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

DONNA RADASZEWSKI, Guardian, on behalf of Eric Radaszewski, Plaintiff,	)	
vs.	)	No. 01 C 9551
BARRY MARAM, Director, Illinois Department of Healthcare and Family Services, Defendant.	)	Judge John W. Darrah

Plaintiff's Reply to Defendant's Closing Argument

Plaintiff replies to Defendant's Closing Argument, as follows:

I. Defendant Ignores the Seventh Circuit's Decision in This Case

Defendant's closing argument fails to address the controlling authority in this case-- *Radaszewski v. Maram*, 383 F.3d 599 (7th Cir. 2004). As recognized by this Court, the Seventh Circuit established specific elements for plaintiff to prove to obtain relief under the ADA and Section 504 of the Rehabilitation Act. (Tr. p. 27, ln. 15-18). In her closing argument, plaintiff set forth the evidence that proved each of the elements. Rather than addressing those requirements, defendant's closing argument asks this Court to substitute elements from other court decisions relating to fact situations that differ from the facts and claims here.

Notwithstanding the Seventh Circuit's decision that Eric stated a claim under the ADA and Section 504, defendant argues on pages 1 to 4 of his closing argument that Eric cannot state a claim under these statutes, advancing arguments that run contrary to the appellate court's decision. The Seventh Circuit stated with specificity how the type of claim that Eric is making in this case is derived from the two statutes involved and their accompanying regulations as interpreted by the United States Supreme Court in *Olmstead v. L.C.,* 527 U.S. 581 (1999) and the court described what is required to make such a claim. *Radaszewski,* 383 F.3d at 606-615.

Similarly, on pages 4 to 14 of his closing argument, defendant makes legal arguments pertaining to eligibility requirements of the waiver programs that ask this Court to disregard the specific requirements of the Seventh Circuit's decision and of *Olmstead.* Defendant sets forth HSP eligibility requirements that differ from those included in the Seventh Circuit's decision and which plaintiff has addressed in pages 2 - 3 of her closing argument. Indeed, defendant argued Eric's lack of eligibility for the HSP to the Seventh Circuit and that argument was rejected. 383 F.3d 612-614.

Defendant's proof did not dispute most of the factual issues that the Seventh Circuit identified as relevant to this Court's decision. Defendant did not put on any evidence to refute that state professionals have found treatment in the community to be appropriate for Eric, that Eric and his parents not oppose community based treatment,[1] that a nursing home cannot meet Eric's medical needs,[2] that the level of care that Eric would require in any institutional setting is the equivalent of the private duty nursing he receives at home[3], that Eric has severe long term disabilities, that he is eligible for Medicaid,[4] that he is at risk of placement in an institution, and

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[1] The Court found that this requirement was proven. (Tr. p. 65, ln. 12 - 15).

[2] In his Proposed Finding of Fact 133, defendant states that plaintiff's expert witness, Dr. Michael Peters, admitted that there may be a nursing facility that could adequately care for Eric. That finding misstates Dr. Peter's testimony. In response to the question, "[a]re you aware of any institution, other than a hospital or intensive care unit, which would be able to adequately care for Eric," Dr. Peters responded: " I am not aware of a facility in this area that accomplishes that, although I have to admit that question has not really come up. I haven't actively sought out facilities like this. There may be someplace, but I am not aware of one."(Tr. p. 116, ln. 11 - 18). As described in plaintiff's closing argument, pp.3-6, Dr. Peters testified about his extensive experience with nursing homes and that they could not meet Eric's needs. Similarly in his Proposed Finding of Fact 134, defendant states that Dr. Peters admitted that he would not admit Eric to a hospital under his current condition omitting Dr. Peter's explanation that because of the quality of care Eric was receiving at home there was no present need to admit him to a hospital. (Tr. p. 134, ln. 20 - 23).

[3] Defendant admits that there is no substantive difference in Eric's medical condition since he turned 21. (Defendant's response to Plaintiff's Proposed Finding of Fact 15)

[4] Defendant admits that Eric is eligible for and a participant in the Illinois Medicaid Program. (Defendant's Response to Plaintiff's Proposed Finding of Fact 3).

that the cost of care at home would not exceed the anticipated cost of his care in an appropriate institutional setting.

II. Illinois has Great Flexibility to Accommodate the Relief Plaintiff Seeks through Reasonable Modifications in the Policies, Practices or Procedures of the HSP

At pages 9 to 13 of his closing argument, Defendant suggests that if Illinois approves higher HSP funding than the cap it approved for Eric it will be in violation of its waiver. He also argues that the nursing home level of care is an essential aspect of the program. These arguments are not supported by the proof in this case or Illinois' regulatory scheme for the HSP. Barbara Ginder, the department's official who oversees Illinois' home-and-community-based waiver programs, testified that Illinois has great latitude in its waiver to provide home-based care for medically complex persons. She testified that the federal government has no requirement that every person in a waiver have a service plan that costs less than care in a nursing facility, nor does the federal government tell the state how to define a nursing home level of care. (Tr. 378, ln. 10-16). The State can choose what level of care it provides in its waiver, and define what the level of care is. It can choose to determine cost neutrality on an individual basis, or aggregate costs over the entire waiver population, such that some persons have plans that cost more than the institutional level of case and some less. (Tr. 378, ln. 17 - p. 379, ln. 11).

Although defendant argues that the State cannot approve an HSP plan that exceeds a nursing home rate, Ms. Ginder admitted that the exceptional care rates Illinois currently uses in the HSP are fictional rates–not actual nursing home rates, since Illinois changed its nursing home reimbursement policies effective January 1st of this year. (Tr. p. 381, ln. 23 - p. 382, ln. 7).[5] She admitted that Illinois has "that kind of flexibility to work around problems to meet the needs

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[5] Ms. Ginder testified that Illinois continues to use exceptional care rates for persons in the HSP, despite the fact that the State no longer pays these enhanced rates for any residents in nursing homes. (Tr. 380). She testified that there are about 150-200 out of 25,000 persons in the HSP who have exceptional care rates (Tr. 382, ln. 19-21) and that there are thirteen categories of exceptional care rates, developed internally by the Department over time without any rulemaking. (Tr. 225, ln.17 - p. 226, ln. 21). Ms. Ginder testified that $10,000 per month was currently the top exceptional care rate in the HSP, almost double the cap imposed on Eric. (Tr. 385, ln. 9-18). She admitted that without any change in the waiver, the Department could add more exceptional care rates to meet the needs of medically complex persons. (Tr. 226, ln. 8 - 21).

of persons who have medical complexity" in its home-and-community based program. (Tr. 382, ln. 5-11). She also agreed that once the federal government approves a waiver, the State is not locked into its terms–it can modify the waiver. (Tr. 379, ln. 15-20). She testified that Illinois has modified its waivers on at least 10 occasions in the past 5 years, and each modification was approved by the federal government. (Tr. 379, ln. 19 - p. 380, ln. 8). She admitted that the federal government has issued a letter to State Medicaid agencies encouraging them to use home -and-community-based waivers to meet the community integration contemplated by *Olmstead* and to work with the federal government to overcome hurdles in rules and requirements that prevent such community integration. (Tr. 377, ln. 15-25, Pl. Exh. 51).[6]

As Ms. Ginder admitted, the waiver document that is Defendant's Exhibit 14 is not part of Illinois' HSP rules. (Tr. 376, ln. 22 - p.377, ln. 13). The Seventh Circuit described the HSP by reference to Illinois' administrative rules for the program. 383 F.3d at 602-603. Contrary to defendant's argument that nursing home level of care is the "very essence" of the program, Illinois' HSP rules do not limit participation to those who require only a nursing home level of care.[7] The HSP rules more broadly provide that the purpose of the program is to prevent unnecessary *institutional* care of individuals who may instead be satisfactorily maintained at home at a lesser cost to the State. 89 Ill.Admin.Code §676.10(a). The HSP rules expressly define the program as "a State and federally funded program designed to allow Illinois residents, who are at risk of unnecessary or premature *institutionalization*, to receive necessary care and services

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[6] Defendant argues that deviation from the waiver policies is per se unreasonable, but reasonable modification in a State's Medicaid rules, policies and practices to prevent unjustified segregation of persons with disabilities in institutions is exactly what is contemplated in the ADA as interpreted in *Olmstead* and *Radaszewski*, as well as the cases cited with approval in *Radaszewski: Fisher v. Oklahoma Healthcare Authority*, 335 F.3d 1175 (10th Cir. 2003)(State may violate ADA when it caps the number of drug prescriptions it will fund through Medicaid), (*Townsend v. Quasim,* 328 F.3d 511, 516-20 (9th Cir.2003)(Washington's Medicaid policy limiting community-based care to categorically needy Medicaid recipients must be altered to include persons who are in the medically needy category as well, unless doing so would fundamentally alter the State's Medicaid programs).

[7] Under Illinois law, statements of general applicability, that implement, apply or interpret policies, like Medicaid policies, must be promulgated as rules under the Illinois Administrative Procedure Act. *Senn Park Nursing Center v. Miller*, 104 Ill.2d 169 (1984).

in their homes, as opposed to being placed in an *institution*." 89 Ill.Admin.Code §676.30(j)(emphasis added). Even without a change in its HSP rules, Illinois can accommodate plaintiff's request to continue the home care services it repeatedly approved as cost effective for Eric while he was in the MFTD.[8]

III. Defendant's Arguments that the Relief Plaintiff Seeks is Unreasonable Mischaracterize Plaintiff's Evidence and Arguments

Defendant argues at pages 13-14 of his brief that the nursing services Eric received while he was in the MFTD were not waiver services, but EPSDT services. This distinction is not relevant. In *Radaszewski,* the court noted that defendant made this same point, but did not find the distinction relevant to its decision. 383 F. 3d at 609 referencing 383 F.3d at 602, n.1. This EPSDT argument is a red herring. The Department's web page describing the MFTD lists private duty nursing as an MFTD service. (Pl. Exh. 43). It also makes clear that the main service MFTD participants receive is nursing. Id. It reports that nursing services accounted for $49.9 million of the $52.2 million (96% of costs) spent on children in the MFTD during the 2004 waiver year. Id. Whether they are EPSDT services or not, the cost of all the services children in the MFTD receive at home, including the nursing services, may not exceed the estimated cost of the institutional care the children in the MFTD would otherwise require. (Ginder Testimony, 219, ln. 18-23, Pl. Exh. 41, p. 003610, 6933, Pl. Exh. 42, p. 6984-6985). HFS officials, including its medical professionals, approved MFTD service plans for Eric with 16 hours per days nursing care because the plans cost considerably less than the estimated cost of the hospital care he would otherwise need at State expense.[9] (Pl. Exh. 1, HFS 006934-

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[8] Defendant argues that *Bertrand v. Maram*, 495 F.3d 452 (7th Cir. 2007) approves the practice of limiting services in a Medicaid waiver through various caps. *Bertrand* is not applicable here. The issue in *Bertrand* was whether a specific provision of the Medicaid statute, 42 U.S.C. §1396a(a)(8), required Illinois to provide the waiver services at issue more promptly. The case did not involve a claim under the ADA as interpreted in *Olmstead* and *Radaszewski*. As the federal government explained in its letter to State Medicaid Directors in the aftermath of the *Olmstead* decision, compliance with federal Medicaid rules is not the same as compliance with the ADA. (Pl. Exh. 51, HFS 300994).

[9] At page 11 of his argument (and in his response to plaintiff's proposed finding of fact #36d) defendant states that if a hospitalized Medicaid-eligible individual would be treated on a

6935; Pl. Exh. 4, p. HFS 007707; Pl. Exh. 5, p. HFS 007711; Pl. Exh. 6, p. HFS 007014; Pl. Exh. 9, p. HFS 007869). These facts did not change when Eric turned 21. As defendant has admitted, Eric's medical condition has not substantively improved since he turned 21 in 2000. (Def. Response to Pl. Finding of Fact #25).

At pages 11-12 of his closing argument, defendant wrongly intimates that plaintiff is attempting to get whatever care Eric's physician prescribes irrespective of cost neutrality requirements. Plaintiff is seeking the care the State's own medical professionals previously approved for Eric as a cost-effective alternative to institutional level of care that Eric needs.[10] As Ms. Ginder admitted, Illinois has the flexibility to offer special enhanced rates for service plans for medically complex persons in the HSP. The evidence is clear that the HSP is very cost effective. With respect to 2005, HFS reported to the federal government that there were 19,827 participants in the waiver and that the cost per participant for care in the community was $19,140, while the estimated cost for care in the institutional setting was $32,816 per participant, a savings of $13,676 per participant (in total, a projected costs savings of $271,154,052). (Ginder Testimony, Tr. p. 388, ln. 24 - p. 390, ln. 4; Def. Exh. 16, p. HFS 301250). Plaintiff's request for relief can be accommodated within the HSP program.

IV. Defendant Has Not Proved A Fundamental Alteration Defense

In his closing argument at page 14 defendant contends that he has established "by reliable and reasonable expert evidence and reliable opinion evidence that the State of Illinois could be subject to unreasonably large costs if Plaintiff were to prevail in this case." (Emphasis added).

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long-term basis in a hospital because a nursing facility cannot be found, the Illinois Medicaid program will not reimburse the hospital more than the nursing facility rate, citing 89 Ill.Admin.Code §140.569, and 42, U.S.C. §1396l. These provisions limit reimbursement to hospitals that are providing a *nursing home level* of care to patients awaiting a discharge to a nursing home. That is not what is at issue in this case, where Eric needs a hospital level of care, as HFS itself found, not a nursing home level of care.

[10] While in the MFTD, Eric did not receive all the nursing services Eric's physicians prescribed. Eric's physician repeatedly prescribed 24 hours nursing care as medically necessary for Eric while he was in the MFTD, but HFS physicians approved 16 hours per day based on their determination that Eric's mother was trained and could perform 8 hours of nursing. See, e.g., Pl. Exh. 5, pp. HFS 007708-7709.

The Seventh Circuit, recognizing that the State has the burden of proof of a fundamental alteration defense, stated that Illinois may be able to show that in view of its obligations to all individuals with similar disabilities, "it cannot fund a home placement for Eric without fundamentally altering the care it provides to others with similar needs." 383 F.3d at 614. The court then continued:

> But the evidence might also show something different to be true. If the State would have to pay a private facility to care for Eric, for example, and the cost of that placement equaled or exceeded the cost of caring for him at home, then it would be difficult to see how requiring the State to pay for at-home care would amount to an unreasonable, fundamental alteration of its programs and services.

Id. The evidence does show that the State would have to pay a private facility to care for Eric. Defendant admits that Illinois does not own or operate facilities for long-term care persons with disabilities other than veterans' nursing homes. (Def. Resp. Pl. Finding of Fact, 36f). As set forth on pages 12 and 13 of plaintiff's closing argument, it would cost less to care for Eric at home than in an institution that would meet his medical needs.[11]

Notwithstanding this evidence, defendant has sought to prove his fundamental alteration defense with the testimony of two expert witnesses: Todd D. Menenberg and Matthew Werner. Neither witness provided cost projections that relate to persons who have medical needs similar to Eric Radaszewski. They did not provide reliable evidence that assists this Court in determining any cost impact that would result from providing Eric with the level of service that HFS

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[11] On page 14 of his closing argument, defendant claims that plaintiff did not put forth any proof to show what the cost of 16 hours per day of in-home nursing would cost the State. Defendant overlooks Donna Radaszewski's testimony that the cost of in-home nursing from 2000, to the present is $29.55 per hour (Tr. p. 56, ln. 11 - 23) and the Report of his expert, Matthew Werner, which stated that the cost of Eric's care at home in 2005 was $20,499 per month. (Def. Exh. 3, p. HFS 009601). In his Response to Plaintiff's Proposed Finding of Fact 36b, defendant argues that Mr. Werner's computations (Id.) which he used in his expert report relied upon by the State, are not relevant because the level of care is provided pursuant to a state court injunction. Defendant's assertion is a distinction without a difference. As Mr. Werner testified, the cost data collected was from the State's data warehouse consisting of "all of the medical assistance spending for Eric by each state fiscal year . . . ." (Tr. p. 562, ln. 4 - 7).

continuously approved and reimbursed from 1995 until 2000.

In *Kumho Tire Co., Ltd v. Carmichael*, 526 U.S. 137 (1999) the Supreme Court explained that its earlier decision in *Daubert v. Merrell Dow Pharmaceuticals*, 509 U.S. 579 (1993) held that Federal Rule of Evidence 702 imposes a special obligation upon a trial judge to "ensure that any and all scientific testimony ... is not only relevant, but reliable. 509 U.S., at 589 . . . ." 526 U.S. at 148. The Seventh Circuit has explained that the relevance requirement of *Daubert is* "[t]o determine whether the evidence or testimony assists the trier of fact in understanding the evidence or in determining a fact in issue. In other words, the suggested scientific testimony must fit the issue to which the expert is testifying." *Chapman v. Maytag Corp.*, 297 F.3d 682, 687 (7th Cir. 2002) [citing from *Porter v. Whitehall Labs., Inc.*, 9 F.3d 607, 616 (7th Cir. 1993)].

Plaintiff has submitted motions in *limine* and accompanying memoranda, which the Court has under consideration, which asked the Court to bar the expert reports and proposed testimony of Mr. Menenberg and Mr. Werner on the bases that their reports and testimony are not relevant or reliable. Plaintiff will not repeat the arguments she made with respect to those motions but will review for the Court how the evidence proffered by HFS fails to demonstrate that a fundamental alteration would occur if Eric were to prevail and maintain the reimbursement he has and continues to receive.

Todd Menenberg

Mr. Menenberg, without any explanation or rationale, testified that two groups of disabled persons would seek increased benefits if Eric were to prevail: (1) current enrollees in the HSP and (2) persons presently residing in nursing homes who would return to the community. (Tr. p. 410, ln. 21 - p. 411, ln. 2).

Group 1 - Present Participants in the HSP

Mr. Menenberg estimated the size of this group as approximately 26,000 persons. (Tr. p. 421, ln. 5). He calculated that plaintiff seeks care that is 250% of the $4593 monthly reimbursement approved for Eric in 2000. (Tr. p. 421, ln. 3 - 4). He then projected that all 26,000 HSP participants, a majority of whom were substantially below their service cost maximums, would be able to request from HFS and receive their service cost maximums at an annual cost of about 200 plus million dollars or a greater cost if HSP participants received 10 or

20 percent more than their service cost maximum. (Tr. p. 421, ln. 1 - 19). His justification for these projections was that Eric is seeking services beyond what the HFS has chosen to offer in its administration of the HSP (Tr. p. 411, ln. 22 - 25) with the result that for all other persons in the HSP, utilization management and review[12] would be eliminated. (Tr. p. 411, ln. 9 - 12). All HSP participants could ignore their present service plans and receive whatever they asked for. (Tr. p. 421, ln. 12 - 13, p. 438, ln. 7 - 12).

Mr. Menenberg's testimony provided no reasons why this result would occur. He acknowledged that not all 26,000 persons would be eligible for a 250 percent increase and his projections were "just to show the mechanics." (Tr. p. 422, ln. 3 - 14). When the Court inquired how Mr. Menenberg determined which of the 26,000 persons would avail themselves of an increase in benefits and what characteristics these persons would possess, Mr. Menenberg responded that he didn't make such a determination. (Tr. p.423, ln.13 - p 424, ln. 3). Mr. Menenberg offered no nexus between the circumstances of all 26,000 HSP participants and Eric's circumstances. (Tr. p. 426-427). In response to the Court's inquiries as to how many other participants would be similar to Eric and what additional costs they would seek, Mr. Menenberg responded that he didn't know, (Tr. p. 430, ln. 3 -5), and that all he was presenting was a model that indicates the result if all 26,000 HSP participants requested and received the maximum amount. (Tr. p. 435, ln. 4 - 9). His testimony made no attempt to compare the medical condition of persons in the HSP with Eric. Thus, he provides no guidance to the Court of the dollar impact of his assumption.

Although conceding that Eric needs the nursing services his mother is requesting in this case, ["My understanding in this case, Eric R is asking for all the nursing care that he needs."] (Tr. p. 465, ln. 6 - 7), and that such services in Eric's case are "intensive nursing care," (Tr. p. 439, ln. 9), Mr. Menenberg opined that the majority of services offered under the HSP are not nursing care, but rather home health services, respite care, vacuuming, cleaning and preparing meals, (Tr. p. 439, ln. 10 - 13) and that they are not medically necessary. (Tr. p. 509, ln..6-15). Although he admitted that the "overwhelming majority" of participants would not require Eric's

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[12] Mr. Menenberg testified that what restricts services in the HSP is the service plan. (Tr. p. 423, ln. 7-11).

intensive nursing care, he nonetheless contended that other HSP participants would take their increase in the other waiver services he described whether they medically needed those other services or not. (Tr. p.439, ln. 3-14), p. 441, ln. 6 - 18).

In his closing argument on page 10, defendant appears to contest Mr. Menenberg's conclusion arguing "that each component of a program under aegis of a home and community-based Medicaid Waiver is subject to a medical need requirement . . . ." Mr. Menenberg's premise simply ignores the distinction between services that are medically necessary and those that are not. As defendant's witnesses Ginder and Werner testified, medical necessity is a requirement for Medicaid reimbursement. (Tr. p. 388, ln. 15-17, p. 585, ln. 21 - p. 586, ln. 4). The services Eric seeks are medically necessary and would be reimbursable by Medicaid. The additional waiver services that persons in the HSP would request, according to Mr. Menenberg, would likely not be medically necessary and not Medicaid reimbursable because virtually all current HSP participants have plans of care that are below their respective SCM's. And, Mr. Menenberg admited that he has no reason to believe that the service plans of any of the HSP participants are not sufficient to allow them to remain safely in the community. (Tr. p. 505, ln. 11 - 15). Thus, those individuals are different than Eric. Mr. Menenberg's analysis does not take medical necessity into account. His maximum projections of the impact on 26,000 HSP participants if Eric prevails are based upon unsupported premises and the methodology he employs consists solely of mathematical calculations

Group 2 - Present Residents in Nursing Facilities

Again without any stated rationale, Mr. Menenberg assumed that persons in nursing homes would be impacted if Eric prevails. With respect to this group, he projected a cost of $32 - 33 million dollars (Tr. p. 458, ln. 24 - 25). He admitted that he had no reason to believe that persons in nursing homes were receiving inadequate care. (Tr. p. 515, ln. 8-22). He offered no testimony that compared Eric's medical needs to the needs of nursing home residents who he projected would be affected. Mr. Menenberg undertook an analysis that contradicts the analysis he presented for persons participating in the HSP. For the latter group, Mr. Menenberg calculated the dollar impact by disregarding the existence of any existing service plan. With respect to persons in nursing facilities, Mr. Menenberg's analysis inconsistently determined cost

by creating service plans for persons in nursing facilities based upon the assessment of HFS nurse, Roberta Sue Coonrod. (Tr. p. 466, ln. 4 - 8, p. 644, ln. 6 - p. 645, ln. 6).

Moreover, Mr. Menenberg's testimony regarding the impact on this second group is inaccurate and utilized methods that are unreliable. Mr. Menenberg testified that under his analysis 12 percent of approximately 9,000 residents of nursing facilities under the age of 60 would return home if there were no controls on their home services. (Tr. p. 458, ln. 6 - 8). He testified that he calculated the 12 percent figure by compiling the answers to three questions on the Minimum Data Set (MDS), a document that all nursing facilities complete quarterly for each resident. (Tr. p. 460, ln. 4 - 10). Those questions were: (1) whether the resident indicated a preference to return to the community; (2) whether the resident had a support person positive toward discharge; and (3) whether the resident's stay at the facility was projected to be greater than 90 days. (Tr. p. 460, ln. 11 - 20). He testified that 216 of the approximately 9,000 persons answered the three questions in the manner he described. (Tr. p. 461, ln. 4). At this point his testimony became unclear. Immediately after he testified that 216 persons answered the questions he stated that 1,100 of the 9,000 persons answered these questions. (Tr. p. 461, ln. 8 - 9, p.461, ln. 24 - p. 462, ln. 2). In response to the Court's question of how many people answered this form, Mr. Menenberg testified, "1,100." (Tr. p. 463, ln. 19-20). What Mr. Menenberg did not testify to is explained in the testimony of Dr. Samuel Flint. Dr. Flint explained that Mr. Menenberg did not find 1,100 persons who had answered the three questions in the manner Mr. Menenberg had established. Rather, less than 216 persons had answered the three questions in the sought for manner. Mr. Menenberg arrived at 1,100 persons by undertaking an extrapolation to arrive at 1,100 persons and assumed that all 1,100 persons would have answered the three questions in the established manner. (Tr. p. 632, ln. 24 - p. 633, ln.3). In fact the 216 number is high because for 193 of the 216, the answer to the third question, the expected duration of stay at the nursing facility, is "uncertain." (Tr. p. 632, ln. 10 - 16).

Mr. Menenberg testified that his analysis was not intended to comply with the rules of statistics. (Tr. p. 459, ln. 17 - 20). Because he was not attempting to meet those standards, Mr. Menenberg was able to take a census, the responses to the three questions of all of the 9,000 persons, and make an extrapolation from a subset of the census - the 216 persons - to include

non-responders and attain the 1,100 persons he used in his cost projections. (Flint Testimony, Tr. p. 628, ln 3 - 6). Dr. Flint explained the unreliability of such a calculation - when you ask everybody the same questions you cannot assume that people who didn't respond are similar to persons who did respond and then extrapolate. (Tr. p. 628, ln 16 - 18). When he analyzed characteristics of the responders and non-responders, Dr. Flint found that the responders were sicker. (Tr. p. 631, ln. 17 - 22).

Mr. Menenberg's analysis then took a non-random judgmental sample of 28 persons chosen not by Mr. Menenberg, but by HFS staff, from the group of 216 to obtain the basis for his extrapolation of costs to the 1,100 persons. (Flint testimony, Tr. p. 633, ln. 15 - p. 634, ln. 9). Dr. Flint explained that judgmental sampling is used by CPA's in doing audits of historical data and that the literature indicates that because it is a non-random sample it is unreliable to extrapolate from the results of the judgmental sample. (Tr. p. 634, ln. 10 - 20). The assessment of the 28 MDS's, as explained by Mr. Menenberg, was undertaken by one person - an HFS nurse (Tr. p. 466, ln. 4 - 11). Dr. Flint explained that to ensure reliability a conventional approach would have required at least two people who would independently undertake assessments. (Tr. p. 640, ln. 19 - p. 641, ln. 4). Ms. Coonrod admitted that in making assessments of need for services she did not take into account family members who might be available to provide assistance to the nursing facility resident returning home. (Tr. p. 547, ln. 21 - p. 548, ln. 1). Dr. Flint pointed out the inaccuracy of this approach as violating HFS's own policies in determining reimbursable need for persons in the HSP. (Tr. p. 641, ln. 5 - 21). By not taking into account the role of family members, Mr. Menenberg's cost figures were inflated.

Dr. Flint testified that the standard type of analysis used by businesses and insurers to determine anticipated expenses is to use actuarial methodology taking into account the number of people who are covered for any particular services, the services that are covered, the limitations on those services, the cost of those services, the anticipated utilization of the covered population for those services, and the cost of administration. (Tr. p. 621, ln. 9 - p. 622, ln. 4). He explained that he knew from working with HFS, that the state used actuaries on a regular basis for purposes of negotiating such items as HMO rates. (Tr. p. 622, ln 10 - 14). Mr. Menenberg did not use this methodology. When asked by the Court, Mr. Menenberg said he didn't think any of the 1,100

persons who were the basis for his cost projection, would need the nursing services that Eric seeks. (Tr. p. 465, ln. 19-22). Mr. Menenberg's chosen methodology and the cost projections it makes with respect to this second group does not provide the Court any assistance in determining the impact, if any, of Eric maintaining the services he presently receives.

Matthew Werner

Defendant's second expert witness was Matthew Werner, the former advisor to the defendant on health care finance and the former chief of HFS's Bureau of Rate Development and Analysis. (Tr. p. 555, ln. 8 - 16, p. 556, ln. 17 - 18). As with the testimony of Mr. Menenberg, Mr. Werner's testimony and report provide no guidance to this Court in determining whether continuing the present reimbursement for Eric's care at home would have any impact on the State's finances.

Mr. Werner assumed that persons in the HSP and in nursing homes would be affected if Eric were to prevail, but he provided no rationale for these assumptions. He took the cost of Eric's care while in the MFTD, and increased it to include cost for 24 hour/day of nursing care. He concluded that the potential maximum impact if 10 percent of current nursing facility residents and 10 percent of current HSP recipients were to receive such 24 hour/day nursing care, the cost to the State would be 2.2 to 2.3 billion dollars. (Def. Exh. 3, p. HFS 009598; Tr. p. 575, ln. 22 - 25). However these dollar amounts are not of any use to the Court. As explained by Mr. Werner, these numbers are the "potential maximum impact" of Eric receiving 24 hours of care each day. (Tr. p. 585, ln 11 - 12, Def. Exh. 3, p.HFS 009598). They are not predictions. (Tr. p. 585, ln 13 - 16). Mr. Werner acknowledged that the 10 percent projections were not a prediction but rather were included for "illustration purposes." (Tr. p. 588, ln. 25 - p. 589, ln. 5). He testified that he did not know how many residents in nursing homes would shift to the community. (Tr. p. 570, ln. 15 -16). He explained that since he didn't know how many people would shift he also included in his report a one percent number so a calculation "could be made flexible." (Tr. p. 570, ln. 17 - 18).

He provided no method by which any prediction of actual cost could be made. In response to the Court's question whether Mr. Werner knew how many people would qualify to receive the same reimbursement as Eric, Mr. Werner testified, "I don't know." (Tr. p. 570, ln. 23

- p. 571, ln. 1). When the Court inquired whether Mr. Werner knew if any would shift, Mr. Werner responded that he didn't know for certain that anyone would shift, but it would be likely that people would shift. (Tr. p. 571, ln. 2 - 4). Mr. Werner admitted that he had no knowledge of Eric's medical condition (Tr. p. 584, ln. 24 - p. 585. ln. 1). Similarly, he did not know how Eric's medical condition compared to the one percent of persons currently in nursing facilities or persons in the HSP waiver. (Tr. p. 585, ln. 2 - 9). He testified that he had no reason to believe that persons in nursing facilities and persons in the HSP did not have their medical or care needs met in their current setting. (Tr. p. 583, ln. 23 - p. 584, ln. 10). He testified that his analysis was not intended to indicate how many hours of care people who shifted would actually need. (Tr. p. 590, ln. 20 - 21).

Unlike Mr. Menenberg whose analysis of impact is based on the erroneous assumption that all waiver services do not have to be medically necessary, Mr. Werner testified that medical necessity is the standard in both community and institutional settings. (Tr. p. 585, ln. 21 - p. 586, ln. 4). Yet, without explanation, his analysis ignores the very concept he admits is the Medicaid standard.

At trial the Court explained that the decision of the Seventh Circuit obligated the Court "to determine the impact that a ruling in favor of the plaintiff would have on the state and whether it would fundamentally alter the care the state provides to others with similar needs." (Tr. p. 437, ln. 2 - 5). Based upon the above, defendant has offered no proof that there would be any impact if Eric continued to receive the reimbursement he has been receiving. Any disabled persons presently in a nursing facility or receiving medical care through the HSP and whose needs are met are different than Eric whose medical needs cannot be met in a nursing facility and under the HSP's reimbursement cap set at a nursing facility rate. Neither of defendant's experts make any attempt to account for this fact despite questions on this point by the Court. If, as both defendant's experts acknowledged, medical needs are currently being met for persons in nursing facilities and those in the HSP, the only source of increased cost are persons aging out of the MFTD whose needs cannot be met under the HSP's present cap. Defendant's witness Barbara Ginder testified that on average only ten children age out of the MFTD program each year. (Tr. p. 231, ln. 4 - 5). As the Seventh Circuit noted, the MFTD, like the HSP has cost neutrality

requirements. *Radaszewski*, 383 F.3d at 613. Ms. Ginder's testimony confirmed that home care, including the nursing care, for MFTD participants costs the State less than the projected cost of their institutional care. (Tr. p. 223, ln. 12 -19). Defendant's witness Matthew Werner testified that Eric's reimbursement costs while in the MFTD waiver were not representative of MFTD recipients and were almost twice the cost of the average reimbursement for that group. (Tr. p. 587, ln. 20 - p. 588, ln. 2). Ms. Ginder testified that Eric Radaszewski was "unique and different from other people that we were looking at that had medically fragile technology dependent needs." (Tr. p. 392, ln. 24 - 393, ln. 5). Thus, the evidence in total indicates minimal or no impact, and possible cost savings if Eric obtains the relief plaintiff requests.

Conclusion

For the foregoing reasons and the reasons stated in her closing argument, plaintiff requests that the Court enter judgment in her favor.

Respectfully submitted,

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Certificate of Service

I hereby certify that on November 11, 2007, I presented the foregoing Plaintiff's Reply to Defendant's Closing Argument with the Clerk of the Court using the CM/ECF system which will send notification of such filing to the following:

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