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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

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

Hearing Date: November 8, 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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SUPPLEMENTAL DECLARATION OF LESLIE HENDRICKSON, Ph.D.

I, LESLIE HENDRICKSON, do hereby declare:

1. I make this supplemental 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. My credentials and experience are set forth in my previous declaration in paragraphs 3-10 (ECF No. 287) and my curriculum vitae is attached to that declaration as Exhibit B.

2. This declaration supplements my opinions set forth in my declaration of July 12, 2011. ECF No. 287.

3. I have reviewed documents that I understand to constitute the Defendants' current transition planning documents, including those which are contained on the California Department of Health Care Services (DHCS) Adult Day Health Care (ADHC) Transition website. DHCS, *Adult Day Health Care (AHDC) Transition*, http://www.dhcs.ca.gov/services/medi-cal/Pages/ADHC/ADHC.aspx (last visited October 14, 2011). In addition to the documentation I reviewed in preparing my first declaration, I have also reviewed: the Department's managed care policy letter of February 28, 2011 sent to managed care providers; copies of the August 2011 and September 2011 managed care enrollment notices and sample enrollment packet sent to ADHC recipients; and the IHO Waiver application documents. I have also reviewed the 1115 waiver, and the CMS response to the 1115 waiver request as stated in CMS' special terms and conditions regarding the care of seniors and person with disabilities, and the proposal submitted by the Defendants to CMS for its dual eligible demonstration grant.

4. In addition, I have read documents containing information about the APS coordinated care management programs and, also read statistical information about the number and eligibility categories of persons using ADHC services, the September 19, 2011 e-mail by Kelly Green of the Department of Health Care Services stating no Multipurpose Senior Service Program (MSSP) services would be available to persons losing their ADHC services, and the August 19, 2011 letter from the Association of California Health Plans to the Department of Health Care Services. I also have read

deposition transcripts of depositions taken of Department of Health Care Services (DHCS) staff on October 10, 2011.

5. Based on my review of these documents, and the evidence set forth in my prior declaration, I conclude that the Defendants' transition plan contains no reasonable prospect that when ADHC services are discontinued on December 1, 2011, appropriate replacement services will in fact be in place for all persons losing their ADHC services. Given the probability that appropriate replacement services will not be in place and the resulting harm to ADHC recipients, ADHC services should not be terminated until Defendants ensure that alternative services are in fact in place and are sufficient to meet the individuals' needs as identified in their ADHC plans of care.

6. The Defendants' records show that 63,136 unique individuals received ADHC services in calendar year 2009. County Medi-Cal and Medicare Breakdown 2009, December 20, 2010, Zirker Decl. Ex. J. In preparing my two declarations, I observed that the number of ADHC recipients who are said to be affected by the Defendant's actions have variously described as ranging from 35,000 to 37,000. In my first declaration I used the number 37,000 based on 2010 information available to me at that time. [1] I observe that approximately 38,000 persons received notices regarding ADHC elimination and thus are presumably currently enrolled in ADHC.[2] Thus in this declaration, based on the 2011 data available to me, I use the number of approximately 38,000. The Defendants' transition plan is solely focused on the current enrollees and has made no provision for the approximately 25,000 similarly situated individuals who would have used ADHC services sometime during the year.[3]

7. In order to prevent unnecessary institutionalization of 38,000 ADHC recipients, as well as the thousands of similarly situated people who would have used ADHC services in a normal year, Defendants should adhere to one fundamental and essential principle: that is, that ADHC services cannot

[1] 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.

[2] *See* ADHC Managed Care Enrollment Project NOTIFICATION MAILING SCHEDULE, Zirker Decl. Ex. Q, which provides a count of 38,735 ADHC recipients. Declarations, depositions and other documents prepared by the Defendants use numbers ranging from 35,000 to 37,000 individuals.

[3] I calculate this estimate by taking references made on the state's ADHC Transition Plan website to 38,000 persons currently using ADHC services and subtract the 38,000 from the number of unduplicated individuals that received ADHC services in calendar year 2009. See Zirker Decl. Ex. J and Ex. Q

be terminated unless the Defendants assure and monitor whether individuals are in fact receiving the replacement services specified in their care plans – before their ADHC services are terminated – not in the anticipation that individuals "might" receive them. To prevent such unnecessary harm, Defendants' obligation should be implemented via a twofold process. First, the Defendants should conduct a prospective analysis of their intended transition plan which focuses on outcomes, not simply process. Second, the Defendants should ensure that replacement services are actually in place prior to the discontinuance of ADHC.

8. The need for clear goals, monitoring of those goals, and an outcome analysis of their performance is especially salient in the case of the ADHC population. The Defendants' records show that 80% of the 63,136 unique individuals that received ADHC services in calendar year 2009 were dually eligible for both Medi-Cal and Medicaid. Zirker Decl. Ex. J. As discussed in previous documents filed in this case, dual eligibles (those who qualify for Medicare and Medi-Cal) are characterized by extensive physical, cognitive, and behavioral health problems. (*See*, Hendrickson Decl. Exs. D and E, ECF Nos. 287-4, 287-5).

9. The Defendants' data shows that of the 37,780 persons who received services on June 30, 2011:

- 25.5% had dementia;
- 6% had mental retardation;
- 46.6% had a psychiatric diagnosis;
- 38.7% were incontinent of bowel or bladder;
- 49.8% needed either physical or occupational therapy;
- 62.4% did not speak English, and
- 76.1% needed skilled nursing services.

See Transition Strategy, Ex. R to Zirker Decl.

9. Preventing risk of institutionalization for this high risk, high cost population cannot happen without appropriate treatment and continuity of care, neither of which are assured by December 1st in Defendants' current transition plan.

OUTCOME-BASED PLANNING

10. In the Defendants' transition documents, the focus is on the process that the Defendant will undertake to transition the current ADHC recipients to managed care and other services, not the outcomes that it intends to achieve. Transition Monitoring Plan, Zirker Decl. Ex. C. The Defendants' proposed monitoring plan is retrospective, focusing on "outcomes of interest" which are limited to "a. Skilled nursing facility admission; b. Hospital admissions; c. Emergency department use." Zirker Decl. Ex. B at ADHC 00039-00040. Simply looking backward on whether or not the transition plan was a success according to those measures is too late for the individuals who have potentially been subjected to those harms that could have been avoided with prospective planning. Moreover, given the controversial nature of this matter, in my opinion, a neutral party or Court-appointed monitor should carry out the retrospective work.

11. The Defendants need to prospectively plan for the main tasks they must carry out, namely:

- Ensure that an adequate, in-person assessment is conducted of each ADHC recipient's physical and mental health status including the need for substance abuse treatment (this includes accounting for language, cultural, and cognitive factors);
- Prepare a plan of care for the recipient that is appropriate for the physical and mental conditions found in the assessment, and that identifies actual services to meet identified needs;
- Obtain providers to provide the services specified in the plan of care, and
- Confirm that the services are in fact being provided and are sufficient to implement the plan of care.

12. While the Defendants intend to hold the managed care plans largely responsible for completing the four tasks listed above, the Defendants have not set forth performance measures for themselves or for the plans to adhere to. The Defendants need to develop a standard set of performance measures, and a uniform data collection mechanism so that the managed care plans, and other responsible entities, will be able to understand what constitutes effective transition performance and how to achieve it.

13. A request for performance measures is a normal operating procedure used by state Medicaid programs. The Defendants now require managed care plans to make extensive quality

improvement efforts and use performance measures in other contexts. For example, DHCS' Quality Improvement Assessment Guide for Medi-Cal managed care plans of November 2010 is 105 pages long. DHCS, *MMCD Quality Improvement & Performance Measurement Reports*, http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/EQRO_QIPs/QIA_Assessment_Guide_November_2010.pdf (last visited October 14, 2011). In 2010 the State required its managed care plans to report on 11 performance measures using 21 indicators. *Id.*

14. As to measuring the quality of the transition process, the Defendants need to establish performance measures to ensure that the tasks required to transition ADHC recipients are done in a manner that meets individuals' physical and mental health needs. Specifically:

- How complete and thorough are the assessments?
- Do the developed plans of care actually reflect the health risks identified in the assessments?
- Do the developed plans of care identify needed services that are actually available?
- Are unmet needs identified? Are unmet needs addressed?
- Do the plans of care include natural, unpaid supports such as family?
- Do the services arranged for reflect the plan of care? Are the right services arranged for?
- Do the plans of care provide for the efficient use of public funds by prioritizing cost-effective services?
- Were the right services delivered at the right times?
- Are mental health and substance abuse services considered in the plan?
- Does the person receiving the care and their family agree that the plan of care makes sense?

15. Establishing and monitoring these performance measures are critical to ensuring that the Defendants' proposed transition away from ADHC is orderly and safe for the affected participants.

16. The Defendants' plan contains no evidence of "outcome planning" – that is, none of the documents yet presented by the Defendants contain any performance measures or goals stating how the Defendants will know or measure when the tasks listed above have been successfully completed. Nor

have Defendants presented data showing they have studied the actual availability of services. Defendants have not published any analyses stating the volume and kind of services these ADHC recipients will need. The Defendants are silent as to outcome expectations, including the quality of outcomes; Defendants should, up front, prepare an analysis of the outcomes they expect to achieve as a result of their efforts.

17. Thus far, the Defendants have provided no data on how many people have been enrolled in managed care, how many assessments have been conducted, how many care plans have been developed, which and how many services have been identified, and how many people are receiving replacement services. Apparently such information is being collected but is not being released. Letter from California Department of Health and Human Services to Senators Leno and DeSaulnier, Zirker Decl. Ex. D at ADHC00027. A responsible transition plan would monitor each step, evaluate the pace and effectiveness of each step, and modify the transition planning as necessary to achieve the desired results, prior to elimination of the ADHC benefit.

18. The need for careful planning exists because the vague assurances given by Defendants cannot be relied upon. In an abrupt change of position from prior statements to the public and the Court, on July 14, 2011, the Department informed the legislature that the elimination date for ADHC was shifted to December 1, 2011. Letter from CMS to Toby Douglas, ECF No. 300-3. Until that date, Defendants had made identical assurances to those they make now that alternatives services would be in place for ADHC recipients by September 1, 2011.

19. Defendants had made numerous assertions that other programs were available to the ADHC recipients. One such program mentioned was the Multipurpose Senior Service Program (MSSP). (For example, *see* Owen Declaration, ECF No. 276). However, the Defendants now admit there is a waiting list for MSSP services and this program is not in fact available to ADHC recipients. The existence of waiting lists for MSSP is a known fact about the program as such lists have existed for years and the Defendants could reasonably be expected to have known the program was not in fact accessible to ADHC recipients.

20. Besides MSSP, the Defendants' declarations in the Defendants' opposition are replete with the names of programs that were suggested as possible alternatives to ADHC services which the Defendants have now abandoned. *See* Ogle Decl., ECF No. 274; Kokkos-Gonzales Decl., ECF No. 271; Ferreria Decl., ECF No. 270; Portela Decl., ECF No. 277; Owen Decl., ECF No. 276. In addition to the deletion of MSSP, I note the Transition Plan documents no longer make reference to the 1115 waiver, Targeted Case Management and the County-Based Administrative Activities program (CMAA). In my opinion, these names have dropped from discussion because they were empty assurances. They were never programs that would have helped transition these ADHC participants by September 1, 2011, or even by December 1, 2011.

21. Under Federal Medicaid law, states must offer nursing home services if the state chooses to have a Medicaid program. While the goal is to avoid such placements, Defendants have not even assessed this fallback option. Nursing home placement is a likely alternative for some persons losing ADHC services given the high risk of such individuals without adequate replacement services. However, the Defendants are silent as to any efforts made to place persons in nursing homes, the capacity of nursing homes to accommodate the need, or the cost of such placements.

22. Given a track record of unreliable assurances, as a starting point for responsible outcome planning, the Defendants should establish and monitor weekly goals as to: how many assessments will be completed each week, how many plans of care will be completed each week, how many persons have services set up each week, and how many verifications of service delivery have been made each week. If the Defendants expect to transition approximately 38,000 persons to other services by December 1, 2011, then they need to measure their progress at achieving this goal.

23. Such a tracking is especially important because:

- only 17 assessments have been done as of October 1, 2011 and approximately 38,000 need to be done before services can be arranged for by December 1. Ogle Dep. 45:14-21, Ex. G to Zirker Decl. ("Ogle Dep.");
- approximately 50 managed care plans are involved and coordination and monitoring of so many plans is difficult. Ogle Dep. 29:13-19;

- the plans do not use the same assessment tools, thus opening the door to the possibility that persons with similar impairments and medical conditions will receive dissimilar treatment depending on which of the 50 plans they are assigned to. Ogle Dep. 39:9-11; 43:25-44:4; 104:6-17;
- the Defendants have specified no qualifications as to who shall do the assessments. Ogle Dep. 46:4-7;
- the plans will not have complete medical information about the dual eligibles since the Defendants have made no provision to supply Medicare utilization data to them. Ogle Dep. 47:21-48:1. Nor, as of October 10, 2011, has Medi-Cal data been provided to the plans Ogle Dep. 47:1-15;
- the assessment process described is incomplete since persons who need to be referred for waiver or other services must be assessed by In-Home Operations. Ogle Dep. 48:13-20. Nor are there are timelines for a plan to make a waiver referral thus raising the possibility of more delay. Ogle Dep. 106:24-107:2. Given the tight timelines a more efficiently designed assessment would determine eligibility for all programs instead of being simply the first step in a time consuming multi-step processing;
- the Defendants have not analyzed how long it takes plans to conduct assessments thus indicating that no analysis of the capability of the plans to accomplish these assessments has in fact been done. Ogle Dep. 45:7-10;
- the Defendants have not indicated that the quality of the assessments will be reviewed prior to December 1, 2011, thus indicating a lack of control over the possibility that hasty or ill conceived assessments will be done to meet these tight timelines;
- there is great uncertainty about the availability of program slots in programs represented to be part of the transition plan, including HCBS Waiver, PACE, and SCAN.

APS ASSESSMENT PROCESS

24. In my experience, including while as an Assistant Commissioner for long-term services and supports in the New Jersey Department of Health and Senior Services, I supervised field staff in eight offices that conducted approximately 160,000 assessments for the purpose of determining eligibility for Medicaid nursing facility services during the five years that I was with the Department.

25. I have read the scope of work that APS has agreed to in regard to the ADHC transition. A reading of this scope indicates that the "initial risk survey" that APS is required to perform must include the following tasks, Ogle Dep. Ex. 42, Ex. G to Zirker Dec. at ADHC01107-01108:

- "Medi-Cal status and history, including primary and secondary diagnosis and current and past medications prescribed;
- Functional status;
- Physical well being
- Mental health status
- History of tobacco, alcohol and drug use or abuse;
- Identification of existing and potential formal and informal supports including personal safety;
- Functional limitations/capabilities;
- Medication, nutrition, ADL support needs;
- Determination of willingness and capacity of family members or where applicable authorized persons and others to provide informal support;
- Condition and proximity to services of current housing, and access to appropriate transportation;
- Identification of current or potential long-term service needs;
- Need for Medi-Cal supplies and DME, and
- Appropriate care setting."

26. Based on my experience, it takes between one to two hours to collect such information not counting travel time. A determination of level of care has to then be made to identify appropriate

programs the person is eligible to be referred to. Such a determination could take from half an hour to an hour depending on whether the person who does the determination also did the assessment and the adequacy of the documentation in the assessment. A care plan then has to be developed and this could take from one to two hours depending on the availability of providers and family members. The care plan could take longer if the person preparing the care plan is not knowledgeable about community resources.

27. Based on my experience, the standard in the field, given the complexity of the situations of people such as the ADHC population, is that assessments should be done face-to-face in the individual's living environment and involve discussions with family members, care givers, and review of medical records if possible. These assessments require skilled staff and cannot be accurately done by unskilled staff or be done by using social workers or licensed vocational nurses making telephone calls. Ogle Dep. 117:14-21. Talking to family members provides an indication of how much support family members are willing to provide and when. This is essential information for the development of a care plan. A home visit can help identify whether home modifications or assistive technology are necessary as well as how safe the living environment is. In contrast, the scope of work between the State and APS permits APS to make up to 1,000 telephone calls to carry out its "initial risk survey"[4] of ADHC recipients (Ogle Dep. Ex. 42, Ex. G to Zirker Decl. at ADHC01107,), which appears to be too cursory to be consistent with current professional standards in the field. .

28. Specifically, APS is responsible for approximately 15,000 assessments plus assessments in Los Angeles County which are due to be completed by November 22. Ogle Dep. 115:21-116:1. APS has hired 100 persons to perform these assessments, and trained these persons in the last two weeks of September. Ogle Dep. 116:10-11; 120:12-14. There are 30 working days in the period from October 5, 2011 (APS's proposed start date for assessments) to November 15, 2011. Each of the 100 workers would have to do 150 assessments or roughly 5 assessments per day. Each of the 100 workers would have to work all 30 days, eight hours a day, and do one assessment every 96 minutes. The 96 minutes has to include travel time, break time, a search for or review of documents, talking with family or

[4] For ease of discussion I use the term "assessment" to refer to the "initial risk survey" that APS is contracted to provide.

caregivers, and the processing of assessments after they are completed. Even if data collection were done on all of these 15,000 assessments by mid-November, the remaining two weeks do not allow sufficient time to fax every survey to the Department of Health Care Services, determine level of eligibility, develop care plans, arrange services, and confirm service delivery.

29. Given that effectively no APS assessments have been done by October 5, 2011 and the Defendants have not presented information on APS assessments done since October 5, 2011, it seems unlikely that all APS assessments will be done by November 22, 2011. Even if all APS assessments were "done" by mid November, and all of the more than 15,000 care plans done the next week, the accuracy and quality of both the 15,000 assessments and care plans are highly questionable as discussed below.

30. While some time will be saved by interviewing recipients at ADHC centers, a review of the "risk factors" APS is contractually obligated to collect and review information on shows that it is unlikely that an interview at a Center will collect good information on all of those risk factors. Ogle Dep. Ex. 42 at ADHC01107-01108. Specifically, the identification of formal and informal supports, the capacity of family members and friends to provide care, the use of medication, the condition of housing and access of its location to services and proximity to transportation, and the need for Medi-Cal supplies and durable medical equipment (DME) are more efficiently checked on when interviewing someone at home when family members and friends are present. However, home interviews will take more time and travel time alone could use up a substantial portion of the 96 minutes.

31. After the assessment is done, APS will prepare a care plan. Jane Ogle, the DHCS representative identified as most knowledgeable about APS, stated that APS will develop the care plan and it will not be reviewed by the individual whose care is being planned nor is the plan reviewed by current caregivers. Ogle Dep. 131:11-132:5. The lack of consumer-directed involvement in this care planning does not comply with the standard of care in the field. It takes time to develop a good care plan, meet with the recipient and their family and caregivers, and obtain their cooperation in the exercise of the plan. When you do not share the care plan with the recipient there is no check or balance on the adequacy or feasibility of the plan and an essential quality control check is lost.

32. Moreover, the care plan used by APS is described by Ms. Ogle as "…a thing that says recommendations and there's a list. It's pretty basic." Ogle Dep. 130-9-11. The APS care plan will not identify providers who might provide the services needed by the recipient. Ogle Dep. 130:25-131:2. The description of the APS approach to care planning does not appear to include the broad comprehensive look at all resources including unpaid care, Older American Act programs, housing, home modifications, socialization, assistive technology and the other care elements that are typically found in care plans used in long-term services and supports programs.

33. It is unclear whether APS staff has the necessary training and credentials to perform the job with which they are tasked. Ms. Ogle says that the 100 persons that APS hired include nurses, clinical social workers and noncredentialed persons. Ogle Dep. 117:14-17. A review of APS job descriptions at different web sites shows that in late September APS was hiring for "Care Coordinator (TEMP)" positions throughout California and the only requirement listed was "Minimum of 2 years Healthcare experience."[5] The Defendants have not released information on the proportion of nurses, social workers and noncredentialed workers APS has hired. From this information I infer that a certain proportion of the persons hired will only have had two years of "healthcare experience" and some training in late September. These assessors will then be tasked with interviewing approximately five persons a day with complex physical, mental and social problems and developing care plans for them.

34. It appears that these assessors have no access to Medi-Cal or Medicare records on the individuals they will be assessing, and except for the nurses, have no skills to read and interpret the medical history of the persons being assessed. When asked what standard APS will use to define how the plan of care identifies what an ADHC recipient needs, Ms. Ogle stated "… probably clinical judgments and an algorithm that they use with this assessment tool to identify some needs.…" Ogle Dep. 125:12-14. The lack of clinical information and the qualifications of the assessors call into question whether the APS assessments will be adequate for the purpose and the population for whom they are responsible.

[5] *See* APS Healthcare, *Current Job Postings,* http://ejob.bz/ATS/PortalViewRequirement.do?reqGK=475883, also available at http://app.brightmove.com/ATS/PortalViewRequirement.do?reqGK=475883 (last visited October 14, 2011).

35. Moreover, the level of care determinations must be done by skilled staff and uncredentialed temporary care coordinators are not qualified to perform these determinations. These determinations will take from thirty minutes to one hour to perform requiring between 7,500 and 15,000 hours of skilled staff time.

36. For the reasons cited above, it seems unlikely to me that the 15,000 plus ADHC persons that APS is responsible for assessing will in fact have service plans in place by December 1, 2011 which is six weeks from now.

NEED TO ENSURE ACTUAL RECEIPT OF REPLACEMENT SERVICES

37. As stated above, to avoid unnecessary institutionalization of ADHC recipients, Defendants need to adhere to the fundamental principle that they should not eliminate ADHC services for individuals until they have confirmed that those individuals have services in place to replace ADHC. This is the approach taken by the State when it has closed institutions for people with developmental disabilities. For example, the plan to close Agnews Developmental Center included a comprehensive stakeholder input process, comprehensive assessments of residents, and development of appropriate community service capacity. The institution did not close until all of the 327 residents were successfully placed in alternative homes.[6] Likewise, the State is taking the same approach with the current closure process for Lanterman Developmental Center.[7] A similar approach regarding ADHC is both reasonable and consistent with other State practices. To avoid harm, no one should have authorization for their existing services discontinued until it is verified that new services are in place and being provided.

38. To provide the services that ADHC recipients need once ADHC is eliminated as an optional Medi-Cal benefit, the Defendants say they are going to rely on programs such as managed care, Home and Community-Based Waivers, and PACE. These options are referenced in the Defendants' transition plan and on the Defendants' website, but it is clear from Defendants' information provided that such services will not be sufficient and will not be able to ensure that all ADHC participants will have services in place when ADHC is eliminated. Each of these options is discussed in turn below.

[6] DDS, *Agnews Center Closure*, http://www.dds.ca.gov/AgnewsClosure/Home.cfm (last updated March 25, 2010)
[7] DDS, *News: Lanterman Developmental Center Closure*, http://www.dds.ca.gov/lantermannews/(last updated July 7, 2011).

MANAGED CARE OPTIONS INCLUDING OPTIONS FOR ADHC DUAL ELIGIBLES

39. The Defendants have proposed a transfer of ADHC recipients into managed care plans as a replacement for ADHC services. As judged by the August 19, 2011 letter from the California Association of Health Plans (CAHP) to the DHCS, this proposal, as understood by the plans, had significant problematic components. Letter from CAHP to Jane Ogle, Ogle Dep. Ex. 8, Ex. G to Zirker Decl. The August 19, 2011 letter from CAHP to DHCS points out that California managed care plans are only obligated to provide primary and acute care services, but not the long-term services and supports that this population requires, which have, until now, been provided separately, or "carved out", as a complement to primary and acute services. Based on information provided by Defendants, it does not appear that these concerns have been resolved.

40. Unfortunately, for the ADHC population, the Defendants currently are enrolling them into Medi-Cal managed care plans, which are charged primarily with managing the primary and acute care services covered by Medi-Cal. For the most part, managed care plans are not responsible or reimbursed for providing long-term services and supports. They are also not responsible for managing the primary and acute care services covered by Medicare (the primary payer for the services for dual eligibles). This is a particularly inappropriate solution for the dually eligible population given their observed higher rates of physical, cognitive, and behavioral health problems, and the plans' inexperience or incentive to provide preventative or home and community-based services (HCBS) long-term services and supports.

41. In contrast to the current transition plan to rapidly move ADHC recipients who are dually eligible for Medicare and Medi-Cal into currently configured managed care plans, a more suitable option would be the "duals integration pilot project," which is currently being developed by Defendants (set forth in Welfare and Institutions Code section 14132.275.) The Defendants have a contract from the federal government to design new models for integrating the financing and delivery of Medicare and Medi-Cal benefits provided to dual eligibles. One model that the Defendants are likely to pursue involves managed care plans tasked with administering all Medicare and Medi-Cal benefits including primary care, acute care, behavioral health and long-term services and supports. These plans would

receive funds from both Medicare and Medi-Cal, and would offer in return a benefit package that would be better designed to meet the needs of dual eligible persons than the acute and primary care benefit packages currently used by the majority of the existing health plans.

42. The benefit to the Defendants and participants is that when health care is managed in an integrated manner, the State and the managed care plans will be able and willing to provide preventative and home and community-based services (HCBS) in order to achieve savings from reduced nursing facility placements, and hospitalization, and better and preferred outcomes for participants. Unfortunately, the ADHC closure is happening before the duals project is established and thus this program option is not yet available.

43. Significantly, the Defendants' "duals integration pilot project," if it becomes operational, would likely contain the components that are missing from the Defendants' plan for the ADHC dual eligibles, namely: 1) the Medicare and Medi-Cal funding would be blended so that plans have an incentive to provide preventative services such as ADHC to minimize costly hospitalizations and nursing facility placement, for which they are financially responsible; 2) plans would have the explicit authority to provide "additional services" to supplement Medicare and Medi-Cal services; and 3) the plans would be compensated in the form of a capitation rate that "carves in," or includes, rather than "carves out," or excludes, home and community-based services.

44. Moreover, the duals integration project is designed as a pilot so that outcome measurements discussed above can be implemented, studied, and modified as the project proceeds. In contrast, in its monitoring plan for ADHC duals, the Defendants will look backwards at how many people are hospitalized or institutionalized, when it is too late to prevent harm to the people affected by the mistakes that could have been avoided.

HCBS Waivers

45. Another part of the Defendants' proposed transition plan is to expand the "In-Home Operations Waiver" (IHO Waiver), which is currently a small program that provides in-home nursing, personal care, and case management to approximately 140 individuals who would otherwise require care in a nursing facility. Owen Dep. 18:21-25, Ex. H. to Zirker Dec. ("Owen Dep."). The Defendants

propose to expand the number of slots to 1,000 statewide, add a service category called "Community-Based Adult Services" Centers (CBAS), and allow ADHC programs who qualify to become certified CBAS providers.

46. The IHO Waiver is a home and community-based waiver program operated by the Defendants, pursuant to section 1915(c) of the Social Security Act. Section 1915(c) Home and Community-Based (HCBS) waivers allow the State to seek a waiver of federal Medicaid requirements to provide home and community-based services to eligible individuals who otherwise would require placement in a nursing facility. While the IHO Waiver, or another 1915(c) waiver, could be an appropriate vehicle for providing ADHC services, Defendants' current plans are uncertain and lack necessary elements.

47. First, Defendants have represented that the IHO Waiver is not approved and is subject to change, even at this late date. Dennis Owen, Branch Chief of In Home Operations, identified by Defendants as the person most knowledgeable about the HCBS Waivers and responsible for administering the program, stated that the IHO Waiver is a "living document… subject to change daily/hourly depending on issues, questions, changes, policy changes, a number of things. What we're looking at was the very first cut that went out. …it's living, confidential document back and forth between us and CMS until such time that both parties agree that it's what we want and it's approved by the federal government." Owen Dep. 42:1-9. As of the date of his deposition on October 10, Mr. Owen indicated that important provisions such as the configuration of CBAS services, whether these would be provided individually or bundled, and the process for becoming a CBAS provider were still being worked out. Owen Dep. 43:25-44:4; 46:1-7.

48. Similar problems exist with the process for assessing and accepting ADHC participants into the IHO Waiver in time for the December 1 deadline. As Mr. Owen explained, the IHO waiver can only be accessed by referrals from three potential sources, the ADHC providers (by utilizing a 16 page level of care evaluation), a referral from one of the numerous managed care plans using "their own systems and algorithms" to screen for NF B level of care, and through APS using key questions from their assessment which may indicate NF B level of care. Owen Dep. 24-30. All referrals are to be

reviewed and processed by IHO nursing staff. Owen Dep. 29:24– 31:5. As of October 10, DHCS has only received two applications from ADHC providers and none from either APS or the managed care plans. Owen Dep. 28:21-29:5. Given the fact that key provisions of the IHO waiver have yet to be worked out, the waiver needs to be approved by CMS, recipients need to be referred and assessed, and providers brought on line, it does not appear likely that this option will be available and in place, ready to serve individuals whose services will be terminated on December 1, 2011.

49. More importantly, Defendants have proposed to add only 1,000 additional slots for this program. However, the Defendants have not provided any analysis of how many individuals would qualify or need these waiver services. Owen Dep. 41:18-43:9. Given that there are currently 38,000 individuals receiving ADHC services, and 63,000 persons who used ADHC services in calendar year 2009, 1,000 does not seem like a substantive contribution to alternative service capacity.

50. The Defendants should instead conduct an analysis and needs planning to determine how many ADHC recipients need services through the IHO Waiver or other waivers, where the persons are located, which existing ADHC programs are qualified and interested in serving them, and the rates necessary for providers to be able to offer needed services. Based on this information, the Defendants should amend the IHO or other waivers, or introduce new 1915 or 1115 waivers to accommodate those needs.

51. The Nursing Facility/Acute Hospital (NF/AH) Waiver is also being amended to add CBAS as a new service and provider category. Eligibility for this waiver is set at a lower standard – NF A level of care – and a much larger pool of current ADHC recipients would be eligible. As of October 10, 2011, Mr. Owens testified that the Department of Health Care Services has received 400 applications for NF/AH services from ADHC recipients, but has not acted on them since there are already 800 persons on the NF/AH waiting list and the wait is one and a half years long. Owen Dec. 57:9-14; 57:24-58:5; 58:22-23. He stated that those 400 applications are sitting on his desk and when asked what he is going to do with them, he replied, "Unknown at this time." Owen Dep. 58:4-11.

52. Appendix J of the NF/AH waiver application shows only 20 users the first year CBAS is offered and the 20 user estimate remains the same for all five years of the NF/AH waiver. Owen Dep.

Ex. 36 at ADHC01051: Ex. H to Zirker Decl. It is clear that the NF/AH Waiver cannot be used as a source of replacement services for ADHC participants come the December 1 termination date.

PACE

53. PACE, or the Program of All-Inclusive Care for the Elderly, is a managed care program in California that integrates Medicare and Medi-Cal funding and provides primary, acute and long-term care services. The Defendants have indicated that PACE is an option for ADHC recipients who are eligible and interested. PACE has limitations, however. PACE only serves individuals age 55 years and older who meet a nursing facility level of care. PACE also only operates in some zip codes in eight counties.[8]

54. PACE programs rely on an adult day health care model in which persons come to a health center for many of their daily services. PACE Programs currently serve approximately 2800 people statewide through five programs: St. Paul in San Diego, Alta-Med in Los Angeles, On Lok in San Francisco, Center for Elderly Independence (CEI) in Alameda County, and Sutter in Sacramento. Shen Dep. 10:25-11:14, 17:7-15, Ex. I to Zirker Decl. ("Shen Dep."). The state has approved 1000 more slots. Shen Dep. 11:15-19. No ADHC participants have yet enrolled in PACE. Shen Dep. 24:25-25:7,

55. According to the Defendants, Alta-Med currently operates seven ADHC programs. They will shut four of them. The remaining three will be converted to PACE centers serving approximately 250-260 ADHC participants. Shen Dep. 13:8-20; 14:13-15:19. Individuals who wish to switch will have to apply and be assessed and approved before they can join the Alta-Med PACE program. Shen Dep. 22:14-25.

56. According to the Defendants, On Lok is discussing the possibility of expanding its capacity and extending PACE to some ADHC participants, but no specific numbers have been identified. It is possible that 30% of San Francisco PACE participants may be eligible, but not all would choose On Lok and On Lok has not determined whether it will expand or how much it will expand. No official proposal has been made to the Defendants, but the Defendants thought they might add about 300 people. Shen Dep. 15:20-16:18; 20:13-21:11.

[8] A list of these zip codes is found at DHCS, *California PACE Plans,* "Service Area Counties and Zip Codes," http://www.dhcs.ca.gov/individuals/Pages/PACEPlans.aspx (last visited October 14, 2011).

57. Defendants say they have been told that CEI may expand to include approximately 120-150 people currently served by the Oakland Chinatown ADHC program. The Chinatown ADHC serves approximately 400 people. Shen Dep. 16:19-17:6.

58. Defendants have no information about whether the remaining two PACE programs, St. Paul in San Diego and Sutter in Sacramento, will take any additional ADHC participants. Shen Dep. 17:7-15.

59. Defendants believe there may be new PACE programs in Los Angeles, Orange, San Bernadino and Riverside Counties, but do not know how many people will be served. The applications require approval by the Defendants and by CMS. No applications have been submitted yet. Shen Dep. 12:23-13:7.

60. Defendants do not know how many current ADHC participants meet the necessary Level of Care admissibility requirement for the PACE program, because participants are still being assessed. Shen Dep 27:14-18.

61. Individuals cannot participate in both managed care and PACE. They have to choose. If they are currently enrolled in managed care, they must apply and be accepted by PACE and then disenroll in managed care. Shen Dep. 26:11-27:2.

62. In order to be accepted into the PACE program, participants need to apply or be referred. They are then reviewed by the PACE program to see if they meet eligibility requirements. The Defendants go out monthly to review the PACE intakes and to interview the PACE team in order to determine whether to approve the enrollment. The cut-off date for enrollment is the 24th of each month. If participants have not had their enrollment/review completed by the 24th of the month to start the following month, then they must wait an additional month to complete the enrollment process. Shen Dep. 22:14-24:24.

63. Defendants will not allow PACE programs to admit participants and have them reviewed later. Shen Dep. 25:16-26:10.

64. Another program identified by Defendants to serve ADHC recipients is SCAN in Los Angeles County. SCAN is a managed care plan for people over age 65, which operates in the Los

Angeles area. For enrollees who meet nursing facility level of care (A or B), SCAN provides long-term care as well as primary health care. Shen Dep.36:3-23.

65. The Defendants do not know how many people will go from ADHC to SCAN. No ADHC participants have enrolled in SCAN as of October 10, 2011. Shen Dep. 33:15-17; 37:7-9.

66. Given the small number of potentially available PACE slots, and the uncertainty about when new slots will become available, who might apply and be eligible, and how long the enrollment process takes, it is unlikely that PACE or SCAN will be a real replacement for very many people before the December 1, 2011 termination of ADHC.

67. Based on the information available to me and in the absence of additional information from the Defendants, I conclude that it is unlikely that the Defendants will have provided alternative services to all current ADHC recipients by December 1, 2011 and that ADHC services should not be discontinued until appropriate physical and behavioral health services have been arranged.

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

Executed on October 14, 2011, in East Windsor, New Jersey.

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
Attorneys for Plaintiffs