Expert Report

of

Samuel S. Flint, Ph.D.

May 7, 2007

Signed: Samuel S. Flint

Grooms v. Maram
United States District Court
for the Northern District of Illinois
Civil No. 06 C 2211

REPORT of SAMUEL S. FLINT, Ph.D.

David Grooms v. Barry S. Maram, No. 06 C 2211, United States District Court, For the Northern District of Illinois, Eastern Division

May 7, 2007

INTRODUCTION: I have been retained as an expert witness by counsel for the plaintiff to express opinions on the March 19, 2007 report of Mr. Todd Menenberg and his team from Navigant Consulting, Inc, related to the case of David Grooms v. Barry S. Maram, herein after referred to as the Menenberg Report.

I have been asked to critique the accuracy of the report's cost projections and the methodology by which these projections were derived, and to comment on the Medicaid policy issues relevant to this case.

PROFESSIONAL QUALIFICATIONS: I have spent more than 25 years in the fields of child and adolescent health, health policy, and health economics. My academic credentials relevant to this issue to which I am reporting to the Court include published research in a half-dozen peer-reviewed journals as well as several technical reports and white papers, the majority of which deal specifically with the Medicaid program. I also have authored five textbook chapters on the topic of health care economics.

Currently I am an Assistant Professor of Public Affairs at Indiana University Northwest where I teach statistics and graduate level courses in health economics and health policy. I have also held adjunct faculty appointments at the University of Chicago, Department of Pediatrics and North Park University, School of Business and Nonprofit Management where I taught health economics and health policy.

Among other relevant professional experiences, I served as the State of Illinois' Medical and Healthcare Services Portfolio Manager in the Bureau of Strategic Sourcing and Procurement in the Department of Central Management Services from March 2004 to July 2005. I also have training and experience in long term care field and held a long term care insurance producer's license issued by the Illinois Department of Financial and Professional Regulation between 2002 and 2006.

I have an earned Ph.D. from the University of Chicago, an M.S.W. from Florida State University, and a B.A. from the University of Rhode Island.

A curriculum vitae is appended which further details my professional background.

CRITIQUE OF THE MENEBERG REPORT ESTIMATES

Mr. Menenberg was asked by counsel for the Illinois Department of Healthcare and Family Services (HFS) "to quantify the economic impact on the cost of the State's current Persons with Disabilities Waiver program, assuming the Grooms' were to prevail on their request for additional home nursing services for David and other individuals were then also able to access additional waiver services." (Menenberg Report, page 6)

As will be detailed below, these cost projections are not just incorrect. They are misleading in the extreme since they were derived by unsound research methodologies and based on invalid assumptions regarding the Medicaid program.

Mr. Menenberg was asked to examine two potential Medicaid populations: (1) current facility residents who potentially would move from skilled nursing facilities (SNFs) to community-based settings and receive services through the Persons with Disabilities (PWD) waiver program; and (2) current PWD waiver recipients who use services at a cost less than their "Service Cost Maximum" (SCM).

Group 1--Current SNF Residents

PROBLEM 1: The Menenberg Report uses an incorrect extrapolation process that quintuples the potential upper bound cost projections.

The Menenberg report used the federally mandated, periodic census of SNF patients, the Minimum Data Set (MDS) assessment, as the instrument to determine how many current SNF residents could return to the community should the Medicaid program entirely eliminate the SCM cost cap now in place. The choice of this data set to make that estimate is quite reasonable since it contains three specific questions regarding SNF residents' desire and potential to return to the community and is asked of every single SNF resident insured by Medicaid and/or Medicare.

The Menenberg team contends it has identified 1,100 PWD beneficiaries among the 9,271 SNF residents who would leave SNF care and would increase state Medicaid costs by determining which residents: (1) stated they wanted to leave their SNF; (2) stated there was a person positive towards their discharge; and (3) were expected to be discharged more than 90 days from the date of their participation in the MDS survey.

The MDS is a credible source for gathering that type of information as it is a comprehensive *census*. However, a census is not a representative sample. It is a survey for which every member of a population under consideration is questioned. As noted in the first chapter of undergraduate statistics textbooks (Fox, 2003) a census is quite different from a sample. Findings gleaned from a census are referred to as population parameters, and they are noted in research findings using Greek letters so as not to be confused with sample statistics.

In the absence of a census, population characteristics are derived from inferential statistical tests performed on an appropriately drawn sample of sufficient size and representativeness from the larger population from which the sample was taken. Statistics are noted in research reports using English letters, so they will not be confused with census data/population parameters.

<u>Standard research practice does not permit taking a nonrandom subset of a census and treating it as if it were a sample.</u> Thus, extrapolating the responses from the subset of the surveyed population that answered questions of interest to survey nonrespondents who have already been asked those very same questions but did not provide full information is a violation of the most fundamental rule in statistical analysis. Yet this is precisely what was done in the Menenberg Report. Only if Mr. Menenberg obtained a random sample of MDS records of sufficient size and representativeness, would he and his team have been justified in the extrapolation used to generate their cost projection.

Let me explain the logic behind the hard and fast rules that pertain here. First, researchers cannot pretend to be mind readers. They are not permitted to fill in missing data for survey respondents in either a census or a sample. In fact, response rate is a standard criterion used by reviewers to determine the validity of a research report since it is understood that some amount of missing data is a part of virtually all research efforts. Whether a census or a sample, researchers cannot surmise how any respondents would answer a question even if their basis is similarities in demographics, other answers to comparable questions, health status, or any other factors that would appear to demonstrate comparability between the respondents and nonrespondents. Such a technique is not standard practice and would <u>never</u> pass peer review for journal publication or presentation at a scientific meeting.

Second, researchers are not permitted to take answers from any size subset of census responses, treat this group like an independently drawn random sample, and draw conclusions on the larger population since such a process is inherently biased. For instance, a researcher could sample a small fraction of 1% of the entire U.S. population and make estimates about the U.S. population, (e.g., one in seven Americans are Latino) Or, a researcher could do a complete "nose count" like the U.S. Census Bureau undertakes every ten years, and one would fully expect to obtain the same finding. But a researcher cannot survey every resident of every other state and assume their responses would be the same as a census taken of the entire country or that their responses would match up with the findings from a random sample of all U.S. residents, even if the sample size were far smaller. The every-other-state technique could have perhaps 50% of all Americans responding, but there is no way of knowing if the people in the surveyed states are different from those in the non-surveyed states. For instance, if picked alphabetically and Alabama was included and Alaska omitted, the national estimated count for Aleuts would be underestimated.

Only from a sufficiently sized random sample, where all members of a population under study have an equal chance of being selected, can you draw conclusions and make estimates regarding the population from which it was drawn. Inferential statistical tests are designed to make accurate estimates about a population from a subset of their members. However, this is entirely different from guessing nonrespondents' answers in a census by proportionately extrapolating from respondents who completed the part of the survey section under study. If you ask the full population, estimation techniques are no longer needed, as there is nothing to estimate. Since you have asked everyone, you have the exact answer.

Yet violating this simple premise is precisely what Mr. Menenberg did. Here are his words. "...we observed that a number of the Medicaid nursing facility residents under age 60 *did not respond* to all three questions. Assuming that these non-responding individuals would have answered the three questions in a similar manner as those who *did respond* to all three questions, there would have been approximately 1,100 Medicaid residents (including the 216 individuals above)... Therefore, for purposes of my analysis, I have determined that approximately 1,100 current nursing facility residents would potentially move from nursing facilities into the community and be served under the Persons with Disabilities Waiver were the SCM limitations removed." (Menenberg, pages 9-10)

No table or data were presented in the report to show how Mr. Menenberg derived his total of 1,100. However, in his April 10, 2007 Deposition[1] (page 109, line 21) he stated that 7,286 SNF residents did not answer the first question regarding whether or not they wanted to leave their facility. These nonrespondents had answers to these questions assigned to them in the aggregate by the Menenberg team. That is roughly four-fifths of the entire population of 9,271.

Were the nonrespondents different from the respondents? Mr. Menenberg just assumed that the 80% were identical to the 20% who responded fully. However, the population under scrutiny has enormous variability, as noted by the ADL variability on page 11 of the report. Extrapolating from SNF patients verbal enough or otherwise capable of revealing their preferences to the nonresponding group, which surely comprised a larger proportion of patients with dementia and other more severely debilitating diagnoses, is absurd on its face and typifies the type of selection bias that randomization and other sampling techniques are designed to safeguard against.

We do not know why the questions were not answered by the respondents. However, the fact that four out of five respondents did not answer all three of the pertinent questions for this government-mandated data collection process is curious indeed. Mr. Menenberg did not report on the nonresponse rate of other

MDS questions, so we do not know how many other sets of questions were not answered fully by 80% of the respondents. But if this is a typical nonresponse rate, the well-regarded MDS data set would not hold the value it does for federal and state government quality control agencies and others who rely on its accuracy and completeness.

There also is a question as to whether Mr. Menenberg's team adhered to their own selection criteria. The Menenberg Report sought to exclude SNF patients who were scheduled for discharge within the next 90 days. Yet 1,937 of 9,271 patients in the universe under study indicated that their discharge date was "uncertain" by answering question Q1c with a "3" (Bates number NAV 001342). Stating that the discharge date was uncertain did not exclude these respondents from the analysis even though it could have allowed for inclusion patients who were in fact going to be discharged within 90 days. This is not a trivial issue since we know that nationally 68% of SNF patients are discharged within 90 days (Hendrickson and Reinhard, 2006).

This aspect of the analysis raises yet another methodological question. It calls into question whether the final 216 cases overestimates the number of SNF patients who would leave institutional care if the benefits package for community-based care was unlimited by SCM cost caps. As noted above, just 21% of the entire group were designated as "uncertain" with respect to their anticipated date of discharge, yet 89% (193 of the 216) were categorized as "uncertain" since they answered "3" to Question Q1c (Bates pages HFS 9077, 9087, 9097, 9107, 9113, NAV 1326). Just 23 (one-quarter of one percent) of the 9,271 potential SNF residents who could become PWD beneficiaries satisfied the Menenberg requirements fully.

Surely, some of the "uncertain" group included SNF patients that would be leaving in 90 days or less, but it was unknown at the time to the survey taker. Since there were more than four times as many discharge time listed as "uncertain" in the 216, logic would point to a reduction in the number proposed in the Menenberg Report, perhaps by a factor of 68% for reasons cited above.

Here's what we know. All 9,271 SNF residents potentially eligible for the PWD waiver were asked if they wanted to return to the community. At *most* 216 (2.4%) want leave the SNF and believe that someone in the community was "positive towards" taking them in.

Two-hundred-sixteen, not 1,100, is the absolute ceiling, and there is good reason to suspect that the 216 may be considerably inflated. As noted above, some patients may have been on their way out of SNF care already under the current rules since nearly nine out 10 fell into the "uncertain" discharge date category.

We also have no idea if the alleged "person positive towards discharge" was prepared and capable to do what is necessary to complete the transfer of the patient from the SNF to the community. No one from the Menenberg team interviewed anyone to determine if this may have been wishful thinking on the part of some of these SNF residents.

Every single SNF patient who could potentially be eligible under the PWD waiver was asked, and the Court has their response. That upper bound figure is 216 or likely less than that. Hence, the Menenberg Report estimate of the size (and estimated incremental added cost) of the group of potential PWD beneficiaries must be reduced by more than 80%.

Problem 2: Community care cost projections were derived from a skewed, sample, drawn by an invalid method.

In order to estimate the cost to serve current SNF residents who the Menenberg team assumed would be opting for community-based care, they attempted to construct what is called a stratified sample with 28 cases. A stratified sample is a type of sample that divides a population into designated subgroups in the same proportion that they exist in the larger population. In this study, the subgroups were supposed to mirror the larger population of 216 with respect to their limitations of "Activities of Daily Living" (ADL) categories which serves as the proxy to capture service need. However, the sampling process employed by the Menenberg team violated two fundamental rules of statistics.

First, a stratified sample must also be random. (Sullivan, 2005) That is, for each of the groups that the researcher wants to be certain is represented in their sample, cases are selected on a random basis from each category. Rather than random selection, cases for this stratified sample were "judgmentally selected" (page 10, Menenberg Report). Nowhere is this unprecedented sampling technique explained or justified, and observing the outcome of this technique demonstrates that, as would be expected by a research methodologist, it failed.

The "judgmental" process resulted in a sample skewed toward a much sicker than average population. Three of the 28 cases, roughly 10% of the sample, have their SNF care paid for under the "Exceptional Care Rate," (Bates pages NAV 706 and NAV 1378). The Exceptional Care rate, as its name implies, is a higher reimbursement rate required for the sickest 1% of SNF patients. Because the MDS is a census, we know for certain that just 540 of the state's 47,624 current SNF patients qualify for this outlier rate category. (Bates NAV 639 and 1293). Thus, this extremely unorthodox sampling process resulted in cost projections made from a sample that overrepresented exceptional care rate patients by a factor more than 10 to 1.

To grasp just how unlikely it is that three of the state's 540 Exceptional Care rate patients (out of a total of 47,624 patients) wound up in a sample of 28 cases, I calculated the probability for the Court. It is .0003. Or stated another way, a researcher using the conventional random sample process would expect to take

3,676 random samples before one would result in the same representation of Exceptional Care cases as the Menenberg's "judgmental method."

In addition to the overrepresentation of exceptional care rate cases, 7% of the sample (two of 28 cases) listed Medicare as their payer with a Daily Rate of "$0.00" for their Medicaid payment. (Bates pages NAV 706 and NAV 1378). Unlike Medicaid, Medicare pays 100% of SNF care only if a patient is discharged directly from a hospital after a stay of at least three days. Those are the only circumstances when Medicare pays full cost and that benefit is limited to a maximum of 20 days. (Another 80 days is covered by Medicare for a partial amount.) Hence, this 7% of the sample likely had greater medical needs than the typical SNF patient since they were just released from a hospital perhaps the day before and in no instances were they longer than 20 days from hospital inpatient care.

Since health care needs drives medical costs, these two factors surely inflated the costs of the 28 cases, and consequently the 216, as well as the hypothetical 1,100.

Problem 3: Sample sizes used in the clinical review were grossly insufficient.

The next major flaw in the sample used to estimate costs for this total population of more than 9,000 patients is a grossly inadequate sample size. As concurred to above, the process of creating a stratified sample using ADLs as a case mix control is a reasonable way to proceed. In Table 2, page 11, there are 22 categories of ADL levels. ADL Score 7 has eight cases, ADL Score 13 has none, and the remaining 20 have one case. Thus, in 20 of the 21 ADL categories, there was just one patient found. "Cell sizes" with less than thirty cases are suspect by researchers, but can be found acceptable in some instances. However, no matter how constrained a sampling process may be, in no instance would findings be regarded as credible if more than 20% of cell sizes have less than five cases. (Fox, 2003). Here we have just one case for 95% of the categories. Such samples are obviously not sufficient to draw conclusions for a larger population.

Problem 4: Community care cost projections were made through a potentially biased review process with no quality controls to assure rater reliability.

To estimate the cost of these alleged 1,100 SNF residents who could potentially seek care under the PWD waiver, Mr. Menenberg and colleagues relied on one nurse who is employed by HFS, the defendant in this case. (Menenberg, page 11, footnote 13). The unconscious desire of an employee to please their employer raises a question of bias.

A sound, scientific process to develop hypothetical treatment plans would be to have an independent group of two or three professionals asked to develop community care plans from the same data set that the career state nurse used. They should not know why they are being requested to develop community-based treatment plans, and they should review samples of each others' work to assure consistency of process and accuracy. This would generate reliable estimates.

Summary and Conclusion Regarding Group 1 Cost Estimates: The cost estimate of $33 million using January 2007 rates was derived by unsound methodology and is vastly overstated. Just scaling back the four-fold increase generated from Mr. Menenberg's extrapolation by use of a population parameter as if it were a sample would bring the cost projection down to $6.5 million.

Further reductions should be made since the 216 potential PWD residents that believe they could reenter the community was not verified to determine if in fact there is a willing person to care for them or that they would actually leave the SNF if the question moved from theoretical to an actionable choice. More importantly, the majority of the 216 may be leaving institutional care anyway since 90% had a discharge date categorized as uncertain and two-thirds of SNF patients are discharged from institutional care within 90 days.

The cost of care in the community was estimated by an unheard of sampling technique that generated a sample so overrepresentative of Exceptional Care-rated SNF residents, that such a distribution is expected to be found once in every 3,676 random draws. It also may have been biased by a career state employee considering the interests of her employer. Finally, the sample was far too small to meet the most minimum reliability standards used by statisticians or actuaries.

If the Grooms' prevail and that is interpreted by the Courts as a mandate to remove the SCM expenditure caps, my opinion is the upper bound cost estimate for Group 1 is certainly less than $6 million and perhaps even less than zero as I will discuss below in the last section of this report.

Group 2--Current Persons with Disabilities (PWD) Waiver Participants

According to Exhibit 2 of Mr. Menenberg's report, there are 26,189 PWD beneficiaries who have aggregate monthly costs of $26,197,059. Annualizing this monthly data results in an average per-beneficiary yearly cost of $12,004 and an aggregate annual program cost of $314 million.

With assistance from the state, Mr. Menenberg and his team used the data to provide four estimates for the Court. The first estimate is a calculation of all PWD beneficiaries' costs assuming every PWD patient immediately shifted their care plans to a service level that would result in expenditures at their Service Cost

Maximum (SCM) cap. Estimates two and three were generated by adding 10% and 20% additional costs to the expenditure levels at the SCM cap. And a fourth projection was derived by calculating the cost of services that would be incurred if each service plan were increased by 196%, the difference between the cost of services that the Grooms requested and the cost of the service plan developed for David in 2005 under the PWD waiver.

This approach resulted in projections that the state could potentially be liable for anywhere from $206 million to $310 million additional dollars should the Grooms' prevail, raising the PWD expenditure level from $314 million to $520 million to $624 million. Thus, by continuing to provide the current array of services for one extremely disabled young Medicaid beneficiary, the state's cost for the PWD waiver population would increase anywhere from 66% to 99% and create an unreasonable burden for the state. This is incorrect for several reasons.

First, with no reason cited in the report, the model assumes that medical necessity standards will be eliminated from the PWD waiver. Menenberg Report Exhibit 2 is entitled "Additional Cost *if Utilization Review Function Removed* - Persons with Disabilities Waiver" (italics added). Yet at no point does the report indicate why beneficiaries' care plans would no longer be subjected to standard utilization review and medical necessity guidelines. It simply assumes that a consequence of a favorable Court ruling would change standard policies and procedures deeply imbedded in Medicaid as well as every other public and private insurance plan in existence and provides no explanation why this policy change would occur.

In his April 10, 2007 Deposition (Page 88, lines 8 -10), Mr. Menenberg opines, "...as I understand it, if he [Eric] prevails he's trying to ignore the SCM and just get whatever services he asks for." On page 162, lines 2 through 6, Mr. Menenberg states, "People given a choice of free services many times avail themselves of that whether or not they need it. But if you say no utilization review, no ceilings, no caps, whatever you want you'll get it, this is the mathematics if you open those ceilings."

I would concur that the body of research evidence in health care financing indicates that all other things being equal, an increase in either benefits and/or a reduction in point-of-service patient cost-sharing should be expected to lead to a marginal increase in utilization in all insured populations, including the Medicaid population. However, as I understand the case, at no point is there a request to eliminate all ceilings or SCM cost caps. And, exceptional care rates already exist to accommodate rare cases like David Grooms.

With respect to policy research in the specific field of long-term-care, concerns over the so-called "woodwork effect" has been examined extensively. However, the woodwork effect issue is related to a spike in costs when states begin a Home Care and Community-Based services (HCBS) program, when only institutional care was previously provided. The concern is that non-paid, informal caregivers such as family and friends would reduce their free care and the state would have to pay for services currently being provided at no charge. But this does not pertain to a population like the Illinois PWD group which already has in place satisfactory home care arrangements. No reading of the empirical evidence could support the enormous spike in care asserted in the Menenberg Report.

The assumption that overnight, demand for care would increase by at least 66% has absolutely no basis. Previously uninsured people gaining coverage show no such increase, yet they are starting at zero coverage, and not with a fully functional care plan in place. Other evidence notes that in any population, including Medicaid, roughly one-fourth of beneficiaries in any given year use no services whatsoever (Feldstein).

Not only is there no empirical evidence in the health economics research literature to support such a claim, simple logic would eliminate this as a plausible outcome viewed from either the patient or the payer perspective.

- Why would people seek treatments for illnesses that they do not have? What otherwise healthy people would queue up for chemotherapy or heart surgery because they could get such care for free?
- Why would any public or private insurance plan end utilization review, concurrent review, disease management, preadmission testing, pharmacy benefits management, prior approval for inpatient care, prescription drug formulary limits, and all the other carefully crafted array of safeguards developed over the past twenty years to control unnecessary utilization of services?

Finally, the experience in this state provides evidence that this should not occur. According to the Illinois Department of Human services (DHS) "Home Services Program 2004 Annual Report" (DHS, Home Services Program Annual Report 2004, www.dhs.state.il.us/ors/dhs_drs-hspar2004.asp), many current services are not used by PWD beneficiaries. For example, just 1% (269 beneficiaries) used Home Remodeling benefits. The same report states that "a physician's approval of the initial plan of care" is required for any services. Why would a favorable decision for the plaintiff change the status quo?

Other than a marginal increase in costs and care of perhaps a few percent, medical necessity would continue to drive utilization, not amount, duration, and scope of an insured party's benefit package. The assumption that 100% of PWD beneficiaries would just demand free services and be allowed to receive them with no medical basis is not justified by prior published research and flies in the face of logic; and nowhere in the Menenberg Report or in Mr. Menenberg's deposition is there any rationale stated to justify the prediction of such an outcome.

Second, if utilization increases were to come as a result of expanded benefits, only 864 of the 26,189 current PWD beneficiaries could possibly receive additional benefits.

Exhibit 2 groups PWD beneficiaries into seven categories based on their SCMs. Within each category, PWD beneficiaries are broken down further into subsets for each of the $100 incremental bands within the seven groups. Presumably all medically necessary services are currently being provided to all the PWD beneficiaries that fall in all but the top tier of medical costs for their expenditure bands. Thus, the only possible group of PWD beneficiaries who could potentially gain new services are those beneficiaries who have reached the cap for their tier. That number is 864, or 3.3% of the total current PWD beneficiary population.

Even that vastly reduced number of 864 is too large. The only PWD beneficiaries who would have any chance of receiving expanded benefits are those who have unmet medical needs, but are capped by the existing Medicaid benefit package. However, there is no way to identify the subset of patients who are in this situation with the data available in the report, so my estimate for the population who could have expanded benefits is less than 864.

Finally, it is unclear to me why any current PWD beneficiary would have their care plans change should David Grooms be permitted to continue his MFTD care plan under the PWD waiver.

Exceptional care rates are currently provided under existing rules to PWD beneficiaries (Bates NAV 465-467), and DHS offered a care plan for David Grooms at a rate of $8,840 per month, more than six thousand dollars per month greater than the highest current SCM cap. Also, the Menenberg Report Exhibit 2 footnote states “38 individuals had projected monthly costs in excess of the SCM.” Consequently, provisions under current law apparently permit Illinois to provide medically necessary care to this quadriplegic young man without any basis for a claim of additional services from any other PWD beneficiary.

<u>Summary and Conclusion Regarding Group 2 Cost Estimates</u>: Considering the fact that exceptional, care rates are now permitted, <u>my lowest estimate for Group 2 is zero dollars</u>. If there are special circumstances surrounding this case that would allow it to serve as a precedent, fewer than 864 current PWD beneficiaries could have existing unmet needs now paid for by the state. Since there is no way to estimate the incremental benefits that would be added, I will arbitrarily propose that uncapped SCMs would increase expenditures between 10% and 30% across-the-board in order to provide the Court with an order of magnitude estimate. <u>A 10% increase for every top tier SCM beneficiary would cost the state an additional $152,124 and a 30% increase would cost an additional $456,372.</u>

Overall Conclusions and Estimates Using the Menenberg Model

Using liberal estimates to generate an upper bound cost risk for the state for both groups 1 and 2, it is my opinion additional costs would be no more than $6.5 million per year. That is approximately 2% of current program costs and between 1/37th and 1/53rd of the Menenberg Report projection range.

In the following section I will present policy findings that could lead an objective observer to conclude that the net impact of permitting David Grooms and other SNF-directed Medicaid beneficiaries to remain in community-based settings may actually reduce total long-term-care expenditures for the state.

Beyond the Menenberg Report Estimates: Why a Reorientation of the Illinois Medicaid Long-Term-Care Program to Accommodate Grooms-like Beneficiaries in the Community Could Reduce State Expenditures

The preceding section of this report addresses the multiple, major flaws in the process by which the Menenberg team generated incremental cost increase estimates for the state, should the Grooms position prevail. I believe the Court would benefit from hearing another perspective on the issue at hand using different assumptions than those used by the Menenberg team.

The defense based their model on health economics research that neither I nor anyone else in the field would likely dispute, i.e., unlimited benefit increases (in the absence of utilization controls and point-of-service cost-sharing) would lead to some increase in utilization of medical services and commensurate cost increase. The Menenberg team and I differ mightily on the cost estimates since I believe they were derived employing incorrect assumptions and improper methodology, but not the interpretation of the policy research evidence.

However, I do not accept framing the debate entirely by limiting the discussion to the selected health policy research findings of the Menenberg team, and I would like the Court to consider another perspective regarding potential state expenditure changes using health policy research findings as widely accepted as the points that buttress the Menenberg Report.

If the state of Illinois wants to contain Medicaid costs, it should reorient its long-term-care program from one which pressures beneficiaries, like David Grooms, to reside in SNFs to one which maximizes suitable home care.

Illinois is perhaps the most overbedded state in the country. According to the U.S. Census Bureau, as of April 1, 2005, Illinois accounted for 4.3% of the U.S. population. (U.S. Census Bureau, Population Division, 2005). Yet the state accounts for 5.1% of the country's SNFs and 6.0% of the nation's SNF beds (AHCA, 2005). This disproportionate SNF capacity exists despite the fact that Illinois has a smaller proportion of the age 65 and older population than the rest of the country, 11.9% vs. 12.1%, and a lower poverty incidence, 12.4% vs. 14.0%, two standard benchmarks for estimating SNF demand (AHCA, 2005).

The presence of excess capacity and the state's bias toward institutionalization is reflected in Medicare statistics. The proportion of Illinois Medicare expenditures for SNF services for Medicare beneficiaries is 39% greater than the national average, 7.5% of total Medicare payments compared to 5.4% for the rest of the country (AHCA, 2005).

It is too easy to be admitted into an Illinois SNF and too hard to get community-based care. Patients are placed in SNFs in Illinois with fewer medical needs than elsewhere in the country. The national average ADL dependence for SNF patients is 3.9. In Illinois it is 3.5 (AHCA, 2005), 10% lower than the national average.

Another indicator that the Illinois SNF patient population has fewer medical needs than their counterparts in other states is the fact that Illinois has the absolute lowest proportion of Alzheimer patients of any state in the country with 34%. Thus, two-thirds of SNF residents in Illinois are non-Alzheimer's patients compared to less than half in other states (CareScout, 2006). Since there is no reason to suspect that Alzheimer's has a lower prevalence in this state than elsewhere, this smaller proportion reflects a disproportionate number less medically needy patients occupying Illinois SNF beds.

Despite this distinctly lower threshold of dependency for SNF residence, Illinois' SNF occupancy rates are just 79.2% compared to a national average census of 85.4% (Hendrickson and Reinhard, 2006). Thus, the state places proportionately more people in SNFs and still has proportionately more empty beds than most states.

The state's historic tendency to institutionalize ranks the Illinois Medicaid program 39th of 50 states with respect to its proportion of dollars expended for community-based care. In FY 2004, only 27% of its long-term-care expenditures were paid for community-based care compared to a national average of 36%, which is one-third greater. More progressive Medicaid programs in states like Oregon use 71% of their long-term-care expenditures for community-based services (HCBS Clearinghouse, 2007).

For the cost of serving one patient in a SNF, Indiana reports that it can serve 1.5 people with community-based long-term-care services; Washington estimates it can serve two to four; and Pennsylvania can serve 2.2 community-based patients for the cost of one SNF patient (Summer, 2005).

The accelerating trend toward community-based care continues to gain momentum in both private and public sector health care financing systems since it is widely accepted that it improves the quality of life of patients, is desired by patients, and is expected to result in cost savings, although the empirical evidence to date is mixed. Nonetheless, private, for-profit LTC insurers generally require no waiting period for LTC services provided at home, but have 30 to 180 day waiting periods for benefits to begin for an institutional placement. Other states and the business community see the cost-containment benefits of community-based care, but Illinois remains far behind the curve.

The federal government also has expressed confidence in the cost-containment potential of community-based care. The Deficit Reduction Act of 2005 (DRA) offers state Medicaid programs an enhanced federal match for states to work with patients who have been in SNFs for six months or longer to create plans to move these patients out of institutions and back to the community (Hendrickson and Reinhard, 2006). The DRA also removed the requirement of states to produce waivers for community-based care and has removed roadblocks to progressive plans like the "money follows the person" plans in Vermont and elsewhere. Previous federal legislation even allowed states to waive federal benefit "comparability" requirements to encourage states to move more rapidly toward "rebalancing" as this popular strategy is called. (Shirk, 2006).

The federal government is so certain that community-based care saves money that they have provided the financial incentives to states cited above despite the fact that the Government Accountability Office (GAO) has reported to the Congress that costs for other federal programs, (e.g., Food Stamps, SSI, housing subsidies) will increase when states shift their long-term-care populations out of institutional settings (Hendrickson and Reinhard, 2006).

Despite all these federal financial incentives and the current thinking in the health insurance community regarding the financial and other benefits to be gained by pressing for community-based long-term-care services, Illinois clings to its institutional bias and is one of the slowest Medicaid programs in the nation to adopt progressive change. In researching this report for the Court, 14 states (IN, WI, IA, MI, OR,VT, AK, WA, MD, MN, CO, NB, CN, NJ) were identified as having one or more noteworthy pilot projects or full-blown programs in place to support the shift from SNF to the community (Shirk, 2006;Hendrickson and Reinhard, 2006).

The state's own published report (DHS, Home Services Program Annual Report 2004, www.dhs.state.il.us/ors/dhs_drs-hspar2004.asp) indicates a savings from the PWD waiver of more than $10,000 per beneficiary per year for each former SNF resident who returns to the community and continues to receive care at home. Even the Menenberg Report 28 case subset (Exhibit 1) which included exceptional care rate beneficiaries ten times as frequent as the overall population, reported projected cost savings in 18% of its cases.

Wisconsin has set the goal of reducing its SNF population by 25% in eight years; and regional states like Michigan, Indiana, and Iowa are being cited for model programs; and Connecticut is projecting savings of $35,000 per year per transitioned SNF beneficiary (Hendrickson and Reinhard, 2006). Why does Illinois focus on preserving SNF care and claim it is doing so to reduce Medicaid costs?

Summary

1. The deep methodological flaws found throughout the Menenberg Report provides the Court with little reliable guidance with respect to potential future state costs.
2. There is no reason to believe that maintaining David Grooms' care plan in the PWD waiver program will somehow create a spike in service demand and all utilization constraints for other PWD beneficiaries will somehow disappear.
3. The state of Illinois is unnecessarily overspending Medicaid dollars by resisting the widely accepted view that a community-based care oriented long-term-care program saves money, and the demand to place David Grooms in a SNF is a reflection of that outmoded thinking.

Disclosures

Compensation: For my work, I will be compensated by Plaintiff's attorney at the rate of $150 per hour.

Expert Witness History: During the past four years I have served as an expert witness in the following cases:

- March 2003 to May 2004: Memisovski *et al.*v. Maram, *et al.*92 C1982, United States District Court for the Northern District of Illinois, Eastern Division.
  Provided written report, deposition and trial testimony.
- May 2006: Oklahoma Chapter of the American Academy of Pediatrics, *et al.*, v. Michael Fogarty, Chief Executive Officer of the Oklahoma Health Care Authority, *et al.* 01-CV-0187-CVE-SAJ, Northern District of Oklahoma.
  Provided written report, deposition and trial testimony.
- April-May 2006: Julie Sidell, Guardian for Gretchen Sidell v. Barry S. Maram, Director of Illinois Department of Public Aid; Carol L. Adams, Secretary , Illinois Department of Human Services. No. 2005 MR 37, Circuit Court of the Fourteenth Judicial Circuit, Whiteside County, Illinois.
  Provided written report and deposition.
- April 2007: Donna Radaszewski Guardian on behalf of Eric Radaszewski v. Barry S. Maram, Director of Illinois Department of Healthcare and