IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

HELEN PITTS, et al.	*	C.A. No. 3:10-cv-00635-JJB-SCR
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PLAINTIFFS	*	
	*	JUDGE JAMES J. BRADY
V.	*	
	*	
BRUCE GREENSTEIN, et al.	*	MAGISTRATE JUDGE STEPHEN
	*	C. RIEDLINGER
	*	
	*	CLASS ACTION

PLAINTIFFS' MEMORANDUM IN OPPOSITION TO
MOTION FOR SUMMARY JUDGMENT

Plaintiffs file the following memorandum of law in opposition to Defendants' Motion to Dismiss under Fed. R. Civ. P. 12(b)(6), which this Court converted to a motion for summary judgment pursuant to Fed. R. Civ. P. 12(d). Because there are material facts in dispute and because Defendants' motion is not correct on the law, the motion should be denied.[1]

INTRODUCTION

In 1990, Congress passed the Americans with Disabilities Act ("ADA"), requiring all public entities to refrain from discrimination, see 42 U.S.C. §12132. Congress's findings explicitly identified unjustified "segregation" of persons with disabilities as a "for[m] of discrimination." See §12101(a)(2);[2] §12101(a)(3) (discrimination … persists in such critical areas as ... institutionalization..."); and §12101(a)(5) ("discrimination, include[s] ... segregation").

Ten years after the ADA was enacted, Louisiana had one of the most segregated systems of long-term care in the country. Ninety-seven percent of individuals with disabilities received long term care[3] under Medicaid only if they were confined in nursing homes.[4] Only

[1] Pursuant to Local Rule 56.2, Plaintiffs also submit a separate Statement of Disputed Facts, which is attached hereto.
[2] Congress found that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem."
[3] "Long term care," as used in this memorandum, means programs that assist the elderly and adults with disabilities with activities of daily living ("ADL's"), such as eating, moving around, bathing, dressing,

approximately 1,000 elderly individuals and persons with disabilities in 2000, out of a total of over 35,000 persons who received long term care services, received Medicaid-funded services in an integrated setting – their homes and communities.[5]

Since 2000, primarily as the result of *Barthelemy, et al.v. Louisiana Department of Health and Hospitals, et. al.*,[6] a class action brought in 2000 against the State, based on the ADA and *Olmstead v. L.C.*, 527 U.S. 581, 596-597 (1999), Louisiana has made progress in providing home- and community-based services. In *Olmstead*, the Supreme Court recognized that unjustified institutional isolation of persons with disabilities is a form of discrimination that violates the ADA. The *Barthelemy* action was dismissed without prejudice in January 2010.

Despite the *Barthelemy* Settlement Agreement, and the *Olmstead* decision, Louisiana has maintained, and even increased, its Medicaid expenditures on segregated nursing home services, even though demand for nursing homes is dwindling. The present action focuses on Louisiana's imposition of heavy and disproportionate service reductions in Medicaid home and community-based services. Specifically, Defendants propose to reduce their Long Term – Personal Care Services ("LT-PCS") from 42 hours a week to a maximum of 32 hours a week, with no exceptions to prevent the unnecessary institutionalization of LT-PCS recipients in nursing homes, and no plan to assure them access to alternative community services instead of institutionalization.

These reductions fall disparately and most heavily on the most vulnerable group of people with disabilities -- those who have the most severe disabilities and the most critical service

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grooming, toileting, transferring, cooking, shopping, housekeeping, and medication administration, because of disabilities. Long term care can be provided in a nursing home, at home, or in another community location. While other populations in Louisiana, notably persons whose disabilities have onset before age 22 and are considered to have developmental disabilities, receive long term care services, this case concerns services only to the population of persons who have adult-onset disabilities or disabilities related to aging.

[4] Defendants' Memorandum in Support of Motion to Dismiss, Doc. No. 11-1 (hereafter "Defendants' Memorandum") at 10.

[5] Attachment A to the Declaration of Hugh Eley (hereafter "Eley Declaration"), Doc. No. 11-3, p. 2.

[6] C. A. No. 00-1083 in the U.S. District Court for the Eastern District of Louisiana.

needs, who are struggling to maintain themselves in the community. Several of these individuals have brought this action claiming that these drastic reductions, as applied to them, constitute illegal discrimination under the ADA and Section 504 of the Rehabilitation Act, 29 USC § 794, because they will force them and the class members whom they represent to go into segregated nursing homes in order to obtain the services they need and could receive in the community.[7]

Defendants argue that the progress Louisiana made as a result of *Barthelemy* in offering home- and community-based services, coupled with its stated commitment to achieving balance between institutional and community-based services, insulates it from ADA discrimination charges. They assert, without any support, that the modifications that Plaintiffs request will be unduly expensive to the State.

FACTS

The LT-PCS Program

Louisiana instituted the LT-PCS program approximately six years ago as part of the settlement in *Barthelemy v. DHH*. It is the largest program providing home- and community-based services to the aged and disabled adult population.[8] From the inception of the program, it provided persons with disabilities who would otherwise need care in a nursing home with up to 56 hours of help with activities of daily living such as bathing, dressing, feeding, and toileting, in their homes.[9] In March of 2009, Defendants reduced the maximum number of hours of LT-PCS to 42.[10] In September of 2010, Defendants promulgated a new rule reducing the maximum

[7] Plaintiffs are not seeking in this action to enjoin the reduction in services as to all recipients of the service—only as to the class members, who are, by definition, at serious risk of institutionalization as a result of reducing community-based services.
[8] Exhibit 1, Deposition of Hugh Eley ("Eley deposition") p. 102 l. 13 – 103 l. 2; Pitts Doc. 44 (documents produced by Defendants in this case were referred to in Mr. Eley's deposition, and will be referred to herein, by the number given them by Defendant).
[9] *Louisiana Register* Vol. 29, No. 6 June 20, 2003, pp. 911-13; Eley deposition p. 66, l. 5-8.
[10] *Louisiana Register* Vol. 35, No. 1 January 20, 2009, pp. 32-34; Eley deposition p. 66, l. 9 – p. 67, l. 17.

number of hours that a participant in its LT-PCS program could receive from 42 to 32. There are no exceptions for people at risk of institutionalization as a result of the reduced hours.[11]

The cut in the maximum number of hours from 42 to 32 will result in an average cut of approximately three hours of services for LT-PCS recipients.[12] However, Plaintiffs all receive 39 or more hours of service a week, and their hours will be reduced by at least seven hours a week.[13] The severity of their disabilities causes them to need far more than the average number of hours of service.[14] The reduction in hours falls disproportionately on them. Plaintiffs do not believe or argue that all of the 3,600 individuals whose LT-PCS will be reduced to 32 hours a week will be placed at risk of institutionalization.[15] In Plaintiffs' cases, their treating physicians confirm that they face this risk.

Facts Pertaining to the Named Plaintiffs:

The named Plaintiffs, Helen Pitts, 78, Kenneth Roman, 47, Denise Hodges, 53, and Rickii Ainey, 30, and class member Cleo Lancaster, 61, all have severe disabilities. Defendants have not disputed any of the following facts regarding their disabilities, their needs for care, nor the dire consequences of the reduced LT-PCS hours.

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[11] *Louisiana Register* Vol. 36, No. 8 August 20, 2010, pp. 1749-52; Attachment E to Eley Decl., Doc. 11-3 p. 11. The State reassesses each recipient annually and sets the number of weekly hours of service. Of the named Plaintiffs, only Rickii Ainey's assessment date has been reached, and Defendants have agreed to temporarily maintain her services at their prior level, rather than require her to seek temporary relief in this action. The same temporary agreement has been reached with Defendants for class member, Cleo Lancaster, *see infra*.

[12] Eley deposition p. 206, lines 18-21.

[13] Exhibit 3, Declaration of Helen Pitts ("Pitts Decl") ¶22; Exhibit 4, Declaration of Kenneth Roman ("Roman Decl.") ¶20; Exhibit 5, Declaration of Denise Hodges ("Hodges Decl.") ¶16; Exhibit 6, Declaration of Rickii Ainey ("Ainey Decl.") ¶28.

[14] Eley deposition p. 206, l. 18 – p. 207, l. 9; p. 208, l. 9-20.

[15] As of the date of the filing of Defendants' Motion to Dismiss, of the approximately 12,000 individuals receiving LT-PCS services, 28% received services in excess of 32 hours per week. The remainder received less. Defendants' Memorandum at 9; *See* Eley Decl., ¶37. Defendants do not have the breakdown of people who receive 33 or up to 42 hours a week. Plaintiffs have requested documents showing the number of hours that recipients of LT-PCS receive now, and how many they were receiving as of July 10, 2010. In response to Request No. 9 of Plaintiffs' First Set of Requests for Production of Documents (Exhibit 2, p. 12), which requested "Documents sufficient to show how many hours (from 1 to 42) of LT-PCS per week recipients of LT-PCS receive: (a) As of July 1, 2010; and (b) Currently," Defendants produced Pitts Docs. 1701-1703, which do not provide any breakdown besides stating the total number percentage of those receiving more than 32 and more than 42 hours a week.

Helen Pitts:[16]

Plaintiff Helen Pitts is 78 years old. She is divorced and lives alone in the community.[17] Ms. Pitts has had osteo- and rheumatoid arthritis, fibromyalgia, congestive heart failure and lymphedema. She requires the use of oxygen daily and at night. She is in constant pain in her legs, arms, shoulders and back[18]. Plaintiff Pitts needs assistance getting in and out of bed and getting in and out of her motorized scooter. She needs help going to the bathroom because she cannot get on and off the toilet without help, needs help pulling her clothes up and down, and needs help cleaning herself (in part to avoid decubitus ulcers). She has incontinent episodes daily. She needs help bathing, dressing and performing most of her personal hygiene. Ms. Pitts is unable to prepare meals, do her laundry or attend to household chores.[19]

Ms. Pitts' physician, Dr. Gregory Ward, a physical medicine and rehabilitation specialist practicing in Baton Rouge, who has treated her for over ten years, confirms her diagnoses, her functional limitations, and her need for in-home care, and notes that her multiple diagnoses put her "in a precarious situation."[20] He notes that when she lacked adequate in-home care for a period of time in 2008 or 2009, her condition greatly deteriorated.[21] He expressed the opinion that the 39 hours a week of in-home care that she is currently receiving is minimally adequate, but that if her hours of care are reduced to the new maximum of 32 hours a week, her condition will again deteriorate and she will be at risk of having to enter a nursing home for care.[22]

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[16] Helen Pitts has been on the waiting list for an Elderly and Disabled Adults waiver slot since September of 2007. Since the filing of this action, she was offered and has accepted a waiver slot, but her waiver services have not begun.
[17] Pitts Dec. ¶¶ 1-3.
[18] Pitts Decl. ¶8-12.
[19] Pitts Decl. ¶¶24-28.
[20] Exhibit 8, Declaration of Gregory Ward, M.D., ("Ward Decl.") ¶¶1-10.
[21] Ward Decl. ¶11.
[22] Ward Decl. ¶¶9, 11-15.

Kenneth Roman:

Plaintiff Kenneth Roman is 47 years old.[23] Plaintiff Roman has had several strokes which has caused left side hemiparesis(paralysis). He also has diabetes, congestive heart failure, peripheral vascular disease, hypertension, coronary artery disease, renal failure and irritable bowel syndrome, as well as had several heart attacks, the most recent of which was in 2009.[24] Mr. Roman lives in the community and is currently separated from his wife. One of the primary reasons they are separated is because his wife did not want to be his caregiver any longer.[25] Due to his impairments, Plaintiff Roman needs assistance with all of his ADLs, including bathing, washing, and brushing his teeth. He is incontinent and needs assistance cleaning after an incontinence episode. This is even more important when his irritable bowel syndrome occurs. He is often incontinent of bowel and bladder at night and often must wait until his personal care worker arrives in the morning to assist with cleaning. Plaintiff Roman needs assistance changing to a standing position from a sitting position. Often he is not able to move in bed without assistance. Not moving causes him severe pain and at risk of falling, when he tries to walk.[26]

Kendra Whitney, M.D., a family practitioner in New Iberia, Louisiana, has been his treating doctor for five years.[27] She states that without adequate home care services, Mr. Roman is at great risk of falling and skin problems. Lack of adequate in-home assistance would cause him to require expensive in-patient hospitalizations and use of hospital emergency rooms much more often.[28] In her experience, not only in treating Mr. Roman but also in treating numerous patients with disabilities, Mr. Roman's 39 hours a week are medically necessary and the minimum that he

[23] Roman Decl. ¶1.
[24] Roman Decl. ¶12.
[25] Roman Decl. ¶10.
[26] Roman Decl. ¶¶15-18.
[27] Exhibit 9, Declaration of Kendra Whitney, M.D. ("Whitney Decl.") ¶¶1-4.
[28] Whitney Decl. ¶8

needs to reside safely in his home.[29] A reduction in his hours of service will put him at significant risk of having to go into a nursing facility.[30]

Denise Hodges: [31]

Plaintiff Denise Hodges is 53 years old and lives alone in the community.[32] She was diagnosed with transverse myelitis in 1989 that left her paralyzed from the waist down, and in 2001, was diagnosed with multiple sclerosis.[33] Due to her multiple sclerosis, Ms. Hodges has frequent extreme fatigue and loss of stability and requires extensive assistance transferring, dressing, toileting and bathing. She cannot push her manual wheelchair, and she requires assistance with personal hygiene, meal preparation, shopping, laundry and household chores. Plaintiff Hodges requires digital stimulation in order to have a bowel movement and needs help with cleaning herself and any laundry that must be done as a result of bowel movements. [34] Ms. Hodges developed decubitis ulcers on one of her heels and on her lower spine during a period of time when she was not receiving adequate community-based assistance.[35]

Ms. Hodges has been under the care of Dr. Alreesa Minegar, a Board-certified neurologist, vascular neurologist, behavioral neurologist, and neuro-immunologist at LSU Medical Center in Shreveport. He detailed Ms. Hodges' need for home care and the devastating consequences to her of a lack of such care.[36] He noted that she faces extreme danger from possible complications of the incurable decubitus ulcers she has on her feet and legs if she does not receive adequate home care. In addition to needing help with all ADLs, she needs frequent assistance after leaks to her urinary catheter. In Dr. Minegar's experience, people with

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[29] Whitney Decl. ¶¶5, 7, 10.
[30] Whitney Decl. ¶¶11, 13.
[31] Like Helen Pitts, Denise Hodges has been on the EDA waiver waiting list for many years, since September 11, 2007. She was finally offered an EDA slot after this litigation began. She has not yet begun to receive EDA waiver services.
[32] Hodges Decl. ¶¶1, 4, 10-12.
[33] Hodges Decl. ¶7.
[34] Hodges Decl. ¶¶17-20.
[35] Hodges Decl. ¶¶21, 23-25.
[36] Exhibit 10, Letter dated October 18, 2010 from Alreesa Minagar, M.D., F.A.A.N.

impairments similar to Ms. Hodges require 8 to 10 hours of home care per day. Therefore, he states that the 39 hours a week of home care that she receives is clearly medically necessary. Without it, he believes that she would be at significant risk of deteriorating or having to enter a nursing facility.[37]

Rickii Ainey:

Plaintiff Rickii Ainey is 30 years old and lives alone in the community. Ms. Ainey has arthrogryposis (a congenital form of arthritis), is paralyzed from the waist up and has limited mobility in her legs. She has limited range of motion in her legs and the range of motion is deteriorating.[38] Ms. Ainey needs assistance with all activities of daily living, including but not limited to bathing her upper body, including her face, arms and torso, and washing her hair; dressing in the morning and undressing when she goes to bed; adjusting her clothing before and after toileting; getting on and off the toilet and cleaning herself after toileting; feminine hygiene; eating and drinking; transferring from any surface to a standing position; and moving once in bed. Plaintiff Ainey cannot prepare meals and cannot shop without assistance. In addition, she requires assistance to do all household chores and laundry.[39]

Ms. Ainey's internist, Christopher Lege, M.D., an internal medicine specialist at Touro Infirmary in New Orleans, has been treating Ms. Ainey for four years. He confirms her diagnosis and functional limitations.[40] He attributes Ms. Ainey's having remained healthy to the fact that she has had home-care assistance. According to Dr. Lege, having dependable home-care has prevented her condition from progressing, by lessening stress she would place on her joints by attempting to do things on her own.[41] He expresses the opinion that the 41 hours of personal care a week that she receives is the minimum that is medically necessary, and that any reduction in her

[37] *Id*.
[38] Ainey Decl. ¶¶1-3.
[39] Ainey Decl. ¶¶ 4, 5.
[40] Exhibit 11, Declaration of Christopher Lege, M.D. ("Lege Decl.") ¶¶ 1-7.
[41] Lege Decl. ¶8.

in-home care is likely to cause her to be institutionalized in a nursing home. He states that nursing home placement would be inappropriate and medically contraindicated for Ms. Ainey.[42]

Ms. Ainey is also the care of a psychiatrist, Robert Ancira of New Orleans.[43] He has been treating her for depression since 2007, which he attributes to uncertainty over whether she would receive adequate personal care assistance.[44] He states that the amount of personal care assistance she receives is necessary for her emotional, as well as her physical health. If she were to have to enter a nursing home for care, he believes her emotional health would decline drastically. [45]

Cleo Lancaster: [46]

Cleo Lancaster, a class member, is 61 years old and lives alone in the community in Rayville, Louisiana.[47] She has achodroplastic dwarfism, severe osteoporosis, and secondary hyperparathyroidism. Her condition has caused multiple fractures of her upper and lower extremities, her shoulders, and her hips, that have never healed. These existing fractures cause both physical deformity and severe pain, and prevent her from engaging in any weight-bearing activities. Her use of her extremities is essentially confined to her hands.[48] Ms. Lancaster unable to stand or to transfer herself from a bed to a wheelchair, or from her wheelchair to a toilet. She cannot use the toilet without assistance, and must therefore use incontinence underwear. Ms. Lancaster requires total assistance with transferring, toileting, dressing, showering, and personal hygiene. She is unable to move herself in bed.[49]

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[42] Lege Decl. ¶¶9-12.
[43] Exhibit 12, Declaration of Robert Ancira, M.D. ("Ancira Decl.") ¶¶1,2.
[44] Ancira Decl. ¶3.
[45] Ancira Decl. ¶¶6-9.
[46] Defendants stipulated that Ms. Lancaster's hours would be extended for 90 days, or through March 31, 2011, rather than requiring her to seek preliminary relief in this action. Ms. Lancaster has been on the EDA Waiver waiting list since 2007, and has been offered an EDA waiver slot since this case was filed. She has not yet begun receiving services under the waiver.
[47] Exhibit 7, Declaration of Cleo Lancaster ("Lancaster Decl.") ¶1.
[48] Exhibit 13, Declaration of Dan J. Lafleur, M.D. ("Lafleur Decl.") ¶7; Lancaster Decl. ¶¶6, 8-9, 11.
[49] Lancaster Decl. ¶¶10, 17, 19.

Ms. Lancaster is currently receiving 39.75 hours of personal care assistance, but received a notice in November of 2010 saying that her services would be reduced to 32 hours a week due to the change challenged in this case. Even now, with almost 40 hours a week of services, there are tasks that at times do not get done for her, and occasions when she has to sit in a wet brief for extended periods. If her hours are further reduced, she fears having to go into a nursing home for care.[50]

Dan J. Lafleur, a physician practicing family medicine in Rayville, Louisiana, has been caring for Ms. Lancaster for 15 years. He works intensively with elderly people and people who have disabilities, such as mobility impairments, who require assistance with 'activities of daily living. His declaration states that none of his 2,000 patients have more serious disabilities than Ms. Lancaster.[51] He confirms her diagnoses and states that the 39.75 hours of home care that she is currently receiving are medically necessary, that Ms. Lancaster's lack of mobility puts her at risk for skin breakdown and decubitus ulcers, and that this condition is extremely dangerous.[52] He states that if Ms. Lancaster's hours of home-care services are reduced, she will be at imminent risk of needing to go into a nursing facility for care. In his medical opinion, Ms. Lancaster's health would be jeopardized if she went to a nursing home due to the effect this would have on her emotional state. He believes that she would become depressed, that her health would decline, and that her life expectancy would be significantly shortened.[53]

None of the Plaintiffs have family or friends who can provide the services they currently receive from LT-PCS.[54]

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[50] Lancaster Decl. ¶¶ 18-20, 23, 26.
[51] Lafleur Decl. ¶¶1-6.
[52] Lafleur Decl. ¶¶7-12.
[53] Lafleur Decl. ¶¶17, 18.
[54] Ainey Decl. ¶9-15, 18,20-23, 28, Hodges Decl. ¶10-12, 27, Roman Decl. ¶8-11, 23, Pitts Decl. ¶3, 7, 30, Lancaster Decl. ¶2, 25.

Louisiana's History of Segregation and Institutionalization

Louisiana's progress in expanding home- and community based services since 2000 was largely the result of a Court-approved Settlement Agreement in the *Barthelemy* case.[55] The original Settlement Agreement was approved at class fairness hearing October 18, 2001 (in SFY 02).[56]

The *Barthelemy* Settlement Agreement required DHH to create additional "slots" for people in its Elderly and Disabled Adults Waiver ("EDA"), its Personal Care Attendant Waiver, and the Adult Day Care Center Waiver. Most importantly for the instant action, the Settlement Agreement required the creation of the LT-PCS program.[57] Due to a delay in implementing the LT-PCS program, the parties negotiated and entered a Supplemental Settlement Agreement, which called for a later date for start of the LT-PCS program, and for additional slots in the Waivers, on top of those to be created pursuant to the original court-approved and ordered Agreement.[58]

The Louisiana Legislature attempted to kill the LT-PCS program before it started. In 2003, the Legislature reduced funding for the new program LT-PCS and ordered the Department to ask the Court for permission to add 2,000 waiver slots instead of implementing LT-PCS as

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[55] Plaintiffs request that the Court take judicial notice, pursuant to Rule 201 of the Federal Rules of Evidence, of pleadings and stipulations filed in that case, in which the Louisiana Department of Health and Hospitals and its Secretary were defendants. Plaintiffs will refer to the *Barthelemy* documents, of which judicial notice is requested by their name, document number, and date filed in Civil Action No. 00-1083 in the U.S. District Court for the Eastern District of Louisiana, *e.g.* "Complaint, 00-1083 Doc. No. 1 (4/11/2000)."

[56] Order and Reasons, 00-1083 Doc. No. 26 (October 18, 2001). The Settlement Agreement was not attached to Doc. No. 26 but is attached hereto as Exhibit 14. It was attached as Appendix C to Joint Motion to Approve Notice and Set Fairness Hearing, 00-1083 Doc. 34 pp. 27-62 (2/4/2003).

[57] Exhibit 14, *Barthelemy* Settlement Agreement, pp. 16-17. The LT-PCS program is not to be confused with a waiver program called the PCA Waiver that was in existence in 2000. That program, a waiver that only served 361 recipients, was absorbed into the EDA waiver in 2005. Pitts Doc. 44, Eley deposition p. 103, l. 7-25.

[58] Order and Reasons, 00-1083, Doc. 38 (3/31/2003); Exhibit 15, Supplemental Settlement Agreement, Appendix A to Joint Motion to Approve Notice and Set Fairness Hearing, 00-1083 Doc. 34 pp. 16-19 (2/4/2003). The Louisiana Nursing Home Association objected to the Supplemental Settlement Agreement and filed a motion to intervene to block the LT-PCS program. Objections by movant LA Nursing Home Assn to proposed settlement agreement, 00-1083, Doc. No. 37 (3/26/2003); Motion, 00-1083 Doc. No. 50 (8/11/2003). The motion to intervene was denied. Smooth Minutes, 00-1083 Doc. No. 62 (9/3/2003).

agreed.[59] The district court denied DHH's motion to modify the settlement to eliminate the LT-PCS program,[60] and the program began serving substantial numbers of recipients in SFY 2005.

In SFY 2000, 1,030 individuals received home- and community-based services ("HCBS") in Louisiana, while 34,727 individuals received LTC services in nursing homes.[61] All of the persons who received HCBS in 2000 received them through waiver programs.[62] In 2000, Louisiana ranked 46th out of 47 states in the percentage of its Medicaid-funded long term care budget that was devoted to home and community-based services.[63]

Well over 14,495 recipients of HCBS, who were added between SCY 2000 and 2010, received their services either because they received services under the LT-PCS program begun as a result of *Barthelemy* or because they received one of the 2,200 waiver slots created pursuant to the *Barthelemy* settlements.[64] [65]

Despite the large increase in HCBS due to the *Barthelemy* case, Louisiana still, in 2011, will spend approximately 73% of its Medicaid long term care budget on institutional nursing home services and only 27% on community-based services. Louisiana has one of the highest, if not the highest, number of nursing home beds per capita in the nation,[66] and institutionalizes a higher percentage of its population over the age of 85 than any other state.[67] In December of

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[59] Motion by defendant LA Dept Health, defendant David Hood to alter or amend court-approved class action settlement, 00-1083 Doc. No. 43, p. 9 (7/16/2003).
[60] Smooth Minutes, 00-1083 Doc. No. 62 (9/3/2003).
[61] Pitts Doc. 44, Eley p. 102 l. 13 – p.103 l. 2.
[62] Pitts Doc. 44.
[63] Eley decl. ¶12.
[64] The combined original *Barthelemy* Settlement Agreement and the Supplemental Settlement Agreement called for the addition of 2,200 waiver slots, see *Barthelemy* Supplemental Settlement Agreement p. 2. Attachment A to Eley Declaration, Doc. No. 11-3, p. 2, shows that 17,185 "unduplicated" HCBS recipients were added between SFY 2000 and SFY 2010. The number of "unduplicated recipients" is normally larger than the number of waiver slots because turnover in slots allows more than one individual to receive services under a waiver slot in a given year. Eley deposition p. 75 l. 24 – p. 76 l. 6. According to Doc. 1041, in 2010 12,295 (71.5%) received only LT-PCS services ("LT-PCS non-waiver"); 905 received ADHC services, 4,870 received EDA waiver services, and 221 of received services under the PACE program. Eley deposition p. 108, l. 15 – p. 109, l. 15.
[65] *Barthelemy* was dismissed without prejudice on January 4, 2010. Order granting motion to dismiss, 00-1083 Doc. 180 (1/4/2010).
[66] Eley deposition, p. 27, lines 1-12; Doc. 1159, Recommendation #68, Eley deposition p. 223, lines 6-21.
[67] Eley deposition, p. 225, line 25 – p. 226, line 24 ; Doc. 1159.

2010, Louisiana's Medicaid Report estimated that expenditures on private nursing homes will be $801,550,525 in SFY 2011, while the expenditures on State nursing homes will add an additional $20,857,156. In contrast to the institutional expenditures, the total for home- and community-based services (the sum of expenditures for LT-PCS ($189,137,091), Waiver-Adult Day Health ($7,577,091), Waiver-Elderly and Disabled Adults ($104,623,458), and PACE ($9,722,518)) is $311,060,252.[68]

Waiting Lists for Appropriate Home- and Community-Based Services

If LT-PCS is reduced to a maximum of 32 hours a week, with no exceptions based on need for services to avoid institutionalization in nursing homes, Plaintiffs and class members who have the most severe needs for in-home care will have no options for community-based services, other than entering nursing facilities. As will be more fully discussed below, people receiving services in the community do not take priority for waiver services. To be able to advance to the top of the waiting list, people must first go into a nursing facility, remain there for at least 90 days, and then wait another 60 to 90 days, or even longer, to receive services once a slot is offered, assuming one will become available within that time period.[69]

In Defendants' Memorandum at pp. 8 and 21, they assert a defense that they have "more comprehensive programs" that "may be more appropriate [than LT-PCS] for individuals with a higher level of need." These programs are the Elderly and Disabled Adult Waiver program, the Adult Day Health Care program, the Program of All-Inclusive Care for the Elderly, and the Money Follows the Person program. However, because of limitations in the number of waiver slots, lengthy waiting lists, limited geographical availability and age limits, many people currently receiving LT-PCS cannot access these services as an alternative to nursing facility care.

Elderly and Disabled Adults Waiver

The Elderly and Disabled Adults ("EDA") waiver affords people who qualify an annual

[68] Pitts Doc. 1487, Eley deposition p. 23, lines 7-19.
[69] Eley deposition p. 78, line 7 – p. 79 l. 5; p. 88, lines 3-12.

"budget" of approximately $40,046, of which $1,680 must be spent for support coordination.[70] The remainder of the budget can be spent on a variety of services including service coordination, environmental modifications (to make a home more accessible), a personal response system, and home care.[71] The major service that is used is payment for a person to come into the home and provide care.[72] At the current rate of $11.32 per hour,[73] the EDA will afford approximately 65 hours a week of home care. This would certainly be adequate to maintain the Plaintiffs and others like them at home, and prevent their having to enter an institution for care.

However, as the following chart shows, there have been since at least 2007, and currently are, lengthy wait times for the EDA Waiver.[74] The chart shows, for each date in the "Date" column, the date the last person who was on the waiting list received an offer for waiver services, and the length of time the next person on the list had been waiting for an offer:

Date	Date of last EDA offer	Length of wait (months)
01/01/07	1/30/2004	35.6
01/01/08	2/28/2005	34.6
01/01/09	1/8/2007	24.1
01/01/10	9/30/2007	27.5
01/01/11	8/15/2007*	41.2

*From March 2009 to September 2010, people on the waiting list who were not receiving LT-PCS were given priority over those who were receiving LT-PCS. In September 2010 DHH changed this policy. The change in policy resulted in reaching people receiving LT-PCS who had been on the waiting list longer than some of those who were not receiving LT-PCS.

[70] Eley deposition p. 73, line 20 – p. 74, line 9.
[71] Eley deposition p. 58, line 16 – p. 62, line 16. The "new, more comprehensive waiver program" that Defendants refer to at p. 11 of their Memorandum as a replacement for the EDA waiver will add services for people who are on the EDA waiver, but will add no new or additional waiver slots. Eley deposition p. 117, lines 4-16.
[72] Eley deposition p. 61, line 7 – p. 62, line 21.
[73] Exhibit 16, Letter dated March 4, 2011 from Caroline Brown to Nell Hahn, item 2.
[74] Doc. 3186, Eley deposition p. 52, lines 1-25; Exhibit 16 ¶11, p. 3; Exhibit 17, Email from Matt Berns to Nell Hahn dated March 6, 2011.

In October of 2010, 46% of the 12,021 people, who received LT-PCS only, were on the EDA waiting list.[75] There has been a waiting list for the EDA waiver since at least 2006, and the waiting list has grown since then.[76]

After a person receives and accepts an offer for a waiver slot, it typically takes 60 to 90 days for services to actually begin.[77] Despite the lengthy wait for EDA, Louisiana has not increased the number of EDA slots since SFY 2009,[78] and they have been capped at 4,603 slots.[79]

Some groups have priority for these waiver slots and do not have to wait as long -- individuals with substantiated cases of abuse or neglect who, absent EDA Waiver services, would require institutional placement to prevent further abuse and neglect; individuals diagnosed with Amyotrophic Lateral Sclerosis (ALS); and individuals presently residing in nursing facilities for 90 or more continuous days. These priorities allow some persons to come to the top of the waiting list —but they do not guarantee an immediate waiver offer. Persons in priority groups are only guaranteed the "next available" waiver slot.[80] In any event, these priorities do not apply to any of the Plaintiffs, nor to many other individuals who need more than 32 hours of personal care services to safely remain in their homes.

Adult Day Health Care Waiver

The Adult Day Health Care ("ADHC") waiver affords care, including meals, nursing, some therapies, and attendants, for at least five hours per day in an adult day care center. ADHC is not available in many areas of the state, has slots for only 825 people, and has a waiting list over five months long.

Wait times for the ADHC waiver are lengthy now and have been so for at least the last

[75] Eley deposition p. 69, line 10 – p. 71, line 16; Doc. 1687, p. 2, items (d) and (e).
[76] Eley deposition p. 77, lines 4-10.
[77] Eley deposition p. 88, lines 3-8.
[78] Eley deposition p. 74, line 24 – p. 75, line 2,
[79] Eley deposition p. 41, lines 4-15. Though the Office of Aging and Adult Services requested funding of 1,000 additional waiver slots in SFY 2011, this recommendation was not carried forward in the Executive Budget. Therefore, the Legislature was never asked to fund the slots. Exhibit 16, p. 1, item 3.
[80] LAC 50:XXI. §8105(B), Louisiana Register V. 36, No. 10, pp. 2217-20.

two and a half years, as shown by the following chart:[81]

Date	Date of last ADHC offer	Length of wait (months)
01/01/07	6/8/2006	6.9
01/01/08	12/17/2007	0.5
01/01/09	9/4/2008	4.0
01/01/10	8/12/2009	4.7
01/01/11	7/15/2010	5.7

Despite the lengthy wait for ADHC services, DHH has not sought new waiver slots for the ADHC waiver since the *Barthelemy* case was dismissed in 2009.[82]

In many areas of Louisiana, there are no ADHC Centers, so even a person able to wait for four to six months for a waiver slot would not be able to access this service.[83] Attachment D to Hugh Eley's deposition[84] purports to show areas of the State within a 20-mile radius of an ADHC Center. According to the map, only the facilities indicated on the map with a star are actually participating in the Medicaid ADHC program. Of the 41 centers shown on the map, only 27 were designated with a star.[85]

PACE

The Program of All-Inclusive Care for the Elderly ("PACE") is available only to people 55 years and older and only in certain parts of New Orleans and in the Baton Rouge area. It has slots only for 400 individuals.[86] Either by reason of geography or age, the named Plaintiffs, and

[81] See n. 75 *supra*.
[82] Eley deposition p. 91, l. 15 – p. 92, l. 5.
[83] Eley deposition p. 54, l. 25 – p. 55, l. 2.
[84] Doc. 11-3, p. 9.
[85] Eley deposition, p. 49, l. 18 – p. 50, l. 5; Exhibit 16, item 1, p. 1. Attachment D to Hugh Eley's declaration is apparently not current.
[86] Eley deposition p. 43, l. 7 – p. 44, l. 18.

many other class members, cannot access this program.[87]

Money Follows the Person

The Money Follows the Person ("MFP") program is a federal demonstration project that offers States enhanced federal match for services to participating individuals who are leaving nursing facilities. It also provides the State with additional funding for services to assist in transitioning people from nursing facilities to the community. It does not increase the number of slots in waivers, nor does it provide any additional services for people once the transition is made to the community.[88] In order to be eligible for the MFP program, participants must have resided in a nursing home for at least 90 days.[89] "Benchmarks" for the MFP program called for only 165 persons to be transitioned out of nursing homes by the end of 2010; however, Louisiana did not meet the benchmarks set in its written protocol for the MFP demonstration project.[90]

Needs of Plaintiffs and Class Members for LT-PCS

Unlike personal care programs in other states,[91] Louisiana's LT-PCS program requires recipients to meet a nursing facility "level of care" in order to qualify for the program. Applicants for home- and community-based programs, as well as nursing facility services, are screened for eligibility using a tool called the "LOCET" or "level of care eligibility tool."[92] In addition, an applicant for the LT-PCS program must demonstrate that he or she "faces a substantial possibility of deterioration in mental or physical condition or functioning if either home and community-based services or nursing facility services are not provided in less than 120 days."[93] The process by which this is determined is set forth in the definition of "imminent risk" in the manual for the

[87] Of the Plaintiffs discussed herein, only Rickii Ainey lives in one of the areas served by the PACE program, and she is only 37 years old.
[88] Eley deposition p. 89, line 7 – p. 91, line 13.
[89] Eley deposition p. 82, lines 5-23.
[90] Eley deposition p. 93, line 19 – p. 94, l. 13; p. 95, lines 8-25; Doc. 59, p. 38.
[91] Eley deposition p. 34, lines 4-8.
[92] Eley deposition p. 132, l. 16 – p. 133, l. 6.
[93] 34 LAC 50 XV §12905, *Louisiana Register*, v. 30 no. 12 December 2004, p. 2831.

screening process for LT-PCS.[94] This requires the administration of stringent criteria set forth in p. 7 of Exhibit 19.[95]

When the LT-PCS program was started as a result of the *Barthelemy* case, the Settlement Agreement provided that the maximum number of hours was 56. Prior to March of 2009, DHH used a level of services guide that attempted to estimate the actual number of care hours needed to determine how many hours of service recipients of LT-PCS would receive.[96] Defendants do not know and have no opinion as to whether or not the hourly amounts of service were excessive to meet the needs of persons who required assistance with ADL's.[97]

As part of the *Barthelemy* Settlement Agreement, in March of 2009 the Defendants reduced the maximum number of hours in the LT-PCS program to 42. The reduction was necessary to restore the EDA waiver to cost-effectiveness, a requirement of the federal Medicaid statute. 42 U.S.C. §1396n(c)(2)(D).[98] At the same time, the Defendants began using a new assessment and allocation method, known as SHARe.[99] The people in the highest acuity levels were are assigned the highest number of weekly support hours to a maximum of 42.[100] Recipients could appeal their SHARe allocation to get a more hours (to a maximum of 42 hours) if they could show that they needed the hours to avoid going into a nursing home.

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[94] Exhibit 18, Level of Care Eligibility Tool (Eley Deposition Exhibit 2), p. 5.
[95] Exhibit 19, Institutional Risk CAP (Eley deposition Exhibit 3), p. 7. The test for "imminent risk," as modified by DHH, is for the person to show that he or she meets at least *three* of eight specified criteria: (1) has had a prior nursing home placement within last 5 years; (2) does not leave their residence more than once in a typical week in the last 30 days before the assessment; (3) urinary incontinence; (4) neurological diagnosis (Alzheimer's, dementia, head trauma, or multiple sclerosis); (5) a functional decline in the last 90 days; (6) loss of ability to care for oneself (bathing, dressing, personal hygiene); (7) a sudden change in mental functioning, or (8) neither meal preparation nor shopping occurred in the last week. People who are seeking to enter a nursing home are screened using the LOCET, but do not have to show that they meet the "imminent risk" criteria in order to qualify for nursing home services. Eley deposition p. 132, line 16 – p. 133, line 6; p. 138, line 14 – p. 141, line 2; p. 148 lines 17-23.
[96] Doc. 1949, p. 15; Eley deposition p. 155 l. 2 – p. 156 l. 17.
[97] Eley deposition p. 155, l. 18 – p. 158, l. 10.
[98] Eley deposition p. 66, line 5 – 67, line 17; p. 119, line 25 – p. 120, line 7.
[99] Eley deposition p. 158, line 16 – 159, line 4. The new allocation methodology used data derived from Exhibit 20, the MDS-HC, to identify recipients' need for support in conducting activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The MDS-HC assessment generates a score that assigns the individual to one of seven Resource Utilization Groups. Some of the groups have subgroups. Each group and subgroup is then assigned a range of weekly support hours.
[100] Eley deposition p. 207, lines 5 – 9.

The reduction of the maximum from 42 to 32 in September of 2010 was not based on any data regarding the weekly LT-PCS needs of the eligible population.[101] In fact, Defendants have no data on how many hours of care that people eligible for LT-PCS might actually need to live safely in the community and to avoid unnecessary institutionalization in a nursing home.[102] They are unaware of any studies, analyses, or data on how many hours of personal care people who are eligible for LT-PCS actually need to live in the community. Defendants have not collected any such data, nor has it tried to collect information even on how long it takes people with disabilities to perform ADLs.[103] Defendants are unaware of any studies that correlate unmet need for home care with increased risk of institutionalization. [104]

Defendant Department of Health and Hospitals in September of 2010 also adopted a different method to determine how many hours of LT-PCS a person could receive.[105] DHH began using an "ADL Index."[106] People who will be eligible to receive the highest number of hours of LT-PCS under this new methodology must score at least a 14 on the ADL index.All persons in the highest category in the ADL index must need actual physical assistance even to move in bed, eat food placed in front of them, go to the toilet, *and* move from a bed to a chair. For more than one of these activities, they must need weight-bearing support to complete these basic tasks.[107]

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[101] Eley deposition p. 160, lines 22-25.
[102] Eley deposition p. 152 l. 23 – p. 153 l. 1; Response to Request No. 5 of Plaintiffs' First Set of Requests for Production of Documents.
[103] Eley deposition p. 149, line 6 – p. 150, line 17.
[104] Eley deposition p. 151 lines 1-4.
[105] Plaintiffs are not challenging the change in allocation methodology in this case.
[106] Doc. 1949, p. 2; Exhibits 21 and 22 (Eley deposition exhibits 4 and 5); Eley deposition p. 164, l. 3-p.172, l. 7; Exhibit 16, p. 2, items 7 and 8.
[107] The ADL index is constructed based on only four activities of daily living: (1) Mobility in bed: including moving to and from lying position, turning side to side, and positioning body while in bed; (2) Transfer—including moving to and between surfaces—to/from bed, chair, wheelchair, sanding position [Note—Excludes to/from toilet]; (3) Eating including taking food by any method, including tube feedings. It does not include "meal preparation" ("planning meals, cooking, assembling ingredients, setting out food and utensils") which is an "IADL." (4) Toilet use—including using the toilet room or commode, bedpan, urinal, transferring on/off toilet, cleaning self after toilet use or incontinent episode, changing pad, managing any special devices required (ostomy or catheter) and adjusting clothes. Exhibit 20, MDS-HC, p. 3, Section H ("ADL Self-Performance, cont") items H(2)(a)(b)(g) and (h); Exhibit 21.

Charlene Harrington, Ph.D., R.N., F.A.A.N., is a nationally-recognized expert in care needs of persons with disabilities. Her teaching and research at the University of California, San Francisco, has been focused on long term care, nursing homes, managed care, and home and community based programs, with primary emphasis on Medicaid-funded programs.[108] She has published widely, has been principal investigator on major government projects dealing with care for people with disabilities and the elderly, and has co-authored two scholarly publications on the unmet needs for personal assistance services and how to estimate the need for personal assistance services for people with disabilities. She has done research for the Centers for Medicare and Medicaid Services and has been an expert for the U.S. Department of Justice.[109]

Dr. Harrington examined the Defendants' evaluations of the named plaintiffs. Her declaration states that the national mean number of personal assistance hours received by persons like Helen Pitts and Kenneth Roman who require assistance with three ADL's, is 59.6 per week to remain safely and appropriately in the community. For persons like Denise Hodges, who requires assistance with four ADL's, the national mean number of hours of personal assistance hours received is 85.9 per week. For persons like Rickii Ainey, who requires assistance with four or five ADL's, the national mean number is 118.5 hours per week. Clearly, 32 hours per week is far below the number of hours of care that these, and similarly-situated, individuals need to avoid the risk of institutionalization and reside in the community.[110]

Mitchell LaPlante, Ph.D. a national expert in personal assistance needs of persons with disabilities has testified before Congress, conducted numerous studies and done extensive

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To score a 4 in any area, a person must need "extensive assistance," "maximal assistance," have "total dependence," or have not had the activity occur at all, in the last three days. Exhibit 20, MDS-HC, p. 2, Section H, Item 2 ("ADL Self-Performance" pp. 2 and 3, items H(2)(a)(b)(g) and (h).

A maximum of 3 points is given for needs for assistance in eating, while each of the other ADL needs can earn 4 points each. Therefore, mathematically, to qualify for the new maximum of 32 hours, a person would have to score at least 4 in two of these areas, and 3 in two others; or 4 in three areas, and 2 in one other. Exhibit 21; Exhibit 20, MDS-HC, p. 2, Section H, Item 2 ("ADL Self-Performance") Exhibits 21 and 22 (Eley deposition exhibits 4 and 5); Eley deposition p. 164, l. 3- p.172, l. 7.

[108] Exhibit 23, Declaration of Charlene Harrington ("Harrington decl.") ¶¶ 1-4.

[109] Harrington decl, ¶¶ 5-13, 20.

[110] Harrington decl. ¶¶14-19.

research on the effects of unmet needs of individuals with disabilities for personal care services. When elderly and disabled individuals in need of personal care assistance do not have adequate levels of help, they experience adverse consequences such as experiencing significant discomfort and risk (for example, by going hungry), wasting (losing weight unintentionally and dehydration), injuries due to falls, burns, bedsores, and contractures.[111] These problems are especially acute for people like the named plaintiffs who live alone. Such individuals "are highly vulnerable and their more detached informal networks do not compensate for lack of access to or reductions in public services." Inadequate levels of help reduce the ability of people with disabilities to live independently and increases their risk of institutionalization and death. Dr. LaPlante goes on to detail the consequences of inadequate levels of assistance:[112]

> Unmet needs are especially serious for persons needing help with activities of daily living ("ADL's") such as when individuals go unbathed, remain in the same clothing for an extended period, are left in a bed or chair longer than is acceptable, or are unassisted when they need to go to the bathroom or eat. These activities involve satisfying primary biological functions that, if not fulfilled, cannot be tolerated for long and have immediate and serious consequences leading to death, institutionalization, injury, or worsening health.

Research has established a link between unmet need in ADL's and increased risk of death in older persons with dementia; increased risk of being admitted to a nursing home; and rates of hospital admission; and depression.[113]

Comparisons with Other States

Defendants' comparisons of Louisiana's LT-PCS maximum to programs in other states (Eley declaration ¶43) ignore critically important differences between HCBS in other states and those in Louisiana. For example, Defendants did not compare the eligibility criteria for LT-PCS in other states to Louisiana's. They did not know if those other states require a nursing facility level of care, or imminent risk of institutionalization, as Louisiana does. [114]

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[111] Exhibit 24, Declaration of Mitchell Laplante ("Laplante decl.") ¶7.
[112] Laplante decl. ¶10.
[113] Laplante decl. ¶¶ 11, 12, 14, and 15.
[114] Eley deposition p. 174, l. 20 - p. 175 l. 9.

Further, a State plan personal care option is only one part of a State's HCBS program.[115] Some States use the personal care option as their main vehicle to provide home and community-based services, and some States use waivers as their main program to provide these services. In comparing Louisiana's offerings in the LT-PCS program to other states', Defendants did not consider what those other states offered in the way of waiver services.[116] They did not compare the waiting lists for the waivers in those states with the waiting lists for Louisiana waivers.[117]

In fact, in 2007, Louisiana served 8,625 in its LT-PCS program, but Arkansas served 14,223, Michigan 57,980, Texas 59,025, and North Carolina 49,877. [118] In 2007, Louisiana served 3,806 people in its waivers for the aged and disabled, while Arkansas served 9,249, North Carolina served 14,502, and Texas served 53,770 individuals.[119]

In 2009, Louisiana had 14,163 on waiting lists for its aged and disabled adults waivers, while Arkansas, the District of Columbia, Nebraska, and Oregon had no waiting lists; Maine had only 107 people on its waiting list, Montana had 600, and Texas had 745,058.[120]

In 2009, Louisiana was ranked 38th in per capita spending on home- and community based waivers for the aged and disabled, expending only $15.85 per capita.[121] Arkansas ranked 19th, Texas 29th, North Carolina 23rd, District of Columbia 2d, and Idaho 8th. Their respective per capita expenditures were: Arkansas $35.05, Texas $21.29, District of Columbia $116.26, and Idaho $57.29.[122]

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[115] Eley deposition p. 173, l. 5-9.
[116] Eley deposition p. 174, l. 1-11.
[117] *Id*. lines 16-19
[118] Exhibit 26, Kaiser Commission, Medicaid and the Uninsured. Medicaid Home and Community-Based Service Programs: Data Update, February, 2011 at p. 19, Table 1C.
[119] *Id*. at p. 34, Table 5.
[120] *Id*. at p. 40, Table 11.
[121] Exhibit 27, Thompson Reuters, Medicaid Long-Term Care Expenditures in FY 2009 at Table I
[122] *Id*.

Disproportionate Reductions in Home- and Community Based Programs

Defendants have not demonstrated that the reduction in the maximum hours of service in the LT-PCS program to a maximum of 32 hours a week, with no exceptions for persons who require more than 32 hours to avoid institutionalization, is necessary for budgetary reasons.

The LT-PCS program is cost-effective. Its participants must meet the level of care for a nursing facility and, if they went into a nursing home, the State would have to pay the Medicaid per diem to the nursing home proprietor. Instead, participants in the LT-PCS program receive services in their own homes. The average cost of services for a person on the LT-PCS program only is considerably less than the cost of maintaining a person in a nursing facility, and it has been so since the inception of the program.[123]

Defendants claim (Memorandum at p. 21) that the reduction of LT-PCS will save $5 million annually. However, while the State is slashing spending for LT-PCS, it is *increasing* spending on nursing facilities. Nursing home rates have increased in every year since SFY 2003, even as numbers of individuals served in nursing homes have steadily declined.[124] In SFY 2011, the nursing home Medicaid per diem reimbursement was increased by approximately $8 per patient per day.[125] The State's Medicaid report shows that private nursing facilities were paid $737,529,166 in SFY 2010[126] and were estimated to receive $801,550,525 in SFY 2011.[127] State-owned nursing homes received another $20,735,439 in SFY 2010, and were allocated $20,857,156 in the budget for SFY 2011.[128] This represents an increase of $64,143,076 (8.5%) in a program in which numbers of individuals served have *declined*.

[123] Pitts Doc. 1041; Exhibit 16, p. 2, item 4.
[124] Pitts Docs. 1188 and 44.
[125] Eley deposition p. 215, line 4 – p. 216, line 3.
[126] Pitts Doc. 43.
[127] Pitts Doc. 1487, p. 5.
[128] *Id*., p. 6.

Louisiana has one of the lowest occupancy rates of nursing facility beds of any state in the U.S,[129] yet expenditures on nursing homes continue to increase. Annually, Louisiana's long term care budget includes over $23 million in payments to nursing homes for *empty* nursing home beds.[130]

Home and community based services, on the other hand, have been cut dramatically. Rates paid provider agencies for LT-PCS services (which include all overhead, employers' share of taxes, workers' compensation premiums, training, and recruitment costs, as well as direct care worker salaries[131]), have been reduced 17.4% since February of 2009. In SFY 2006, the reimbursement rate was $12 per hour.[132] In February, 2007, the rate was raised by $2 per hour to increase the wages of direct service workers.[133] In February of 2009, the reimbursement rate was reduced by 3.5%, to $13.51.[134] In August of 2009, the reimbursement rate was again reduced, this time by 4.8%, to $12.86.[135] In August of 2010, the reimbursement rate was reduced by 4.6% to $12.27, and in January of 2011, the rate was reduced by another 5.8% to $11.56.[136]

Defendants have produced no evidence as to the cost of providing services in excess of the 32-hour cap only to those individuals who face a risk of institutionalization as a result of the cap. Defendants have also produced no evidence that in calculating the budgetary effect of the 32-hour cap, they took into account any increased costs in the other long-term care programs, such as nursing home care, the EDA waiver, the ADHC waiver, or PACE, from individuals such as plaintiffs who face institutionalization as a result of the cut.[137] Similarly, Defendants have not

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[129] Eley deposition p. 31, lines 19-21.
[130] Pitts Doc. 1353, Eley deposition p. 220, l. 21 – p. 223, line 5.
[131] Eley deposition p. 213, line 213, line 8 – p. 214, line 7.
[132] Pitts Doc. 1188, Eley deposition p. 19, lines 4-24.
[133] Louisiana Register, V. 34, No. 2 p. 253 (February 20, 2008).
[134] Louisiana Register, V. 35, No. 9 p. 1901 (September 20, 2009).
[135] Louisiana Register, V. 36, No. 2 p. 215 (February 20, 2010).
[136] Louisiana Register, V. 37, No. 1 p. 37-8 (January 20, 2011).
[137] In Exhibit 2, Plaintiffs' First Request for Production of Documents, no. 22, Plaintiffs requested all documents that contain, refer, or relate to estimates of the budgetary effect that the implementation of the Emergency Rule of August 2010, effecting a reduction in the hours of LT-PCS available to recipients from 42, on Defendants' Medicaid expenditures for nursing facilities, the EDA program, the ADHC program, or

included in any cost estimates the effect of reductions in services on hospitalization or emergency room Medicaid expenditures.

Decision-making Process for Reduction in Maximum Hours-

The decision to reduce the maximum hours of LT-PCS that the Plaintiffs could receive from 42 to 32 was not made pursuant to any long-term plan for providing a mix of nursing facility and home and community-based services to Louisiana's population of elderly and disabled adults. Instead, it was made in response to a specific $61 million line-item reduction in the budget for the LT-PCS program in the Executive Budget for SFY 2011.[138] The Office of Aging and Adult Services, the agency that is primarily responsible for developing the overall direction of programs for the A/D population, did not recommend this reduction—in fact, it had recommended an increase in the LT-PCS program for SFY 2011.[139] As late as February 23, 2011, Mr. Eley had no idea where the idea for the reduction originated,[140] At the same time that the Secretary of DHH and the Governor were reversing the Office of Aging and Adult Services on the issue of the LT-PCS budget, they failed to put OAAS's recommendation for an additional 1,000 slots in the EDA waiver in the Executive Budget.[141]

Steve Kaye, a nationally-recognized expert,[142] analyzed trends in Louisiana's long-term care services and compared them to those of other states. Louisiana's per capita expenditures on home- and community-based services, starting from very low spending in 2000, increased above

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the PACE program. Defendants' response (Exhibit 2) invited further discussion. Plaintiffs' counsel corresponded with Defendants' counsel on February 4, asking: "Did DHH make any estimates of the effect the reduction of hours of LT-PCS from 42 would have on the budget for Medicaid expenditures for nursing facilities, the EDA program, the ADHC program, or the PACE program? If so, we are seeking documents related to these estimates."After a discussion, Defendants' counsel responded on February 15 that Defendants had not identified any responsive documents.

[138] Eley deposition p. 195, l. 15 – p. 203, l. 2; Pitts Docs. 3142 and 3121 (redacted by Defendants).

[139] Eley deposition p. 196, lines 14-23.

[140] Eley deposition p. 196, lines 10-11.

[141] Eley deposition, Letter from Caroline Brown, item 3, p. 1.

[142] Exhibit 25, Declaration of H. Stephen Kaye ("Kaye decl.") ¶¶1-3. Dr. Kaye is on the faculty of the University of California San Francisco, Co-Director of the UCSF Disability Statistices Center, is principal or co-principal investigator projects funded by the U.S. Department of Education and the Social Security Administration, has published extensively in peer-reviewed literature on disability issues, and is Chair of the Disability Section of the American Public Health Association.

that of the other southern states and briefly approached the national average in 2009. However, since 2009, Louisiana's expenditures on HCBS have declined, and remain far below the national average.[143] This is also true when the proportion of expenditures on HCBS, as compared with institutional care (for the non-DD population), is compared among states and nationally. Louisiana's proportion of spending on HCBS grew from 2000 to 2009, but has declined sharply since, so that it is now below both the national and the regional average.[144] Louisiana has deviated from the national trend of realizing cost savings on institutional care as HCBS expenditures have increased.[145] Though there has been a large reduction in the institutionalized population in the state, with declines exceeding both the national average and the other states in the South Central region, per capita nursing home expenditure has increased substantially in Louisiana.[146] While other states that have increased their HCBS spending generally saw a commensurate reduction in nursing home expenditures, Louisiana has not succeeded in achieving such savings, because of increases in per-resident nursing home expenditures. Dr. Kaye opines that reducing nursing home spending, in line with already-achieved reductions in nursing home usage, would be more likely to generate savings in overall LTC expenditures than would cuts in HCBS programs, which would probably drive more people into nursing homes.[147]

ARGUMENT

Standard For Summary Judgment

Summary judgment is appropriate when the record discloses "that there is no genuine issue of material fact and that the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c). The moving party bears the burden of identifying those portions of the pleadings and the discovery in the case that demonstrate the absence of a genuine issue of material fact. *Lincoln General Ins. Co. v. Reyna,* 401 F.3d 347, 349 (5th Cir. 2005), *citing Celotex*

[143] Kaye decl. ¶9, Figure 1.
[144] Kaye decl. ¶10, Figure 2.
[145] Kaye decl. ¶¶ 11-13, Figures 3-5.
[146] Kaye decl. ¶¶ 12-14, Figures 6 and 7.
[147] Kaye decl. ¶¶ 15-17.

Corp. v. Catrett, 477 U.S. 317, 325, (1986). "If the moving party fails to meet its initial burden, the motion for summary judgment must be denied, regardless of the nonmovant's response." *Duffie v. United States,* 600 F.3d 362**,** 371 (5th Cir. 2010).

In deciding a summary judgment motion, the court must draw all reasonable inferences in the light most favorable to the nonmoving party. *Id. Citing Anderson v. Liberty Lobby, Inc*., 477 U.S. 242, 255, 106 S. Ct. 2505, 91 L. Ed. 2d 202 (1986). Furthermore, the party opposing a motion for summary judgment does not need to present additional evidence, but may identify genuine issues of fact extant in the summary judgment evidence produced by the moving party. *Lavespere v. Niagara Mach. & Tool Works, Inc*., 910 F.2d 167, 178 (5th Cir. 1990); *Isquith v. Middle South Utilities, Inc*., 847 F.2d 186, 198-200 (5th Cir. 1988). The evidence of the nonmovant is to be believed, with all justifiable inferences drawn and all reasonable doubts resolved in his favor. *Groh v. Ramirez*, 540 U.S. 551, 562, 124 S. Ct. 1284, 157 L. Ed. 2d 1068 (2004).

1. Analytical Framework

In *Olmstead v. L.C.*, 527 U.S. 581, 598-603 (1999), the Supreme Court held that unjustified institutional isolation of persons with disabilities is a form of discrimination based on disability. Thus, public entities must make *reasonable* accommodations in policies, practices and procedures regarding the services that they provide to avoid such discrimination. *Id*. at 603-606. They are not required to make modifications that constitute "fundamental alterations" of their programs. *Id*.

In the instant action, the ADA requires Defendants allow persons who need more than 32 hours of personal care services in order to avoid institutionalization to receive those services. It is important to note that plaintiffs are not seeking to enjoin reductions in the LT-PCS program to *all* recipients in the LT-PCS program — only those reductions to people who will be put at risk of unnecessary institutionalization by the reduction.

Defendants do not contest the fact that Plaintiffs are qualified persons with disabilities,

who can appropriately be served in the community. Neither do they contest Plaintiffs' claims that these reductions, if applied to them and to others like them, place them at risk of having to move into institutions to receive care.[148] Indeed, Defendants' motion assumes the truth of Plaintiffs' allegations that the named Plaintiffs and class members will be forced into institutions to receive the services they are currently receiving in the community. *See* Defendants' Memorandum at 20, "The complaint alleges that Plaintiffs are likely to require institution-based services but those allegations, even if true, do not constitute discrimination"; and "…a State does not violate the ADA's antidiscrimination principle solely because some qualified individuals who prefer HCBS might instead receive services in institutional settings."

Defendants' Memorandum misunderstands the ADA, ignores the Supreme Court's *Olmstead* decision, and misstates the parties' burdens of pleading and proving discrimination.

2. Plaintiffs have established a violation of the ADA and the Rehabilitation Act by showing that they will be unnecessarily institutionalized.

Far from establishing, as Defendants contend in their Memorandum at 2, that in challenges like this one, "the court is not to look at individual plaintiffs or a single aspect of the State's program but rather the entirety of the State's program…," *Olmstead* and its progeny make it clear that individuals with disabilities, who could appropriately be served in the community and are placed unnecessarily at risk of institutionalization by a State's policies, establish discrimination under the ADA unless the State demonstrates that to provide services to them in the community would entail a fundamental alteration of its programs. *See, e.g.*, *Radaszewski v. Maram,* 383 F.3d 599, 614-15 (7th Cir.2004); *Ball v. Rogers*, No. 00-67 (D. Ariz. April 24, 2009)

[148] Defendants do point out that one of the named plaintiffs, Denise Hodges, by virtue of the fact that she has already been on the waiting list for the EDA waiver since September 11, 2007, will soon be offered an EDA waiver slot and therefore will be able to access additional services. Since Defendants' motion was filed, she and one of the other named Plaintiffs, Helen Pitts, and class member Cleo Lancaster, have also been offered waiver slots by virtue of their having already been on the EDA waiting list for more than three years. However, it takes 60 to 90 days after a slot is offered and accepted for services to begin. Defendant has not established that these persons have received approval for their EDA services to begin. When and if they do, their claims in this case will be moot. Yet other named plaintiffs, and many class members, will continue to be at risk.

(holding that defendants' failure to provide adequate services to avoid unnecessary institutionalization was discriminatory); *Makin v. Hawaii*, 114 F. Supp. 2d 1017, 1034 (D. Haw. 1999) (holding that individuals in the community on the waiting list for community-based services offered through the State's Medicaid program, could challenge administration of the program as violating Title II's integration mandate because it "could potentially force Plaintiffs into institutions"); *M.A.C. v. Betit*, 284 F. Supp. 2d 1298, 1309 (D. Utah 2003) (ADA's integration mandate applies equally to those individuals already institutionalized and to those at risk of institutionalization); *Crabtree v. Goetz*, No. 3:08-0939, 2008 WL 5330506, at *30 (M.D. Tenn. Dec. 19, 2008) (unpublished decision) ("Plaintiffs have demonstrated a strong likelihood of success on the merits of their [ADA] claims that the Defendants' drastic cuts of their home health care services will force their institutionalization in nursing homes"); *see also Brantley v. Maxwell-Jolly*, 656 F. Supp. 2d 1161,1164 (N.D. Cal. 2009); *Cota v. Maxwell-Jolly*, 688 F. Supp. 2d 980, 985 (N.D. Cal. 2010); and *V.L. v. Wagner*, 669 F. Supp. 2d 1106, 1109 (N.D. Cal. 2009) (all granting preliminary injunctions where plaintiffs were at risk of institutionalization due to cuts in community-based services).

3. Plaintiffs have established a violation of the ADA and the Rehabilitation Act by showing that Defendants' implementation of budget cuts discriminates against those LT-PCS recipients based on the severity of their disabilities.

Further, Defendants reduction of the maximum number of hours from 42 to 32 disproportionately affects people who receive close to 42 hours a week. While the average reduction that LT-PCS recipients will receive is 3 hours a week, recipients with the greatest needs for services face cuts of 7 or more hours a week. These are the people whose current allocation of service hours is greatest because their "acuity level"—the extent of their disabilities—is greatest. The way in which these cuts are being implemented thus discriminates against LT-PCS recipients based on the severity of their disabilities, in violation of the ADA. *See Clark v. Cohen,* 613 F.Supp. 684, 693 (E.D.Pa.1985) (holding that a claim of a denial of access to a program based on the relative severity of disability qualifies under section 504); *Jackson by Jackson v.*

Fort Stanton Hospital and Training School, 757 F.Supp. 1243 (D.N.M.), *rev'd in part on other grounds,* 964 F.2d 980 (10th Cir.1992) (holding the failure of community programs for people with developmental disabilities to accommodate the "severely handicapped" while serving less severely handicapped persons stated a claim under section 504); *Plummer by Plummer v. Branstad,* 731 F.2d 574, 578 (8th Cir.1984) (same); *see also Wagner v. Fair Acres Geriatric Center*, 49 F. 3d 1002 (3d Cir. 1995).

4. Plaintiffs and class members have no practical alternatives to nursing facility admission.

While Defendants assert that it has other, comprehensive programs for persons who need more than 32 hours a week of personal care for ADL's, these programs are not in fact available to many class members. People who are living in the community are not able to access Defendants' other programs (e.g., EDA, ADHC, PACE) without lengthy waits. Though it may be possible to shorten this wait time if they enter a nursing facility and remain there for 90 days, they will still not be guaranteed adequate community services on the 91st day. What they will have is "priority" for the next available waiver slot.

To the extent that Defendants' policy forces Plaintiffs to physically enter a nursing facility as a condition of receiving the same services they have been receiving in the community, it.violates the ADA. The Tenth Circuit, in *Fisher v. Oklahoma Health Care Auth.*, 335 F. 3d 1175, 1181 (10th Cir. 2003), rejected the defendants' argument that plaintiffs could not make an integrate mandate challenge until they were placed in the institution, reasoning that the protection of the integration mandate, 28 C.F.R. §35.130(d):

> ..would be meaningless if plaintiffs were required to segregate themselves by entering an institution before they could challenge an allegedly discrimination law or policy that threatens to force them into segregated isolation. ..[W]hile it is true that plaintiffs in *Olmstead* were institutionalized at the time they brought their claim, nothing in the *Olmstead* decision supports a conclusion that institutionalization is a prerequisite to enforcement of the ADA's integration requirements..

Congress did not intend that a person must wheel into the nursing facility in order to demonstrate to the State they want community-based services instead of institutional services.

In *Fisher*, the Court concluded that "*Olmstead* does not imply that disabled persons who, by reason of a change in state policy, stand imperiled with segregation, may not bring a challenge to the state policy under the ADA's integration mandate without first submitting to institutionalization." *Id* at 1182. *See also M.A.C. v. Betit*, 284 F.Supp. 2d 1298,1309 (D.Utah 2003), *Brantley v. Maxwell-Jolly,* 2009 WE 2941519,*7 (N.D.Cal. Sept. 10, 2009); *Haddad v. Arnold*, Case No. 3:10-cv-414-J-99-MMH-TEM, at DE #49 (M.D. Fla. July 9 2010); *cf. Long v. Benson*, 2008 WL 4571903 (N.D. Fla. Oct 14, 2008), *aff'd* 2010 WL2500349 (11th Cir.2010).

5. The modification that Plaintiffs propose is a reasonable accommodation.

The modification that Plaintiffs propose is that they, and others in the class, be permitted to retain their hours of LT-PCS, which they have already been receiving, to the extent that the receipt of those hours of service is necessary to prevent their institutionalization. Again, Plaintiffs wish to emphasize that this does not necessarily mean that *no one* will be subject to the 32-hour maximum—only that those individuals who would be placed at risk of institutionalization as a result of such reductions should be able to receive the services necessary to maintain their independence.

Defendants have failed to establish that there are no material issues of fact in dispute and that they are entitled to summary judgment on reasonableness of Plaintiffs' requested accommodation. They do not argue that Plaintiffs or other LT-PCS recipients should have their services reduced because they are receiving services in excess of their needs.

Plaintiffs are not seeking a new service, as were the plaintiffs in *Rodriguez v. City of New York*, 197 F. 3d 611 (2d Cir. 1999), or seeking to require Defendants to request new slots on their waiver programs, as were the plaintiffs in *ARC of Washington State v. Braddock,* 427 F.3d 615 (9th Cir. 2005). Plaintiffs are simply seeking to be allowed to keep the services that Defendants have been and are currently providing, because those services are vital to their ability to continue to live independently in the most integrated setting, 28 C.F.R. §35.130(d).

Plaintiffs' ADA claims are very similar to those in *Fisher v. Oklahoma Health Care*

Authority, 335 F.3d 1175 (10th Cir. 2003), in which plaintiffs living in the community sought to retain pharmacy benefits that they already had, and to avoid having to enter a nursing home in order to receive the same services they could be and were receiving in the community. The *Fisher* Court held it was not clear "why the preservation of a program as it has existed for years and as approved by the federal government would 'fundamentally alter the nature' of the program." *Id*. at 1183.

Defendants cite examples of other states that they allege either do not offer LT-PCS as part of their State plan at all, or that have such services capped at less than 32 hours a week.[149] However, these comparisons ignore important differences between the home and community based service programs in the other states and in Louisiana, such as eligibility criteria for the personal care program, the existence and ready availability of alternative programs, and overall expenditures on HCBS. These differences present clear factual disputes regarding the extent to which Louisiana compares favorably with other states. But more importantly, without a showing that these other states are in compliance with the Americans with Disabilities Act's integration mandate, such comparisons are not probative on any material issue.

6. Defendants have not proved an affirmative defense.

In order to avoid liability under the ADA and Section 504, Defendants must establish, as an affirmative defense, that the requested relief is not a reasonable accommodation but a fundamental alteration. *See Olmstead*, 527 U.S. at 604; *Frederick L. v. Dep't of Pub. Welfare*, 364 F.3d 487, 492 n. 4 (3d Cir. 2004); *Townsend v. Quasim*, 328 F.3d 511, 520 (9th Cir. 2003); *Disability Advocates, Inc. v. Paters*on, 598 F.Supp.2d 289 (E.D. N.Y. 2009); *Joseph S. v. Hogan*, 561 F. Supp. 2d 280, 293 (E.D.N.Y. 2008); *Messier v. Southbury Training Sch.,* 562 F.Supp.2d 294, 323 (D.Conn.2008); *Makin v. Hawaii*, 114 F. Supp. 2d 1017, 1034 (D. Haw. 1999). *C.f. Johnson v. Gambrinus Company/Spoetzl Brewery*, 116 F. 3d 1052, 1059-60 (5th Cir. 1997) (in an ADA Title III case, plaintiff bears burden of introducing evidence of accommodation that is

[149] See Defendants' Memorandum at 22 and Eley decl, Doc. 11-2 ¶43.

reasonable "in the general run of cases"; burden then shifts to defendant to plead and prove that the requested modification would fundamentally alter the nature of the public accommodation: "The type of evidence that satisfies this burden focuses on the specifics of the plaintiff's or defendant's circumstances and not on the general nature of the accommodation.")

A. DHH does not have an "effectively working plan"

The *Olmstead* Court's delineation of defenses to unjustified institutionalization claims was in the context of a claim by two individuals who were institutionalized and were on a waiting list for waiver services. The two Plaintiffs argued that, because the cost of providing services in the community was less than the cost of institutional services, it could not be a "fundamental alteration" of the State's programs for them to receive community-based waiver services rather than remain on a waiting list. It was in that context that the Court stated that a State could avoid liability by demonstrating that it had "a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated."[150] If there was a plan to address the needs of institutionalized people on waiting lists and if the waiting list moved at a "reasonable pace," then the modifications the *Olmstead* plaintiffs suggested would entail a fundamental alteration of those plans.

The instant action presents a very different situation. Here, the named plaintiffs and class members are not institutionalized and do not request to move ahead of others on the waiting lists for waiver services. They are simply seeking to maintain the services that they already have in the community through the LT-PCS program. Thus, to constitute an affirmative defense to plaintiffs' claims, Defendants' plans would need to address persons with disabilities who are in the community and at risk of institutionalization, and the services necessary to prevent this.

Defendants point to two documents as constituting their "*Olmstead*" plans. (1) A

[150] *Olmstead*, 527 U.S. at 601-03.

document entitled "Plan for Immediate Action," developed in 2005,[151] which it states was a "first step" that "sought to identify the key system components and hallmarks that States must have in place if they are to rebalance their long-term care systems and provide a choice between institutionally-based and community-based long-term care services;" and (2) a 2007 document entitled "Louisiana's Plan for Choice in Long-Term Care,"[152] which outlines a number of "concrete steps" to be implemented over several year period. Defendants claim that the existence of these documents, and the fact that home- and community-based services have greatly increased since Louisiana's near-total reliance on institutions in 2000, constitutes a complete defense to Plaintiffs' request for a reasonable modification in its program to prevent their unjustified and unnecessary institutionalization.

These documents do not establish an affirmative defense to Plaintiffs' claims for three reasons. First, they do not actually contain plans for maintaining qualified persons with disabilities in community settings. They do not even articulate meaningful, measurable goals for actually providing adequate community services. Second, they are not "effectively working." Sufficient services continue to be unavailable and waiting lists continue to be unreasonably long and continue to grow. Finally, and perhaps most importantly in this case, the actions that Plaintiffs are challenging here are not part of these plans. If anything, the reduction in LT-PCS contravenes the goals and strategies set forth in the plans.

Lack of specificity:

While Defendants' plans pronounce a commitment to the goal of allowing people to choose to receive long-term care in the community rather than in institutions, they do not actually set forth a plan to achieve that goal. They do not address specific programs, like the LT-PCS program, or the question of how people who cannot continue to survive in the community with

[151] Exhibit 2, Defendants' Response to Plaintiffs' First Set of Requests for Production of Documents, Request 6; Pitts Doc. 256
[152] Pitts Doc. 216.

only 32 hours of LT-PCS can be enabled to continue to live at home, rather than in institutions.[153] They do not even estimate the funding that would be needed to provide the services necessary to sustain such individuals in the community.[154] The only time that the 2005 "Plan for Immediate Action" refers to the lengthy waiting list for waiver services for the aged and disabled population is when it states that it cannot include a recommendation for "allocating funding for all people currently on home and community-based waiver waiting lists," because that would be inconsistent with the requirement that the plan be "budget neutral."[155] The only reference to waiting lists or registries in Louisiana's Plan for Choice for Long Term Care is a "Major Action Step" listing: "Develop strategies to address management of the Request for Services Registry."[156]

A fair reading of the plans and of updates to the plans,[157] reveals that they do not set forth plans for actually achieving the stated goal of permitting people who meet a nursing facility level of care to choose community-based services over institutional services.

Cases subsequent to *Olmstead* have held that to demonstrate a "comprehensive, effectively working plan" as an affirmative defense to a claim of unjustified institutionalization requires more than simply introducing a document styled as a plan. For example, in *Frederick L. v. Dep't of Pub. Welfare* (*Frederick L. II*), 422 F.3d 151 (3d Cir. 2005), the Third Circuit held that to constitute a defense under *Olmstead*, a State plan had to "adequately demonstrate a reasonably specific and measurable commitment to deinstitutionalization for which [the state] may be held accountable." *Id*. at 157. Though the State had a plan, it was insufficient because:

> DPW remains silent as to when, if ever, eligible patients at NSH can expect to be discharged. Instead, DPW proffers general assurances and good faith intentions to effectuate deinstitutionalization. General assurances and good-faith intentions neither meet the federal laws nor a patient's expectations. Their implementation may change

[153] Eley deposition p. 182, lines 4-13.
[154] Eley deposition p 183 line - p. 184, line 5.
[155] Doc. 256, Plan for Immediate Action, p. 15-16, item 4.
[156] There are other references in this document to "Direct Service Worker" or "DSW" registries. These are workforce listings, not lists of people waiting for community services.
[157] Pitts Docs. 26 and 31.

> with each administration or Secretary of Welfare, regardless of how genuine; they are simply insufficient guarantors in light of the hardship daily inflicted upon patients through unnecessary and indefinite institutionalization. Thus, notwithstanding any announced commitment to deinstitutionalization, DPW's failure to articulate this commitment in the form of an adequately specific comprehensive plan for placing eligible patients in community-based programs by a target date places the "fundamental alteration defense" beyond its reach.

Id. at 158-59. See *Haddad v. Arnold*, supra at 34 (holding that an effectively working plan, would need to show more than the fact that other programs had increased in size and expenditures but would have to address the effectiveness of the particular program available to the plaintiff).

Louisiana's plans have far less substance than the plans found lacking in *Frederick L.*[158] Its "outcomes/indicators" are mostly lists, reports, and communications with "stakeholders." The only "outcome or indicator" that calls for actual services to persons with disabilities is utterly non-specific: under the fourth objective, one "outcome/indicator" is "implementation of services that are currently under development." What those services are, to whom they will be available, and when—all are significantly absent from the plan.

There is nothing inherently wrong with Defendants' having plans of this nature, but such documents cannot serve as a defense to claims of unjustified institutionalization.

Plan is not "effectively working":

Not surprisingly, these plans have not resulted in the provision of adequate services to prevent institutionalization of people in the named plaintiffs' situation. The waiting list for people in the community to access the most comprehensive service, the EDA waiver (except "documented cases of abuse and neglect" and people with ALS), is over 41 months long. Alternative programs, such as the ADHC waiver and the PACE program, are not available

[158] The section dealing with Aging and Adult Services in "Louisiana's Plan for Long-term Care," Pitts Doc. 216, pp. 13-15, states as its goal: "to provide affordable, accessible, timely, and customer-driven supports and services to the elderly and persons with adult onset disabilities in a variety of settings." Placement of persons with disabilities in less restrictive settings, or diverting them from institutions via the provision of adequate community services is not even a stated goal. Under the stated goal of providing timely services in a variety of settings, there are four "objectives": (1) assess the current array of supports and services to identify gaps and evaluate for effectiveness; (2) identify, evaluate and propose new or improved services and supports consistent with the stated goal; (3) develop a strategy to address barriers and obstacles to implementation, access, and use of new and improved services; and (4) implement new or improved services consistent with the stated goal.

statewide. The ADHC waiver has a waiting list that is almost 6 months long. People may access these waivers sooner if they enter a nursing home for services, but Defendant has recently passed a rule that even people in nursing homes must wait three months before gaining priority for waiver services. Once they are offered a waiver slot, it takes another 60 to 90 days, or more, for community services to begin.

LT-PCS reduction is not included in plans:

Finally, it would not make sense to permit Defendants to use these plans as a defense to Plaintiffs' claims unless they show, at the least, that the LT-PCS reduction was contemplated in those plans or is at least consistent with them. Defendants do not and cannot make such a showing. When these plans were developed in 2005 and 2007, people in Plaintiffs' position were entitled to access up to a maximum of 56 hours a week of LT-PCS. Neither of these plans, nor any updates, mention the reduction in available hours to a maximum of 32, with no exceptions for people who may be institutionalized without more services. They do not discuss budget cuts in LT-PCS, decreases in reimbursement rates to providers of LT-PCS, increases in reimbursement to nursing homes, or decreases in the proportion of the long term care budget devoted to home- and community-based services.

7. Defendants have not shown that to grant the modification Plaintiffs request would be inequitable

The fundamental alteration defense under *Olmstead* permits Defendants to demonstrate that, despite the fact that the challenged action puts Plaintiffs at risk of unnecessary institutionalization, it would be inequitable to grant the reasonable accommodation. Defendants cannot show that the modest accommodation Plaintiffs request—the maintenance of services to those LT-PCS recipients who would be placed at risk of institutionalization if the maximum were enforced as to them--would be in any way inequitable.

Defendants do not actually substantiate their claim that the "change" Plaintiffs are requesting would cost the State "close to $5 million annually." Defendants' Memorandum at 21.

Defendants have produced no evidence regarding the number of people, out of the approximately 3,000 who currently receive services above the 32-hour-a-week level, that will be actually placed at risk of institutionalization as a result of the cuts. Many of them will probably *not* be placed at risk because the cuts they will receive may be minimal (e.g., from 33 to 32 hours a week), or because they have family members or other unpaid caregivers who can and will make up the reduced hours. Without any evidence of the actual cost of allowing only those persons placed at risk of institutionalization to retain their service, Defendants cannot assert that they have established an affirmative defense.

Further, Defendants have not included the cost of institutionalizing Plaintiffs or other class members in any of their estimates of the cost of continuing to provide LT-PCS to them in excess of 32 hours a week. LT-PCS costs are far less than nursing facility costs.[159] Assuming, *arguendo*, a person presently receives the maximum of 42 hours of LT-PCS a week, at the current provider rate of $11.56 per hour it costs the State $485.52 per week or $25,247 per year. The average cost of providing care to a Medicaid recipient in a nursing facility, on the other hand, is $37,480.[160] By failing to even consider the cost of providing services to Plaintiffs and class members in nursing facilities, Defendants have ignored one side of the cost equation and stacked the deck.

Even if the modification Plaintiffs request to prevent their unnecessary institutionalization did cost "close to $5 million annually," as Defendants assert, that alone would not establish that to provide them with this relief would be inequitable. Budgetary constraints, taken alone, are not enough to establish a fundamental alteration defense. *Pa. Prot. & Advocacy, Inc. v. Pa. Dep't of Public Welfare*, 402 F.3d 374, 381 (3d Cir. 2005). As the Court of Appeals for the Tenth Circuit stated, in rejecting Oklahoma's argument that its limitation on a prescription drugs for people receiving services through a Medicaid HCBS waiver in the community (while

[159] Pitts Doc. 44; Exhibit 16, item 4, p. 2.
[160] Pitts Doc. 1687, p. 3, item h.

providing unlimited prescriptions to nursing home residents) was necessary because of the state's fiscal crisis:

> [T]he fact that Oklahoma has a fiscal problem, by itself, does not lead to an automatic conclusion that preservation of unlimited medically-necessary prescription benefits ... will result in a fundamental alteration .... *If every alteration in a program or service that required the outlay of funds were tantamount to a fundamental alteration, the ADA's integration mandate would be hollow indeed.*

Id. at 1182-83 (*emphasis added*); see also *Radaszewski*, 383 F.3d at 613-15; *Crabtree v. Goetz*, 2008 WL 5330506 at *26; *Messier v. Southbury Training Sch*., 562 F.Supp.2d 294, 323, 345 (D.Conn.2008); *Cota v. Maxwell-Jolly*, 688 F.Supp. 2d 980, 995 (N.D. Cal. 2010).

On the contrary, the evidence before the Court suggests that it is the cut in LT-PCS that is inequitable. The LT-PCS program is in demand and has been steadily growing. The people served by the LT-PCS program have to meet criteria for care in a nursing facility—in fact, they have to meet are additional objective criteria that as to "imminent" or "institutional" risk, that persons seeking services in a nursing home do not have to meet.

There is no reason to believe that people in the program are utilizing more services than they need. The reduction in hours came about strictly in response to a budget cut targeted specifically at the LT-PCS program by someone in either the office of the Secretary of DHH or the Governor's office. The Office of Aging and Adult Services—the agency responsible for all long term care services, both in nursing facilities and in the community-- did not propose this cut and in fact proposed increases in the program.

In contrast, the number of persons in nursing facilities has been steadily declining, both in Louisiana and nationally. Louisiana's nursing home occupancy rate is only 72%--among the lowest, if not the lowest, in the nation.[161] Despite the fact that this program is serving fewer and fewer people, the nursing facility budget, the per capita cost of nursing facility services, and the

[161] Pitts Doc. 1484. Annually, payments to nursing homes include payments for empty nursing facility beds that total more than $23 million. Pitts Doc. 1353; Eley deposition p. 220, l. 21 – p. 223, line 5.

average nursing facility reimbursement rates have increased in SFY 2011 as in previous years, while rates to LT-PCS providers were cut drastically and maximum hours of service reduced from 56 to 32 hours a week over a two year period. In the same year that LT-PCS was targeted for a $61 million reduction in Medicaid reimbursements, nursing facilities received an increase in their Medicaid budget of over $48 million. The reduction in LT-PCS services, with no exceptions, will force people like the Plaintiffs into more expensive, as well as more segregated nursing homes..

CONCLUSION

Defendants have failed to carry their burden of demonstrating that there are no issues of material fact and that they are entitled to judgment as a matter of law on Plaintiffs' claims. Plaintiffs therefore request that Defendants' Motion to Dismiss (converted to a Motion for Summary Judgment) be denied.

Date: March 9, 2011.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on March 9, 2011, a copy of the foregoing was filed electronically with the Clerk of Court using the CM/EDF system. Notice of this filing will be sent to all counsel by operation of the court's electronic filing system.

/s/ Nell Hahn_____