IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

DONNA RADASZEWSKI, Guardian, on Behalf of Eric Radaszewski,	)	
Plaintiff,	)	
v.	)	No. 01 C 9551
	)	Judge John W. Darrah
BARRY S. MARAM, Director of the Illinois Department of Healthcare and Family Services,	)	Magistrate Judge Schenkier
Defendant.	)	

DEFENDANT'S RESPONSE TO PLAINTIFF'S PROPOSED FINDINGS OF FACT AND DEFENDANT'S PROPOSED FINDINGS OF FACT

NOW COMES Defendant, BARRY S. MARAM, Director of the Illinois Department of Healthcare and Family Services, by his attorney, LISA MADIGAN, Attorney General of Illinois, and hereby submits his Response to Plaintiff's Proposed Findings of Fact and his Proposed Findings of Fact after trial of the case.

RESPONSE TO PLAINTIFF'S PROPOSED FINDINGS OF FACT

1. Admitted.
2. Admitted.
3. Admitted.
4. Admitted.
5. Admitted.
6. Admitted.
7. Admitted.
8. Admitted.

9. Admitted.

10. Admitted, but not relevant.

A. State Officials Have Determined That Home Care Is Appropriate For Eric Radaszewski

11. Admitted in part, deny that skilled nursing care is a service under the MFTD Waiver.

12. Admitted.

13. Admitted in part, deny that services not covered under MFTD Waiver, such as EPSDT services (i.e. nursing services) are approved services under MFTD Waiver.

14. Admitted in part, but not relevant. Deny that skilled nursing care is a service under the MFTD Waiver.

15. Admitted, but not relevant.

16. Admitted.

17. Admitted.

18. Admitted.

19. Admitted.

20. Denied as an opinion unsupported by competent medical testimony.

B. A Nursing Home Cannot Meet Eric Radaszewski's Medical Needs; He Requires A Hospital Level Of Care

21. Denied.

22. Denied.

22a. Admitted.

22b. Admitted.

22c. Admitted.

22d. Admitted.

22e. Denied.

22f. Denied.

23. Denied as speculative.

24. Admitted that these were the summary of the testimony in the administrative hearing in 2000, but that this testimony is not relevant in this matter.

25. Admitted, but not relevant since the institution for cost comparison under the MFTD Waiver for individuals under the age of 21 is a hospital, whereas the relevant institutional cost comparison for individuals over the age of 21 in the PWD Waiver is a nursing facility.

26. Denied.

C. Eric Requires The Equivalent Of One-on-One Skilled Nursing Care In Whatever Setting He Would Be Placed

27. Denied.

28. Denied.

E.[sic] **Extensive One-on-One Nursing Services Are Included In HSP Service Plans**

29. Deny that skilled nursing services can be equated with private duty nursing, deny that HFS pays for skilled nursing in HSP, and admit that HSP Service Plans may contain skilled nursing services.

30. Admitted.

D. Eric Radaszewski Is A Qualified Person Within The Meaning Of The ADA

31. Denied.

32. Denied.

33. Admitted.

34. Admitted.

35. Denied.

E. The Cost Of Eric's Continued Care At Home Would Not Exceed The Cost Of Care At The Hospital Level He Requires

36. Denied.

36a. Admitted in part, but not relevant since the institution for cost comparison under the MFTD Waiver for individuals under the age of 21 is a hospital. Plaintiff did not present any evidence that cost in the community after Eric Radaszewski attained the age of 21 would not exceed the cost in a nursing facility.

36b. Admitted, but not relevant because this level of care is provided pursuant to an injunction entered in proceedings in *Radaszewski v. Maram*, 00 CH 1475, 18th Judicial Circuit, DuPage County, Illinois.

36c. Denied.

36d. Admitted, with the qualification that long-term care payments for those residing in hospitals are paid at long-term care rate. 42 U.S.C. § 1396l; 89 Ill. Admin. Code § 140.569(j).

36e. Admitted.

36f. Admitted.

F. The Relief Plaintiff Seeks Would Not Fundamentally Alter Illinois' Programs and Services

37. Denied.

37a. Denied.

37b. Admitted, but not relevant.

37c. Admitted, but not relevant.

37d. Admit the first, second, and third sentences of ¶ 37d, but not relevant. Deny the fourth sentence of ¶37d.

37e. Deny the first, second and third sentences of ¶37e as conclusions of law. Admit the fourth sentence of ¶37e, but deny that an exceptional care rate could be applied to Eric Radaszewski, because there is no evidence of record that Eric Radaszewski is ventilator-dependent and HIV-positive. Deny the fifth sentence of ¶37e.

37f. Denied as a conclusion of law.

37g. Denied.

37h. Denied. Illinois has chosen the options that 1) every person in the PWD Waiver require a nursing facility level of care, (DX 14 at item No. 2, at 003025), and 2) that the state will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a nursing facility level of care, (DX 14 at item No. 8, at 003027), and under federal approval of those options, the federally approved PWD Waiver becomes the federal requirement.

37i. Denied. Illinois has chosen the options that 1) every person in the PWD Waiver require a nursing facility level of care, (DX 14 at item No. 2, at 003025), and 2) that the state will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a nursing facility level of care, (DX 14 at item No. 8, at 003027), and under federal approval of those options, the federally approved PWD Waiver becomes the federal requirement.

37j. Admitted in part. However, the State has the authority to establish reasonable and appropriate limits on the amount duration, and scope of each service. Moreover, HCBS waivers need only be designed to serve as an alternative to institutionalization for a preponderance of the State's selected target group. (PX 51, DX 22 at HFS 300997).

37k. Denied, as not an accurate recitation of the statement in the Exhibit, which is limited to a federal review of federal policies and practices.

37l. Denied as a state law claim.

38. Admitted in part, but denied to the extent that those are the only bases of Defendant's fundamental alteration defense.

39. Admitted.

40. Denied.

40a. Deny the first, third, and sixth sentences of ¶40a. Admit the second, fourth and seventh sentences of ¶40a. Fifth sentence is neither admitted nor denied as non-grammatical.

40b. Defendant denies that Dr. Flint is a "medicaid [sic] and health policy expert," and that ¶40b is nothing more than a recitation of Dr. Flint's testimony, which defendant need not admit nor deny the accuracy. (Guidelines for Proposed Findings of Fact).

40c. Deny first sentence of ¶40c. The remainder of ¶40c is a recitation of witness' testimony, which defendant need not admit nor deny the accuracy, and are not relevant. (Guidelines for Proposed Findings of Fact).

40d. Admitted, but there is no requirement that Menenberg need have performed his study as Plaintiff believes it should have been conducted.

40e. Admit the first sentence of ¶40e. The second and third sentences of ¶40e are a recitation of witness' testimony, which defendant need not admit nor deny the accuracy. (Guidelines for Proposed Findings of Fact). Admit the fourth sentence of ¶40e, further stating there is no requirement this be done. Deny the fifth sentence of ¶40e.

40f. Deny the first sentence of ¶40f. The remainder of ¶40f is a recitation of witness' testimony, which defendant need not admit nor deny the accuracy. (Guidelines for Proposed Findings of Fact).

40g. No response required. ¶40g is a recitation of witness' testimony, which defendant need not admit nor deny the accuracy. (Guidelines for Proposed Findings of Fact).

40h. Admit the first sentence of ¶40h. The remainder of ¶40h is a recitation of witness' testimony, which defendant need not admit nor deny the accuracy. (Guidelines for Proposed Findings of Fact).

40i. Denied.

40(i)(1). ¶40(i)(1) is a recitation of witness' testimony, which defendant need not admit nor deny the accuracy. (Guidelines for Proposed Findings of Fact).

40(i)(2). Admit the first sentence of ¶40(i)(2). The second and third sentences of ¶40(i)(2) are a recitation of witness' testimony, which defendant need not admit nor deny the accuracy. (Guidelines for Proposed Findings of Fact). Deny the fourth sentence of ¶40(i)(2).

40(i)(3). ¶40(i)(3) is a recitation of witness' testimony, which defendant need not admit nor deny the accuracy. (Guidelines for Proposed Findings of Fact).

40(i)(4). ¶40(i)(4) is a recitation of witness' testimony, which defendant need not admit nor deny the accuracy. (Guidelines for Proposed Findings of Fact).

40(i)(5). Admit the first sentence of ¶40(i)(5). The remainder of ¶40(i)(5) is a recitation of witness' testimony, which defendant need not admit nor deny the accuracy. (Guidelines for Proposed Findings of Fact).

40(i)(6). Denied.

41. Admitted.

42. Denied.

42a. Admitted.

42b. Admitted, but there is no requirement that standardized actuarial processes be used, that Menenberg and Werner conducted different analyses, and that Plaintiff's expert did not perform any study.

42c. ¶42c is a recitation of witness' testimony, which defendant need not admit nor deny the accuracy. (Guidelines for Proposed Findings of Fact).

42d. ¶42d is a recitation of witness' testimony, which defendant need not admit nor deny the accuracy. (Guidelines for Proposed Findings of Fact).

42e. ¶42e is a recitation of witness' testimony, which defendant need not admit nor deny the accuracy. (Guidelines for Proposed Findings of Fact).

42f. Admitted, as medical needs are not relevant.

42g. Admitted, as medical needs are not relevant.

42h. Denied.

DEFENDANT'S PROPOSED FINDINGS OF FACT

TITLE XIX MEDICAID.

43. In 1965, Congress enacted Title XIX of the Social Security Act to establish the voluntary federal-state health care program known as Medicaid. (Judicial Notice).

44. A State participating in the Medicaid program is required to satisfy the Secretary of the United States Department of Health and Human Services that it complies with the requirements of federal law. The United States Department of Health and Human Services reimburses a participating State by matching the State's expenditures on the covered services provided through the program. The agreement between the U.S. Department of Health and Human Services and the participating State is evidenced in the State Plan for Title XIX. (Testimony of Francis Kopel, Tr. p. 280; DX 11, 12).

45. After an individual applies for services under Medicaid, and has been determined to be eligible, a medical assistance card is issued to that individual. (Testimony of Francis Kopel, Tr. p. 281).

46. A medical assistance card is, in effect, an insurance card that allows Medicaid eligible individuals to access healthcare from any provider who is enrolled with HFS. (*Id*.).

47. A provider is an individual or institution that has agreed to provide services in compliance with the Title XIX State Plan, has agreed to accept HFS' reimbursement rates for services covered under the Title XIX State Plan as payment in full, and has agreed to abide by all of the rules and regulations of the Medicaid program. (*Id*.).

48. A service is covered under Medicaid if it is listed in the Title XIX State Plan as a covered service. (*Id*. at p. 283).

49. Services under Medicaid are divided into two groups: 1) mandatory services, which the federal government requires the states to provide, and 2) optional services, which may or may not be provided at the option of the state. (*Id*. at p. 284).

50. Mandatory Medicaid services include inpatient hospital services, physician services, long-term care (nursing facility) for individuals over 21 years of age, and EPSDT. (*Id*. at p. 285).

51. Illinois furnishes payment to Medicaid-enrolled providers for all mandatory Medicaid services to eligible persons. (*Id*. at p. 286).

52. Optional services include, for example, prescription drugs, and private duty nursing. (*Id*.).

53. Illinois does not furnish payment for all optional Medicaid services. Those optional Medicaid services Illinois does provide under its Title XIX State Plan are checked-off in the State Plan. (*Id*. at p. 287; DX 11 at 01398).

54. Private duty nursing is continuous and individual one-on-one care provided to a person who has medical need for that care. (Testimony of Francis Kopel, Tr. pp. 290-291).

55. Under the Illinois Title XIX State Medicaid Plan, private duty nursing is not a Medicaid covered service. (*Id*. at p. 291; DX 11 at 001400).

EPSDT.

56. EPSDT is an acronym that means Early and Periodic Screening, Detection and Treatment, as defined by 42 U.S.C. §1396d.

57. Under EPSDT, Illinois is required to provide payment for Medicaid services to Medicaid eligible children (under 21 years of age) for any service that is listed in §1905(a) of the Social Security Act, if medically necessary, including all optional services, whether covered under Illinois Title XIX State Plan or not. (Testimony of Francis Kopel, Tr., pp. 288, 290).

58. For those services provided under Illinois' Title XIX State Plan that have some limitations, those limitations do not apply to Medicaid-eligible individuals under the age of 21 who receive services as a result of EPSDT. (*Id*. at pp. 289-90).

59. Adults over the age of 21 years cannot qualify for services under EPSDT. (*Id*. at p. 290).

THE HCBS-PERSONS WITH DISABILITIES MEDICAID WAIVER.

60. Waivers are grants of authority by which the federal government will allow the State to provide services that are not otherwise covered under the Title XIX State Medicaid Plan. (Testimony of Francis Kopel, Tr. p. 292).

61. In Illinois, home and community-based services for Medicaid eligible persons are only authorized pursuant to Medicaid Waivers granted by the federal government under 42 U.S.C. § 1396n(c). (DX 14 at 3016).

62. Illinois requested a Home and Community-Based Services Medicaid Waiver in order to provide home and community based services to individuals, who, but for the provision of such services, would require a nursing facility level of care, the cost of which would be reimbursed under the approved Medicaid State Plan. The Secretary of HHS approved Illinois' Home and Community-Based Services Waiver for Disabled Individuals, effective October 1, 2004 through September 30, 2009, pursuant to 42 U.S.C. § 1396n(c). (hereinafter referred to as "Persons with Physical Disabilities Medicaid Waiver" or "PWD"). (Testimony of Barbara Ginder, Tr. p. 325; DX 14 at 3016-17, 3025).

63. The state requested the PWD in order to provide home and community-based services to individuals who, but for the provision of such services, would require a

nursing facility level of care, the cost of which could be reimbursed under the approved Title XIX State Medicaid Plan. (DX 14, Item 2, at 3025).

64. The PWD Medicaid Waiver targets waiver services to the disabled and to persons under the age of 60 at the time of application. (DX 14, Items 3, 4, at 3025-26).

65. To be eligible for the services authorized by the PWD Medicaid Waiver, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 (of the PWD Medicaid Waiver) *in addition to meeting the targeting criteria in items 2-4* of the PWD. (DX 14, Item 5, at 3025) (emphasis added).

66. Under the Persons with Disabilities Medicaid Waiver, the State will refuse to offer home and community-based services to any person whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a nursing facility. (Testimony of Barbara Ginder, Tr. pp. 327-329; DX 14, Item 8, at 3025, 3027).

67. Under the PWD Medicaid Waiver, the amount, duration and scope of services contained in section 1902(a)(10)(B) of the Act is waived, in order that services not otherwise available under the approved Medicaid State Plan may be provided to individuals served as a result of the Waiver. (Testimony of Barbara Ginder, Tr. pp. 331-332; DX 14, Item 10, at 3027).

68. The services available under the PWD Medicaid Waiver are not available to all Medicaid eligible persons. Only Waiver-eligible persons can receive waiver services. (*Id.*).

69. The State has the authority to establish reasonable and appropriate limits on the amount, duration, and scope of each service, and HCBS waivers are only designed to

serve as an alternative to institutionalization for a preponderance of the State's selected target group. (DX 22, PX 51 at HFS 300997).

70. Services available under PWD Medicaid Waiver include homemaker, home health aide services, personal care services, respite care, adult day health, environmental accessibility adaptations, skilled nursing, specialized medical equipment and supplies, personal emergency response systems, extended State Plan services (physical therapy services, occupational therapy services, speech, hearing and language services) and home delivered meals. (Testimony of Barbara Ginder, Tr. pp. 332-333; DX 14 at 3028-29).

71. Under the Persons With Disabilities Medicaid Waiver, private duty nursing is defined as "individual and continuous care (in contrast to part-time or intermittent care) provided by licensed nurses within the scope of state law. These services are provided to an individual at home." (DX 14 at 3053-3054).

72. Under the Persons With Disabilities Medicaid Waiver, as approved in Illinois, private duty nursing is not an included service. (DX 14 at 3028, 3053-54).

73. Under the Persons With Disabilities Medicaid Waiver, skilled nursing is defined as "Consumer directed services in the plan of care, which are within the scope of the State's Nurse Practice Act and are provided by a registered nurse or licensed practical or vocational nurse licensed to practice in the State and are not otherwise covered through EPSDT." (DX 14 at 3050).

74. Under the PWD Medicaid Waiver, as approved in Illinois, skilled nursing services are included services. (DX 14 at 3028, 3050).

75. If an individual is eligible for the PWD Medicaid Waiver, that individual is also eligible for Medicaid services covered under Illinois' Title XIX State Plan. (Testimony of Barbara Ginder, Tr. p. 333).

76. As part of the PWD Medicaid Waiver, the state makes assurances to the federal government that the waiver is being operated in conformance with all express terms of the waiver. (DX 14 at 3030-3033).

77. Failure by the state to comply with the approved waiver may result in a sanction of termination of the waiver. (Testimony of Barbara Ginder, Tr. p. 337).

78. The state has assured the federal government that the agency will provide for an evaluation (and periodic reevaluations, at least annually) of the participant's need for a nursing facility level of care. The requirements for such evaluations and reevaluations are detailed in Appendix D to the PWD Medicaid Waiver. (DX 14 at 3031, 3082-3094).

79. The federal government requires that all home and community based waivers be cost neutral. In the PWD waiver application, the state outlines its estimates of service cost, number of individuals to be served, and how the waiver compares to the institutional costs of a similar population. (DX 14, Appendix G, at 3123-3142).

80. Factor D is the estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program. (DX 14 at 3125).

81. Factor D^1 is the estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program. (*Id*. at 3133).

82. Factor G is the estimated annual average per capita Medicaid cost for hospital, nursing facility, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted. (*Id*. at 3135).

83. Factor G^1 is the estimated annual average per capita Medicaid cost for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted. (DX 14 at 3136).

84. Cost neutrality under the PWD Medicaid Waiver for a nursing facility population is demonstrated to the federal government by comparing the sum of Factor D and Factor D^1 and comparing them to the sum of Factor G and G^1. If the sum of factors D and D^1 is less than or equal to the sum of Factors G and G^1, the Waiver is cost neutral. (Testimony of Barbara Ginder, Tr. pp. 348-350; DX 14 at 3138, 3139).

85. The federal government allows the state to operate HCBS waivers only if they are cost neutral, *i.e.*, the state is not spending more money than it would pay for that same individual in an institutional setting. (Testimony of Barbara Ginder, Tr. p. 350).

86. Illinois' PWD Medicaid Waiver is cost-neutral. (DX 14 at 3138-3139; DX 15, 16).

87. The federal government requires the state to comply with all provisions in the federally-approved HCBS PWD Medicaid Waiver, including the appendices attached to the waiver. (Testimony of Barbara Ginder, Tr. p. 341; DX 14, at 3033-3034).

88. Appendix D to the PWD Medicaid Waiver contains the instrument utilized by the agency to evaluate the need for the nursing facility level of care chosen in item No. 2 of the PWD Medicaid Waiver. (DX 14 at Appendix D, at 3076).

89. The Determination of Need ("DON") evaluates the ability of the individual to perform activities of daily living, and assigns a score that corresponds to a cost equivalent of what services the individual needs would cost, if that person were in a nursing home. (Testimony of Barbara Ginder, Tr. pp. 344, 346; DX 14 at 3082-3089; DX 18).

90. The federal government has never notified HFS that the PWD Medicaid Waiver does not comply with the Americans with Disabilities Act. (Testimony of Barbara Ginder, Tr. p. 362).

91. The federal government has never notified HFS that the PWD Medicaid Waiver does not comply with the Rehabilitation Act. (*Id*. at pp. 362-63).

THE ILLINOIS HOME SERVICES PROGRAM.

92. An individual applies for home and community based services to the specific program Illinois administers under the Home Services Program ("HSP"). (Testimony of Barbara Ginder, Tr. p. 342).

93. The authorization to provide services to physically disabled Medicaid-eligible persons under age 60 through the HSP derives from the PWD Medicaid Waiver. (*Id*.).

94. The terms of the PWD Medicaid Waiver control HSP requirements for services to physically disabled Medicaid-eligible persons under age 60. (*Id*. at p. 343).

95. The Illinois Department of Human Services, Division of Rehabilitation Services, has the day-to-day operational responsibility of implementing the PWD. (Testimony of Barbara Ginder, Tr. p. 341; DX 14 at 3035).

96. DHS implements the PWD Medicaid Waiver though the HSP. (DX 14 at 003035).

97. In order to enroll in the Home Services Program, the individual must, among other things, be eligible for Medicaid, apply for services through the Home Services Program, have a severe disability which is expected to last at least twelve months, be an individual who is in need of long-term care, obtain certification from a physician that the individual is in need of long-term care and that this care can be safely and adequately

provided in the individual's home as provided in the service plan developed for the individual, and not require in-home services that are expected to cost more than the costs that the State would pay for institutional care for persons similarly situated. (DX 14 at 3025, 3028-34).

98. The initial step in determining eligibility for HSP is to be assessed by a DHS case manager for a determination of need. (Testimony of Barbara Ginder, Tr. pp. 341-342).

99. The instrument used to assess the individual is the Determination of Need ("DON"). (DX 14, at Appendix D, 3082-3090; DX 18, 19; Testimony of Barbara Ginder, Tr. pp. 343-44).

100. A DHS Division of Rehabilitation Services case manager completes the DON. The case manager conducts a mini-mental status examination of the individual and evaluates 15 activities of daily living and independent activities of daily living to determine the score. The impairment of the individual is scored and the support the individual needs the individual has. An individual needs a minimum score of 29 to be eligible for HSP. (Testimony of Barbara Ginder, Tr. p. 344).

101. The DON assessment is also utilized as the preadmission screening to evaluate whether an individual qualifies for admission to a nursing facility. (*Id.*).

102. Service cost maximums are service cost caps determined by the DON score. Service cost maximums increase as the DON score increases, (*Id*. at p. 346), as follows:

DON Range	SCM (monthly).
29-32	$1,249
33-40	$1, 435
41-49	$1,597
50-59	$1, 912
60-69	$2,247
70-79	$2,430
80-100	$2,612

(Testimony of Todd Menenberg, Tr. pp. 415-416).

103. Exceptional care rates were developed to reimburse long-term care facilities for care rendered to individuals who have exceptional or extraordinary medical needs that are non-acute, but still require intense nursing services. (Testimony of Barbara Ginder, Tr. p. 347).

104. The long term care system developed as a way to move people out of hospital based care to nursing homes. HFS developed exceptional care rates for nursing homes. The nursing homes then developed specialized units to work with individuals and provide care at a much higher level of care than nursing homes traditionally provided. (Testimony of Barbara Ginder, Tr. p. 347).

105. Exceptional care rates are utilized in the Home Services Program, serving the same purpose as Service Cost Maximums, giving the upper limit of cost for services per month that the individual can utilize. (Testimony of Barbara Ginder, Tr. p. 347).

106. HSP is still extending exceptional care rates in appropriate cases even though the exceptional care program for nursing homes is no longer in existence. (*Id.* at p. 348).

107. The next step in determining HSP eligibility is for the applicant and case counselor to develop a written Home Services Plan. (*Id.* at p. 345).

108. A Home Services Plan outlines the services an individual needs, how frequently those services are to be provided, and the type of provider. Service plans are developed by the individual and case manager and are limited by the Service Cost Maximum corresponding to the individual's DON score, or if appropriate, the Exceptional Care Rate extended to the individual. (*Id.* at p. 346). No physicians for HFS or DHS participate in the development of the Homes Services Plan.

109. In HSP, a physician from DHS or HFS does not evaluate medical need for anyone participating in or applying to participate in HSP. (Testimony of Barbara Ginder, Tr. pp. 382-83, 387-88).

110. The service plan is sent to the individual applicant's physician. The physician signs a certification that he approves the service plan so developed. The Certification provides, in part: "In my professional judgment, the above-referenced patient is (mark only one): ___ appropriate for Home Services Program. The Services described on the attached Service Plan are necessary for the patient to live independently

in the community. Without HSP services, I would recommend placement in an ICF or SNF to protect his/her well-being." (*Id*. at p. 345-346; DX 46).

111. When the applicant's physician signs the certification form, the applicant moves into HSP eligibility status.

112. If the physician does not sign the certification, no services under HSP are provided to the individual. (Testimony of Thomas Napolski, Tr. p. 275).

ERIC RADASZEWSKI IS NOT A QUALIFIED INDIVIDUAL WITH A DISABILITY UNDER THE ADA OR UNDER THE REHABILITATION ACT.

113. When Eric Radaszewski turned 21 years old on August 5, 2000, he began receiving home and community based services under the Persons With Physical Disabilities Medicaid Waiver through the Home Services Program. (JX 2-JX 6, DX 41-DX 54; Testimony of Donna Radaszewski, Tr. p. 48).

114. Pursuant to Eric Radaszewski's application to the HSP, DHS personnel evaluated Eric Radaszewski with the DON on October 7, 1999. (DX 41).

115. DHS extended an Exceptional Care Rate to Eric Radaszewski in the amount of $4,593 per month. (DX 48, JX 5).

116. A Home Services Plan was developed for Eric Radaszewski, which included registered nurse services and personal assistant services. (JX 6).

117. Plaintiff, Donna Radaszewski, signed up to be Eric's personal assistant, provided care to Eric as a personal assistant, and submitted time sheets for payment to DHS. (Testimony of Donna Radaszewski, Tr. p. 50-51; DX 45, DX 50, DX 51, DX 54).

118. Eric Radaszewski received home and community based services under HSP for the month of August, 2000. (Testimony of Donna Radaszewski, Tr. p. 51; DX 45, DX 53, DX 54).

119. In September, 2000, Plaintiff removed Eric Radaszewski from HSP. Eric has not received services under HSP since August 31, 2000, including to this day. (*Id*. at pp. 50-52).

120. The State of Illinois did not stop any services or benefits to Eric Radaszewski through the HSP. (*Id*. at pp. 51-52).

121. Eric Radaszewski has not been evaluated for any Home Service Program operated by DHS since August, 2000. (Testimony of Donna Radaszewski, Tr. p. 60).

122. Eric Radaszewski is not currently receiving any services under any Home Services Program operated by DHS. (*Id*.).

123. Eric Radaszewski currently resides in the community at his parents' home in Naperville, Illinois and receives nursing services pursuant to an injunction entered in proceedings in *Radaszewski v. Maram*, 00 CH 1475, 18th Judicial Circuit, DuPage County, Illinois. (Testimony of Donna Radaszewski, Tr. pp. 34-35, 55-56, 66).

124. Eric Radaszewski will only apply to DHS for any in-home service program under any Medicaid waiver after his guardian evaluates the outcome of court cases. (*Id*. at p. 61).

125. Donna Radaszewski has not looked into whether any nursing home could provide care for Eric Radaszewski. (*Id*. at p. 84).

126. While Donna Radaszewski desires a hospital level of care for Eric, Donna Radaszewski does not know of any doctor who would admit Eric to Children's Memorial Hospital on a long-term basis. (*Id*. at pp. 89-90).

127. Donna Radaszewski never investigated whether any hospital would admit Eric on a long-term basis. (*Id*. at p. 90).

128. Donna Radaszewski does not know how much it would cost to place Eric in a hospital on a long-term basis. (Testimony of Donna Radaszewski, Tr. p. 90).

129. Donna Radaszewski admitted that she has no basis to claim that it would be less expensive to provide care for Eric at home rather than in an institutional setting. (*Id.* at pp. 90-91).

130. Dr. Peters, Eric Radaszewski's physician, opined that Eric needs to have an experienced and knowledgeable RN-level nurse, who will be available to Eric on a daily basis, several times during the day to assess any change in his status. (Testimony of Michael Peters, Tr. p. 113).

131. Eric Radaszewski's physician opined that if Eric were placed in an institution, he would recommend care on a level that Eric is getting now – a hospital level of care. Dr. Peters admitted that in the real world, Eric would not have access to a hospital level of care for very long. (Testimony of Michael Peters, Tr. pp. 115-116).

132. Dr. Peters admitted that he has not actively looked into whether any institution, other than a hospital, would be able to adequately care for Eric. (*Id.* at p. 116).

133. Dr. Peters admitted that there may be a nursing facility that could adequately care for Eric. (*Id.*).

134. Dr. Peters admitted that he would not admit Eric Radaszewski to a hospital under his current condition. (*Id.* at p. 132).

135. Dr. Peters admitted that if Eric's parents were not available to care for him or the level of care he was getting at home were withdrawn, Eric would be assessed, in

the hospital, for those services and treatments he would need upon discharge from the hospital. (Testimony of Michael Peters, Tr. p. 135).

136. Dr. Peters admitted that reimbursement for hospital services is based upon the insurance plan of the patient and the agreed-upon reimbursement between the hospital and insurance plan, and not the $2,000-$3,000 per night that Edward Hospital charges. (*Id*. at p. 130).

137. The Illinois Department of Healthcare and Family Services does not pay the usual and customary charges that are billed for services to Medicaid eligible individuals by hospitals. (Testimony of Matthew Werner, Tr. p. 559).

138. HFS reimburses hospitals at a diagnosis related grouping rate (“DRG”). (Testimony of Matthew Werner, Tr. p. 560, *see also*, Testimony of Francis Kopel, Tr. pp. 210-211).

139. Hospitals enrolled as providers of services to Medicaid recipients agree to accept payment at the rate set by HFS. (Testimony of Matthew Werner, Tr. p. 560).

140. Eric Radaszewski’s home service program case is currently in case interrupt status, and he is not receiving services under the HSP. (Testimony of Thomas Napolski, Tr. pp. 273-74).

141. In order to receive services under HSP, Eric Radaszewski’s eligibility would have to be determined, including, a new DON assessment made, service cost maximum or exceptional care rate established, a new service plan developed, and Eric’s personal physician would need to certify his appropriateness for HSP. (*Id*. at pp. 274-275).

142. If Eric’s physician did not certify him as appropriate for HSP, then HSP could not provide him any services. (*Id*. at p. 275).

143. Eric Radaszewski is not eligible for the HSP.

144. By filing this lawsuit, Eric Radaszewski is seeking to receive funding through the State to provide private duty nursing services. (Testimony of Donna Radaszewski, Tr. p. 47).

145. When the lawsuit was originally filed, Eric Radaszewski was seeking 24 hours of private duty nursing, seven days per week. At trial, he now seeks 16 hours of private duty nursing plus respite hours. (*Id.* at pp. 79-80).

ERIC RADASZEWSKI'S PARTICIPATION IN THE MEDICALLY FRAGILE AND TECHNOLOGY DEPENDENT MEDICAID WAIVER IS NOT RELEVANT TO HIS CLAIMS.

146. The Home and Community Based Services for Medically Fragile and Technology Dependent Children ("MFTD") provides home and community based services for children to allow them to stay in their homes with their families and not be institutionalized. (Testimony of Barbara Ginder, Tr. p. 353).

147. MFTD allows a family's income to be waived so that children can become eligible for Medicaid regardless of the family's income. (*Id.* at p. 355).

148. A child who is eligible for Medicaid is eligible for all Medicaid services, including the Early Periodic Screening Diagnostic and Treatment Program ("EPSDT"). (*Id.;* 42 U.S.C. §§1396a(a)(43), 1396d(r)).

149. The target population for MFTD is children under the age of 21 who would require a hospital level of care or an intermediate care facility for mentally retarded persons. (Testimony of Barbara Ginder, Tr. p. 357; DX 13 at 002845).

150. Services available under MFTD are respite care, environmental adaptations, family training, nurse training, placement maintenance, counseling services, and medically supervised day care. (*Id*. at p. 358; DX 13 at 002849-002851).

151. Skilled nursing services are not a covered service under MFTD. (DX 13 at 002849-002851).

152. Private duty nursing is not a service covered under MFTD. (Testimony of Barbara Ginder, Tr. p. 359).

153. Persons in MFTD must have a written plan of care, which is reviewed by physicians in HFS' Bureau of Comprehensive Healthcare Services for medical necessity and approval. (Testimony of Barbara Ginder, Tr. pp. 360-361).

ASSUMING, *ARGUENDO*, THAT PLAINTIFF HAS SUCCESSFULLY SHIFTED THE BURDEN TO DEFENDANT, THE MODIFICATION PLAINTIFF SEEKS IS NOT REASONABLE AND WOULD FUNDAMENTALLY ALTER THE PERSONS WITH DISABILITIES MEDICAID WAIVER.

154. Defendant adopts by reference all the Proposed Findings of Fact at Paragraphs 60 through 112 as if they were fully stated here.

155. Todd Menenberg has taught and presented economic analysis and damages at American Bar Association conferences, to agencies of the federal government, state Medicaid Directors, and to various groups of public welfare attorneys. (Testimony of Todd Menenberg, Tr. p. 403).

156. Mr. Menenberg has been involved with litigation over home and community based waivers in Oregon, California, Pennsylvania, Indiana. (*Id*. at pp. 406-407).

157. Mr. Menenberg has also estimated costs of moving populations from institutions into the community for the states of New York and Pennsylvania. (*Id*. at p. 407).

158. Defendant tendered, and the Court accepted, Todd Menenberg as an expert in the field of estimating economic impact. (*Id*. at pp. 407-408).

159. Mr. Menenberg quantified the economic impact on the cost of the State's current Persons with Disabilities Waiver, assuming Eric Radaszewski were to prevail on her request for additional home nursing services and other individuals were then also able to access additional waiver services. (*Id*. at p. 408).

160. Mr. Menenberg's analysis focused on two populations:

1) current nursing facility residents who would potentially move from nursing facilities to community based settings through the PWD, and 2) current PWD recipients who currently use services at a cost less than their SCM (Service Cost Maximum). (Testimony of Todd Menenberg, Tr. pp. 410-411).

161. If SCM limitations were removed, the cost to move nursing home residents into the community and access services through the PWD would approximately be $32 million using fall 2006 nursing home rates, or $33 million using January 2007 rates. (*Id*. at pp. 486,499).

162. If SCM limitations were removed, the cost to provide additional services to current PWD Waiver recipients would be as follows:

a) The difference between the cost of PWD recipients' service plans and their respective SCMs would be approximately $206 million annually,

b) The difference between the cost of PWD recipients' service plans and their respective SCMs increased by 10% would be approximately $258 million annually,

c) The difference between the cost of PWD recipients' service plans and their respective SCMs increased by 20% would be approximately $310 million annually, and

d) The difference between the cost of PWD recipients' service plans and their respective SCMs increased by 250% would be approximately $472 million annually. (*Id.* at pp. 412, 498).

163. Matthew Werner prepared an analysis to illustrate the potential maximum impact if individuals who require some level of nursing care had access, without restriction, to individual nursing care equivalent to that which Eric Radaszewski is requesting in this lawsuit, 24 hours per day. (Testimony of Matthew Werner, Tr. pp. 560-561; DX 3 at HFS 009598).

164. The analysis that Mr. Werner performed follows the approach used by HFS in analyzing proposed legislative initiatives and policy changes. (DX 3 at HFS 009598).

165. A shift of only 10% of the current nursing home population to home care receiving benefits equivalent to Eric Radaszewski in his last year in the MFTD Waiver would cost an additional $1.25 billion. (*Id*. at HFS 009599, HFS 009601).

166. That $1.25 billion amount is more than the $578 million spent on all expanded eligible populations in FY 2005. (*Id*. at HFS 009599, HFS 009609).

167. In addition, it would cost another $931 million if 10% of the individuals in HSP were to begin receiving benefits equivalent to Eric Radaszewski in his last year in the MFTD Waiver. (*Id*. at HFS 009599, HFS 009601).

168. This combined $2.2 billion shift is almost equal to the total amount of $1.8 billion spent on all children in the medical assistance program. (*Id*. at HFS 009599, HFS 009609).

169. The Illinois Medical Assistance (Medicaid) Program serves over 2 million people per month. (Testimony of Matthew Werner, Tr. p. 575).

170. The current annual cost of the Medicaid Program is over 12 billion dollars. (*Id*.).

171. Such a large shift in costs would force the State to fundamentally alter the current Medicaid program from one that takes care of a mix of uninsured families, disabled, and elderly to one that only takes care of a small population of the most severely ill. (Testimony of Matthew Werner, Tr. pp. 576-577; DX 3 at HFS 009599).

172. Samuel Flint, Ph.D., lacks the qualifications to render expert opinion on Medicaid health policy or Medicaid Finance.

173. Dr. Flint does not possess a degree in statistics at any level. (Testimony of Samuel Flint, Tr. pp. 612-613).

174. Dr. Flint does not possess a degree in economics at any level. (*Id*.).

175. Dr. Flint does not possess a degree in business at any level. (*Id*.).

176. Dr. Flint does not possess a degree in accounting at any level. (*Id*.).

177. Dr. Flint did not describe what "health economics" encompasses. (*Id*. at p. 614).

178. Dr. Flint has not published any peer-reviewed articles about home and community based Medicaid waivers. (*Id*.).

179. Dr. Flint has not published any peer-reviewed articles about the effect of removing service cost maximum requirements to allow individuals to receive benefits in excess of service cost maximums in a home and community-based waiver. (*Id*. at pp. 614-15).

180. Dr. Flint has no experience administering policy regarding programs that implement home and community-based waivers. (*Id*. at p. 617).

181. Dr. Flint did not do any budget forecasting or economic impact analyses for Illinois home and community-based waivers. (*Id*. at pp. 617-618).

182. Dr. Flint has never been retained to provide any major consulting services to any State Medicaid program. (*Id*. at p. 618).

183. Dr. Flint critiqued Mr. Menenberg's cost calculations concerning moving current nursing home residents into the community based on a statistical review of Menenberg's work. (*Id*. at p. 660).

184. Mr. Menenberg never represented that his cost calculations were based on a statistical model. (*Id*.).

185. Dr. Flint did not review the provisions of the PWD Medicaid waiver prior to preparing his report. (*Id*.).

186. Dr. Flint prepared an Expert report in *Memisovski v. Maram*, 92 C 1982 (N.D.Ill.). that utilized non-statistically valid data. (*Id*. at pp. 662-664).

187. Dr. Flint admits that he uses best information available to an expert, regardless of statistical-validity, if it provides information to assist the court. (*Id*. at p. 664).

188. Dr. Flint admitted that judgmental sampling is a technique commonly used by government agencies. (*Id*. at pp. 665-666).

189. Dr. Flint did not attempt to duplicate Mr. Menenberg's work. (*Id*. at p. 666).

190. Dr. Flint did not conduct any independent studies in this case for his report. (*Id*. at p. 667).

THERE IS A NATIONAL SHORTAGE OF REGISTERED NURSES.

191. Congress has found that there is a shortage of registered nurses in the United States. H.R. Rep. No. 101-288 at 1 (1989), reprinted in 1989 U.S.C.C.A.N. 1984.

192. To alleviate this shortage of registered nurses, Congress established a program allowing qualified nurses from foreign countries to come to the United States to work as non-immigrant aliens for a period of up to five years. *See*, 8 U.S.C. §§1101(a)(15)(H)(i)(a), 1182(m)(4)(1994) repealed.

193. Congress formally repealed the H-1A statute in the Nursing Relief for Disadvantaged Areas Act of 1999, Pub. L. 106-95, §§2(b) & (c), 113 Stat. 1312, 1312-16 (1999), and replaced it with a substantially similar program for admitting alien nurses to the United States. *See*, 8 U.S.C. §§1101(a)(15)(H)(i)(c), 1182(m).

194. Donna Radaszewski has trouble staffing nursing care for Eric Radaszewski because nurses frequently do not report for their shift. (Testimony of Donna Radaszewski, Tr. p. 80).

Respectfully submitted,

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