4] Missaelides Decl., Ex. D at PL00870. Five data elements were used in this analysis:

- The Defendants' budget documents show that the average projected monthly cost of ADHC services in FY 2011-12 is **$1,050**. [Docket No. 245-4] Missaelides Decl. Ex. D at PL00868.
- The average monthly projected cost of a nursing home stay in FY 2011-12 is **$5,193**. [Docket No. 245-5] Missaelides Decl. Ex. E at PL00874.
- Consistent with the data from California Department of Aging, I used the assumption that a reasonable estimate of the monthly average number of ADHC participants is **37,000**.
- The projected total budget for ADHC services in FY 2011-2012 is $423,474,000 which is **$35,289,500** per month. [Docket No. 245-4] Missaelides Decl. Ex. D at PL00870.
- Due to the fact that Defendants have provided no data regarding the expenses and utilization of other services by ADHC participants, I used IHSS hours as a proxy, or estimation of these costs, since two-thirds of the persons losing ADHC use IHSS personal care hours and the Defendants are planning to expand the use of those IHSS hours. The hourly wage paid to IHSS workers varies by county and periodically has been subject to budget cuts, but for purposes of the analysis below I will assume a rate of **$12.10** below.

55. Table 1 below shows the impact of using the five data points mentioned above: an amount of $1,050 for the average monthly ADHC cost, $5,193 for the nursing home cost, 37,000 for the average number of monthly ADHC users, $35,289,500 for the average monthly cost and $12.10 for an average IHSS wage. Again, the IHSS figure is used as a proxy for expenses for other Medi-Cal services used by ADHC participants.

Table 1 Sensitivity Analysis of ADHC Nursing Home Utilization

Assumed % of ADHC Monthly Average Persons Shifting to Nursing Home Use	Number of Monthly Average ADHC Persons Shifting to Nursing Homes	Monthly Cost of Nursing Home Services	Number of Former Monthly Average ADHC Persons Using Other Services	Amount Available for Other Services (before savings are eroded)	Amount per Person Available for Other Services (before savings are eroded)	Number of Additional IHSS Monthly Hours at Assumed Hourly Wage
10.0%	3,700	$ 19,214,100	33,300	$ 16,075,400	$482.74	39.90
11.0%	4,070	$ 21,135,510	32,930	$ 14,153,990	$429.82	35.52
12.0%	4,440	$ 23,056,920	32,560	$ 12,232,580	$375.69	31.05
13.0%	4,810	$ 24,978,330	32,190	$ 10,311,170	$320.32	26.47
14.0%	5,180	$ 26,899,740	31,820	$ 8,389,760	$263.66	21.79
15.0%	5,550	$ 28,821,150	31,450	$ 6,468,350	$205.67	17.00
16.0%	5,920	$ 30,742,560	31,080	$ 4,546,940	$146.30	12.09
17.0%	6,290	$ 2,663,970	30,710	$ 2,625,530	$85.49	7.07
18.0%	6,660	$ 34,585,380	30,340	$ 704,120	$23.21	1.92
18.4%	6,808	$ 35,353,944	30,192	$ (64,444)	$(2.13)	(0.18)
19.0%	7,030	$ 36,506,790	29,970	$ (1,217,290)	$(40.62)	(3.36)

56. Table 1 uses a "sensitivity analysis" which shows cost results using different assumptions. The analysis shows that the "tipping point," the point at which nursing home utilization is so high that no funds are left over to pay for additional other services, without the State expending more than it budgeted for ADHC, is about 6,800 persons. This analysis assumes the Defendants had all the $423,474,000 it estimated in the 2011-2012 ADHC budget.

57. Since the 2011-2012 budget, passed on June 30, 2011, contains $85 million in State funds for transition and provision of long-term care services to replace ADHC, I next performed a budget calculation to consider the question of whether the $170,000,000 (assuming the $85 million is fully matched by federal dollars) budgeted for the transition activities and other services is sufficient.

58. To examine this question I took the $170,000,000 million and divided it by the monthly average nursing home cost, $5,193, and calculated the number of nursing home months that the $170,000,000 would pay for, and I then divided the number of months by 12 to get the full-time annual number of residents that the $170,000,000 would pay for.

Table 2 Shows How Many Nursing Home Residents can be Paid for with $170 million

Amount of funds available for ADHC related services =	$ 170,000,000
Cost of one month of nursing home services =	$ 5,193
Number of nursing home months that can be paid for =	32,736
Number of annual nursing home residents that can be paid for =	2,728

59. The analysis in Table 2 shows that the $170,000,000 can pay for 2,728 persons in nursing homes and at this utilization level there is no money left over for anyone else before the State expends more than it has budgeted for this population.

60. From my analyses I draw three conclusions: First, using a conservative 10% estimate, 10% of the 55,400 persons, or 5,540, who used ADHC services could go into a nursing home. This is a well-studied population nationally and is known to have high rates of disability and hospital and nursing home utilization as well as significant co-morbidities of substance abuse, mental health, and cognitive difficulties. The data discussed above more than justify this estimate.

61. Second, I conclude that the original budget of the ADHC program paid for services to 55,400 persons at an amount equal to the costs of paying for approximately 6,800 nursing home residents. For example, Table 1 shows that even if you had all the $423 million originally budgeted for the program, if 4,800 persons go into a nursing home, there is only about 26 hours a month, or $320 a month per person, of IHSS services for the remaining 50,600 (55,400-4,800) persons, before the State spends more than it had originally budgeted for ADHC.

62. Third, I conclude that if only 2,728 of the 55,400 ADHC persons go into a nursing home, none of the $170,000,000 will be available for services in the community to the 52,672 persons who did not go to a nursing home. From these specific conclusions I draw the general

observations that the $170,000,000 is insufficient to pay for the alternative services that will be used by these dual eligibles, and if 5,540 persons go into nursing homes, then Table 1 shows Defendants will only have about $200 a month per person to pay for services to the 49,860 (55,400-5,540) individuals who will use services in the community. In this situation, it is likely that additional funds will be needed beyond the $423 million originally budgeted.

63. In my opinion, the State will realize some cost savings from the elimination of ADHC as a Medi-Cal benefit in fiscal year 2012 if alternative services are not in fact provided to persons after September 1, 2011. These savings will diminish throughout 2012 and 2013 as nursing home utilization rates of former ADHC recipients increase and as their use of other Medi-Cal services increases.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on July 12, 2011, in East Windsor, N.J.

By: /s/
LESLIE HENDRICKSON, Ph.D

I hereby attest that I have on file all holograph signatures for any signatures indicated by a "conformed" signature (/S/) within this e-filed document.

By: /s/
Elizabeth Zirker
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