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' REPLY TO DEFENDANTS' RESPONSE IN OPPOSITION TO MOTION FOR PRELIMINARY INJUNCTION

To require people with disabilities who need more than 32 hours of LT-PCS to go into nursing homes in order to access sufficient personal care service is segregation and discrimination that violates their rights under the ADA. When cuts are made to community-based programs, States must insure that the alternative services needed to avoid institutionalization are *actually* (not merely theoretically) available.[1]

While Defendants' response suggests that they have accomplished this, the reality, for most class members, is that they still must actually be admitted to a nursing facility in order to immediately access the care they need, whether in the community (by way of an immediate waiver slot offer[2]) or in a nursing facility. The circumstances of the named plaintiffs and class members set forth in their own and their physicians' declarations, undisputed by Defendants, show that they need more than 32 hours of

[1] Exhibit 19, Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C., p. 3, question 9: "Can budget cuts violate the ADA and Olmstead?," http://www.ada.gov/olmstead/q&a_olmstead.htm (last visited November 9, 2011).

[2] While this motion was pending, the name of the waiver program that would provide sufficient home-based services for class members was changed from the Elderly and Disabled Adult waiver to the Community Choice waiver. Plaintiffs will refer to this waiver as the CC waiver. References in previous pleadings to the EDA waiver apply to the CC waiver.

personal care services to remain safely in their homes and to avoid institutionalization. Defendants have voluntarily, and temporarily, extended their services. To require Defendants to provide a process by which this can be done for similarly-situated class members while this action is pending would not fundamentally alter Defendants' programs—indeed, this can be accomplished by a reasonable expansion of steps Defendants have already taken.

When, following class certification, Defendants promulgated a new rule providing for emergency waiver opportunities for class members,[3] Plaintiffs hoped that this would obviate the need for preliminary injunctive relief. However, Plaintiffs have learned that the opportunities under this policy are far too limited to provide for class members with the services they need pending trial on the merits.

1. Class members are at risk

The detailed declarations of named plaintiffs, class members, and their doctors and nurses show the risks to which the reduction in services subjects the class in this case. While none of them have sought admission to nursing facilities, the risks they run are real and immediate. They risk not being cleaned after incontinence episodes because no one is there to change them.[4] They risk missing meals or being bathed.[5] They risk

[3] Exhibit 20 37 La. Reg. 1490-91 (June 20, 2011) (amending La. Admin. Code tit. 50, §8105).
[4] Exhibit 5, Declaration of E.M.S., ¶15; Exhibit 21, Declaration of Mary Dunn, ¶16; Exhibit 22, Declaration of Bessie Foreman, ¶16; Exhibit 23, Declaration of Estelle Curtain, ¶11 and 12.
[5] Exhibit 5, Declaration of E.M.S., ¶¶19, 21; Exhibit 7, Declaration of C.D., ¶23; Exhibit 8, Declaration of Lecy Broussard, ¶8; Exhibit 9, Declaration of I.M.L., ¶¶20, 21, 27; Exhibit 10, Declaration of Scharmaine Baker, ¶9; Exhibit 11, Declaration of V.U.S. ¶17; Exhibit 12, Declaration of Cherie Drez, M.D. ¶13; Exhibit 13, Declaration of S.M. ¶7; Exhibit 14, Declaration of Daniel Renois, M.D. ¶10; Exhibit 15, Declaration of L.M. ¶16; Exhibit 21, Declaration of Mary Dunn, ¶¶19, 25; Exhibit 22, Declaration of Bessie Foreman, ¶¶13, 14; Exhibit 23, Declaration of Estelle Curtain, ¶18, 20.

having to limit their fluid intake so that they will not have to urinate as often.[6] They risk falling if no one is with them to assist them with transferring.[7] They risk having to remain in bed even during the day after their worker leaves, because no one will be available to put them to bed later.[8] These are exactly the types of unmet needs that studies have shown lead to death, institutionalization, injury, or worsening health in people with disabilities.[9]

The defendants have voluntarily extended LT-PCS services at their pre-September 2010 levels for these class members, through February 29, 2012.[10] This case will probably not be tried before that date, so these class members have no assurance that they will continue to receive the services they need without the intervention of this Court. Further, here is no reason to think that all class members know to contact the Advocacy Center so that class counsel can request a voluntary extension of their services until next February. This Court must intervene to prevent irreparable harm, through the denial of medically necessary services, to the class.

2. The steps Defendants have taken to date are not sufficient to prevent irreparable harm to class members

While Defendants persuasively extol recent changes to their programs, these changes do not alter the situation facing many class members: in order to obtain enough personal care service to remain safely at home, without experiencing a years-long wait, they must be first admitted to a nursing facility.

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[6] Exhibit 7, Declaration of C.D., ¶23; Exhibit 8, Declaration of Lecy Broussard, ¶8
[7] Exhibit 10, Declaration of Scharmaine Baker, ¶9; Exhibit 21, Declaration of Mary Dunn ¶23; Exhibit 23, Declaration of Estelle Curtain, ¶14.
[8] Exhibit 5, Declaration of E.M.S., ¶¶19, 21; Exhibit 7, Declaration of C.D., ¶23; Exhibit 8, Declaration of Lecy Broussard, ¶8; Exhibit 9, Declaration of I.M.L., ¶¶20, 21, 27; Exhibit 10, Declaration of Scharmaine Baker, ¶9; Exhibit 11, Declaration of V.U.S. ¶17.
[9] See Exhibit 24, Declaration of Mitchell LaPlante ¶¶ 10-17 (Rec. Doc. 36-4, pp. 389-91).
[10] Third Eley Decl. (Rec. Doc. 81-1) ¶70.

A. The replacement of the EDA waiver with the CC waiver

This is not a new development. Though approval from CMS for the CC Waiver only came through in October of 2011, Defendants bruited this revamp in connection with their motion to dismiss and for summary judgment.[11] As Plaintiffs pointed out then,[12] the changes in the CC waiver will add services for people who are already on the waiver, but since the CC waiver will add no new waiver slots, by itself it will do nothing to reduce the lengthy wait for adequate community services that is the central problem facing the class.

B. Creation of a process for granting expedited waiver slots

The process for granting expedited CC waiver slots for some class members (the July 2011 Emergency Rule) is indeed a positive development. Its adoption, and the fact that several of the individuals who have been brought to Defendants' attention in this action have received waiver slots under the program, shows that an exception to Defendants' rules that will offer expedited services to class members is indeed workable.

However, the current rules and procedures limit this program so that it cannot help many class members.

1. Class members who are not approved to receive at least 32 hours a week cannot even apply for these slots.

According to the Third Declaration of Hugh Eley, ¶7, [13] approximately 2,000 of the 2,900 persons who are now receiving LT-PCS, who have had their hours reduced from above 32 hours a week, had them reduced to *less than* 32 hours. These individuals

[11] Memorandum in Support of the Motion to Dismiss (Rec Doc 11-1) p. 11; Defendants' Reply to Plaintiffs' Response to Motion for Summary Judgment (Rec. Doc. 39) p. 4.
[12] Memorandum in Opposition to Summary Judgment (Rec. Doc. 36-1) p. 14, n. 71.
[13] Rec. Doc. 81-1.

are not eligible to apply for an emergency waiver slot. About 375 individuals have not yet had the 32-hour cap applied to them.

Contrary to Defendants' contention, the class in this case is *not* limited to individuals who are currently approved to receive exactly 32 hours of LT-PCS a week. The class definition is as follows:

> Louisiana residents with disabilities who have been receiving Medicaid-funded services through the LT-PCS program; who desire to reside in the community instead of a nursing facility; who require more than 32 hours of Medicaid-funded personal care services per week in order to avoid entering a nursing facility, and who do not have available (including through family supports, shared living arrangements, or enrollment in the ADHC waiver) other means of receiving personal care services.[14]

Also contrary to Defendants' assertions, at pp. 16-17 and n. 10 of their Response, class members who are receiving less than 32 hours of care *are* affected by the 32-hour cap. Because of it, they cannot access the expedited waiver slots through the existing appeals process.

This was recently demonstrated in the case of R.M., a twenty-six-year-old woman with severe disabilities caused by a traumatic brain injury in 2003. Her father has submitted a detailed declaration concerning her disabilities and needs. [15]

R.M. had been receiving 36.5 hours of LT-PCS for at least the last two years prior to May of 2011.[16] In May, she was reassessed under the September 2010 rule that is challenged here. Though her abilities had declined since her last assessment, she was approved for only 29 hours of LT-PCS 2011, because her "ADL index" (explained

[14] Ruling on Plaintiffs' Motion for Class Certification (Rec. Doc. 58, June 6, 2011) pp. 5-6.
[15] Exhibit 25, Declaration of C.M, ¶¶ 2-9, 17; Attachment B to Declaration of C.M. (letter dated August 8. 2011 from Mario Moreno, M.D.)
[16] Exhibit 25, Declaration of C.M., ¶12.

below) only came out to 11.[17] Her application for an emergency waiver slot was denied because she was not approved to receive exactly 32 hours.[18]

When she attempted to use the appeals process to appeal the award of only 29 hours, arguing that she needed more than 32 hours of LT-PCS to avoid placement in a nursing home, and that she had to be approved for 32 hours in order to be able to apply for an emergency waiver slot, the Administrative Law Judge denied her appeal on the grounds that the maximum amount of LT-PCS that could be awarded, 32 hours, would *not be sufficient* to keep Ms. M. from having to enter a nursing home. In her appeal, Ms. M. showed that her family cannot physically or emotionally cope with any additional caregiving, and cannot go on paying out of pocket for the 8 to 10 hours of care a week that have been taken away. She presented evidence that her parents have already taken steps to determine her eligibility for nursing home services, in preparation for admitting her to a nursing home if additional hours of LT-PCS are not provided. R.M.'s doctor is also concerned that the decrease in R.M.'s service hours could force the family to seek nursing home placement, as she is in constant need of care and supervision. He expressed concern that her health could deteriorate if she is not provided with more than 32 hours a week of care.[19]

The Administrative Law Judge credited this evidence, yet specifically held:

> …Although Appellant's representative presented credible evidence that Appellant requires additional hours, the LT-PCS program is limited to 32 hours a week. *Louisiana Register* 36:2818. Both Appellant's representative and her doctor have stated that thirty-two hours a week of LT-PCS will not be enough to prevent Appellant from entering a nursing facility. Therefore Appellant failed to show that obtaining additional hours per week of LT-PCS will avoid her entering into a nursing facility.

[17] Id. ¶¶ 13, 14.
[18] Id. ¶16.
[19] Id. ¶17, 18 and Attachments B and C.

The Department correctly held that Appellant is entitled to twenty-nine hours a week of LT-PCS.[20]

Thus Ms. M., and other class members who were awarded less than exactly 32 hours under the September 2010 rule, are caught in a classic Catch-22: they cannot obtain the hours of care that they need to remain out of a nursing facility unless they receive an emergency waiver slot, but they cannot succeed in appealing the 32 hours of care they need in order to apply for an emergency waiver slot because they need more than the 32 hour maximum to stay out of a nursing home. Any appeal for 32 hours, for a person who needs *more than* 32 hours to remain in his or her home, would be futile.

Lest the Court believe that individuals who are approved to receive less than 32 hours of services a week do not have severe disabilities, and cannot require more than 32 hours of care to remain safely in their homes, Plaintiffs would remind the Court that, in order to even qualify for the LT-PCS program, recipients must meet a nursing facility "level of care," and must demonstrate that they "face 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."[21] This "imminent risk" determination requires the administration of stringent criteria, and can be satisfied by a statement from a physician that the person is at substantial risk of nursing home placement or mental or physical deterioration if he or she does not receive home- and community-based services within 120 days.[22]

Since September of 2010, the determination of how many hours of LT-PCS a

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[20] Attachment C to Exhibit 25, Declaration of C.M., p. 5.
[21] See Plaintiffs' Memorandum in Opposition to Motion for Summary Judgment (Rec. Doc. 36-1) pp. 17-18, and exhibits and testimony cited nn. 92-95; Exhibit 26, 30 La. Reg. p. 2831-32 (December 20, 2004) (amending La. Admin. Code tit. 50, Part XV, §12905(B)(3)).
[22] Exhibit 27 LOCET manual excerpts, Section 7.2, p. 21 of 32.

person can receive has been based on an "ADL Index."[23] The ADL index is constructed based on only *four* of the eight activities classed as "activities of daily living" or "ADL's."[24] It does not consider recipients' inability to perform bathing, dressing, ambulating, and personal hygiene and grooming tasks. The index does not include information obtained on Defendants' assessment instruments about what are termed "instrumental activities of daily living" or "IADL's" (meal preparation, housework, managing finances, managing medications, using the phone, shopping, or transportation). The index similarly ignores data *that is collected in Defendants' assessment instruments on each recipient*[25] about such crucial factors as cognitive impairments; difficulty with vision, hearing, or communicating; behavioral symptoms; bladder and bowel continence; disease diagnoses; health problems such as diarrhea, fever, loss of appetite, shortness of breath, edema, delusions, and hallucinations; exent of pain; falls; nutritional status (unless the person is tube-fed); presence or absence of pressure sores; the number and types of medication the person takes; and, most importantly, how much informal support the person has.

People are not eligible to receive 32 hours a week of LT-PCS under this methodology unless they score at least a 14 on the ADL index. 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. A maximum of 3 points is

[23] Exhibit 28, 36 La. Reg. p. 1749 (August 20, 2010) (amending La. Admin. Code tit. 50, Part XV, §12901(C)).
[24] Exhibit 29, Eley deposition p. 162, l. 12 - p. 163, l. 13; Exhibit 30, Doc. 1949, pp. 2, 13-14 (Rec. Doc. 36-6, pp. 210, 221-22); Exhibit 31, MDS-HC (Eley Deposition Exhibit 1, Rec. Doc. 36-4, p. 369-373.
[25] Exhibit 31, MDS-HC, Sections B, C, D (Rec. Doc. 36-4, p. 369); Sections E, F, and G (Rec. Doc. 36-4, p. 370); Section H(1) and H(2)(c)-(f) and (i)-(j), H(3)-(7) (Rec. Doc. 36-4, p. 370-71); Sections (I) – (Q) (Rec. Doc. 36-4, pp. 371-73).

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 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.[26]

Examples of class members who have scored less than a 14 on the ADL index, and thus have been approved for fewer than 32 hours a week of LT-PCS, are P.M. (Paula Marshall), E.M.S. (Eddie Mae Shaw), C.D., R.M., Mary Dunn, Bessie Foreman, and Estelle Curtain. The needs of Ms. Marshall, Ms. Shaw, and C.D. were discussed in Plaintiffs' Memorandum of Law in Support of their Motion for Preliminary Injunction.[27]

Mary Dunn

Mary Dunn is 81 years old and lives alone.[28] She has a submitted a detailed declaration. Ms. Dunn uses a wheelchair and needs complete assistance with moving from one surface to another, toileting, bathing, grooming, and dressing. Because of a fall she experienced as a result of her attempting to transfer to her bedside commode unattended, she has a fracture in her hip.[29]

Until June of this year, she was receiving 38 hours a week of LT-PCS. In May 2011, she was notified that her hours would be reduced to 29.[30] She attempted to appeal the reduction. Due to her medication and her advanced age, she is becoming forgetful,

[26] Exhibit 29, Eley deposition p. 164, l. 3 – p. 172, l. 11; Exhibit 31, MDS-HC, p. 2, Section H, Item 2 ("ADL Self-Performance" pp. 2 and 3, items H(2)(a),(b),(g) and (h) (Rec. Doc. 36-4 p. 371); Exhibit 32, Doc. 1949, pp. 2, 13-14 (Rec. Doc. 36-6, pp. 210, 221-22); Exhibit 31 MDS-HC (Eley Deposition Exhibit 1, Rec. Doc. 36-4, p. 369-373); Exhibits 32 (Eley deposition exhibit 4, Rec Doc 36-4, p. 374-75) and 33, Detailed Explanation of Scoring (Eley deposition exhibit 5, Rec. Doc. 36-4, pp. 374-77); Exhibit 34, letter dated March 4, 2011 from Caroline Brown to Nell Hahn, item 8 p. 3 (Rec. Doc. 36-4, p. 341).
[27] Rec. Doc. 75, pp. 14-19.
[28] Exhibit 21, Declaration of Mary Dunn, ¶1.
[29] Id. ¶¶5, 6.
[30] Exhibit 21, Declaration of Mary Dunn, ¶4.

and she is not exactly sure what happened with her appeal, but she only succeeded in obtaining approval for one additional hour. She was not notified that if she appealed and received 32 hours, she would be eligible to apply for an emergency waiver slot.[31] She needs 38 to 40 hours of LT-PCS to remain in her own home.[32]

As her declaration details, 32 hours of personal care a week is not enough for a worker to handle all of Ms. Dunn's personal care, meal preparation, housework, and accompanying to medical appointments, so she is sometimes forced to miss meals and skip hygiene tasks.[33] Since her hours were reduced, she has had incontinence "accidents" when her worker was not there, and has had to wait for many hours for her worker to change and clean her.[34]

Ms. Dunn's declaration, and that of Emile A. Barrow, Jr., the Board-certified cardiologist who has treated her for the last 24 years, establish that it is medically necessary for Ms. Dunn to receive more than thirty-two hours per week to live safely in her home. Dr. Barrow stated unequivocally that in his professional medical opinion, if Ms. Dunn's hours are not increased, her condition will deteriorate quickly, and she will have to consider going into a nursing facility.[35]

Bessie Foreman

Bessie Foreman is 86 years old and lives alone in Iowa, Louisiana.[36] She has a submitted a detailed declaration.

[31] Id. ¶5, 6.
[32] Id. at ¶7.
[33] Id. ¶¶8-22, 25.
[34] Id. ¶24.
[35] Exhibit 35, Declaration of Emile A. Barrow, Jr., M.D. ¶¶7-9.
[36] Exhibit 22, Declaration of Bessie Foreman ¶1.

Ms. Foreman was receiving 38 hours a week of LT-PCS until March of 2011, when she was notified that her hours would be reduced to 26 hours a week. She filed an appeal of that decision. On or about May 1, 2011, her hours were reduced to thirty-two hours per week pending the appeal hearing.[37] The hearing was held by phone and Ms. Foreman could not participate because she cannot hear. The decision on appeal was to uphold the Department's reduction of her hours to 26.[38] The appeal hearing was held prior to the Department's implementation of the new emergency waiver rule, but because her hours were reduced to under 32 per week, Ms. Foreman will not be able to apply for a waiver slot unless this Court requires it.

As her declaration details, 32 hours a week is insufficient to provide for the home care Ms. Foreman needs. Since her LT-PCS hours have been reduced, Ms. Foreman has had to cut down on meals, is no longer able to have a bath daily, and often has to wait for extended periods without being cleaned after bowel or bladder accidents.[39] Her daughter, who lives 30 miles away and works two jobs, is currently helping her, but she cannot continue to provide this help on a daily basis.[40]

Estelle Curtain

Estelle Curtain is 58 years old and lives alone in Baton Rouge.[41] She has submitted a detailed declaration.

Until she was reassessed in 2011, Ms. Curtain was receiving 37.25 hours of LT-PCS a week. At the time she was notified that her hours would be reduced to 29 per week, she did not know about the Advocacy Center. She tried to appeal the reduction,

[37] Id. ¶3,
[38] Id. ¶4.
[39] Id. ¶¶13, 14, and 16.
[40] Id. ¶¶9 and 10.
[41] Exhibit 23, Declaration of Estelle Curtain ¶1.

but the appeals agency told her that they could not find her paperwork. Her hours were reduced to 29 in mid-June of 2011, prior to the July 2011 emergency rule.[42]

After her hours were reduced (and before they were restored in October by request from the Advocacy Center), Ms. Curtain had to sit or lie in wet diapers or bed pads for many hours because her worker was not there to change her.[43] Her worker did not have time to do her laundry for days at a time, which forced her to live in unclean and unsanitary conditions.[44] Her nutrition suffered, and she began experiencing a recurrence of symptoms of depression.[45]

When class members appeal cuts in service to below 32 hours a week, they can only receive continued benefits while appeals are pending of up to 32 hours a week. It typically takes the agency several months to decide an appeal.[46]

2. It is likely that more than 100 class members need emergency waiver slots

Though Defendants state that they will request 500 additional waiver slots to accommodate class members and others on the years-long waiting list for waiver services, there is no assurance that this request will be funded, or even make it into the Executive Budget.[47] One hundred slots may or may not be sufficient to provide

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[42] Id. ¶¶2-4.
[43] Id. ¶14.
[44] Id. ¶15
[45] Id. ¶¶25, 28.
[46] In response to discovery requests, Defendants have provided Plaintiffs with a spreadsheet listing the dates and dispositions of appeals of reductions in LT-PCS since September 5, 2010. Three hundred appeals have been decided, and the agency took an average of 68 days to decide them. The maximum number of days a decided appeal pended was 183. Forty appeals had not been decided as of the date of the spreadsheet, and they had pended an average of 57 days. The longest an open appeal had pended was 314 days. Exhibit 36. Fourth Declaration of Jeanne Abadie, ¶4.
[47] The fact that the Office of Aging and Adult Services ("OAAS") requests additional waiver slots does not mean that these slots will become available. As Hugh Eley testified in his deposition, each DHH office comes up with a proposed budget. The Secretary of DHH then submits a proposed budget to the Division of Administration, which may or may not fully fund each

emergency waiver services to all class members who are reduced to exactly 32 hours, but it is very unlikely that it will be enough to serve all class members who are affected by the cap, if the 2,000 individuals whose services have been reduced to below the cap, as well as the 375 whose services have not yet been reduced, are permitted to apply.

3. Class members must not be required to demonstrate that they will enter nursing facilities "immediately" in order to qualify for additional hours of service

On the one hand, Defendants appear to deny that only persons for whom a cut in services would necessitate an *immediate* admission to a nursing facility will be granted waiver slots. On the other hand, they make it clear that they are not prepared to follow the standard set forth in the United Stated Department of Justice's technical assistance for evaluating risk of institutionalization or segregation. Defendants claim that it is impossible for them to apply a standard that would award an emergency waiver slot to individuals for whom the cuts in LT-PCS are "likely to cause a decline in health, safety, or welfare that would lead to the individual's eventual placement in an institution," because many LT-PCS recipients have degenerative diseases and conditions, and because Defendants are not aware of "sound diagnostic tools" that would assess whether a person requires a specified number of hours to avoid such a decline.

Class members' doctors can and have stated that in their medical opinions they will suffer such a decline if their hours of home care are reduced to 32 or fewer.[48] To the

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office's budget proposal. The Division of Administration then develops the Executive Budget to submit to the Legislature, which usually includes less that the amounts that agency offices ask for. Exhibit 29, Eley deposition, p. 196, l. 24 – p. 200, l. 7. In SFY 2010, OAAS requested funding for 1,000 additional waiver slots, but these were not even included in the Secretary's proposed budget to the Division of Administration. Exhibit 34, letter dated March 4, 2011 from Caroline Brown to Nell Hahn, item 3 p. 1 (Rec. Doc. 36-4, p. 340-41.)

[48] Exhibit 37, Declaration of Kendra Whitney, M.D. (re Kenneth Roman) (Rec. Doc. 36-4, pp. 279-82) ¶¶ 7-8, 11; Exhibit 38, Declaration of Christopher Lege, M.D. (re Rickii Ainey) (Rec. Doc. 36-4, pp. 287-89) ¶¶9-10; Exhibit 39, Declaration of Robert Ancira, M.D. (re Rickii Ainey)

extent that Defendants require a showing of an "immediate" or "near term" admission to a nursing facility in order to qualify for an emergency waiver slot, their new policy will not prevent unlawful discrimination against class members.

4. Interim relief must be made available while emergency waiver applications are processed and services initiated.

Defendants' new emergency waiver slot policy makes no provision for continuing or restoring necessary LT-PCS hours while requests for emergency slots are pending, applications processed, and waiver services planned and initiated. Though Defendants claim that it is takes only two weeks for it to process emergency waiver applications, this is not borne out by Defendants' response to discovery dated November 2, 2011,[49] and ignores that historically it has typically taken 60 to 90 days for waiver services to begin, once an offer has been made. As of October 11, 2011, only three emergency waiver offers had been made. Two were made within two weeks of their request dates, but one was made on September 7, 2011, 43 days after it was requested. This person's waiver services were not started until October 18, 2011.[50]

As of October 11, 2011, six requests for emergency waiver slots were pending for class members who are approved to receive 32 hours a week of LT-PCS. Defendants' spreadsheet shows that four of these had requested emergency waiver slots between July 26, 2011 and September 15, 2011.

(Rec. Doc. 36-4, pp. 290-92) ¶6; Exhibit 40, Declaration of Mark Operario, M.D.(re Eddie Mae Shaw) ¶¶9-10; Exhibit 4, Declaration of Patrick Gahan, M.D. (re Paula Marshall) (Rec. Doc. 73-3, pp. 40-41) ¶¶8-10; Exhibit 18, Declaration of Lisa Richards, M.D. (re Elizabeth Foster) (Rec. Doc. 73-3, pp. 114-15) ¶¶10-11; Exhibit 8, Declaration of Lecy Broussard, A.P.R.N.(re C.D.) (Rec. Doc. 73-3, pp. 55-59) ¶¶9-10; Exhibit 10, Declaration of Scharmaine Baker, D.N.P. (re I.M.L.) (Rec. Doc. 73-3, pp. 66-69) ¶¶7-10; Exhibit 12, Declaration of Cherie Drez, M.D. (re V.U.S.) (Rec. Doc. 73-3, pp.79-82) ¶¶11-13; Exhibit 35, Declaration of Declaration of Emile A. Barrow, Jr., M.D. at ¶¶7-9.

[49] Exhibit 36. Fourth Declaration of Jeanne Abadie, ¶5 and attached spreadsheet.

[50] *Id*.

Moreover, waiver services do not start right away. Hugh Eley testified earlier in this case that it takes an average of 60 to 90 days, and sometimes longer—for services to begin once a waiver offer is made.[51] To avoid deterioration and risk of institutionalization during this period, interim LT-PCS exceeding the 32-hour limit is needed.

C. Elimination of the 90-day stay rule for offers to nursing facility residents still requires unlawful segregation and institutionalization in order to receive adequate personal care services.

Prior to June 20, 2011, Defendants not only required people with disabilities to be admitted to a nursing facility in order to get access to immediate home care services in excess of 32 hours a week—they also required them to remain in the nursing home for at least 90 consecutive days before they could receive an EDA waiver offer.[52] On June 20, 2011, the Department revised its rule to delete the requirement that the person remain for 90 consecutive days in a nursing facility before a waiver offer can be made. However, it has retained the requirement that a person be actually admitted to a nursing facility in order to qualify for a waiver offer.

Though clearly the elimination of the 90-day consecutive stay requirement is an improvement, any requirement that a person actually be admitted to a nursing facility before he or she receives a waiver offer violates the ADA (especially given the 60- to 90-day start-up period for waiver services). *See, e.g., Marlo M. v. Cansler*[53] (granting preliminary injunction because plaintiffs would suffer regressive consequences if "even

[51] Defendants' Statement of Undisputed Facts in Support of the Motion for Summary Judgment (Rec. Doc. 39-1) at 10, no. 65.
[52] Exhibit 41, 36 La. Register 2217-20 (October 20, 2010) (amending La, Admin. Code tit. 50, part XXI. §8105(B)). The only exceptions to this rule were individuals with substantiated cases of abuse or neglect referred by Adult Protective Serivces or Elderly Protective Services, and individuals with Amyotrophic Lateral Sclerosis (Lou Gehrig's disease).
[53] 679 F. Supp. 2d 635, 638 (E.D.N.C. 2010)

temporarily" returning to an institutional setting); *Cruz v. Dudek*[54] (granting preliminary injunction where state proposed entry into nursing home for sixty days prior to providing community-based services); *Haddad v. Arnold*[55] (granting preliminary injunction after finding that the plaintiff would suffer irreparable injury if forced to enter a nursing home). "Temporary" unjustified institutionalization disrupts the individual's established life in the community and places him or her at risk of psychological, emotional, and physical deterioration.

Defendants must provide meaningful opportunities for class members to obtain the same personal care services that they would obtain in a nursing facility in the most integrated setting appropriate for them—their own homes and communities. It must not condition receipt of those services upon first being admitted to a segregated institutional setting.

D. Offering EDA waiver slots to LT-PCS recipients who have had to wait for years for those services does not meet immediate needs of class members

Defendants tout progress in offering waiver slots to 1,500 recipients of LT-PCS in the last year, including two of the original named plaintiffs—Helen Pitts and Denise Hodges. What Defendants neglect to say is that these individuals, like virtually all individuals in the community who need services in excess of 32 hours a week, have had to wait for years on a waiting list before being offered these services. No new EDA waiver slots have been added since 2009; as of the first of this year, there were 19,156

[54] No. 10-23048, 2010 WL 4284955, at *3-7 (S.D. Fla. Oct 12, 2010) (Order adopting Magistrate's Report and Recommendation, Nov. 24, 2010).
[55] 784 F.Supp. 2d 1284 (M.D. Fla. 2010).

people on the waiting list for these services.[56] As of March 30, 2011, there was a wait time of 40.5 months for EDA services.[57]

Plaintiffs Helen Pitts and Denise Hodges, for example, had been on the waiting list since September of 2007 when they were offered slots in 2011. Because their situations were spotlighted in this action, they were spared the reduction in their LT-PCS hours that would have placed them at grave danger of physical and mental deterioration.[58] Defendants voluntarily extended their services at their pre-September 2011 level because of their involvement in this case. But many members of the certified class in this action have been, or will be, waiting years for waiver slots, without the protections that Ms. Pitts and Ms. Hodges were able to get because they personally came to the attention of class counsel. They need this Court to protect them against the risk of mental and physical deterioration that may lead to institutionalization.

E. Voluntary extensions of LT-PCS services to named Plaintiffs and others identified by class counsel do not meet the needs of unnamed class members.

Defendants have voluntarily extended LT-PCS services at their pre-September 2010 level for approximately 20 class members that class counsel has brought to their attention. However, Defendants have made it clear that they have not committed to extending these services past February 29, 2011. Further, this does nothing to meet the needs of class members that class counsel has not encountered.

The Advocacy Center has not succeeded, despite its attempts to reach out to

[56] Exhibit 42, Document 2482, Email from Steven Buco to Rick Henley.
[57] Second Declaration of Hugh Eley (Rec. Doc. 39-2) ¶21.
[58] Ms. Pitts' physician, Dr. Gregory Ward, a physical medicine and rehabilitation specialist practicing in Baton Rouge, who has treated her for over ten years, noted that her multiple diagnoses put her "in a precarious situation," and that that when she lacked adequate in-home care for a period of time in 2008 or 2009, her condition greatly deteriorated. Exhibit 43, Declaration of Gregory Ward, M.D. (Rec. Doc. 36-4, pp. 275-278).

members of the class, in identifying more than a small fraction of the persons placed at risk by these cuts. For example, Defendants have provided, in response to discovery in this case, a list of 366 people who have filed administrative appeals of the cuts in their LT-PCS hours since September 2010. Only 26 of them have contacted the Advocacy Center (not necessarily about the appeals).[59]

The fact that Defendants have extended LT-PCS hours at their previous level for numerous class members shows that to do so is not a "fundamental alteration" of their program. All Plaintiffs are seeking to do in this motion is to obtain this same consideration *pendente lite* on a fair and even-handed basis to all class members who need it.

ARGUMENT

A. Plaintiffs have standing to seek preliminary injunctive relief for the class

Defendants devote considerable effort to arguing that the named plaintiffs do not have standing to challenge aspects of the emergency waiver process. Defendants claim that the named plaintiffs are not affected by the alleged deficiencies in the process. However, of the three named plaintiffs, only Rickii Ainey has been offered an emergency waiver slot[60] under the new policy. Kenneth Roman and Elizabeth Foster have been permitted to apply for emergency slots, but a decision has not yet been reached on their applications. Defendants have voluntarily extended LT-PCS hours for all the named plaintiffs at their pre-September 2010 levels until February 29, 2011.

[59] Exhibit 36, Fourth Declaration of Jeanne Abadie, ¶3.
[60] This offer was made on or about October 27, 2011. *Id*., ¶7.

Defendants cite *Lewis v. Casey*[61] for the proposition that the named plaintiffs do not have standing to seek additional slots beyond the 100 currently allocated, to seek to provide emergency slots to people approved to receive fewer than 32 hours of LT-PCS, to provide interim benefits for persons while they apply for emergency slots, or to challenge the standard for awarding emergency slots.

When they brought this action, all of the named plaintiffs were at risk of deterioration and institutionalization because of the September 2010 rule mandating reductions in their LT-PCS hours. This policy had no exceptions process for people who need more than 32 hours of LT-PCS to remain in their homes and communities. The named plaintiffs were all personally affected by this lack of an exceptions policy and had standing to challenge it. The fact that Defendants have now voluntarily adopted an exceptions policy of sorts does not deprive the named plaintiffs of standing.

Voluntary actions taken by a defendant in a class action to alleviate harm to the named class representative do not affect that representative's standing. As the Fifth Circuit explained in *Mississippi Prot. & Advocacy Sys., Inc. v. Cotton*,[62] named plaintiffs who present a live controversy when filing their complaint and at the time of class certification cannot be "mooted out" by voluntary actions of defendants in such a way as to destroy their ability to represent the class. Their claims are seen as "capable of repetition, yet evading review." *Sosna v. Iowa*;[63] *Zeidman v. J. Ray McDermott.*[64]

Lewis v. Casey is inapposite. In Lewis, a sweeping injunction minutely regulating Arizona's prison law libraries had been obtained even though actual harm had only been

[61] 518 U.S. 343 (1996).
[62] 929 F.2d 1054, 1057-58 (5th Cir. 1991)
[63] 419 U.S. 393, 399-400 (1975),
[64] 651 F. 2d 1030 (5th Cir. 1981)

shown by two class members, and the harm they had suffered did not rise to the level of a systematic constitutional violation. Similarly, *Hodgers-Durgin v. de la Vina*,[65] differs from the instant case because there, the named plaintiffs did not have standing to seek injunctive relief when the case was filed, because they were not threatened with future harm. These cases do not support the argument that the named plaintiffs in this case, who, when the case was filed, were threatened with actual harm from a systematic policy whose effects they shared with other class members, lack standing.

The applications of plaintiffs Roman and Foster for an emergency waiver slot are still pending. Thus, they have standing to challenge the standard being used in the exceptions process.

The one area in which the named plaintiffs may differ from some class members is that they have all been approved to receive 32 hours a week of LT-PCS in their most recent assessment. Thus, they are eligible to apply for emergency waiver slots under the July 2011 Emergency Rule. To satisfy any necessity for a class representative that is approved to receive less than 32 hours of LT-PCS, class members Eddie Mae Shaw ("E.M.S." in Plaintiffs' Memorandum in Support of Motion for Preliminary Injunction), Paula Marshall ("P.M."), Mary Dunn, Bessie Foreman, and Estelle Curtain will seek leave to intervene as additional class representatives.

B. Plaintiffs have satisfied the the preliminary injunction requirements..

Though Defendants characterize this motion as seeking a mandatory injunction, and cite cases that purport to establish a higher standard for such relief, for most class members the relief requested here will simply retain the *status quo* as of the date this action was instituted. Where a defendant an injunction proceeding takes the actions

[65] 199 F.3d 1037 (1999).

sought to be enjoined, the court may enter a preliminary injunction to restore the status quo."[66] In any event, the need for Court intervention to protect the civil rights of class members outweighs any considerations purporting to disfavor mandatory injunctions.

Defendants' cite *Martinez v. Matthews*[67] (finding despite a "clearly favoring" analysis, that the Migrant Health Act required immediate appointment of migrant workers to a majority of the health provider's board of directors), for the proposition that mandatory injunctions require a much higher standard than those seeking to only maintain the status quo. While Plaintiffs do not concede they are requesting any more than protecting the *status quo ante*, reading on in *Martinez* reveals that while that facts and law should *clearly* favor the moving party, the analysis the Court is to apply is otherwise the same. There must "…be an evaluation of the equitable considerations involved: the plaintiffs' likelihood of prevailing on the merits, the possibility of irreparable harm to the plaintiffs, the counterbalancing risk of harm to the defendants, and the public interest. *Id.* The *Martinez* court then went on to look at congressional concern in the adoption of the Migrant Health Act, which was to assure the recipients of migrant health services had a voice in the provision of their health care, and to prevent health care for migrants from being lost in the shuffle, and found that Plaintiffs were entitled to their preliminary injunction.

Plaintiffs have set forth in their Memorandum of Law in Support of Motion for a

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[66] *Porter v. Lee*, 328 U.S. 246 (1946) (reversing denial of preliminary injunction restoring tenant to property from which evicted); *Cohen v. Brown University*, 991 F.2d 888 (1st Cir. 1993) (affirming grant of preliminary injunction in Title IX case restoring women's varsity teams); *F.T.C. v. Weyerhouser Co*., 648 F.2d 739 (D.C. Cir. 1981) (enjoining challenged merger which had already occurred). In such cases, courts have defined the "status quo" as the "last peaceable uncontested status" between the parties, *United States v. F.D.I.C*., 881 F.2d 207, 210 (5th Cir. 1989); *Alexander v. Sav. Life Ins. Co*., CIV.A. 87-1477, 1987 WL 13226 (E.D. La. June 30, 1987).

[67] 544 F.2d 1233, 1243 (5th Cir. 1976).

Preliminary Injunction a detailed argument regarding how they meet the four *Winter* requirements for issuance of an injunction. Plaintiffs are entitled to injunctive relief under the ADA's and the Rehabilitation Act's integration mandate. With this Court's earlier ruling that the state's system violates the ADA by requiring a greater risk of institutionalization for people who require more than 32 hours per week of assistance, and the fact that Defendants still require a person to enter the nursing home before getting an immediate waiver slot, prevailing on the merits of the ADA claim is utterly clear. Irreparable injury and the balance of the equities are clear from the loss of services Plaintiffs will suffer because of the Defendants' policies. Likewise, an injunction is clearly in the public interest.

C. The relief Plaintiffs are requesting would not fundamentally alter Defendants' programs.

Plaintiffs suggest two alternative means of preventing irreparable harm to the class pending trial on the merits: (1) an expansion of the steps Defendants have already taken to provide access to immediate waiver services for class members; and (2) the institution of an exceptions process that would allow class members to receive LT-PCS in excess of the 32-hour limit if they can show that they need more than 32 hours to avoid deterioration and eventual placement in a nursing facility. These types of relief will not fundamentally alter Defendants' programs.

1. It is workable for Defendants to provide emergency Community Choice waiver slot offers to persons who can demonstrate that they need more than 32 hours of LT-PCS to avoid "a decline in health, safety, or welfare that would lead to the individual's eventual placement in an institution."

Defendants assert that it would be impossible for it to administer the standard articulated by the Justice Department in its June 2011 technical assistance guide to state

and local governments on *Olmstead* compliance:

> A plaintiff could show sufficient risk of institutionalization to make out an Olmstead violation if a public entity's failure to provide community services or *its cut to such services will likely cause a decline in health, safety, or welfare that would lead to the individual's eventual placement in an institution.* (emphasis supplied).

Defendants contend this standard is impossible to apply because (1) the program primarily serves the elderly and persons with degenerative conditions; and (2) they are not aware of any "sound diagnostic tool" that can be used to assess whether someone needs a particular level of assistance to avoid institutionalization. They claim that "nursing home admission is often the result of unpredictable (e.g., a slip-and-fall, the loss of a caregiver, or a family's decision that a nursing home is most appropriate) rather than someone receiving 32 hours of personal care assistance every week"[68] and therefore assert that they cannot apply the Justice Department's standard to determine whether or not class members are placed at risk.

Though Mr. Eley may be unaware of any "sound diagnostic tool" to determine the number of hours of services that are necessary to prevent deterioration in health, safety, and welfare that will lead to eventual nursing home placement, medical professionals routinely make these judgments. The medical professionals who have treated the named plaintiffs and other class members in this case, have in fact testified precisely to the fact that a reduction in service hours to these individuals will indeed place them at risk of physical and mental deterioration and eventual institutionalization.[69]

Further, Defendants' rules *currently* permit a class member to appeal to obtain

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[68] Third Eley Decl. at ¶47; Attachment E to Third Eley Declaration, pp. 2, 3 (Rec. Doc. 81-2, pp. 23 and 24) (showing plan amendment not submitted until September 30, 2010, and not approved until December 14.)

[69] See n. 48 supra.

more hours than number dictated by their ADL index (up to a maximum of 32 hours), by showing "that he or she needs additional hours to avoid entering a nursing facility."[70] Defendants do not explain why it is workable for a recipient to show that he needs more hours, up to a maximum of 32, to avoid institutionalization, but not workable for a recipient to show they need more than 32 hours to avoid deterioration and eventual institutionalization.

Similarly, Defendants' policies already require a finding that a person is at "imminent risk" of nursing facility placement if home and community-based services are not provided within 120 days.[71] This requires just the type of medical judgment that Defendants contend in their response is impossible to make.

2. The changes Plaintiffs seek in the emergency waiver slot program would not overwhelm the system.

If current experience is any indication, the number of people who will apply for an emergency waiver slot if the eligibility for the slot is expanded is not huge. Defendants state that of the 2,900 people whose services have been reduced to a maximum of 32 hours a week, and who still receive LT-PCS, 500 individuals had their services reduced to *exactly* 32 hours a week, and were thus eligible to apply for emergency waiver slots. Yet even though this change was implemented last July, as of the middle of October, only about 30 applications had been received. At this response rate, the number of applications for emergency slots is extremely unlikely to overwhelm the system, even if (as Defendants suggest at p. 18 of their Response) "the percentage of requests that are actually granted would likely be relatively small."

[70] Exhibit 44, 37 La. Register 1113 (April 20, 2011), amending La. Admin. Code Tit. 50, part XV, §12901(D)(2)(b).
[71] See nn. 21 and 22, supra.

Similarly, extending LT-PCS benefits temporarily, for those who apply for emergency waiver slots, is not likely to overwhelm the system. Defendants suggest that it is able to start waiver services within six weeks of a request, for those whose emergency waiver requests are granted. If this is true,[72] the extension of LT-PCS for this short period will not cost very much, and will alleviate much unnecessary and unjustified suffering on the part of class members.

3. It would not fundamentally alter Defendants' LT-PCS program to provide a mechanism for class members to seek an exception to the 32-hour maximum.

a. The State Medicaid plan is not a barrier to services in excess of the 32-hour cap.

Louisiana has had several different rules placing maximum hours on its State Medicaid plan LT-PCS. Until 2009, the maximum was 56 hours a week. In 2009, the State reduced the maximum to 42 hours a week. In September of 2010, Defendants implemented the 32-hour cap on LT-PCS. The Centers for Medicare and Medicaid services ("CMS") approved all of these arrangements. Louisiana did not seek to amend its State Medicaid plan prior to implementing the rule challenged in this case, and in fact Mr. Eley states that approval was not received until December of 2010.[73] If this Court requires the State to provide a mechanism for class members to seek an exception to the 32-hour cap, there is absolutely no reason to believe that CMS will not readily approve such an amendment retroactively to the date of its implementation, as it has routinely done in the past.

[72] Only four waiver slot offers have been extended to date. Three of these were to class members brought to the attention of Defendants by class counsel. None of these persons services were started within six weeks of their request. Exhibit 36, Fourth Declaration of Jeanne Abadie, ¶¶6,7.
[73] Third Eley Decl. ¶67; Attachment E to Third Eley Declaration, pp. 2, 3 (Rec. Doc. 81-2, pp. 23 and 24) (showing plan amendment not submitted until September 30, 2010, and not approved until December 14).

b. Allowing class members who need more than 32 hours to alleviate the risk of institutionalization by obtaining an exception to the cap does not "redefine" the LT-PCS benefit.

Defendants' argues that the LT-PCS benefit is *by its nature* limited to 32 hours, and that the program is not intended to satisfy class members' need for services to prevent them from having to be institutionalized. They cite *Alexander v. Choate*[74] for the proposition that the ADA does not require it to "redefine" the "particular package of health care services" available through the LT-PCS program.

Alexander v. Choate is distinguishable from this case because it did not involve claims of unnecessary institutionalization and segregation. While *Alexander* stands for the proposition that not every distinction in Medicaid benefits that disproportionately disfavors individuals with disabilities violates the ADA, *Olmstead v. L.C.* stands for the proposition that states may not condition the receipt of Medicaid services upon the acceptance of unnecessary segregation and institutionalization. For Louisiana to define its benefit so that people who need more than 32 hours of personal care must enter a nursing facilty to obtain it does violate the ADA.

Defendants' characterization of the LT-PCS program is disingenuous. The program has always been aimed at providing home- and community-based services as an alternative to nursing facility services. It was instituted in 2003 as a result of the *Barthelemy* litigation, which was a case under the ADA to require the Defendants to provide home- and community-based services as an alternative to nursing facility services. The rule establishing LT-PCS provided that "The purpose of personal care services is to enable an individual whose needs would otherwise require placement in an

[74] 369 U.S. 287 (1985).

acute or long-term care facility to remain safely in that individual's own home."[75] This rule was repromulgated many times with similar language.[76] Though the rule Plaintiffs challenge here omits (for the first time) any reference to allowing individuals with disabilities to remain safely in their own homes, neither it, nor any subsequent repromulgations, have announced any fundamental change in the program, other than to cut the maximum hours. Defendants did not offer any additional services, when the September 2010 rule was promulgated, to take the place of the LT-PCS program. And as in previous rules, the September 2010 rule allows class members to obtain the maximum number of hours on appeal, despite their ADL index, if they show that they need that number of hours to avoid having to enter a nursing facility. To credit Defendants' argument that the purpose of the LT-PCS program is simply to offer a limited benefit, and that to require changes in that benefit to accommodate people who require more services to avoid deterioration and eventual nursing facility placement will *ipso facto* fundamentally alter the program, would be to allow Defendants to circumvent the ADA by simply "wordsmithing" their rule.

Defendants' argument that creating a means for class members to obtain services in excess of the 32-hour cap would fundamentally alter its program because DHH "does not allocate services in the LT-PCS program based on how many hours of assistance an individual requires to avoid entering a nursing home"[77] is difficult to understand. Defendants claim that their allocation of hours is based on "an evidence-based uniform assessment tool not to determine how many hours of assistance each recipient "needs" but the recipient's demonstrated independence in performing ADL's as compared with

[75] La. Register 29:911 (June 20, 2003).
[76] *See* La Reg 38: (December 20, 2008); La Reg 39:11 (November 20, 2010).
[77] Defendants' Memorandum at 21; Third Eley Decl. at ¶66),

others in the LT-PCS program."[78] They claim that this method produces an allocation of LT-PCS hours that is "more fair and efficient" than an unspecified "previous approach,"[79] and that to permit approval of more hours based on a showing of a need for more hours to avoid institutionalization would somehow disrupt the program.

Defendants do not explain how an allocation of hours of service that does not consider the individual's need for services can be considered "fair." Though they assert that there is some "evidence" that supports an allocation mechanism that does not consider need, it is hard to imagine what question this evidence might address. Indeed, using an allocation method that provides different levels of services to Medicaid recipients based on distinctions unrelated to medical need would violate the Medicaid statute's "comparability" requirement, 42 U.S.C. ß 1396a(a)(10)(B).[80]

As noted above, DHH already permits class members to receive services in excess of the amount dictated by the allocation mechanism if they can show that they need more hours *up to a maximum of 32*, to avoid entering a nursing facility.[81] The class members discussed in Plaintiff's motion have demonstrated, through their own testimony and the testimony of their treating physicians, that they need hours *in excess* of 32 to remain

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[78] Defendants' Memorandum at 21.

[79] Defendants assert that their current methodology was adopted in 2009. In fact, a completely different methodology—one which took into account significantly more information from the MDS—was adopted in 2009, and the current methodology was only adopted in August, 2010.

[80] *V.L. v. Wagner*, 669 F. Supp. 2d 1106, 1114-15 (N.D. Cal. 2009) *order enforced*, C 09-04668 CW, 2009 WL 4282079 (N.D. Cal. Nov. 25, 2009) (holding use of numerical scores to determine eligibility for in-home services likely violates the comparability requirement because scores do not reasonably measure the individual's need for a particular service), *citing* 42 C.F.R. ß 440.240; *Jenkins v. Washington State Dep't of Social & Health Servs.,* 160 Wash.2d 287, 157 P.3d 388, 392 (2007); *Sobky v. Smoley,* 855 F.Supp. 1123, 1139 (E.D.Cal.1994) (comparability requirement "creates an equality principle" for all medically needy individuals); *Schott v. Olszewski,* 401 F.3d 682, 688-89 (6th Cir.2005); *White v. Beal,* 555 F.2d 1146, 1151-52 (3d Cir.1977). *See also Cota v. Maxwell-Jolly*, 688 F.Supp.2d 980, 993 (N.D. Calif. 2010).

[81] Defendants' previous rules, using a different allocation methodology and applying a 42-hour cap, permitted recipients to obtain services up to the maximum cap of 42 hours, on a showing that they needed more hours than the allocation method assigned to avoid entering a nursing facility.

safely in their homes. To allow them and others to obtain additional services on such a showing will not fundamentally alter the LT-PCS program.

b. There is no reason to believe that requiring an exceptions mechanism while this action is pending will jeopardize the financial stability of the LT-PCS program.

Defendants have already allowed exceptions to the ceiling on LT-PCS hours for the named Plaintiffs and other class members brought to their attention by class counsel. Defendants have pointed to no harm to the LT-PCS program as a result of these exceptions, and they have not offered *any* estimate of the cost of providing such exceptions to other class members, as Plaintiffs are requesting here. They acknowledge that only 30, of a potential 500, class members have come forward to request emergency waiver slots under the rule implemented last July, that permits them to seek an emergency slot if 32 hours of LT-PCS are insufficient to prevent them from having to enter a nursing facility. There is no reason to believe that extending or restoring the LT-PCS services to class members who are able to come forward and demonstrate that they need more hours to avoid deterioration and nursing facility placement while this case is pending will jeopardize the financial stability of the program.

Conclusion

For the reasons and on the authority cited above, Plaintiffs respectfully requests that this Honorable Court grant preliminary injunctive relief to the class.

Date: November 14, 2011.

Respectfully submitted:

/s/ Nell Hahn
Nell Hahn, T.A., Louisiana Bar No. 22406
ADVOCACY CENTER
600 Jefferson St., Suite 812
Lafayette, LA 70501

(337) 237-7380, ext. 311
(337) 237-0486 FAX
Email: nhahn@advocacyla.org

Stephen F. Gold
PA Bar No. 09880
1709 Benjamin Franklin Parkway
Second Floor
Philadelphia, PA 19103
(215) 627-7100, ext 227
Facsimile: 215-627-3183
stevegoldada1@gmail.com

Ken Zeller, D.C. Bar No. 986787
kzeller@aarp.org
Bruce Vignery, D.C. Bar No. 297911
bvignery@aarp.org
AARP Foundation Litigation
601 E Street N.W.
Washington, D.C. 20049
(202) 434-2138
Fascimile (202)434-6424

Counsel for the Plaintiff

CERTIFICATE OF SERVICE

I hereby certify that on November 14, 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

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

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

ADDITIONAL EXHIBITS IN SUPPORT OF
MOTION FOR PRELIMINARY INJUNCTION

Plaintiffs submit the following additional exhibits in support of their Motion for Preliminary Injunction:

Date: November 14, 2011.

Respectfully submitted:

/s/ Nell Hahn
Nell Hahn, T.A., Louisiana Bar No. 22406
ADVOCACY CENTER
600 Jefferson St., Suite 812
Lafayette, LA 70501
(337) 237-7380, ext. 311
(337) 237-0486 FAX
Email: nhahn@advocacyla.org

Stephen F. Gold
PA Bar No. 09880
1709 Benjamin Franklin Parkway

Second Floor
Philadelphia, PA 19103
(215) 627-7100, ext 227
Facsimile: 215-627-3183
stevegoldada1@gmail.com

Ken Zeller, D.C. Bar No. 986787
kzeller@aarp.org
Bruce Vignery, D.C. Bar No. 297911
bvignery@aarp.org
AARP Foundation Litigation
601 E Street N.W.
Washington, D.C. 20049
(202) 434-2138
Fascimile (202)434-6424

Counsel for the Plaintiff

CERTIFICATE OF SERVICE

I hereby certify that on November 14, 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

Exhibit 19 Statement of the Dept. of Justice on Enforcement of the Integration Mandate

U.S. Department of Justice
Civil Rights Division

Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.*

In the years since the Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), the goal of the integration mandate in title II of the Americans with Disabilities Act – to provide individuals with disabilities opportunities to live their lives like individuals without disabilities – has yet to be fully realized. Some state and local governments have begun providing more integrated community alternatives to individuals in or at risk of segregation in institutions or other segregated settings. Yet many people who could and want to live, work, and receive services in integrated settings are still waiting for the promise of *Olmstead* to be fulfilled.

In 2009, on the tenth anniversary of the Supreme Court's decision in *Olmstead*, President Obama launched "The Year of Community Living" and directed federal agencies to vigorously enforce the civil rights of Americans with disabilities. Since then, the Department of Justice has made enforcement of *Olmstead* a top priority. As we commemorate the 12th anniversary of the *Olmstead* decision, the Department of Justice reaffirms its commitment to vindicate the right of individuals with disabilities to live integrated lives under the ADA and *Olmstead*. To assist individuals in understanding their rights under title II of the ADA and its integration mandate, and to assist state and local governments in complying with the ADA, the Department of Justice has created this technical assistance guide.

The ADA and Its Integration Mandate

In 1990, Congress enacted the landmark Americans with Disabilities Act "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." [1] In passing this groundbreaking law, Congress recognized 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." [2] For those reasons, Congress prohibited discrimination against individuals with disabilities by public entities:

[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity. [3]

As directed by Congress, the Attorney General issued regulations implementing title II, which are based on regulations issued under section 504 of the Rehabilitation Act. [4] The title II regulations require public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." [5] The preamble discussion of the "integration regulation" explains that "the most integrated setting" is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible . . . ." [6]

In *Olmstead v. L.C.*, 527 U.S. 581 (1999),the Supreme Court held that title II prohibits the unjustified segregation of individuals with disabilities. The Supreme Court held that public entities are required to provide community-based services to persons with disabilities when (a) such services are appropriate; (b) the affected persons do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of others who are receiving disability services from the entity. [7] The Supreme Court explained that this holding "reflects two evident judgments." First, "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." Second, "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." [8]

To comply with the ADA's integration mandate, public entities must reasonably modify their policies, procedures or practices when necessary to avoid discrimination. [9] The obligation to make reasonable modifications may be excused only where the public entity demonstrates that the requested modifications would "fundamentally alter" its service system. [10]

In the years since the passage of the ADA and the Supreme Court's decision in *Olmstead*, the ADA's integration mandate has been applied in a wide variety of contexts and has been the subject of substantial litigation. The Department of Justice has created this technical assistance guide to assist individuals in understanding their rights and public entities in understanding their obligations under the ADA and *Olmstead*. This guide catalogs and explains the positions the Department of Justice has taken in its Olmstead enforcement. It reflects the views of the Department of Justice only. For questions about this guide, you may contact our ADA Information Line, 800-514-0301 (voice), 800-514-0383 (TTY).

Date: June 22, 2011

Questions and Answers on the ADA's Integration Mandate and *Olmstead* Enforcement

1. What is the most integrated setting under the ADA and *Olmstead*?

A: The "most integrated setting" is defined as "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." [11] Integrated settings are those that provide individuals with disabilities opportunities to live, work, and receive services in the greater community, like individuals without disabilities. Integrated settings are located in mainstream society; offer access to community activities and opportunities at times, frequencies and with persons of an individual's choosing; afford individuals choice in their daily life activities; and, provide individuals with disabilities the opportunity to interact with non-disabled persons to the fullest extent possible. Evidence-based practices that provide scattered-site housing with supportive services are examples of integrated settings. By contrast, segregated settings often have qualities of an institutional nature. Segregated settings include, but are not limited to: (1) congregate settings populated exclusively or primarily with individuals with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals' ability to engage freely in community activities and to manage their own activities of daily living; or (3) settings that provide for daytime activities primarily with other individuals with disabilities.

2. When is the ADA's integration mandate implicated?

A: The ADA's integration mandate is implicated where a public entity administers its programs in a manner that results in unjustified segregation of persons with disabilities. More specifically, a public entity may violate the ADA's integration mandate when it: (1) directly or indirectly operates facilities and or/programs that segregate individuals with disabilities; (2) finances the segregation of individuals with disabilities in private facilities; and/or (3) through its planning, service system design, funding choices, or service implementation practices, promotes or relies upon the segregation of individuals with disabilities in private facilities or programs. [12]

3. Does a violation of the ADA's integration mandate require a showing of facial discrimination?

A: No, in the *Olmstead* context, an individual is not required to prove facial discrimination. In *Olmstead*, the court held that the plaintiffs could make out a case under the integration mandate even if they could not prove "but for" their disability, they would have received the community-based services they sought. It was enough that the state currently provided them services in an institutional setting that was not the most integrated setting appropriate. [13] Additionally, an *Olmstead* claim is distinct from a claim of disparate treatment or disparate impact and accordingly does not require proof of those forms of discrimination.

4. What evidence may an individual rely on to establish that an integrated setting is appropriate?

A: An individual may rely on a variety of forms of evidence to establish that an integrated setting is appropriate. A reasonable, objective assessment by a public entity's treating professional is one, but only one, such avenue. Such assessments must identify individuals' needs and the services and supports necessary for them to succeed in an integrated setting. Professionals involved in the assessments must be knowledgeable about the range of supports and services available in the community. However, the ADA and its regulations do not require an individual to have had a state treating professional make such a determination. People with disabilities can also present their own independent evidence of the appropriateness of an integrated setting, including, for example, that individuals with similar needs are living, working and receiving services in integrated settings with appropriate supports. This evidence may come from their own treatment providers, from community-based organizations that provide services to people with disabilities outside of institutional settings, or from any other relevant source. Limiting the evidence on which *Olmstead* plaintiffs may rely would enable public entities to circumvent their *Olmstead* requirements by failing to require professionals to make recommendations regarding the ability of individuals to be served in more integrated settings.

5. What factors are relevant in determining whether an individual does not oppose an integrated setting?

A: Individuals must be provided the opportunity to make an informed decision. Individuals who have been institutionalized and segregated have often been repeatedly told that they are not capable of successful community living and have been given very little information, if any, about how they could successfully live in integrated settings. As a result, individuals' and their families' initial response when offered integrated options may be

reluctance or hesitancy. Public entities must take affirmative steps to remedy this history of segregation and prejudice in order to ensure that individuals have an opportunity to make an informed choice. Such steps include providing information about the benefits of integrated settings; facilitating visits or other experiences in such settings; and offering opportunities to meet with other individuals with disabilities who are living, working and receiving services in integrated settings, with their families, and with community providers. Public entities also must make reasonable efforts to identify and addresses any concerns or objections raised by the individual or another relevant decision-maker.

6. Do the ADA and *Olmstead* apply to persons at serious risk of institutionalization or segregation?

A: Yes, the ADA and the *Olmstead* decision extend to persons at serious risk of institutionalization or segregation and are not limited to individuals currently in institutional or other segregated settings. Individuals need not wait until the harm of institutionalization or segregation occurs or is imminent. For example, a plaintiff could show sufficient risk of institutionalization to make out an *Olmstead* violation if a public entity's failure to provide community services or its cut to such services will likely cause a decline in health, safety, or welfare that would lead to the individual's eventual placement in an institution.

7. May the ADA and *Olmstead* require states to provide additional services, or services to additional individuals, than are provided for in their Medicaid programs?

A: A state's obligations under the ADA are independent from the requirements of the Medicaid program. [14] Providing services beyond what a state currently provides under Medicaid may not cause a fundamental alteration, and the ADA may require states to provide those services, under certain circumstances. For example, the fact that a state is permitted to "cap" the number of individuals it serves in a particular waiver program under the Medicaid Act does not exempt the state from serving additional people in the community to comply with the ADA or other laws. [15]

8. Do the ADA and *Olmstead* require a public entity to provide services in the community to persons with disabilities when it would otherwise provide such services in institutions?

A: Yes. Public entities cannot avoid their obligations under the ADA and *Olmstead* by characterizing as a "new service" services that they currently offer only in institutional settings. The ADA regulations make clear that where a public entity operates a program or provides a service, it cannot discriminate against individuals with disabilities in the provision of those services. [16] Once public entities choose to provide certain services, they must do so in a nondiscriminatory fashion. [17]

9. Can budget cuts violate the ADA and *Olmstead*?

A: Yes, budget cuts can violate the ADA and *Olmstead* when significant funding cuts to community services create a risk of institutionalization or segregation. The most obvious example of such a risk is where budget cuts require the elimination or reduction of community services specifically designed for individuals who would be institutionalized without such services. In making such budget cuts, public entities have a duty to take all reasonable steps to avoid placing individuals at risk of institutionalization. For example, public entities may be required to make exceptions to the service reductions or to provide alternative services to individuals who would be forced into institutions as a result of the cuts. If providing alternative services, public entities must ensure that those services are actually available and that individuals can actually secure them to avoid institutionalization.

10. What is the fundamental alteration defense?

A: A public entity's obligation under *Olmstead* to provide services in the most integrated setting is not unlimited. A public entity may be excused in instances where it can prove that the requested modification would result in a "fundamental alteration" of the public entity's service system. A fundamental alteration requires the public entity to prove "that, in the allocation of available resources, immediate relief for plaintiffs would be inequitable, given the responsibility the State [or local government] has taken for the care and treatment of a large and diverse population of persons with [ ] disabilities." [18] It is the public entity's burden to establish that the requested modification would fundamentally alter its service system.

11. What budgetary resources and costs are relevant to determine if the relief sought would constitute a fundamental alteration?

A: The relevant resources for purposes of evaluating a fundamental alteration defense consist of all money the public entity allots, spends, receives, or could receive if it applied for available federal funding to provide services to persons with disabilities. Similarly, all relevant costs, not simply those funded by the single agency that operates or funds the segregated or integrated setting, must be considered in a fundamental alteration analysis. Moreover, cost comparisons need not be static or fixed. If the cost of the segregated setting will likely increase, for instance due to maintenance, capital expenses, environmental modifications, addressing substandard care, or providing required services that have been denied, these incremental costs should be incorporated into the calculation. Similarly, if the cost of providing integrated services is likely to decrease over time, for instance due to enhanced independence or decreased support needs, this reduction should be incorporated as well. In determining whether a service would be so expensive as to constitute a fundamental alteration, the fact that there may be transitional costs of converting from segregated to integrated settings can be considered, but it is not determinative. However, if a public entity decides to serve new individuals in segregated settings ("backfilling"), rather than to close or downsize the segregated settings as individuals in the plaintiff class move to integrated settings, the costs associated with that

decision should not be included in the fundamental alteration analysis.

12. What is an *Olmstead* Plan?

A: An *Olmstead* plan is a public entity's plan for implementing its obligation to provide individuals with disabilities opportunities to live, work, and be served in integrated settings. A comprehensive, effectively working plan must do more than provide vague assurances of future integrated options or describe the entity's general history of increased funding for community services and decreased institutional populations. Instead, it must reflect an analysis of the extent to which the public entity is providing services in the most integrated setting and must contain concrete and reliable commitments to expand integrated opportunities. The plan must have specific and reasonable timeframes and measurable goals for which the public entity may be held accountable, and there must be funding to support the plan, which may come from reallocating existing service dollars. The plan should include commitments for each group of persons who are unnecessarily segregated, such as individuals residing in facilities for individuals with developmental disabilities, psychiatric hospitals, nursing homes and board and care homes, or individuals spending their days in sheltered workshops or segregated day programs. To be effective, the plan must have demonstrated success in actually moving individuals to integrated settings in accordance with the plan. A public entity cannot rely on its *Olmstead* plan as part of its defense unless it can prove that its plan comprehensively and effectively addresses the needless segregation of the group at issue in the case. Any plan should be evaluated in light of the length of time that has passed since the Supreme Court's decision in *Olmstead*, including a fact-specific inquiry into what the public entity could have accomplished in the past and what it could accomplish in the future.

13. Can a public entity raise a viable fundamental alteration defense without having implemented an *Olmstead* plan?

A: The Department of Justice has interpreted the ADA and its implementing regulations to generally require an *Olmstead* plan as a prerequisite to raising a fundamental alteration defense, particularly in cases involving individuals currently in institutions or on waitlists for services in the community . In order to raise a fundamental alteration defense, a public entity must first show that it has developed a comprehensive, effectively working *Olmstead* plan that meets the standards described above. The public entity must also prove that it is implementing the plan in order to avail itself of the fundamental alteration defense. A public entity that cannot show it has and is implementing a working plan will not be able to prove that it is already making sufficient progress in complying with the integration mandate and that the requested relief would so disrupt the implementation of the plan as to cause a fundamental alteration.

14. What is the relevance of budgetary shortages to a fundamental alteration defense?

A: Public entities have the burden to show that immediate relief to the plaintiffs would effect a fundamental alteration of their program. Budgetary shortages are not, in and of themselves, evidence that such relief would constitute a fundamental alteration. Even in times of budgetary constraints, public entities can often reasonably modify their programs by re-allocating funding from expensive segregated settings to cost-effective integrated settings. Whether the public entity has sought additional federal resources available to support the provision of services in integrated settings for the particular group or individual requesting the modification – such as Medicaid, Money Follows the Person grants, and federal housing vouchers – is also relevant to a budgetary defense.

15. What types of remedies address violations of the ADA's integration mandate?

A: A wide range of remedies may be appropriate to address violations of the ADA and *Olmstead*, depending on the nature of the violations. Remedies typically require the public entity to expand the capacity of community-based alternatives by a specific amount, over a set period of time. Remedies should focus on expanding the most integrated alternatives. For example, in cases involving residential segregation in institutions or large congregate facilities, remedies should provide individuals opportunities to live in their own apartments or family homes, with necessary supports. Remedies should also focus on expanding the services and supports necessary for individuals' successful community tenure. *Olmstead* remedies should include, depending on the population at issue: supported housing, Home and Community Based Services ("HCBS") waivers, [19] crisis services, Assertive Community Treatment ("ACT") teams, case management, respite, personal care services, peer support services, and supported employment. In addition, court orders and settlement agreements have typically required public entities to implement a process to ensure that currently segregated individuals are provided information about the alternatives to which they are entitled under the agreement, given opportunities that will allow them to make informed decisions about their options (such as visiting community placements or programs, speaking with community providers, and meeting with peers and other families), and that transition plans are developed and implemented when individuals choose more integrated settings.

16. Can the ADA's integration mandate be enforced through a private right of action?

A: Yes, private individuals may file a lawsuit for violation of the ADA's integration mandate. A private right of action lies to enforce a regulation that authoritatively construes a statute. The Supreme Court in *Olmstead* clarified that unnecessary institutionalization constitutes "discrimination" under the ADA, consistent with the Department of Justice integration regulation.

17. What is the role of protection and advocacy organizations in enforcing *Olmstead*?

A: By statute, Congress has created an independent protection and advocacy system (P&As) to protect the rights of and advocate for individuals

with disabilities. [20] Congress gave P&As certain powers, including the authority to investigate incidents of abuse, neglect and other rights violations; access to individuals, records, and facilities; and the authority to pursue legal, administrative or other remedies on behalf of individuals with disabilities. [21] P&As have played a central role in ensuring that the rights of individuals with disabilities are protected, including individuals' rights under title II's integration mandate. The Department of Justice has supported the standing of P&As to litigate *Olmstead* cases.

18. Can someone file a complaint with the Department of Justice regarding a violation of the ADA and *Olmstead*?

A: Yes, individuals can file complaints about violations of title II and *Olmstead* with the Department of Justice. A title II complaint form is available on-line at www.ADA.gov and can be sent to:

U.S. Department of Justice
Civil Rights Division
950 Pennsylvania Avenue, NW
Disability Rights Section - NYAV
Washington, DC 20530

Individuals may also call the Department's toll-free ADA Information Line for information about filing a complaint and to order forms and other materials that can assist you in providing information about the violation. The number for the ADA Information Line is (800) 514-0301 (voice) or (800) 514-0383(TTY).

In addition, individuals may file a complaint about violations of Olmstead with the Office for Civil Rights at the U.S. Department of Health and Human Services. Instructions on filing a complaint with OCR are available at http://www.hhs.gov/ocr/civilrights/complaints/index.html.

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[1] 42 U.S.C. § 12101(b)(1).

[2] 42 U.S.C. § 12101(a)(2).

[3] 42 U.S.C. § 12132.

[4] *See* 42 U.S.C. § 12134(a); 28 C.F.R. § 35.190(a); Executive Order 12250, 45 Fed. Reg. 72995 (1980), *reprinted in* 42 U.S.C. § 2000d-1. Section 504 of the Rehabilitation Act of 1973 similarly prohibits disability-based discrimination. 29 U.S.C § 794(a) ("No otherwise qualified individual with a disability . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance . . . ."). Claims under the ADA and the Rehabilitation Act are generally treated identically.

[5] 28 C.F.R. § 35.130(d) (the "integration mandate").

[6] 28 C.F.R. Pt. 35, App. A (2010) (addressing § 35.130).

[7] *Olmstead v. L.C.*, 527 U.S.at 607.

[8] *Id*. at 600-01.

[9] 28 C.F.R.§ 35.130(b)(7).

[10] *Id.*; *see also Olmstead*, 527 U.S. at 604-07.

[11] 28 C.F.R. pt. 35 app. A (2010).

[12] *See* 28 C.F.R. § 35.130(b)(1) (prohibiting a public entity from discriminating "directly or through contractual, licensing or other arrangements, on the basis of disability"); § 35.130(b)(2) (prohibiting a public entity from "directly, or through contractual or other arrangements, utilizing criteria or methods of administration" that have the effect of discriminating on the basis of disability").

[13] *Olmstead*, 527 U.S. at 598; 28 C.F.R. 35.130(d).

[14] *See* CMS, Olmstead Update No. 4, at 4 (Jan. 10, 2001), available at https://www.cms.gov/smdl/downloads/smd011001a.pdf.

[15] *Id.*

[16] 28 C.F.R. § 35.130.

[17] *See* U.S. Dept. of Justice, ADA Title II Technical Assistance Manual § II-3.6200.

[18] *Olmstead*, 527 U.S. at 604.

[19] HCBS waivers may cover a range of services, including residential supports, supported employment, respite, personal care, skilled nursing, crisis services, assistive technology, supplies and equipment, and environmental modifications.

[20] 42 U.S.C. §§ 15001 *et seq.* (Developmental Disabilities Assistance and Bill of Rights Act, requiring the establishment of the P&A system to protect and advocate for individuals with developmental disabilities); 42 U.S.C. § 10801 *et seq.* (The Protection and Advocacy for Individuals with Mental Illness Act, expanding the mission of the P&A to include protecting and advocating for individuals with mental illness)

[21] 42 U.S.C. §§ 10805, 15043.

Exhibit 20 37 La. Reg. 1490-91 (June 20, 2011)

trended forward for direct care services (plus 70 percent of any direct care incentive added to the rate). The Medicaid Program will recover the difference between the direct care floor and the actual direct care amount expended. If a provider receives an audit disclaimer, the cost settlement for that year will be based on the difference between the direct care floor and the lowest direct care per diem of all facilities in the most recent audited and/or desk reviewed database trended forward to the rate period related to the disclaimer.

D. Support Coordination Services Reimbursement. Support coordination services previously provided by ADHC providers and included in the rate, including the Minimum Data Set Home Care (MDS/HC), the CPOC and home visits will no longer be the responsibility of the ADHC provider. Support coordination services shall be provided as a separate service covered in the ADHC Waiver. As a result of the change in responsibilities, the rate paid to ADHC providers shall be adjusted accordingly.

1. - 2. Repealed.

E. New Facilities, Changes of Ownership of Existing Facilities, and Existing Facilities with Disclaimer or Non-Filer Status

1. New Facilities are those entities whose beds have not previously been certified to participate, or otherwise have participated, in the Medicaid program. New facilities will be reimbursed in accordance with this Rule and receiving the direct care, care related, administrative and operating, property rate components as determined in §2915.B.1 - §2915.B.7. These new facilities will also receive the state-wide average transportation rate component, as calculated in §2915.B.7.e.i.(a), effective the preceding July 1.

2. A change of ownership exists if the beds of the new owner have previously been certified to participate, or otherwise have participated, in the Medicaid program under the previous owner's provider agreement. Rates paid to facilities that have undergone a change in ownership will be based upon the rate paid to the previous owner for all rate components. Thereafter, the new owner's data will be used to determine the facility's rate following the procedures in this rule.

3. Existing providers that have been issued an audit disclaimer, or are a provider who has failed to file a complete cost report in accordance with §2903, will be reimbursed based upon the statewide allowable quarter hour median costs for the direct care, care related, administrative and operating, and property rate components as determined in §2915.B.1 - §2915.B.7. The transportation component will be reimbursed as described in §2915.B.7.e.iii.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2170 (October 2008), repromulgated LR 34:2575 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein
Secretary

1106#053

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing

Home and Community-Based Services Waivers
Elderly and Disabled Adult Waiver
Emergency Opportunities and Reimbursement Methodology
(LAC 50:XXI.8105, 9101, 9107-9121)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amend LAC 50:XX1.8105, 9101 and adopts §§9107-9121 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act and as directed by Act 11 of the 2010 Regular Session of the Louisiana Legislature which states: "The secretary is directed to utilize various cost containment measures to ensure expenditures in the Medicaid Program do not exceed the level appropriated in this Schedule, including but not limited to precertification, preadmission screening, diversion, fraud control, utilization review and management, prior authorization, service limitations, drug therapy management, disease management, cost sharing, and other measures as permitted under federal law." This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

As a result of a budgetary shortfall in state fiscal year 2009, the department amended the provisions governing the reimbursement methodology for the Elderly and Disabled Adult (EDA) Waiver to reduce the reimbursement rates paid for designated services (*Louisiana Register,* Volume 35, Number 9).

As a result of a budgetary shortfall in state fiscal year 2011, the department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for EDA Waiver services to further reduce the reimbursement rates for personal assistance and adult day health care services and adopted provisions governing the reimbursement for adult day health care services (*Louisiana Register*, Volume 36, Number 8).

The Department now proposes to amend the August 1, 2010 Emergency Rule to adopt provisions to allow for emergency waiver opportunities for individuals who require emergency waiver services, and to revise the reimbursement methodology for adult day health care services to implement a quarter hour reimbursement rate. This action is being taken to avoid a budget deficit in the medical assistance

programs and to promote the health and welfare of EDA Waiver recipients.

Effective July 1, 2011, the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amend the provisions of the August 1, 2011 Emergency Rule governing the Elderly and Disabled Adult Waiver.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXI. Home and Community Based Services Waivers
Subpart 7. Elderly and Disabled Adults
Chapter 81. General Provisions
§8105. Programmatic Allocation of Waiver Opportunities

A. - B.1. …

2. individuals diagnosed with Amyotrophic Lateral Sclerosis (ALS), also known as Lou Gehrig's disease;

3. individuals admitted to a nursing facility who are approved for a stay of more than 90 days;

4. - 5. …

C. If an applicant is determined to be ineligible for any reason, the next individual on the registry is notified as stated above and the process continues until an individual is determined eligible. An EDA Waiver opportunity is assigned to an individual when eligibility is established and the individual is certified.

D. Notwithstanding the priority group provisions, 75 EDA Waiver opportunities are reserved for qualifying individuals who have been diagnosed with Amyotrophic Lateral Sclerosis (ALS). Qualifying individuals who have been diagnosed with ALS shall be offered an opportunity on a first-come, first-serve basis.

E. Notwithstanding the priority group provisions, up to 100 EDA Waiver opportunities may be granted to qualified individuals who require emergency waiver services. These individuals shall be offered an opportunity on a first-come, first-serve basis.

1. To be considered for an emergency waiver opportunity, the individual must currently receive the maximum amount of services allowable under the Long Term Personal Care Services Program and require institutional placement, unless offered an emergency waiver opportunity.

2. The following criteria shall be considered in determining whether or not to grant an emergency waiver opportunity:

a. support through other programs is either unavailable or inadequate;

b. the death or incapacitation of an informal caregiver leaves the person without other supports;

c. the support from an informal caregiver is not available due to a family crisis; or

d. the person lives alone and has no access to informal support.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:1699 (August 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Division of Long Term Supports and Services, LR 32:1245 (July 2006), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:1030 (June 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:2447 (November 2009), amended LR 37:900 (March 2011), LR 37:

Chapter 91. Reimbursement
Subchapter A. General Provisions
§9101. Reimbursement Methodology

A. Reimbursement for EDA Waiver services, with the exception of ADHC services, shall be a prospective flat rate for each approved unit of service provided to the recipient. Adult day health care services shall be reimbursed according to the provisions of Subchapter B of this Chapter 91.

B. – C. …

D. Effective for dates of service on or after August 1, 2010, the reimbursement rates for personal assistance services in the EDA Waiver shall be reduced by 2 percent of the rates on file as of July 31, 2010.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:251 (February 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:1893 (September 2009), amended LR 37:

Subchapter B. Adult Day Health Care Services Reimbursement
§9107. General Provisions

A. Adult day health care services shall be reimbursed a per quarter hour rate for services provided under a prospective payment system (PPS). The system shall be designed in a manner that recognizes and reflects the cost of direct care services provided. The reimbursement methodology is designed to improve the quality of care for all EDA waiver recipients by ensuring that direct care services are provided at an acceptable level while fairly reimbursing the providers.

B. Reimbursement shall not be made for EDA Waiver services provided prior to the Department's approval of the CPOC.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:

§9109. Cost Reporting

A. Cost Centers Components

1. Direct Care Costs. This component reimburses for in-house and contractual direct care staffing and fringe benefits and direct care supplies.

2. Care Related Costs. This component reimburses for in-house and contractual salaries and fringe benefits for activity and social services staff, raw food costs and care related supplies for activities and social services.

3. Administrative and Operating Costs. This component reimburses for in-house or contractual salaries and related benefits for administrative, dietary, housekeeping and maintenance staff. Also included are:

a. utilities;

b. accounting;

c. dietary;

d. housekeeping and maintenance supplies; and

e. all other administrative and operating type expenditures.

Exhibit 21 Declaration of Mary Dunn

DECLARATION OF MARY DUNN

Mary Dunn subscribes under penalty of perjury, pursuant to 28 U.S.C. § 1746, as follows:

1. My name is Mary Dunn. I am 81 years old, and I live alone in my home in Monroe, Louisiana.
2. I have osteoporosis, arthritis, heart problems and have had back surgery. I had back surgery, when I was about thirty years old, to correct a spinal problem that I had at birth. It does not seem that my back ever healed properly. Due to the combination of the osteoporosis, the arthritis and the back surgery, I am often in excruciating pain. I take medication to help with the pain. The effects of the medication, and the fact that I am getting older, makes it hard for me to remember things. The facts in this declaration are true to the best of my knowledge and recollection.
3. I am eligible for and receive Medicaid. I have also been found eligible for and receive Long-term Personal Care Services.
4. In September of 2010, I was receiving thirty-eight hours per week of Long-term Personal Care Services. I received notification sometime in May of 2011 that as of June 1, 2011, my hours would be reduced to twenty-nine hours per week.
5. At my request, the personal care worker I had at that time appealed for me. I do not know to whom she sent the appeal, and I do not know when she sent the appeal. I do not remember attending an appeal hearing.ecause of the medication I take and my problems remembering things, I was not able to deal with the appeal

personally. I do not remember being notified that if I appealed and received 32 hours of LT-PCS, I would be able to apply for an emergency waiver slot.

6. On October 7, 2011, I met with someone, who I assumed worked for the state of Louisiana, about my need for more hours through Long-term Personal Care Services. After our discussion, I was awarded one more hour per week, and I am now approved for thirty hours per week.
7. I need thirty-eight to forty hours to continue to live in my home and remain independent.
8. I need assistance with transferring from and to my bed and my wheelchair. I need help transferring to and from the toilet and need help cleaning myself after toileting. My worker also helps me bathe, dress and perform all grooming tasks. I also need assistance with meal preparation, laundry, household chores and shopping.
9. In the morning my personal care worker comes to my home to help me. She begins her work by helping me to bathe, tend to personal hygiene tasks and get dressed. This takes an hour and thirty minutes to one hour and forty-five minutes. She then helps me get into my wheelchair and that takes about fifteen minutes.
10. As I said above, due to the combination of the osteoporosis, the arthritis and the back surgery, I am often in excruciating pain. During those times I return to bed to lie down in the late morning. Lying down is sometimes the only position that gives me some relief from the pain. This means that it takes another twenty to thirty minutes to help me transfer in and out of bed.

11. I use a motorized wheelchair when I am not in bed. I can maneuver the chair myself once I am in it, but I cannot get in and out of the chair on my own. I do not remember when I started using the wheelchair. It seems that it was three to five years ago.

12. My personal care worker prepares my breakfast after helping me get into my wheelchair. Preparing my meal and cleaning the kitchen after I eat takes about thirty minutes.

13. I need help eating when I am too weak to hold the utensils. When this happens, my worker must spend an extra fifteen minutes or so feeding me.

14. She fixes my lunch before she leaves and also gets something for dinner prepared in a crock-pot or makes sure that a frozen meal bought from the grocery is readily available. Preparing the meals and cleaning the kitchen after preparation takes about forty-five minutes.

15. During the day, I will go to the toilet once or twice. My personal care worker helps me to get on and off the toilet, as well as helps me to clean myself. Each of these tasks takes approximately fifteen minutes.

16. I am incontinent, and my worker assists me with pads and to clean myself after accidents. If the worker is not around when I have an accident, I have to wait until she arrives the next day to be cleaned. I try to control my incontinence with medication and fluid intake, but the accidents still occur.

17. When I do have a bowel accident and my personal care worker is with me, she helps clean me and change my pad. This activity can take approximately thirty minutes.

18. If you add the time that I need from my worker on a daily basis, you will see that I need approximately four hours and fifteen minutes each day. This means that if I am not feeling well and move slower, something doesn't get done. What doesn't get done can be a hygiene task, preparation of a meal, or assisting me back into and out of bed in the late morning.

19. It also means that when I have shopping, laundry or household chores that must be done, something else doesn't get done during that day. If I have to go to a doctor, which seems to be about once each month, my personal care worker accompanies me. On those days, she has no time to prepare my meals and may not have time to do all of my personal care.

20. I live approximately 15 minutes from the closest grocery store, so grocery shopping takes approximately one and a half hours. It takes longer if I go with my worker because I must use my manual wheelchair since my worker cannot transport my motorized chair.

21. My personal care worker must do all of my household chores, including cleaning my home and doing my laundry. She also assists me with my mail and paying my bills. I seem to be forgetting things lately, so she helps to make sure I don't forget anything important.

22. Assisting me with household chores, bill paying and laundry can take another two hours per week.

23. I have a bedside commode, which I attempt transfer to and from at night or whenever I am in bed, but I have fallen several times. Some of the falls have taken place during times of the day when if my hours had not been reduced, my

personal are worker would have been with me. After my most recent fall, which was only about three weeks ago, I fractured my hip; however, the doctor does not recommend surgery because of the affects the anesthesia may have on my heart.

24. Since that fall, I find I have had great difficulty to transferring to the commode and have had accidents when my worker wasn't with me, which means I wasn't cleaned and changed for many hours.

25. With the reduction in hours, my worker does not have time to prepare proper meals for me. I often have to buy food that is already prepared, which, often times, does not follow the diet that has been suggested by my doctor as a result of my heart problems.

26. Presently, I only receive sponge baths because I have a wound on my foot that will not heal and the doctor things might be cancerous. My doctor has said that I cannot submerge my foot into water. Once I am able to have full baths again, I am not sure my worker will have time to fully bathe me on a daily basis because in the past each bath took forty-five minutes to an hour because my personal care worker had to undress me, transfer me to the bath, wash me, dry me, dress me and transfer me back to the wheelchair.

27. I have a home health nurse that provides wound care for the wound on my foot, and also checks my vital signs.

28. I had eight children. Two died as infants, One of my daughters died when she was an adult as a result of seizures, and my youngest son died in 2010 from cancer. I have four living children. Three of them do not provide me with any help: a son who lives in about 22 miles away in Rayville, and who has health

problems similar to mine; a daughter who lives in Choudrant, LA and cannot drive due to seizures; and a second daughter in Rayville that I only see one or two times each year.

29. I have one son who lives in the same apartment complex as I do; however, he has osteoporosis and rheumatoid arthritis. He can and does check in on me, but he cannot lift me due to his own health issues, nor can he help with toileting or other ADLs. When I am not feeling well, he sometimes stays with me at night; however, he is often in the hospital attending to his own health problems.
30. When my son is able, he helps me by putting the dinner that was prepared earlier by my personal care worker on a plate, and putting the plate of food on the table for me.
31. My husband died approximately twenty years ago. I have no other family that can assist me.
32. If I continue to receive only thirty hours per week, I believe my health will deteriorate and I will be forced to go into a nursing home.
33. I also wish to continue to control my own life and do not want to move to a nursing home where that opportunity will be taken from me.
34. I do not think I should be forced into a nursing home. I know from past experience that I can remain healthy and safe in my own home, if I am provided with adequate assistance. I want to stay in my own home.

/s/ Mary Dunn
Mary Dunn

11-9-2011
Date

Exhibit 22 Declaration of Bessie Foreman

DECLARATION OF BESSIE FOREMAN

Bessie Foreman subscribes under penalty of perjury, pursuant to 28 U.S.C. § 1746, as follows:

1. My name is Bessie Foreman. I live alone in Iowa, Louisiana. I am 86 years old.
2. I am eligible for and receive Medicaid. Until May of 2011, I was receiving thirty-eight hours per week of Long-Term Personal Care Services. I have been receiving Long-term Personal Care Services for approximately seven years.
3. In March, I was told that my hours would be reduced from thirty-five to twenty-six hours per week. I appealed that decision, and on or around May 1, 2011, my hours were reduced to thirty-two hours per week pending my appeal hearing.
4. In May of 2011, my daughter participated in my hearing, which was held over the phone. Because the hearing was over the phone, I would not have been able to hear the proceedings, so my daughter represented me. My daughter participated from my home using my phone. After the hearing she told me that the Judge said that the state's decision to reduce my hours would be upheld.
5. My hours were reduced to 26 hours per week in June of 2011.
6. Since May of 2011, my daughter has been doing what my worker does not have time to do; however, this is only temporary, while we try to find out if there is any way my services can be restored to 38 hours a week. If my hours of home care have to stay at 26 per week, I will have to enter a nursing home.
7. Right now, my daughter helps me to get dinner, she assists me to clean myself after incontinence episodes and redress. My daughter also helps to get me ready for bed in the evening. In addition, to save time, my daughter has been helping

my personal care worker bathe me, so that there is time for the worker to complete other tasks such as meal preparation, household chores and assisting me with toileting.

8. My daughter and I have had discussions about me needing more assistance than the twenty-six hours per week that I am provided and the possibility of me entering a nursing home. If I do not have more help, I do not think I can avoid having to enter a nursing home.

9. My daughter cannot continue to provide the help I need to stay in my home. She lives approximately thirty miles from my home. She has two part-time jobs, and she has had to cut back on hours at one of these jobs. She needs to return to working the hours she was working before my hours were reduced. She has many friends and a boyfriend that she enjoys seeing in the evenings and on weekends and she has not been able to spend time with these friends because she assists me every morning and every night.

10. My daughter will continue to be there for me in an emergency, and will continue to see me a few times each week, but she has told me that she cannot and will not keep assisting me on a daily basis. If my hours of LT-PCS are not restored, I will have no choice but to enter a nursing home.

11. I have heart problems, diabetes, arthritis, asthma, cataracts in both eyes, and I am hard of hearing. I have had right knee replacement and three back surgeries. I had surgery on my right arm, which has left my right arm fairly immobile. I am also obese.

12. With these impairments, I cannot do anything for myself, other than feed myself. If I am alone, I cannot walk to get a glass of water or get food, cannot get on and off the toilet, cannot dress or undress myself and cannot rise to a standing position. If I am in my wheelchair, I cannot propel the chair very far without becoming completely fatigued. In addition, I do not have the strength to prepare meals, even simple meals such as a sandwich, do my laundry or my other household chores.

13. Since my hours have been reduced, my personal care worker has not been able to attend to all of my care needs. She leaves at noon everyday, which means she only helps me to get one meal each day, rather than the three meals and snacks I should have because of my diabetes. She is not available to help me use the toilet in the afternoon or evening, undress me and dress me for bed, or help me into bed.

14. In the morning, my personal care worker helps me to get out of bed, bathe, brush my teeth, brush my hair, wash my face, prepare my breakfast, and while I am eating she attends to household chores. Since my hours have been reduced, I no longer get a bath daily. Typically, I bathe only three times each week. Because I am obese and have incontinent episodes, I need to bathe daily, and I think that it would be healthier for me to do so.

15. Because my hours have been reduced, my daughter has been assisting my personal care worker to bathe me. Bathing, even with my daughter assisting my personal care worker, takes approximately 45 minutes to one hour, because I need help getting into the shower then my worker and my daughter bathe me. Once I am bathed, my worker and my daughter then help me out of the shower, dry me

and dress me. Without my daughter's assistance this task would probably take approximately one hours and thirty minutes.

16. I am incontinent of bowel and bladder. When I have accidents, I need immediate assistance to clean myself. My personal care worker is not with me past noon, so she is not able to assist me. If my daughter is not with me when this happens, I have had to wait for her to return to my home or have had to wait until my personal care worker arrives in the morning until I can be cleaned.

17. I have two to three incontinent episodes each day and must be cleaned after each accident. Because of my size, it takes either my personal care worker or my daughter approximately thirty minutes to undress me, clean me, change my pad, redress me.

18. I believe that the surgeries and my arthritis are the major reasons that I can no longer physically care for myself. My doctor has told me that my left knee is in need of replacement, too, but this surgery is not yet scheduled.

19. I have great difficulty walking and must use a wheelchair, a cane or a walker around my home. When I leave my home, I always use a wheelchair. I do not walk unattended for fear of falling. It seems that I fall almost once a month, and as a result of a fall in March of 2010, I broke my ankle. I am fearful of what a fall could do to my physical condition, so I always try to have someone with me when I walk.

20. When I use the wheelchair, I have difficulty propelling my own, so whenever I want to move in the chair, someone usually pushes me.

21. If there is a table or something to hang on to, I can move my wheelchair by pulling myself along the table or other object and moving by chair that way. I cannot even do this for long distances because I become fatigued.

22. When I stand, I become very dizzy and must wait for that feeling to subside before moving, again. This is another reason, I do not like to stand or attempt to transfer into my bed or any other surface when I am alone.

23. As a result of the back surgeries, I no longer walk completely erect. My body is always in a position of leaning forward when I am standing. I also walk very slowly.

24. I take 18 different medications, including insulin injections. Due to my diabetes and the number of medications that I take, it is important that I eat healthy meals and snacks on a regular schedule. Because my worker is only here until noon, she is only able to give me breakfast and sometimes a mid-morning snack. My worker prepares my lunch and dinner before leaving my home, but I must depend on my daughter to get my meals and place them on the table.

25. My husband died in 1998. When he was living we both worked hard to raise our children, and make sure we could provide for them. We owned a grocery store and were also rice farmers.

26. Only the daughter I have mentioned assists me with my care. None of my other children assist me with my care, and I have no other family that assists me.

27. If I do not get more assistance, I am afraid that a nursing home will be my only option.

28. I do not want to go into a nursing home.

29. After raising a family and assisting my husband with the family businesses, I thought that I could live the remaining years of my life in my own home. I believe that I should have the opportunity to do just that. And, I believe I should be provided with the necessary assistance to do that.

30. I do not believe I would receive the assistance I need to get out of bed on a regular basis and believe that my health would decline as a result if I were in a nursing home.

31. I want to continue living in my own home, where I am relatively healthy and in control of my own life.

/s/ Bessie Foreman
Bessie Foreman

11/9/11
Date

Exhibit 23 Declaration of Estelle Curtain

DECLARATION OF ESTELLE CURTAIN

Estelle Curtain subscribes under penalty of perjury, pursuant to 28 U.S.C. § 1746, as follows:

1. My name is Estelle Curtain. I am fifty-eight years old and live alone in Baton Rouge, Louisiana.
2. I began receiving Long-term Personal Care Services on September 28, 2004. In 2009, I was approved for 37.25 hours per week. When I was reassessed in 2011, I was told that I would receive only 29 hours of services per week.
3. I asked the program director of my LT-PCS provider to fax in an appeal for me, but the appeal was not acknowledged, so my hours were reduced to 29 hours per week in mid-June of 2011. When I called to ask about the status of my appeal, my appeal could not be found. I asked the program director for the fax receipt, but she told me that she did not save it.
4. When I decided to appeal, I did not know about the Advocacy Center, or I would have called for assistance when I first received the notice about my reduction in hours. I found information about the Advocacy Center in paperwork given to me by the assessor who works for the Capital Area Agency on Aging after the time for my appeal had passed. When I found the paperwork, I contacted the Advocacy Center and requested assistance with my reduction in hours.
5. In October of 2011 my hours were increased to 37.25 per week, which was a result of a request made to OAAS by the Advocacy Center.

6. I have rheumatoid arthritis, Chronic Obstructive Pulmonary Disease, asthma, lower lumbar disk disease, diabetes and high blood pressure. I also have bi-polar disorder and schizophrenia, which are controlled with medication.
7. Both of my feet have deformities caused by calluses, corns, bunions and hammer-toes, which makes it difficult for me to walk.
8. I use a cane to walk but am always at risk of falling because I am very unsteady.
9. I need assistance from my personal care worker with eating, bathing, dressing, transferring, toileting, walking and driving me to and from my numerous medical appointments. I see my primary care physician one time each month and I go to the diabetic foot clinic approximately once every ten weeks. In addition, my doctor has recommended that I go to physical therapy one time a week, but the therapy has not started.
10. I cannot get on or off the toilet without my personal care workers help. I also need her to help clean me after bowel movements. My worker must also help me to get into and out of the bed.
11. I am incontinent due to a neurological problem that causes my bladder muscles to be very weak. I do not have the sensation that tells me that I need to urinate. I have had this problem since I was a child.
12. I will also defecate on myself at times while I am urinating. I do not know what causes this to happen and my doctors do not know what causes this.
13. I wear adult diapers but should be cleaned immediately after each bladder and/or bowel accident. If I do not have assistance when I have an accident, I am not cleaned until my personal care worker arrives and can clean me.

14. Since my hours were reduced, I have on a number of occasions had to sit or lie down for many hours on a wet pad or in a wet diaper. I am afraid that this will cause me to have skin breakdowns, which I know can cause serious harm
15. I also need my clothing and sheets washed when I have accidents and soil my clothing and/or my bed linens. When my personal care worker could only work 29 hours per week, my laundry would not get done for days at a time, causing my bedroom to fill with gnats and flies, and my bedroom and clothes often smelled of urine and feces.
16. Approximately four months ago and during the time that my hours were reduced, I came close to falling while trying to walk unattended, and bruised myself significantly. The only I did not fall to ground was because I was able to brace myself against a wall.
17. Due to the COPD, I often find I have no energy to walk at all, so I often remain still and do not even attempt to walk or move.
18. My personal care worker also assists me by preparing my meals, grocery shopping, and performing my household chores. Because I cannot stand for long periods of time, these chores are impossible for me to complete.
19. When my worker arrives in the morning she assists me to get out of bed and get a bath. She undresses me, prepares the bath, assists me to bathe, dries me, and then helps me to get dressed and tend to personal hygiene tasks. These activities can take approximately two hours or more.
20. She then prepares my breakfast. She often has to feed me if my hands are cramped due to my arthritis, which happens about five days per week. Fixing

breakfast, cleaning the kitchen and feeding me can take forty-five minutes to an hour.

21. When I have an accident, which occurs three to four times each day, she has to clean me and redress me. Each time I have an accident it requires twenty to thirty minutes of my worker's time.

22. She also prepares lunch, which she also has to feed me, and she prepares dinner, which is something that I can eat without utensils. This takes approximately one hour.

23. I need my laundry done two to three times each week due to my bowel and bladder incontinence. I do not have laundry facilities in my apartment, so she must take my clothes to a Laundromat. It takes her approximately two hours to do my laundry. Grocery shopping takes approximately one hour each week.

24. My doctor is watching my diabetes very carefully. At present my circulation is becoming worse, and my feet are beginning to turn black. We attribute this to my diabetes, which is why I have been referred to the diabetic foot clinic. I was diagnosed with diabetes when I was in my forties.

25. Because I have diabetes, it is important that I eat regularly and eat a healthy diet. When my personal care worker was only working 29 hours per week, she did not always have time to prepare healthy meals for me, and she did not have time to get snacks for me. In addition, she did not always have time to go to the grocery on a weekly basis, so I did not always have fresh ingredients in the house.

26. I recently had an MRI done so that my doctor could see the progression of my lumbar disk disease. My doctor has ordered physical therapy for me one time a

week. I depend on my personal care worker to bring me to doctor's appointments and will also need her to bring me to the therapy appointments. I am worried that she will not have time to bring me if my hours are reduced to 32 hours per week or less.

27. I am also fearful that if I start therapy, my worker will have even less time to assist me with my personal needs, and not only will she not have time to prepare meals and do my laundry, but she will not have time to assist me with bathing, which is so important to me because of my incontinence.

28. When my hours were decreased to 29 hours per week, it caused me physical and emotional stress. When I was 42 years old, I was diagnosed with severe depression, and when my hours were reduced I began to feel many of the same symptoms that I felt then, such as not sleeping and losing interest in things I enjoy such as television. I believe that the depression I was feeling was directly related to my fear of not having adequate personal care services and also due to being in a room with sheets and clothes that smell of urine and feces.

29. My mother died in 1998, and both of my siblings are also deceased. My sister died in a car accident in 1996 and my brother died of a heart attack approximately six years ago.

30. I have four children that all have families of their own for whom to care. My children do not have time to care for me, and they do not help me. I do speak to my children on a daily basis, but I do not see them often. One of my daughters lives in Arkansas. ~~One of my sons~~ my son also has diabetes, and he was recently in the ICU with complications from the diabetes.

31. I have no other family, and I depend solely on my personal care worker to provide all of my care.

32. If my LT-PCS hours are reduced, I will have to go into a nursing home, which I do not want to do.

33. I do not want to be forced into a nursing home. I would prefer to continue living in my own home where I am comfortable and happy, where I enjoy visits from my neighbor, bible studies, and sporadic visits from my children and grandchildren.

Estelle L. Curtain
Estelle Curtain

November 15th 2011
Date

Exhibit 24 Declaration of Mitchell LaPlante

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

HELEN PITS, KENNETH ROMAN, DENISE HODGES, and RICKII AINEY, on behalf of themselves and all others similarly situated, Plaintiffs, v. BRUCE GREENSTEIN, in his official capacity as Secretary of the Louisiana Department of Health and Hospitals, and LOUISIAN DPEARTMENT OF HEALTH AND HOSPITALS, Defendants.	C.A. No.3:10-cv-00635-JJB-SCR Judge James J. Brady Magistrate Judge Stephen C. Riedlilnger

DECLARATION OF MITCHELL LAPLANTE

I, Mitchell LaPlante, hereby verify that the followings statements are true and correct, to the best of my knowledge, information and belief. I understand that false statements herein are made subject to the penalties of 28 U. S.C. § 1746 relating to unsworn falsification to authorities.

1. I am a Professor at the University of California San Francisco Department of Social and Behavioral Sciences and the Institute for Health and Aging. A true and correct copy of my curriculum vitae is attached hereto as Exhibit A.
2. My academic research has addressed the demography and epidemiology of health and disability and long-term care, how the prevalence of disability varies by race and ethnicity and by state; the relationship of disability with various chronic illness and impairments; the relationship of disability to use of health care and health care expenditures; the relationship of disability and insurance rates; employment of

individuals with disabilities; the housing of individuals, families and children with disabilities; the use of, and unmet need for, assistive technology; and the use of and unmet need for personal assistance with activities of daily living and adverse consequences associated with such unmet needs.

3. I have served, by invitation, on several high-ranking national and international expert panels in the fields of disability research and policy, including the Institute of Medicine, the National Academy of Social Insurance, the National Institutes on Health, the Social Security Administration Disability Research Institute Advisory Panel, the United Nations and the World Health Organization. I have advised Congress on the costs of the Community Choice Act and similar legislation, testified before the United States Senate Finance Committee, and advised the Congressional Budget Office and Centers for Medicare and Medicaid Services on the costs and cost effectiveness of community long term services and support. I have also served as a consultant to the State of California Medicaid Infrastructure Grant and the California Governor's Committee on Disability. I was a member of the Institute of Medicine study panel that produced the book *Disability in America: Toward a National Agenda for Prevention* and the National Academy of Social Insurance Disability Policy Panel. In 2007, I received a Commendation Award from the National Association of Rehabilitation Research and Training Centers recognizing my career accomplishments in disability research, teaching, and policy. I am recognized as one of the foremost researchers in the field of disability in the United States and internationally. As Co-Principal Investigator of the Center on Personal Assistance Services, a Rehabilitation Research and Training Center funded primarily by the National Institute on Disability and Rehabilitation Research, and Co-Director of the

UCSF Disability Statistics Center, I have been consulted widely as an authority on disability statistics, epidemiology, and disability policy.

4. I am a member of many professional organizations; have given numerous juried and invited presentations at professional society conferences; am a popular reviewer for several professional journals, currently on the Editorial Board of the *Disability and Health Journal* and the *Journals of Gerontology: Social Sciences* and previously on the Editorial Board of the *Disability Studies Quarterly*.

5. I am the current recipient of research grants from the National Institute on Disability and Rehabilitation Research, establishing the Personal Assistance Services Rehabilitation Research and Training Center, and the San Diego State University Research Foundation. I have previously received research grants from the National Institute on Aging, the Social Science Research Council, the United States Departments of Health and Human Services and Education, and the California Department of Health Care Services Office of Disability and Health.

6. I am the author or co-author of numerous peer reviewed publications on disability and personal assistance needs including *Estimating paid and unpaid hours of personal assistance services in activities of daily living provided to adults living at home*, 37 Health Services Research 397-415 (2002); *Unmet need for personal assistance services: estimating the shortfall in hours of help and adverse consequences*, 59(2) J Gerontol B Psychol Sci Soc Sci S98-S108 (2004); *Living quarters and unmet need for personal care assistance among adults with disabilities*, 60(4) J Gerontol B Psychol Sci Soc Sci. S205-213 (2005); *Estimating the expense of a mandatory home- and community-based personal assistance services benefit under Medicaid*, 19(3) Journal of Aging & Social

Policy 47-64 (2007); *Do non-institutional long-term care services reduce Medicaid expenditures?* 28(1) Health Affairs 262-272 (2009); and *Long term care in the United States: Who gets it, who provides it, who pays, and how much does it cost?*, 29(1) Health Affairs 11-21 (2010).

7. I recently published, with co-authors, the results of a study of unmet need for personal assistance services, which relied on data from the National Health Interview Survey, a large, nationally representative survey of individuals living in households conducted by the Census Bureau for the United States National Center for Health Statistics (LaPlante, Kaye, Kang, & Harrington, 2004). For some individuals, unmet need occurred when they needed help with activities of daily living but did not receive any help at all. However, that was rare. Most people with unmet needs for personal assistance got some help, but they lacked help with certain activities (such as getting help with personal care like bathing and dressing, but not getting any help with meal preparation), or they did not get sufficient help in one or more activities (such as only getting help with preparing breakfast but not other meals). We found that, when elderly and disabled individuals who were in need of personal assistance services with activities of daily living did not have adequate levels of help, they had higher rates of adverse consequences in 48 of 53 measures tested than those whose needs were met, including experiencing discomfort (such as going hungry), wasting (losing weight unintentionally and dehydration), injuries due to falls, burns, bedsores, contractures (limbs that cannot be straightened out) and dissatisfaction with help (such as not being satisfied with scheduled hours or availability of help when it is actually needed).

8. These problems are particularly acute for disabled individuals who live alone rather than with family members. Individuals who live alone report higher unmet needs than those living with others (31 percent versus 19 percent) (LaPlante, et al., 2004) and experience higher rates of adverse consequences. Such individuals are highly vulnerable and their more detached informal networks do not compensate for lack of access to or reductions in public services.

9. Having inadequate levels of help compromises the safety, comfort, and hygiene of individuals requiring help with ADLs and IADLs, reducing their ability to live independently and increasing their risk of institutionalization and death.

10. Unmet needs are especially serious for persons needing help with activities of daily living ("ADLs") 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 (Allen & Mor, 1997; Gaugler, Kane, Kane, & Newcomer, 2005; LaPlante, et al., 2004).

11. A link between unmet need in ADLs and increased risk of death has been established in a longitudinal study of older persons with dementia (Gaugler, et al., 2005). Persons with two or more unmet ADL needs (measured as not getting any or enough help as assessed by caregivers) were 1.4 times as likely to die within 18 months, controlling for age, gender, and other demographics, severity of disability, and cognitive and behavioral functioning. The study did not assess unmet needs in instrumental activities of daily

living ("IADLs"). While the study is limited to persons with dementia, it is important in demonstrating that many persons with severe disabilities are at higher risk of death when their needs go unmet.

12. Gaugler and colleagues (2005) also established a link between unmet need in ADLs and being admitted within 18 months to a nursing home. Individuals with unmet needs in two or more ADLs (measured as not getting any or enough help) were 1.8 times as likely to enter a nursing home than those whose needs were met, controlling for age, gender, and other demographics, severity of disability, and cognitive and behavioral functioning.

13. A retrospective mortality study of older persons who needed home care before their death (Nanda, Bourbonniere, Wetle, & Teno, 2010) investigated the perceptions of the decedents' survivors, and found that 23 percent experienced unmet needs for home care before their death, and that after adjusting for age, gender, insurance, education, race, cause of death, functional status, and place of residence, decedents who were reported as not receiving enough care were 1.8 times as likely to die in a nursing home than those who had adequate care.

14. One study has found that the rate of hospital admission was 1.5 times as high for frail older persons with unmet needs (measured as not getting any or enough help) prior to their enrollment in a formal services program and 1.3 times as high 6 months after enrollment (Sands, et al., 2006). However, after 6 months, the provision of adequate services eliminated the higher risk of hospitalization for those who had entered the study with unmet needs. In this study, unmet need was measured as the absence of any help in one or more ADLs rather than insufficient help. The study suggests that having adequate help with ADLs is protective against hospitalization.

15. Higher rates of depression have been found among older persons with unmet needs in IADLs and ADLs compared to those whose needs are met (Choi & McDougall, 2009). In this study, unmet need was measured as not having enough help with formal services in IADLs or ADLs, as well as lacking other formal supportive and enabling services.

16. While most studies have focused on unmet needs in ADLs, unmet needs in IADLs also create adverse consequences that impact individuals' paying their bills, keeping their home clean and managed, communicating, managing their medications, and getting around and participating in their communities. As a group, these may appear to be less serious than unmet needs in ADLs, but in fact, some can be quite serious. Lack of help managing medications can lead to dire health results if medications are not taken appropriately, and lack of help to participate in social and community activities can lead to isolation and depression. Lack of help shopping for groceries and preparing meals elevates the risk of poor nutrition, which can lead to unintentional weight loss and dehydration.

17. In summary, unmet need in IADLs and ADLs, are associated with numerous life threatening adverse events, reduced mental and physical health, discomfort, and diminished quality of life, all of which threaten the ability of individuals to live safely and independently in their own homes. This is the case even if the unmet need in ADLs or IADLs is temporary, but especially so if those unmet needs last over time. The correlations with negative consequences are especially strong among persons with severe levels of disability and those who live alone and lack familial support.

18. My colleagues and I have analyzed historical Medicaid spending patterns on institutional services versus what are called home- and community-based services (HCBS) under

Medicaid, including the Louisiana Medicaid program (Kaye, LaPlante, & Harrington, 2009). The Medicaid program is the primary financier of long term care for persons with low incomes and assets. Medicaid requires all participating states to provide institutional long term care services. Medicaid also allows states to provide home and community based services as an option, one that is designed to allow states to provide long term care more cost-effectively while allowing greater choice to individuals to live more independently and in the least restrictive setting. Some states do not fully utilize the options that are available to them, which results in the underfunding of community based services and the overfunding of institutional services, a situation that is not cost-effective. Research has shown that states that provide less home and community based services have higher risks of institutionalization (Muramatsu et al., 2007). My colleagues and I have also found that states that provide less home and community based services overpay for institutional services, which is not cost effective (Kaye, LaPlante, & Harrington, 2009).

19. The state of Louisiana has, in the past decade, utilized several options to serve thousands more individuals under the Medicaid personal care services program and under several Medicaid waivers. In 2004, 10.6 % of the state of Louisiana's Medicaid expenditures for Aged and Disabled Adult long term services and supports went to community services with the rest to institutions. By 2009, 32.5% of the state of Louisiana's Medicaid expenditures for Aged and Disabled Adults on long term services and supports went to community services with the rest to institutions. Among all the states, Louisiana now ranks in the middle in the amount of total Medicaid long term services and supports expenditures that go to community based services. While Louisiana has shown much

progress, the state still has more progress to make, as is suggested by the states of Oregon and Washington which spent two-thirds or more of their total long term services and supports budget for Aged and Disabled Adults on community services.

20. Based on an analysis of a decade of Medicaid spending data from several states, my colleagues and I have observed that several states that have expanded home and community-based services, as Louisiana has done over the past decade, have achieved reductions in institutional spending and long-term cost savings (Kaye, LaPlante, & Harrington, 2009). This is mainly attributable to the greater cost of institutional care as compared to home and community-based care. A national study (Kitchener et al.: 2006) showed that the average total public expenditure on a recipient of Medicaid home and community-based services was substantially less per year than a person receiving institutional services. However, cost savings have been offset in some states, including Louisiana, when they have also increased institutional reimbursement rates (see separate testimony of Dr. H. Stephen Kaye).

21. Providing more personal assistance services is not only cost-effective, it also reduces unmet needs in the community and adverse consequences leading to hospitalization and institutionalization. The reverse is also true. A state like Louisiana that has recently developed and expanded its community-based long term care programs and that then substantially reduces spending on home and community-based services, by limiting hours, as Louisiana proposes to implement, is likely to experience an overall increase in long-term care costs resulting from increased utilization of institutions and other costs associated with increased levels of unmet needs (Mollica, Kassner, & Houser, 2009).

22. Louisiana state has proposed to cap the number of hours in its Medicaid personal care option program ("LT-PCS") to 32 hours a week, where it had previously had a cap of 42 hours a week. Given the extremely restrictive eligibility limits for the LT-PCS program, [1] such a reduction in hours would result in actual care hours falling well below the level that many people eligible for the program, particularly those with the most serious care needs, require to avoid the adverse consequences detailed above, including discomfort (such as going hungry), wasting (losing weight unintentionally and dehydration), injuries due to falls, burns, bedsores, contractures (limbs that cannot be straightened out), risk of institutionalization, and death.

23. The proposed reduction is of sufficient magnitude that it is likely to create unmet needs and an increase in the many adverse consequences that are documented in the several studies discussed in this declaration. The creation of unmet need is likely to increase institutionalization and other health care costs, including hospitalization costs, resulting from treating these unmet needs. While the average amount of hours cut may be as low as 3 hours a week, the reductions will be on the order of 7 to 10 hours a week for persons who have already demonstrated the most acute needs for services. Thus, the reductions in hours will have a disproportionate negative impact on individuals who have the most

[1] Unlike many states, Louisiana requires that persons meet a nursing facility level of care and demonstrate, according to objective criteria, that they face a substantial possibility of deterioration in mental or physical condition or functioning if either home and community-based services or nursing home services are not provided in less than 120 days. People who meet these criteria are likely to need a substantial amount of assistance with ADLs, especially if they live alone or otherwise lack unpaid care givers.

severe disabilities and individuals who live alone.

Executed this _2___ day of March, 2011 at San Francisco, California.

Mitchell LaPlante

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Exhibit 25 Declaration of C.M.

DECLARATION OF C.M.

C.M. subscribes under penalty of perjury, pursuant to 28 U.S.C. § 1746, as follows:

1. My name is C.M. I am 55 years old and I live in Baton Rouge, Louisiana with my wife and my daughter, R.M.
2. R.M. is my only daughter. She is twenty-six years old. At the age of eighteen, when she was a student at LSU, she was in an automobile accident. She suffered a traumatic brain injury. After a lengthy period of hospitalization and rehabilitation, she returned home to live with us.
3. Our only other child, our son, died in 2007.
4. As a result of her injuries, R.M. has been diagnosed with dementia, peripheral vascular disease and depression. She has hemiparesis (paralysis) on her left side, and ataxia (gross lack of coordination) on her right side. R.M. has no fine motor control and her gross motor control is very limited. She has double vision.
5. R.M. has little functional use of her hands. She cannot walk without assistance and has little coordination. She cannot propel herself in a wheelchair. She has no fine motor control and her gross motor control is very limited. She has a history of decubitis. She needs assistance with all of her activities of daily living, including walking, eating, transferring, toileting, bathing, dressing, and attending to personal hygiene. She cannot prepare a meal for herself, manage her medication or dial the phone without difficulty. The only task she can even participate in is eating, and she can barely bring a fork or spoon to her mouth. She needs to be spoon-fed much of the time.

6. She can operate a remote control for the television, but if she drops or misplaces it, someone must fetch it for her.
7. The most challenging effect of R.M.'s injury is her lack of short-term memory, lack of inhibition, and poor judgment. She frequently has outbursts of anger and frustration because of her situation, and takes her frustration out on either her family or her paid supports. She is combative and disruptive. She also wakes up at least once every night and needs help with toileting.
8. R.M.'s lack of judgment makes caring for her very challenging. Although she cannot walk, and she will try to get up and walk if left unattended. When she tries to walk on her own, she falls.
9. If her mother is home, R.M. insists on being cared for by her. She calls out to every 15 to 20 minutes, to do little things that often do not really need to be done. For example, R.M. decided recently that she was not getting enough to eat, and she cried out for food and snacks virtually constantly. We would give her a snack, and twenty minutes later, she would forget having eaten and call out for us to feed her again. Despite our efforts to resist, she gained weight. If we do not respond to her when she wants something, she will scream and scream until we do respond.
10. I am the sole support for my family. I work full time as an accountant for an insurance company. I also run my own CPA business at home, which requires me to work approximately 40 hours a week between January and April every year. Other times, I devote 10-20 hours per week to the business. My wife attends school and spends hours per day studying, and she also volunteers at her church. During tax time, she puts in about 20 hours a week working in my tax business.

11. Since her accident, my wife and I have cared for R.M. in our home. She has received LT-PCS from the State of Louisiana since approximately 2006. This assistance is critical to enabling us to continue to keep her at home with us. The LT-PCS worker is there from 8:00 a.m. to 4:00 p.m. on Mondays, Tuesdays, Thursdays, and Fridays and from 8:00 a.m. to 12:30 p.m. on Wednesdays, while both my wife and I are out of the home.

12. For the last two years, until June of 2011, R.M. had been receiving 36.5 hours through the LT-PCS program. Before that, she was receiving 38 hours of care. She needs at least that amount of care.

13. R.M.'s needs have not decreased over the last two years—in fact, her condition has gotten worse in a number of ways—in her cognitive ability, her mental state, her vision, her ability to communicate, and her behavioral symptoms. She needs more assistance now than she did when she was approved for 36.5 hours of care in ADL's of transferring, dressing, personal hygiene, bathing, and locomotion. She is becoming more difficult to care for because of her behavioral issues.

14. In June of 2011, I received the attached notice (Attachment A) that stated that R.M.'s hours would be reduced to 29 a week, based on a new method for determining service hours. I filed an appeal of this action. While the appeal was pending, R.M. was able to get 32 hours a week of LT-PCS. I was able to pay $50 a week out of pocket to cover the hours of care that had been taken away while the appeal was pending.

15. I filed R.M.'s appeal the last week of June, 2011. I did not request any postponement of the hearing, but I did request an in-person hearing so the judge could see R.M.. The hearing was postponed once because the judge did not realize it was supposed to

be in person, and once the State asked for a continuance so they could have their lawyer present. The hearing did not take place until October 5, 2011, and the decision denying the appeal was dated October 25, 2011.

16. I understood that the Advocacy Center requested an emergency waiver slot for R.M. in July of 2011, while her appeal was pending. I understand that the waiver program would provide her with at least 36.5 hours a week of personal care. I received a denial of that request, on the ground that she had to be approved to receive the maximum amount of LT-PCS, 32 hours a week, in order to apply for an emergency waiver slot.

17. I was able to obtain a statement from R.M.'s physician, Dr. Mario Moreno, to submit at the administrative hearing. It is attached as Attachment B. Dr. Moreno also testified by telephone at the hearing.

18. The decision on R.M.'s administrative appeal to get the maximum number of hours is attached as Attachment C. As I understand it, the decision said that R.M. couldn't be awarded the maximum number of hours of LT-PCS, 32 a week, because she needs more than that to avoid going to a nursing home.

19. If R.M.'s hours of LT-PCS are not restored, a 24-hour nursing home is the solution for R.M. to obtain the assistance she needs. My wife and I are already providing 136 hours of week of care and cannot assume the additional home-based care hours that R.M. needs. The 24-hour care that my wife and I provide for R.M. on weekends, and the 16 to 20 hours a day every weekday, are all that we can do. We love R.M., but we are simply exhausted both physically and emotionally from the demands of her care. We have not been one night away from R.M. since her accident in 2003.

20. I have taken the first steps toward placing R.M. in a nursing home, by contacting the State's Options in Long-term Care program and completing the preliminary application. I was told that she was eligible and that the next step is to choose a nursing home to complete the registration process. I will not take this step until I exhaust all avenues of appeal. As any parent would, I want to avoid institutional care for my daughter because, as with most disability cases, home-based care is better for Regan.

Date: November 9, 2011 /s/C.M.
C.M.

Attachment A

DEPARTMENT OF HEALTH & HOSPITALS
Long Term-Personal Care Services Program

RE-ASSESSMENT APPROVAL

6/15/2011

Baton Rouge, LA 70816

Dear

You have been approved to continue receiving Long-Term Personal Care Services (LT-PCS). You have been approved to receive 29 hours per week. This is based on our new method for determining service hours and on the questions that were answered about you during your recent assessment.

If you disagree with this decision, please see page 3 of this notice for detailed information about your Fair Hearing Rights, including the steps you need to take to have services continue at the current level or at the new program maximum of 32 hours per week, whichever is less, while your appeal is pending.

How your number of hours was determined:

We have enclosed two documents with this notice. The first is a copy of your MDS-HC assessment. The answers coded on Section H—Physical Functioning are used to assign you an Activities of Daily Living (ADL) index which determines the *maximum* number of weekly hours of service you can receive. The maximum number of hours approved for you is based on answers to questions about how much help you receive to eat, use the toilet, transfer, and move around in bed.

A more complete explanation of how the number of hours is determined was provided to you at the time of your MDS-HC assessment. If you would like more detail on how the assessment results are used to determine the maximum number of hours of service that you can receive, please consult the Louisiana Register, Vol. 36, No. 08, August 20, 2010 (pp. 1749 - 1752), which can be accessed at http://www.doa.louisiana.gov/osr/reg/1008/1008.pdf.

The second document that is enclosed is a copy of your new Plan of Care which explains the services you have been approved to receive and sets forth the *actual* number of weekly hours for which you have been approved. If you find that the Plan of Care does not give enough time for help with tasks of daily living (for example, dressing, bathing, toileting, feeding), then you should call Capital Area Agency on Aging at (225) 925-4777 or 1-800-280-0908 to see if you can receive additional assistance, but no one can receive more than the program maximum of 32 hours per week. **Talking with Capital Area Agency on Aging does not extend the time for you to ask for a Fair Hearing if you want to appeal.**

Changing your provider:

Requests to change provider agencies may be made only once every 3 months unless there is a good reason for you to change sooner. Examples of good reasons include a provider who does not send workers or have adequate back-up workers. If you would like to change providers, please contact us at (225) 925-4777 or 1-800-280-0908. A decision will be made as to whether you have a good reason to change.

Khilah Greening /bm

Capital Area Agency on Aging Representative
(225) 925-4777 or 1-800-280-0908

DEPARTMENT OF HEALTH & HOSPITALS
Long Term-Personal Care Services Program

YOUR FAIR HEARING RIGHTS

Date: 6/15/2011

If you disagree with this decision, you may ask for a Fair Hearing. If you want to request a Fair Hearing, you **must** do so by 7/15/2011 (thirty days from the date of this notice).

If your services are going to be reduced, you have the right to have your services continued at their present level or at the new program maximum of 32 hours, whichever is less, until your appeal is heard and a decision is rendered. **However, in order for your services to continue at their present level or at the new program maximum of 32 hours, whichever is less, during your appeal, your request must be received on or before** 7-15-11 **(date of proposed reduction).**

On appeal, you may qualify for more hours:

- If you show that one or more answers are incorrect as recorded on the MDS-HC in Section H—Physical Functioning for the questions involving eating, toileting, transfers and bed mobility, or

- If you show that you need more hours to avoid entering a nursing facility. At the hearing, you must explain specifically why you need more hours and why you will have to enter a nursing facility without these hours. However, no one can receive more than 32 hours of service per week.

Your request for an appeal may be made directly in writing, by fax, or by calling the DHH Bureau of Appeals as follows:

Division of Administrative Law - HH Section
P. O. Box 4189
Baton Rouge, La 70821-4189
(225) 342-0443 phone
(225) 219-9823 fax
HH Oral Appeals phone number (225) 342-5800

If you ask for an appeal, you will have the right to:

- Review your case and/or any information the agency plans to use before the hearing;
- Appear in person;
- Represent yourself or choose anyone else to represent you;
- Present your own evidence or witnesses; and
- Question any person who testifies against you.

COMPLETE THIS SECTION ONLY IF YOU WANT TO REQUEST A FAIR HEARING

I want to appeal the decision on my case because:

Date: _____

Signature: _____
Recipient/Representative

Telephone No: _____

Address: _____

_____

Attachment B

STANOCOLA
C L I N I C

PHYSICIANS PLAZA I
16777 Medical Center Drive
Baton Rouge, LA 70816
(225) 926 – 7200

Ron Johnson
CHIEF EXECUTIVE OFFICER

Michael Guarisco, M.D.
MEDICAL DIRECTOR

August 8, 2011

RE: DAL Docket # 2011-11232-HH
Recipient # [redacted]

To Whom It May Concern:

I am [redacted]'s treating physician and have been for several years. Ms. was in a car accident in 2003, which resulted in her having a traumatic brain injury. She has progressed as much as she will post injury, and is now at a stage where she could start to lose the abilities she has due to the aging process.

Ms. needs assistance with all of her activities of daily living including, walking, eating, transferring, toileting, dressing, bathing and attending to personal hygiene. Ms. has little functional use of her hands due to her left side having hemiparesis and her right side having ataxia. She has no fine motor control and her gross motor control is limited at best. Ms. Mautner has a history of decubitis, so her skin must be checked when she is undressed.

Ms. 's need for physical care is compounded by her loss of short-term memory, lack of inhibition and poor judgment, all, of which, are symptoms of her brain injury. Although may not physically be able to walk on her own, she will try, which causes falls. She should be monitored at all times.

My understanding is that the program that provides her with home care gives a maximum of 32 hours per week of care. Ms. needs that and more to remain at home with her family. Conversations with her family indicate that her father works more than forty hours per week, and her mother also works and attends classes. Neither is available to attend to Ms. during the day. This decrease in service hours could force the family to seek nursing home placement as is in constant need of care and supervision.

Ms. has been in good health, lately, which is partially attributed to her receiving proper home care. Without the continued care, her health could deteriorate. If placed in a nursing home, she would not get out of bed as often, which would likely result in decubitis ulcers, which could become life threatening.

Please consider this information, when deciding the number of home care hours Ms. should receive.

Sincerely,

Mario Moreno M.D.

Appellants Exh. F

Attachment C

STATE OF LOUISIANA
DIVISION OF ADMINISTRATIVE LAW

DEPARTMENT OF HEALTH AND HOSPITALS	*	
	*	DOCKET NO. 2011-11232-HH
	*	
IN THE MATTER OF	*	
	*	
	*	AGENCY ID. 4970222510704

****

DECISION AND ORDER

requested a hearing to appeal the Department of Health and Hospitals' (Department) decision approving her to receive only twenty-nine hours per week of Long Term-Personal Care Services. The Department's decision is **affirmed** because the assessment correctly captured Ms. need for support in performing late-loss activities of daily living and receipt of the maximum number of hours available under the Long Term-Personal Care Services program will not prevent Appellant from entering a nursing facility.

APPEARANCES

An in-person hearing was conducted October 5, 2011, in Baton Rouge before Administrative Law Judge Mary M. Daly. Present at the hearing were Nell Hahn, Appellant's attorney; , Appellant; Appellant's father and representative; Michael Coleman, attorney for the Department; Gretchen Allman, Department representative, present via speaker telephone.

Present as a witness for Appellant via speaker telephone, was Dr. Mario Mereno, Appellant's doctor.

STATEMENT OF THE CASE

(Appellant) asked for a fair hearing on the Department's determination that she is eligible for twenty-nine hours per week of Long Term-Personal Care Services (LT-PCS). Evidence was submitted at the hearing that Appellant needs thirty-six hours and thirty minutes in LT-PCS to meet her needs. Appellant's representative, stated that the program limit of thirty-two hours of LT-PCS is not enough to prevent Appellant from entering a nursing facility. He wants Appellant to be awarded the maximum amount of services available through the LT-PCS program so she can apply for an emergency Elderly and Disabled Adult (EDA) Waiver position. Appellant is already on the EDA Waiver waiting list. Mr. wants to use the LT-PCS program as a means of moving Appellant more quickly to the top of the waiting list.

The Department claims that the decision was based on an assessment of Appellant's needs. The Department further claims that Appellant does not qualify for the maximum of thirty-two hours per week of LT-PCS.

This adjudication is conducted in accordance with the Division of Administrative Law Act, La. R.S. 49:991, *et seq.*, and the Administrative Procedure Act, La. R.S. 49:950, *et seq.*

FINDINGS OF FACT

Appellant currently receives thirty-two hours per week of LT-PCS. On May 5, 2011, the Department conducted an in-home assessment of her needs, using a uniform assessment tool called the Minimum Data Set-Home Care (MDS-HC). Appellant and Appellant's father, participated in the in-home assessment. served as the primary respondent during the assessment.

The MDS-HC assessment reflected that during the specific look-back period prior to the assessment, Appellant required extensive assistance with transferring and toilet use, limited assistance with eating, and was independent with bed mobility. Appellant scored eleven in the Activities of Daily Living (ADL) Index, which allows a range of one to thirty hours per week of LT-PCS. She was approved for twenty-nine hours per week of LT-PCS.

CONCLUSIONS OF LAW

The Department's determination that Appellant is entitled to twenty-nine hours per week of LT-PCS is correct.

To determine the number of LT-PCS hours, the Department must first assess the individual using the MDS-HC uniform assessment tool. The MDS-HC is designed to verify that the individual meets eligibility qualifications and to determine resource allocation while identifying his need for support in the performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs).[1] The MDS-HC generates an ADL Index score from four through fifteen that indicates the individual's degree of self-performance of late-loss ADLs (eating, toileting, transferring, and bed mobility).[2] Based on the ADL Index score, he is assigned to a level of support category and is eligible for a range of weekly service hours associated with that level. If the individual disagrees with the allocation of weekly service hours, he may request a fair hearing to appeal the allocation. However, he may only obtain additional hours upon showing that (a) one or more of the answers to the questions involving late-loss ADLs are incorrect as recorded on the assessment, or (b) he needs additional hours to avoid entering into a nursing facility.[3]

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[1] Louisiana Register 37:1113.
[2] Id.
[3] Id.

The MDS-HC assessment performed in Appellant's home resulted in a score of eleven on the ADL Index, which allows one to thirty hours per week of LT-PCS. The Department prepared Appellant's Plan of Care and approved her to receive twenty-nine hours per week of LT-PCS.

The MDS-HC assessment reflected that during the specific look-back period prior to the assessment, Appellant required extensive assistance with transferring and toilet use, limited assistance with eating, and was independent with bed mobility. The Department determined that Appellant's need for assistance in transferring has worsened from a need for extensive assistance to a need for maximal assistance. This is not disputed by Appellant.[4] Appellant's attorney argued that the amount of time allowable for transferring has been decreased on the May of 2011 Plan of Care. She also argued that the time allotted for eating and toileting have decrease on the May of 2011 Plan of Care.[5] Appellant's attorney acknowledged that the program limits have been reduced from forty-two to thirty-two hours of available LT-PCS per week. She also points out that this reduction is a cost-control measure.[6] She stated that the amount of time allotted to Appellant for assistance with eating is insufficient. She did not argue that Appellant's need for limited assistance in eating was incorrectly recorded on the MDS-HC. She did not address whether Appellant's needs in bed mobility, transferring, and toilet use were incorrectly recorded on the MDS-HC. Appellant's attorney stated in her post-hearing brief that the method of allocation of service hours used during Appellant's 2009 assessment used factors other than the four ADLs used in the 2011 assessment. Appellant failed to show that one or more of the answers to the questions involving late-loss ADLs are incorrect as recorded on the assessment.

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[4] Appellant's Post-Hearing Memorandum, page 4.
[5] Id., page 5.
[6] Id., Page 6.

Appellant's attorney, Ms. Hahn, stated in her brief that in order to find Appellant eligible for LT-PCS the Department had to first find that she is at imminent risk of placement in a nursing facility.[7] Ms. Hahn argued that Appellant's family cannot physically or emotionally cope with any additional care giving and cannot go on paying out of pocket for hours of care.[8] She further stated that Appellant's family "...have announced their intention to place in a nursing home if her hours are not restored to at least 36.5 hours of service a week."[9] She also argued that Appellant's doctor expressed concerns that Appellant's health could deteriorate if she is not provided more than thirty-two hours per week of care.[10] Although Appellant's representative presented credible evidence that Appellant requires additional hours, the LT-PCS program is limited to up to thirty-two hours of LT-PCS per week.[11] Both Appellant's representative and her doctor have stated that thirty-two hours of LT-PCS per week will not be enough to prevent Appellant from entering a nursing facility. Therefore, Appellant failed to show that obtaining additional hours per week of LT-PCS will avoid her entering into a nursing facility.

The Department correctly determined that Appellant is entitled to twenty-nine hours per week of LT-PCS.

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[7] Appellant's Attorney's brief page 8.
[8] Id.
[9] Id. Page 1.
[10] Id. Page 8.
[11] *Louisiana Register* 36:2818.

ORDER

IT IS ORDERED that the Department of Health and Hospitals' determination that is entitled to twenty-nine hours per week of Long Term-Personal Care Services is **AFFIRMED.**

Rendered and signed October 25, 2011, in Baton Rouge, Louisiana.

Mary M. Daly
Administrative Law Judge

CERTIFICATE OF SERVICE

I certify that I have served a copy of this document on all parties to this proceeding or their counsel of record by regular mail on October 26, 2011.

Administrative Hearings Clerk

REVIEW RIGHTS

This decision exhausts your administrative remedies with the Department of Health and Hospitals. If you are dissatisfied with this ruling, you have the right to seek judicial review in accordance with Louisiana Revised Statute 46:107(C). Your request for judicial review may be filed either in the 19th Judicial District Court, Parish of East Baton Rouge, or the district court of the parish of your domicile, within 30 days from the date of this certification.

Exhibit 26 30 La. Reg. 2831-32 (December 20, 2004)

RULE

Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Personal Care Services Long Term
(LAC 50:XV.12901-12913)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has amended LAC 50:XV.12901, 12903, 12905, 12907, 12909, 12913, and adopted 12911 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends the June 20, 2003 Rule and October 1, 2003 Emergency Rule governing personal care services to establish provisions governing when a recipient may change personal care service providers and staffing requirements for personal care agencies. In addition, the bureau amends the general provisions, standards for participation and the place of service requirements contained in the June 20, 2003 Rule.

Title 50
PUBLIC HEALTH MEDICAL ASSISTANCE
Part XV. Services for Special Populations
Subpart 9. Personal Care Services
Chapter 129. Long Term
§12901. General Provisions

A. ....

B. An assessment shall be performed for every recipient who requests personal care services. This assessment shall be utilized to identify the recipient's long-term care needs, preferences, the availability of family and community supports and to develop the plan of care. The Minimum Data Set-Home Care (MDS-HC) System will be used as the basic assessment tool. However, other assessment tools may be utilized as a supplement to the MDS-HC to address the needs of special groups within the target population.

C. Authorization. Personal care services (PCS) shall be authorized by the Bureau of Health Services Financing or its designee. The bureau or its designee will review the completed assessment, supporting documentation from the recipient's primary physician, plan of care and any other pertinent documents to determine whether the recipient meets the medically necessity criteria for personal care services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:911 (June 2003), amended LR 30:2831 (December 2004).

§12903. Covered Services

A. Personal care services are defined as those services that provide assistance with the distinct tasks associated with the performance of the activities of daily living (ADL) and the instrumental activities of daily living (IADL). Assistance may be either the actual performance of the personal care task for the individual or supervision and prompting so the individual performs the task by him/herself. ADLs are those personal, functional activities required by an individual for continued well-being, health and safety. ADLs include tasks such as:

1. eating;
2. bathing;
3. dressing;
4. grooming;
5. transferring (getting in/out of the tub, from a bed to a chair);
6. ambulation; and
7. toileting.

B. IADLs are those activities that are considered essential for sustaining the individual's health and safety, but may not require performance on a daily basis. IADLs include tasks such as:

1. light housekeeping;
2. food preparation and storage;
3. grocery shopping;
4. laundry;
5. assisting with scheduling medical appointments when necessary;
6. accompanying the recipient to medical appointments when necessary due to the recipient's frail condition;
7. assisting the recipient to access transportation; and
8. reminding the recipient to take medication.

C. …

D. Constant or intermittent supervision and/or sitter services are not a component of personal care services.

E. The performance of complex and non-complex medical procedures is not a component of personal care services. If the recipient's physician delegates the performance of medical procedures and the agency agrees to furnish these tasks, the agency must accept all liability for their employee's performance of medical tasks. The agency must have a current, signed and dated statement from the recipient's physician stating what medical procedures are being delegated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:912 (June 2003), amended LR 30:2831 (December 2004).

§12905. Recipient Qualifications

A. Personal care services shall be available to recipients who are 65 years of age or older, or 21 years of age or older and disabled. Disabled is defined as meeting the disability criteria established by the Social Security Administration.

B. Personal care services for elderly or disabled recipients must meet medical necessity criteria as determined by the Bureau of Health Services Financing and must be prior authorized by bureau or its designee. Personal care services are medically necessary if the recipient:

1. meets the medical standards for admission to a nursing facility, including all Preadmission Screening and Annual Resident Review (PASARR) requirements; and
2. is able, either independently or through a responsible representative, to participate in his/her care and direct the services provided by the personal care services

worker. A responsible representative is defined as the person designated by the recipient to act on his/her behalf in the process of accessing and/or maintaining personal care services; and

3. 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. This criterion is considered met if:

a. the recipient is in a nursing facility and could be discharged if community-based services were available;

b. is likely to require nursing facility admission within the next 120 days; or

c. has a primary caregiver who has a disability or is over the age of 70.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:912 (June 2003), amended LR 30:2831 (December 2004).

§12907. Recipient Rights

A. - A.9. ....

B. Changing Providers. Recipients may request to change PCS providers without cause once after each three-month service authorization period. Recipients may request to change PCS providers with good cause at any time during the service authorization period. Good cause is defined as the failure of the provider to furnish services in compliance with the service plan. Good cause shall be determined by the bureau or its designee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:912 (June 2003), amended LR 30:2832 (December 2004).

§12909. Standards for Participation

A. - B.2. ...

3. ensure that a criminal background check is performed for all direct care and supervisory staff and that the results are maintained in each employee's personnel record:

a. the criminal background check must be performed by the Office of the State Police or an agency authorized by the Office of the State Police:

i. the agency may make an offer of temporary employment to an individual pending the results of the criminal background check. In such instances, the worker shall perform his/her duties under the direct supervision of a permanent employee or in the presence of a member of the recipient's immediate family or of a caregiver designated by the immediate family;

4. ensure that the direct care staff is qualified to provide personal care services. Assure that all new staff satisfactorily completes an orientation and training program in the first 30 days of employment;

5. - 10. ...

11. have proof of general liability insurance of at least $200,000. The certificate holder shall be the Department of Health and Hospitals; and

12. maintain an office in each DHH administrative region in which it proposes to provide services. The agency must obtain a separate license from the Department of Social Services and a separate Medicaid provider number for each region in which it provides services. Consideration shall be given to an agency's request to provide services in one parish that is adjacent to its designated service region if the agency's main office is within a 50-mile radius of the selected parish's borderline.

a. Each office must have hours of operation that conform to the customary operating hours for similar businesses in the local community and have written provisions for emergency contact that include a toll-free telephone line with 24-hour accessibility. The written policy governing emergency contact shall be made available to recipients and staff.

b. Each office must house the case records and billing documentation for the individuals served by that office.

c. Each office must also house the personnel and payroll records for all of the employees who are assigned to that office.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:912 (June 2003), amended LR 30:2832 (December 2004).

§12911. Staffing Requirements

A. Personal care services agencies participating in the Medicaid Program must ensure that all staff providing direct care to the recipient meets the qualifications for furnishing personal care services. The PCS worker shall demonstrate empathy toward the elderly and persons with disabilities, an ability to provide care to these recipients, and the maturity and ability to deal effectively with the demands of the job. In addition, all supervisors of direct care staff must meet the qualifications set forth in this §12911.

B. Personal Care Services Worker Qualifications

1. Age. The worker must be at least 18 years old or older at the time the offer of employment is made. Verification of age must be maintained in each employee's personnel record.

2. Education and Experience. All PCS workers must meet one of the following minimum education and experience qualifications:

a. a high school diploma or general equivalency diploma (GED); or

b. a trade school diploma in the area of human services; or

c. documented, verifiable experience providing direct care services to the elderly and/or persons with disabilities.

3. The PCS worker must have the ability to read and write in English as well as to carry out directions promptly and accurately.

C. Restrictions. A legally responsible relative is prohibited from being the paid PCS worker for a family member. Legally responsible relative is defined as the parent of a minor child, foster parent, curator, tutor, legal guardian or the recipient's spouse.

Exhibit 27 LOCET manual excerpts

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS

POLICY CHAPTER: LEVEL OF CARE ELIGIBILITY FOR LONG-TERM CARE PROGRAMS

Guidelines for the Processing of Long Term Care Program Eligibility Requests

11/25/2008

6.5. PHONE LOCETS RENDER PRESUMPTIVE APPROVALS

First-hand visual knowledge of a client's condition is always a positive factor in conducting a functional assessment. In these cases, the Intake Analyst is able to see how the individual moves and interacts with all persons present during the interview. The analyst has a greater ability to know when additional probing is needed for any LOCET item in order to get to the point in question. For some programs, this face-to-face LOCET interview is possible. For other programs, the LOCET Intake Analyst will only have contact with the client by telephone. Most HCBS programs utilize a contracted telephone call center for LOCET completion.

When the LOCET is conducted by telephone, an approval determination is said to be "presumptive." When the LOCET interview is conducted in person (face-to-face with the individual), that approval determination stands, and is not considered to be "presumptive." It can, however, be superseded by an Audit Review determination as explained in Section 10.0.

MDS-HC assessments are done as face-to-face interviews and therefore are able to capture a full range of assessment criteria as compared to a telephone LOCET. For this reason, Louisiana OAAS has determined that an MDS-HC assessment done by a qualified and consistently accurate assessor will supersede or "override" a telephone LOCET in determining nursing facility level of care.

7.0. IMMINENT RISK DETERMINATION

Some programs which OAAS administers require a determination of Imminent Risk of Nursing Facility Placement prior to final eligibility for the programs. Consult the specific program chapter to determine if Imminent Risk of Nursing Facility Placement is required for a particular program.

In addition to the presumptive determination of nursing facility level of care, information gathered on the LOCET will also help to determine if the individual has met Imminent Risk criteria. Imminent Risk criteria are designed to point out those individuals who are at risk of entering a nursing facility within the four month period immediately following the date the LOCET is completed.

> **NOTE:** The Imminent Risk determination on LOCET is not to be confused with the Institutional Risk CAP on the MDS-HC. An Imminent Risk determination will be made only via the LOCET. There is no requirement that the Imminent Risk determination be verified by any data gathered on the MDS-HC.

The Imminent Risk determination will be a two-part process if Imminent Risk is not triggered in the first part of the determination.

Part One of the Imminent Risk determination is indicated by the Imminent Risk CAP display of "Did Not Trigger" or "Triggered" on the LOCET.

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7.1. IMMINENT RISK -- PART ONE:

Part One of the Imminent Risk determination is made by using the information gathered during a LOCET interview. The three ways in which an individual may meet Imminent Risk in this manner are:

1. As a current resident of a Nursing Facility (Section 7.1.1.), OR

2. By having a caregiver who is disabled or who is age 70 or over (Section 7.1.2.), OR

3. By meeting three of eight criteria which are designated as indicators of risk of nursing facility placement in the near future (Section 7.1.3.).

7.1.1. IMMINENT RISK, PART ONE: NURSING FACILITY RESIDENCE:

Residents of nursing facilities are deemed to meet Imminent Risk criteria by their presence in the nursing facility. LOCET elicits the location of the client at the time of the interview. When this location is stated to be a nursing facility, the Intake Analyst will ask further questions to verify residence, such as admit date and facility address. Verification of nursing facility residence may be made using the MEDS system.

7.1.2. IMMINENT RISK, PART ONE: CAREGIVER AGE OR DISABILITY:

Caregiver Age of 70 and older or Caregiver Disability will trigger the Imminent Risk determination alone, without the presence of any other Institutional Risk item. Caregiver disability is defined as any condition which can be verified which points to a disabling condition which may impact the caregiver's ability to function.

7.1.2.1. Caregiver Status Requires Verification:

If a client has met Imminent Risk criteria solely on the basis of caregiver status, he will be asked to submit documentation of the caregiver's age and/or disability. After review of this documentation, the confirmation or rejection of caregiver status is entered into the software system. The software display will then show the result of this caregiver status documentation review.

Acceptable forms of verification of age are a birth certificate or any identification document issued by a government agency which shows date of birth. If the caregiver submits other

forms of documentation of age, the Level of Care Administrator (or other OAAS designee) must be contacted to determine validity of such documents.

Documentation of caregiver disability must be submitted in the form of a Social Security Disability award letter, or a determination letter generated by an insurance company which names the caregiver as recipient of disability benefits. Other documents may be accepted after review by the Level of Care Administrator or other OAAS designee.

7.1.3. IMMINENT RISK, PART ONE: THREE OF EIGHT INSTITUTIONAL RISK ITEMS REQUIRED:
Several factors have been identified which, in combination with other characteristics, point to the individual's potential for nursing facility placement within the next 120 days. Those factors are shown in the diagram below. (Detailed instruction regarding the definitions of each item and the proper coding thereof are found in the LOCET System User Intake Manual.)

THREE of the following Institutional Risk Items

1. ☐ Nursing home resident in last 5 years
2. ☐ Days out of house within a week
3. ☐ Bladder Continence
4. ☐ ADL status change in last 90 days
5. ☐ Change in mental functioning in last 7 days
6. **The following group counts as one item of the three**
   (Any item triggering in this group triggers the whole group)
   - ☐ Alzheimer's Disease
   - ☐ Dementia
   - ☐ Head Trauma
   - ☐ Multiple sclerosis
7. **The following group counts as one item of the three**
   (Any item triggering in this group triggers the whole group)
   - ☐ Dressing
   - ☐ Personal Hygiene
   - ☐ Bathing
8. **The following group counts as one item of the three**
   (Both items in this group must trigger to trigger the whole group)
   - ☐ Meal Preparation
   - ☐ Shopping

It should be noted that items one through five on the diagram shown are "stand-alone" items in the total count of three required Imminent Risk elements. That is, if an individual's LOCET indicates that he has any of the conditions listed in items one through five, one point is counted for each of the items one through five.

Items six and seven on this portion of the Imminent Risk determination both have multiple conditions / factors, only one of which is needed to count as one point of the three necessary for this Imminent Risk criteria to be met.

However, item eight requires a combination of factors to be present in order for one of the three required Imminent Risk points to be counted. That is, both shopping and meal preparation must trigger in order for item eight's one point to be counted in the Imminent Risk determination.

7.2. IMMINENT RISK -- PART TWO:

If the individual did not meet Imminent Risk at Part One of the Imminent Risk review process (as determined by LOCET), he moves on to Part Two of the Imminent Risk review. This second part consists of review of medical statements and / or medical documentation

If the individual must meet Imminent Risk criteria, the contracted agency will review the LOCET results for the presence of "Triggered" in the Imminent Risk Client Assessment Protocol (CAP). If the Imminent Risk CAP has not triggered, the contracted agency will send the client a Medical Deterioration Form (OAAS-RF-07-009) for his physician to complete. Upon completion, this form is faxed to the OAAS designee and is reviewed by OAAS-designated reviewers, which will include medical personnel.

A determination will be made as to whether the physician's documentation submitted indicates:

1. The individual will be at risk of Nursing Facility Placement if Home and Community-Based Services are not provided within 120 days -- OR --

2. The individual will be at substantial risk of medical or mental deterioration if Home and Community-Based Services are not provided within 120 days.

The results of this Imminent Risk Part 2 review will be input into Section K and in the Notebook of the LOCET, as instructed in the LOCET System User Intake Manual.

If the review of the Medical Deterioration Form (OAAS-RF-07-009) indicates that the criteria for Imminent Risk of Nursing Facility placement is not met, the individual must complete another LOCET according to current protocol in order to submit another Medical Deterioration Form (OAAS-RF-07-009) for review.

8.0. USE OF THE MDS-HC IN LEVEL OF CARE DETERMINATIONS

8.1. INITIAL ELIGIBILITY: USE OF THE MDS-HC IN LEVEL OF CARE DETERMINATIONS

Verification of the LOCET results can be accomplished, in part, by viewing the Client Assessment Protocols (CAPs) on the Louisiana Minimum Data Set - Home Care (MDS-HC). to determine if LOCET Pathways 1, 2 or 6 are triggered. This will indicate whether or not nursing facility level of care is met on the Activity of Daily Living, Cognition or Behavior Pathways in LOCET. This is possible because the LOCET questions are taken directly from the MDS assessment tool and eligibility as determined by LOCET Pathways 1, 2 and 6 can be verified from the answers provided on the MDS-HC. The Louisiana MDS-HC has been enhanced to compute and display the LOCET Pathways 1, 2 and 6 triggers.

An MDS-HC assessment done by a qualified and consistently accurate assessor will supersede or "override" a telephone LOCET in determining nursing facility level of care.

8.2. ANNUAL REASSESSMENTS AND CHANGE IN STATUS ASSESSMENTS: USE OF THE MDS-HC IN LEVEL OF CARE DETERMINATIONS

The MDS-HC is also used annually to determine continued eligibility for HCBS programs. This annual determination is called an annual reassessment.

When an individual chooses a long-term care service, he is responsible for reporting changes in condition or situation to the OAAS designee. A subsequent MDS-HC assessment may be conducted within a shorter time frame than annually if the client has had changes in condition, supports or residence environment. These subsequent MDS-HC assessments are coded as "change in status" assessments and were previously called interim assessments. An individual must trigger a pathway upon a change in status MDS-HC

Exhibit 28 36 La. Reg. 1749 (August 20, 2010)

responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Alan Levine
Secretary

1008#029

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing
and
Office of Aging and Adult Services

Personal Care Services—Long-Term
Policy Clarifications and Service Limit Reduction
(LAC 50:XV.12901-12909 and 12911-12915)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amend LAC 50:XV.12901-12909 and §§12911-12915 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953.B(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

Senate Resolution 180 and House Resolution 190 of the 2008 Regular Session of the Louisiana Legislature directed the department to develop and implement cost control mechanisms to provide the most cost-effective means of financing the Long-Term Personal Care Services (LT-PCS) Program. In compliance with these legislative directives, the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amended the provisions governing the LT-PCS Program to: 1) implement uniform needs-based assessments for authorizing service units; 2) reduce the limit on LT-PCS service hours; 3) mandate that providers must show cause for refusing to serve clients; and 4) incorporate provisions governing an allocation of weekly service hours (*Louisiana Register,* Volume 35, Number 11).

The department now proposes to amend the provisions governing long-term personal care services to: 1) establish provisions that address requests for services; 2) revise the eligibility criteria for LT-PCS; 3) clarify the provisions governing restrictions for paid direct care staff and the place of service; and 4) reduce the maximum allowed service hours. This action is being taken to avoid a budget deficit in the medical assistance programs. It is estimated that implementation of this Emergency Rule will reduce expenditures in the Medicaid Program by approximately $5,193,352 for state fiscal year 2010-2011.

Effective September 5, 2010, the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amend the provisions governing long-term personal care services.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XV. Services for Special Populations
Subpart 9. Personal Care Services
Chapter 129. Long Term Care
§12901. General Provisions

A. The purpose of personal care services is to assist individuals with functional impairments with their daily living activities. Personal care services must be provided in accordance with an approved service plan and supporting documentation. In addition, personal care services must be coordinated with the other Medicaid and non-Medicaid services being provided to the recipient and will be considered in conjunction with those other services.

B. Each recipient requesting or receiving long-term personal care services (LT-PCS) shall undergo a functional eligibility screening utilizing an eligibility screening tool called the Level of Care Eligibility Tool (LOCET), or a subsequent eligibility tool designated by the Office of Aging and Adult Services (OAAS).

C. Each LT-PCS applicant/recipient shall be assessed using a uniform assessment tool called the Minimum Data Set-Home Care (MDS-HC) or a subsequent assessment tool designated by OAAS. The MDS-HC is designed to verify that an individual meets eligibility qualifications and to determine resource allocation while identifying his/her need for support in performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The MDS-HC assessment generates a score which measures the recipient's degree of self-performance of late-loss activities of daily living during the period just before the assessment.

1. The late-loss ADLs are eating, toileting, transferring and bed mobility. An individual's assessment will generate a score from 4 through 15 which is representative of the individual's degree of self-performance on these four late-loss ADLs.

2. - 7. Repealed.

D. Based on the applicant/recipient's uniform assessment score, he/she is assigned to a level of support category and is eligible for a set allocation of weekly service hours associated with that level.

1. If the applicant/recipient is allocated less than 32 hours per week and believes that he/she is entitled to more hours, the applicant/recipient or his/her responsible representative may request a fair hearing to appeal the decision.

2. The applicant/recipient may only obtain additional hours upon showing that the:

a. assessment was inaccurate and the resulting allocation methodology was incorrectly applied; and

b. correct application of the methodology would result in additional hours.

E. Requests for personal care services shall be accepted from the following individuals:

1. a Medicaid recipient who wants to receive personal care services;

2. an individual who is legally responsible for a recipient who may be in need of personal care services; or

3. a responsible representative designated by the recipient to act on his/her behalf in requesting personal care services.

F. Each recipient who requests PCS has the option to designate a responsible representative. For purposes of these provisions, a responsible representative shall be defined as the person designated by the recipient to act on his/her behalf in the process of accessing and/or maintaining personal care services.

1. The appropriate form authorized by OAAS shall be used to designate a responsible representative.

a. The written designation of a responsible representative does not give legal authority for that individual to independently handle the recipient's business without his/her involvement.

b. The written designation is valid until revoked by the recipient. To revoke the written designation, the revocation must be submitted in writing to OAAS or its designee.

2. The functions of a responsible representative are to:

a. assist and represent the recipient in the assessment, care plan development and service delivery processes; and

b. to aid the recipient in obtaining all necessary documentation for these processes.

3. The paid PCS worker providing services to a recipient may not act as the recipient's responsible representative.

4. An owner or employee of a personal care attendant services agency may not be designated as a responsible representative for any recipient who receives personal care services from an agency he/she owns or is employed by.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:911 (June 2003), amended LR 30:2831 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 32:2082 (November 2006), LR 34:2577 (December 2008), , amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:2450 (November 2009), LR 36:

§12902. Participant Direction Option

A. The Office of Aging and Adult Services implements a pilot program, the Louisiana Personal Options Program (La POP), which will allow recipients who receive long term personal care services (LT-PCS) to have the option of utilizing an alternative method to receive and manage their services. Recipients may direct and manage their own services by electing to participate in La POP, rather than accessing their services through a traditional personal care agency.

1. La POP shall be implemented through a phase-in process in Department of Health and Hospitals administrative regions designated by OAAS.

A.2. – B.1....

2. With the assistance of a services consultant, participants develop a personal support plan based on their approved plan of care and choose the individuals they wish to hire to provide the services.

C. - E.1. ...

2. Change in Condition. The participant's ability to direct his/her own care diminishes to a point where he/she can no longer do so and there is no responsible representative available to direct the care.

3. Misuse of Monthly Allocation of Funds. The LA POP participant or his/her responsible representative uses the monthly budgeted funds to purchase items unrelated to personal care needs or otherwise misappropriate the funds.

4. Failure to Provide Required Documentation. The participant or his/her responsible representative fails to complete and submit employee time sheets in a timely and accurate manner, or provide required documentation of expenditures and related items as prescribed in the Louisiana Personal Options Program's Roles and Responsibility agreement.

5. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2578 (December 2008) amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 36:

§12903. Covered Services

A. Personal care services are defined as those services that provide assistance with the distinct tasks associated with the performance of the activities of daily living (ADLs) and the instrumental activities of daily living (IADLs). Assistance may be either the actual performance of the personal care task for the individual or supervision and prompting so the individual performs the task by him/herself. ADLs are those personal, functional activities required by the recipient. ADLs include tasks such as:

1. - 7. ...

B. IADLs are those activities that are considered essential, but may not require performance on a daily basis. IADLs cannot be performed in the recipient's home when he/she is absent from the home. IADLs include tasks such as:

1. light housekeeping;
2. food preparation and storage;
3. shopping;
4. laundry;
5. assisting with scheduling medical appointments when necessary;
6. accompanying the recipient to medical appointments when necessary;
7. assisting the recipient to access transportation; and
8. reminding the recipient to take his/her medication as prescribed by the physician.

C. Emergency and nonemergency medical transportation is a covered Medicaid service and is available to all recipients. Non-medical transportation is not a required component of personal care services. However, providers may choose to furnish transportation for recipients during the course of providing personal care services. If transportation is furnished, the provider agency must accept any liability for their employee transporting a recipient. It is the responsibility of the provider agency to ensure that the employee has a current, valid driver's license and automobile liability insurance.

1. La POP participants may choose to use some of their monthly budget to purchase non-medical transportation.

a. If transportation is furnished, the participant must accept all liability for their employee transporting them. It is the responsibility of the participant to ensure that the employee has a current, valid driver's license and automobile liability insurance.

D. - F. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:912 (June 2003), amended LR 30:2831 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2578 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 36:

§12905. Eligibility Criteria

A. …

B. Recipients must meet the eligibility criteria established by OAAS or its designee. Personal care services are medically necessary if the recipient:

B.1. - D. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:912 (June 2003), amended LR 30:2831 (December 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office of Aging and Adult Services, LR 32:2082 (November 2006), LR 34:2579 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 36:

§12907. Recipient Rights and Responsibilities

A. - A.2. …

3. training the individual personal care worker in the specific skills necessary to maintain the recipient's independent functioning while maintaining him/her in the home;

4. developing an emergency component in the plan of care that includes a list of personal care staff who can serve as back-up when unforeseen circumstances prevent the regularly scheduled worker from providing services;

5. – 9. …

B. Changing Providers. Recipients may request to change PCS agencies without cause once after each three month interval during the service authorization period. Recipients may request to change PCS providers with good cause at any time during the service authorization period. Good cause is defined as the failure of the provider to furnish services in compliance with the plan of care. Good cause shall be determined by OAAS or its designee.

C. In addition to these rights, a La POP participant has certain responsibilities, including:

1. ...

2. notifying the services consultant at the earliest reasonable time of admission to a hospital, nursing facility, rehabilitation facility or any other institution;

2.a. - 8.…

9. training the direct service worker in the specific skills necessary to maintain the participant's independent functioning to remain in the home;

10. - 13. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:912 (June 2003), amended LR 30:2832 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2579 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 36:

§12909. Standards for Participation

A. - A.1.c. ...

d. the policy and procedures contained in the Personal Care Services provider manual or memorandums;

A.2. - B.12.c. ...

C. An LT-PCS provider shall not refuse to serve any individual who chooses his agency unless there is documentation to support an inability to meet the individual's needs, or all previous efforts to provide service and supports have failed and there is no option but to refuse services.

C.1. - D.2. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:912 (June 2003), amended LR 30:2832 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2579 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:2451 (November 2009), amended LR 36:

§12911. Staffing Requirements

A. - B.3.…

C. Restrictions. The following persons are prohibited from serving as the paid direct service worker for a recipient:

1. the recipient's spouse;
2. the recipient's curator;
3. the recipient's tutor;
4. the recipient's legal guardian;
5. the recipient's responsible representative; or
6. the person to whom the recipient has given Representative and Mandate authority (also known as Power of Attorney).

D. - E.1.b. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2832 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2580 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 36:

§12912. Training

A. - C.6. ...

D. New direct care staff must also receive training in cardiopulmonary resuscitation (CPR) and basic first aid within one week of employment. A current, valid certification for CPR and first aid may be accepted as verification of training. This CPR and first aid certification must be maintained and kept current as long as the direct service worker is employed with the PCS agency.

E. - E.7. ...

8. maintenance of a clean environment; and

E.9. - G.3.c. …

4. New La POP direct service workers must also receive training in cardiopulmonary resuscitation (CPR) and basic first aid within one week of employment. A current, valid certification for CPR and first aid may be accepted as verification of training. This CPR and first aid certification must be maintained and kept current throughout the worker's employment period as a La POP personal care service worker.

G.5. - H. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2580 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 36:

§12913. Service Delivery

A. Personal care services shall be provided in the recipient's home or in another location outside of the recipient's home if the provision of these services allows the recipient to participate in normal life activities pertaining to the IADLs cited in the plan of care. The recipient's home is defined as the place where he/she resides such as a house, an apartment, a boarding house, or the house or apartment of a family member or unpaid primary care-giver. IADLs cannot be performed in the recipient's home when the recipient is absent from the home.

1. - 4. Repealed.

B. ...

C. Participants are not permitted to receive LT-PCS while living in a home or property owned, operated, or controlled by a provider of services who is not related by blood or marriage to the participant.

C.1. - E. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:913 (June 2003), amended LR 30:2833 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2581 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Financing and the Office of Aging and Adult Services, LR 36:

§12915. Service Limitations

A. Personal care services shall be limited to up to 32 hours per week. Authorization of service hours shall be considered on a case-by-case basis as substantiated by the recipient's plan of care and supporting documentation.

B. There shall be no duplication of services.

1. Personal care services may not be provided while the recipient is admitted to or attending a program which provides in-home assistance with IADLs or ADLs or while the recipient is admitted to or attending a program or setting where such assistance is available to the recipient.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:913 (June 2003), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2581 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:2451 (November 2009), amended LR 36:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Anthony Keck
Secretary

1008#102

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing

Personal Care Services—Long-Term
Reimbursement Rate Reduction
(LAC 50:XV.12917)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amend LAC 50:XV.12917 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act and as directed by Act 11 of the 2010 Regular Session of the Louisiana Legislature which states: "The secretary is directed to utilize various cost containment measures to ensure expenditures in the Medicaid Program do not exceed the level appropriated in this Schedule, including but not limited to precertification, preadmission screening, diversion, fraud control, utilization review and management, prior authorization, service limitations, drug therapy management, disease management, cost sharing, and other measures as permitted under federal law." This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first. As a result of a budgetary shortfall in state fiscal year 2010, the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amended the provisions governing the reimbursement methodology for long-term personal care services (LT-PCS) to reduce the reimbursement rates (*Louisiana Register,* Volume 36, Number 6).

Exhibit 29 Eley Deposition Excerpts

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

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

* *

THE TRANSCRIPT OF THE DEPOSITION OF

HUGH ELEY

TAKEN ON BEHALF OF THE PLAINTIFFS, REPORTED IN THE ABOVE-ENTITLED AND NUMBERED CAUSE, BEFORE A. FAYE HUFFMAN, RPR, AND A CERTIFIED COURT REPORTER FOR THE STATE OF LOUISIANA

* *

REPORTED AT THE OFFICES OF:
LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
628 NORTH 4TH STREET, ROOM 474
BATON ROUGE, LOUISIANA 70802
COMMENCING AT 9:00 A.M. ON FEBRUARY 23, 2011

INDEX

THE WITNESS: Okay. All right.
BY MS. HAHN:
Q. So I'm just going to sort of explain to you my understanding of how it works and I want you to correct me if I get it wrong.
It's to identify people who are at high risk of institutionalization in the coming months, and in order to determine if a person meets that risk there's a specific set of things that they're required to have, and there's a list of eight different things, and this protocol says that at least four of these have to be present for institutional risks to be found; is that right?
A. That's right.
Q. And I believe you said that we negotiated about that during the Barthelemy case and changed that. Was the change that we made that you would only have to have at least three of those factors?
A. That's right.
Q. And the other change that we made during the negotiations over the Barthelemy case was that we also said that if they did not meet these they could provide medical documentation that they were at risk of either institutionalization, or I think it was substantial deterioration and mental or physical condition if they

didn't get care within 120 days?
A. Yeah, that's the process we just described.
Q. Okay. Under prior nursing home placement, I just want to relate this if I can. I'm looking over on this same page that says institutionalization risk on the Exhibit 3 --
A. Uh-huh (affirmative response)
Q. -- these numbers and letters off to the right. It says under prior nursing home placement, it says CC-7 equals 1 in brackets. Can you relate that to Exhibit 1, the MDS-HC? Is that referring to questions that are asked on Exhibit 1?
A. I honestly don't know.
Q. Can you look, for example, under Section CC?
A. You're consulting your MDS expert and I don't have mine in the room, but I'll look and see.
Q. Section CC is on the first page.
A. Okay.
Q. So under CC-7, what does CC-7 say?
A. It says, "Prior nursing home placement. Resided in a nursing home during five years prior to the case opening."
Q. Doesn't it actually say "resided in a nursing home at any time during five years prior to case opening"?

A. Yes.
Q. Has it ever been higher than that?
A. I don't believe it's ever been higher than 14 dollars, no.
Q. And since then would the reductions in the LT-PCS rate be reflected in the rules in the Louisiana Register?
A. Yes.
Q. Would that be the best source of information for that?
A. Yes.
Q. If you'll look at page 2 of Document 1949, is that the document shows the maximum number of hours per week that can be awarded to different groupings of people on the LT-PCS Program?
A. Yes.
Q. So that's your current -- that's the guide that's being used in the current program?
A. Yes, I believe so.
Q. Okay. Now if you'll turn to pages 13 and 14 of Document 1949, there's a document that explains how Louisiana determines Long-Term Personal Care Services hours. Is that a document that describes how -- that partially describes how a person's ADL index in the guide on page 2 is determined?

A. Yes, I think that's what that does. It's an explanation of how that ADL index number is derived based on your answers to the MDS-HC.

Q. And the MDS-HC is the document that was Eley Exhibit 1; is that correct?

A. Yes.

Q. So if I understand it correctly, to get the ADL index you look at only four activities of daily living: getting in or out of bed or a chair, also known as transferring, that's one; going from a lying to a sitting position in bed, bed mobility, using the toilet, and eating; is that correct?

A. That's what it says.

Q. Now when you talk about eating, a minute ago we went over the questions on the MDS-HC dealing with meal preparation. Eating is different from meal preparation; is it not?

A. That's my understanding, yes. I'm not an expert in this assessment tool, but that's my understanding.

Q. Eating means actually getting food into your mouth or into your stomach if you don't eat by mouth; is that right?

A. I believe so, yes.

Q. So that the types of activities you're talking

about here are pretty basic; would you agree with me?
A. Yes.
Q. The people that score in the highest group that would get the 32 hours of the LT-PCS have to score a 14 or 15 or their ADL index, right?
A. That's correct.
Q. How do you get to the score of 14 or 15; do you know? Do you know what you have to be able to do or not be able to do in order to get to that point?
A. No, I don't. I mean it's a cumulative number. It's based on your answers to these questions about these ADLs, but exactly what -- that's as much as I know.
Q. Okay. So you don't actually know how the scores are assigned to the ADL index except for through an algorithm of some kind?
A. It's based on the answers to the ADL questions and how you answer those questions. I don't think it's an algorithm. I think it's just additive, but I may be wrong.
Q. I'm showing you what's been marked Eley Exhibit 4. Could you identify that document?
(ELEY EXHIBIT NO. 4 FOR IDENTIFICATION WAS MARKED FOR THE RECORD.)
A. It appears to be the questions on the MDS and

how they relate to the calculation of the index. I don't think I've ever seen this particular document before.

Q. It says at the bottom, "prepared by Mandi Jones." Is that somebody that works for you?

A. Yes.

Q. I'm showing you a document that's been marked Exhibit 5. Can you identify that document?

(ELEY EXHIBIT NO. 5 FOR IDENTIFICATION WAS MARKED FOR THE RECORD.)

A. Again, I don't know that I've seen it before, but it says, "Detailed Explanation of Scoring Method."

Q. Does it appear to be an explanation of the construction of the ADL index?

A. I wouldn't say that. It looks more like it's some sort of instructions about how to score the specific responses on the assessment tool.

Q. Are you aware of any other document that shows actually how the ADL index is constructed?

A. I would assume it's in the MDS-HC manuals, the training manuals and the user manuals for those things that are put out by the people who developed the tool, but I don't know that for sure.

Q. Does your Department have a copy of something that would show how the ADL index is constructed?

A. I think this document right here shows how it's constructed; the first document you handed me, Exhibit 4.

Q. You think Exhibit 4 explains how the ADL index is constructed?

MS. BROWN: Well, he said he's not familiar with either document.

THE WITNESS: But that's what it appears to do.

BY MS. HAHN:

Q. Are you aware of any other document within your department that shows how the ADL index is constructed?

A. As I said, it may be in the manual. I don't know for sure if it is or not.

MS. HAHN: Was the manual supplied to us as part of discovery; do you know?

MS. BROWN: I don't know.

BY MS. HAHN:

Q. Well, if you have any other document that shows how the ADL index is constructed, would you supply that to us?

A. Sure.

MS. BROWN: By that you mean how it's scored?

MS. HAHN: How it's scored, how you get from

the answers to questions on the MDS-HC or the LOCET to the index.

BY MS. HAHN:

Q. But looking at the MDS-HC and looking, for example, under eating, let me just take you to page 3 of Exhibit 1, the MDS-HC.

A. Okay.

Q. And looking at mobility in bed, it's defined as "moving to and from a lying position, turning side to side, and positioning body while in bed"; is that correct?

A. Yes.

Q. Okay. Now just comparing that to the explanation which was on page 13 of Document 1949, it described bed mobility as "going from a lying to a sitting position in bed."

Which definition is actually used in constructing the ADL index: the one on the MDS-HC, Exhibit 1, or the one in this explanation, how Louisiana determines Long-Term Personal Care Service hours?

MS. BROWN: If you know the answer.

THE WITNESS: Ask me the question again.

BY MS. HAHN:

Q. Okay. Which definition of mobility in bed is

actually used in constructing a person's ADL index to determine how many hours of personal care service they're going to get? Is it the definition on the MDS-HC which says "moving to and from a lying position, turning side to side, and positioning body while in bed," or is it the shorter definition on 1949, page 13, which says "going from a lying to a sitting position in bed"?

Which one of these is the actual definition to use?

A. The one on the MDS-HC.

Q. The one on Exhibit 1?

A. Yes.

Q. And in terms of the -- if you'll look on the previous page on the MDS-HC, you look at what is meant by the different values that can be assigned from independence to activity did not occur, that's down in the lower right-hand corner of the page.

A. Yes.

Q. So there are eight possible -- no, there are seven possible --

MS. BROWN: Eight.

BY MS. HAHN:

Q. -- eight possible values that could be shown under mobility in bed; is that right?

A. Yes.
Q. And it shows on this guide, Exhibit 4, how many points you would get depending on what answer was given for mobility in bed; is that correct?
A. It appears to.
Q. And so what this guide appears to be saying -- first of all --
MS. BROWN: He's already said he's not familiar with this.
MS. HAHN: I know he did, but can I get you to check and let us know if this, indeed, is the way you compute the ADL index?
MR. BERNS: He already agreed to that.
MS. HAHN: He did?
MS. BROWN: Yes.
MS. HAHN: Okay. Thank you. I just wanted to make sure.
BY MS. HAHN:
Q. Let's just go on the assumption that this is the way you compute it.
MS. BROWN: All right. Although he's already said he's not familiar with it and we're not certain of it and we have a long list of questions and limited time. I'm not sure it's productive. It's your deposition.

MS. HAHN: It's my deposition.
MS. BROWN: I know. I know.
MS. HAHN: But I just kind of want to know -- let me just do this one, and then I won't go through the whole thing -- how's that -- and then could we stipulate if it works this way we can apply it to the rest of the things. Okay?
MS. BROWN: Yes.
BY MS. HAHN:
Q. So just taking bed mobility, if you score a zero, 1 or a 2 in bed mobility, that would be independent, set-up help only, or supervision under ADL self-performance, Section H-2, right?
A. I'm sorry. Where are you?
Q. That's okay. I've been over it before. All right. You take MDS question H-2-A.
A. Which is?
Q. It's in Section H, physical function.
A. ADL self-performance. All right.
Q. And that's A, mobility in bed?
MS. BROWN: Next page.
THE WITNESS: Okay. There's a lot of A's on here. Okay.
BY MS. HAHN:
Q. And you're going to fill in a value in the

little square next to mobility in bed. Okay?
A. Okay.
Q. It's going to be a number from zero to 8.
A. Okay.
Q. All right. And if you score a zero, a 1 or a 2, and those are all defined on the previous page -- independent, set-up help only, or supervision -- you'd get one point toward your ADL index, right?
A. H-2-A, zero, 1 or 2, you'd get one point. That's what this document says, yes.
Q. And to get a 3, you would have to score a 3 in bed mobility, and that would be limited assistance, right?
A. Right.
Q. And then it defines limited assistance as "received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times or a combination of non-weight bearing help with more help provided only 1 or 2 times during the period, for a total of 3 or more episodes of physical help."
That's what limited assistance is defined as, right?
A. That's what it says, yes.
Q. Okay. Now to score a 4 in that category, you would have to get extensive assistance, maximal

assistance, or total dependence, or the activity did not occur?

A. That's what it says.

Q. That's what it says. And it would be during the last three days?

A. Yes, that's what -- well, I believe that's correct.

Q. I guess 8 would be you haven't moved in bed in three days. So that's how that would work, right, if this is a correct document?

A. Yes.

Q. Does the state have to report to the CMS on some documents called 372 and 64, some forms?

A. Yes.

Q. And these forms will list the number of participants and the Medicaid expenditures in various programs?

A. Yes.

Q. You have an attachment to your declaration, Attachment F. You testified about it in Paragraph 43 of your declaration. Attachment F is talking about 15 states that have been reported in the -- let me just look at it again.

You talk about 15 states that provide less than 32 hours a week of personal care assistance?

BY MS. HAHN:

Q. Maybe I better go back. Tell me how this came about if you can starting when you learned you were going to make -- that you were going to need to make a cut in the LT-PCS Program.

A. There was a 61 million dollar line item reduction in LT-PCS.

Q. Specifically in that program?

A. Specifically in that program.

Q. And who suggested that line item cut?

A. I have no idea.

Q. Did you suggest it?

A. No, absolutely not.

Q. If it had been your decision to make, would you have suggested it?

A. Well, let me answer your question this way. When we submitted our budget documents in 2000 in the budget preparation we actually submitted to add money to LT-PCS, and if you look at the actual budget documents there is some money added to account for projected utilization, you know, increase, but then that's added and then the 61 million dollars is taken away.

Q. When you start preparing the budget for the next fiscal year, is each department head asked to

submit a proposed budget or how does that work?
A. Yes, each department, each office, submits a proposed budget. Medicaid submits a proposed budget.
Q. When you submit the budget for your office, do you include things like LT-PCS and the waiver programs?
A. Those funds are not in the OAAS budget. They're in the Medicaid budget. But we're involved in preparing those sections of the Medicaid budget that cover those programs that we manage.
Q. And when you put in your budget, you put in for an increase in the LT-PCS Program for fiscal 2011?
A. A utilization increase, yes.
Q. And a utilization increase means more people are using the service so you need more money; is that right?
A. Correct.
Q. How did you learn that there was a line item cut to the LT-PCS Program?
A. I'm honestly not sure. I was either told by someone or I saw it when the budget documents came out, but I really don't remember.
Q. We got a couple of e-mails in the documents that we got recently. Let me see if I can find them. I want you to look at Document 3142, please.
A. Okay.

Q. If you look at these, it's an e-mail chain, and to look at them you've got to start at the bottom.

A. Yeah.

Q. Was this the e-mail in which you learned about the proposed sixty -- well, in this one it says a 62 million cut or a 61 million cut.

A. This is dated February -- the first e-mail is dated February 19th. This is probably not the first information I had, but I don't know what exact date the executive budget was released that year. But I would certainly have known about it by then.

Q. When do you usually learn?

A. I don't think there is a usually. We have budget meetings and we talk about what's in or what's not in the budget, but there's nothing official until the Governor releases the executive budget.

Q. When does that happen?

A. Forty-five days before the start of the legislative session. So this year it's March 11th. Last year the session started earlier, so it would have been sometime in February.

Q. This set of e-mails, you've got an e-mail from Randy Davidson. Who is Randy Davidson?

A. He is a Medicaid waiver assistant in the compliance unit in Medicaid.

Q. And he sent you an e-mail on February 19th saying, "Jerry asked me to do a one-pager about a 62 million decrease for LT-PCS in next year's budget. Is this number familiar to you?" And Jerry, who is the Jerry that he refers to?

A. Jerry Phillips.

Q. And who is Jerry Phillips?

A. He was at that time I believe still the Medicaid director. He's currently the Under Secretary of DHH.

Q. And your reply to the question was that you were not familiar with the number 62 million. You said, "The best I can piece together, this number was -- it should be agreed to -- in meetings between the 9th floor and the Division or Governor's Office."

What did you mean when you referred to the ninth floor?

A. The Secretary's office.

Q. The Secretary of DHH?

A. Yes.

Q. And what is the Division?

A. The Division of Administration.

Q. And what does the Division of Administration have to do with it?

A. Well, the Division of Administration is the

ones who make the budget.

Q. They draw up the budget of all the agencies?

A. They take what the agencies have submitted to them as a budget request, they determine what the size of the pie is, and then they divvy up the pie amongst all those agencies and either give you more or less than what you ask for. Usually less.

Q. And then they -- and of course the Governor's Office. So you say it was somewhere between the Secretary of DHH, the Division of Administration, and the Governor were the ones that told you to make the 62 million dollar cut in the LT-PCS Program?

A. It came out in the executive budget. So it's part of that process that goes on within the Division of Administration. That's where that got put in.

Q. And it wasn't cut 62 million dollars from the Medicaid budget or the Long-Term Care budget; it was cut 62 million dollars from the LT-PCS Program?

A. That's correct.

Q. And you really didn't have an option of cutting it somewhere else?

A. No, although at the end of the day we didn't cut at 61 million dollars.

Q. Well, you didn't feel like you could cut at 61 million dollars, did you?

Exhibit 30 Doc. 1949

Office of Aging and Adult Services
Service Hour Allocation of Resources (SHARe) Guide

Long Term Personal Care Services (LT-PCS) Program
(With Adult Day Health Care Waiver Services)

Support Coordinators use this guide when developing Plans of Care based on Minimum Data Set – Home Care (MDS-HC) assessments completed on or after September 5, 2010.

LT-PCS is subject to a weekly maximum as outlined in this guide.

There is no mandated minimum allotment for any of the five (5) ADL Index groups. An allotment as small as one (1) hour per week is acceptable regardless of the participant's ADL Index score. For example, a participant with an ADL Index score of 7 who has other community and informal care may require as little as one (1) hour per week of paid services.

LT-PCS SHARe Guide

ADL INDEX	LTPCS Max Hrs\wk
(4 - 5)	18
(6 - 8)	22
(9 - 10)	26
(11 - 13)	30
(14 - 15)	32

Office of Aging and Adult Services
Service Hour Allocation of Resources (SHARe) Guide

Long Term Personal Care Services (LT-PCS) Program

Single Point of Entry Agency Assessors use this guide when developing Plans of Care based on Minimum Data Set – Home Care (MDS-HC) assessments completed on or after September 5, 2010.

LT-PCS is subject to a weekly maximum as outlined in this guide.

There is no mandated minimum allotment for any of the five (5) ADL Index groups. An allotment as small as one (1) hour per week is acceptable regardless of the participant's ADL Index score. For example, a participant with an ADL Index score of 7 who has other community and informal care may require as little as one (1) hour per week of paid supports.

LT-PCS SHARe Guide

ADL INDEX	LTPCS Max Hrs\wk
(4 - 5)	18
(6 - 8)	22
(9 - 10)	26
(11 - 13)	30
(14 - 15)	32

Bobby Jindal
GOVERNOR

Anthony Keck
SECRETARY

State of Louisiana

Department of Health and Hospitals

Office of Aging and Adult Services

August 19, 2010

Dear Long Term – Personal Care Services Recipient:

Beginning September 5, 2010, the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services will make changes to the Long Term – Personal Care Services (LT-PCS) program. These changes will make it easier to identify your personal care needs and help control program costs.

Weekly personal care hours will be based on your need for help with your daily activities such as eating, dressing and bathing. **No one will be approved for more than 32 hours a week.**

These changes will take place at your next reassessment. If you do not agree with your reassessment result, you may request an appeal. However, appeals for more than 32 hours a week will not be allowed because this change is for everyone who gets LT-PCS.

These changes **will not** affect your Medicaid eligibility. Please see the enclosed flyer for more information.

If you have any questions or need more information, please call the Office of Aging and Adult Services at 1-866-758-5035.

Sincerely,

Hugh Eley
Assistant Secretary

HE/rh

Enclosure

Bienville Building • P.O. Box 2031 • Baton Rouge, Louisiana 70821-2031
Phone #: 1-866-758-5035 • Fax #: 225/219-0202 • www.dhh.la.gov
"An Equal Opportunity Employer"

Changes to the Long Term – Personal Care Services Program

Will my services change?

- Your personal care services will continue to be approved as a maximum number of hours that may be provided each week. You will still have the freedom of deciding how you receive your service each week.

- The number of hours you receive each week will be based on your need for "hands on" assistance with the activities of daily living, such as moving from bed to chair/wheelchair, grooming, toileting, and walking as indicated by your assessment result.

- No one will receive more than **32 hours** of service a week.

Will everyone get less service hours?

No. Under this new plan, some people will receive fewer hours, some will have the same hours and some may receive more hours.

When will these changes take place?

These changes will take place at your next reassessment.

Can I appeal if I disagree with the hours approved?

Yes. You will have the right to appeal if you disagree with the decision made at the time of your reassessment. However, you will not have a right to appeal the weekly cap of 32 hours. The weekly cap applies to all LT-PCS recipients and is not individually determined.

Issued August 19, 2010
Effective September 5, 2010

OAAS-RC-10-001

Bobby Jindal
GOVERNOR

Anthony Keck
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of Aging and Adult Services

MEMORANDUM **OAAS-SC-10-021**

TO: Support Coordination Agencies

FROM: Rick Henley, Policy Division Director RLH
Office of Aging and Adult Services

DATE: August 18, 2010

SUBJECT: Long Term – Personal Care Services (LT-PCS) Program Changes – Effective September 5, 2010

The following changes are being made to the Long Term Personal Care Services program effective September 5, 2010:

- The maximum allowable weekly allotment is being reduced to 32 hours (from 42 hours).
- The Activities of Daily Living (ADL) Index instead of the Resource Utilization Group scoring (RUGs) categories will be used to determine weekly allocations for LT-PCS.

These changes apply to all MDS-HC assessments completed on or after September 5, 2010. These changes do not effect the allocation of Adult Day Health Care (ADHC) Waiver or Elderly and Disabled Adult (EDA) Waiver services. Support Coordinators will continue to use the Resource Utilization Group scoring categories for allocation of EDA Waiver services.

The following documents related to these changes are attached:

- Letter being sent to all LT-PCS program participants August 19, 2010 (OAAS-R-10-007)
- *Changes to the Long Term – Personal Care Services Program* recipient flyer being sent to all LT-PCS program participants August 19, 2010 (OAAS-RC-10-001).
- *Service Hour Allocation of Resources (SHARe) Guide – Long Term Personal Care Services Program (With Adult Day Health Care Waiver Services)* (OAAS-SC-10-017) – This guide is to be used to develop plans of care based on MDS-HC assessments completed on or after September 5, 2010.
- *Support Coordination Assessor Checklist* (OAAS-SC-09-027) is a step-by-step guide for assessment and care plan development meetings. It explains the use and disposition of the MDS-HC and the next three (3) forms on this list.

- *Rights and Responsibilities for Applicants/Participants of Home and Community Based Waiver Services (HCBWS)* (OAAS-RF-10-005)

- *Description of Groups Used In Louisiana Long Term – Personal Care Services (LT-PCS) Program* (OAAS-RC-10-002)

- *Descriptions of Groups Used in Louisiana Elderly & Disabled (EDA) Waiver Program* (OAAS-RC-09-012)

- *Long Term – Personal Care Services Program Fact Sheet* with ACS contact information (OAAS-RC-09-008)*

- *Long Term – Personal Care Services Program Fact Sheet* with CAAA contact information (OAAS-RC-09-001)*

  * The "Other Service" of "Grocery Shopping" has been changed to "Shopping" on the fact sheet.

Please share this information with all support coordination staff and contact the local OAAS regional office if you have any questions.

C: OAAS Regional Office Staff
OAAS State Office Staff
Medicaid Waiver Compliance Section
DHH Legal

Attachments

State of Louisiana

Department of Health and Hospitals
Office of Aging and Adult Services

Support Coordination Assessor Checklist

The *"Office of Aging and Adult Services (OAAS) Rights and Responsibilities for Applicants/Participants of Home and Community-Based Services (HCBS)"* document (OAAS-RF-08-003) has been replaced with *"Office of Aging and Adult Services (OAAS) Rights and Responsibilities for Applicants/Participants of Home and Community-Based Waiver Services (HCBWS)"* document (OAAS-RF-10-005). This form is specifically for applicants and participants of Home and Community-Based Waiver Services (HCBWS). Rights related to OAAS Service Hour Allocation of Resources methodology for Elderly and Disabled Adult (EDA) Waiver Services and Long Term – Personal Care Services (LT-PCS) are included. Resource Utilization Group Scoring (RUGs) is used for allocation of EDA Waiver services and Activities of Daily Living (ADL) Index Scoring is used for allocation of LT-PCS services for Adult Day Health Care (ADHC) Waiver participants who receive LT-PCS. The support coordinators' (SC's) responsibilities for explaining use of the Minimum Data Set-Home Care (MDS-HC) assessment to determine number of services hours to be recommended for approval are as follows:

At the face-to-face initial or annual assessment meeting:

1. The SC shall explain and provide the applicant/participant with a copy of one of the following documents:
   - *"Descriptions of Groups Used in Louisiana Elderly & Disabled (EDA) Waiver Program"* (OAAS-RC-09-012) to EDA Waiver applicants/participants

   OR
   - *"Descriptions of Groups Used in Louisiana Long Term – Personal Care Services (LT-PCS) Program"* (OAAS-RC-10-002) to ADHC Waiver applicants/participants also applying for or receiving LT-PCS

2. If conducting a reassessment for an ADHC Waiver participant who receives LT-PCS, the SC shall also explain the LT-PCS program changes and provide the participant with a copy of the following document:
   - *"Changes to Long Term Personal Care Services Program"* flyer (OAAS-RC-10-001)

3. After gathering all MDS-HC information, the SC shall review with the applicant/participant the completed MDS-HC item by item to determine if it is accurate.

4. If applicable, the SC shall explain that the applicant/participant has the right to request more hours, in excess of the maximum of the RUG or ADL Index Scoring group to which he/she has been assigned, if needed to avoid entering a nursing facility.

5. If applicable the SC shall explain that the applicant/participant has the right to request more hours of service within his/her RUG or ADL Index Scoring category if he/she has not been given the maximum.

Support Coordination Assessor Checklist

6. The SC shall explain that the applicant/participant has the right to appeal for more hours if he/she believes that the MDS-HC assessment was not completed correctly or if more hours are needed to avoid entering a nursing facility. Explanation to the ADHC and LT-PCS applicant/recipient shall include the following: No one can receive more than 32 hours per week of LT-PCS effective September 5, 2010.

7. The SC shall explain that the applicant/participant has the right to contact the SC's supervisor and the OAAS Regional Office if the SC did not explain all of these rights to him/her. Space is provided for the SC to add his/her supervisor's telephone number and, the number for the local OAAS Regional Office to the Rights and Responsibilities document.

8. A copy of the Rights and Responsibilities document (OAAS-RF-10-005) shall be given to the applicant/participant.

At the face-to-face initial or annual planning meeting:

The SC shall explain to the applicant/participant how many hours of each kind of service are proposed to be included in the POC. A part of the assessor's explanation is to include that this is only a proposed amount based on the information gathered during the face-to-face assessment and is contingent upon review by the assessor's supervisor and review and approval by the OAAS Regional Office or its designee.

After the POC has been completed and reviewed and approved by the SC's supervisor and the OAAS Regional Office or its designee:

The SC shall provide the applicant/participant with a copy of the MDS-HC along with a copy of all finalized POC documents.

Note: The SC shall always provide the applicant/participant with a copy of any and all documents signed by the applicant/participant.

Bobby Jindal
GOVERNOR

Anthony Keck
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of Aging and Adult Services

MEMORANDUM **OAAS-ADM-10-025**

TO: Affiliated Computer Systems Administration
Capital Area Agency on Aging Administration

FROM: Rick Henley, Policy Division Director RLH
Office of Aging and Adult Services

DATE: August 18, 2010

SUBJECT: Long Term – Personal Care Services (LT-PCS) Program Changes – Effective September 5, 2010

The following changes are being made to the Long Term Personal Care Services program effective September 5, 2010:

- The maximum allowable weekly allotment is being reduced to 32 hours (from 42 hours).
- The Activities of Daily Living (ADL) Index instead of the Resource Utilization Group scoring (RUGs) categories will be used to determine weekly allocations for LT-PCS.
- When level of care eligibility is established on a medical pathway (i.e., 3-Physician Involvement, 4-Treatments and Conditions, and/or 5-Skilled Rehabilitation Therapies) only, the LT-PCS certification period will be 90 days. The start of the 90-day certification shall be the prior authorization effective date. Reassessments must not be completed any sooner than 14 working days prior to expiration of the 90-day certification period.

These changes apply to all MDS-HC assessments completed on or after September 5, 2010.

The following documents related to these changes are attached:

- Letter being sent to all LT-PCS program participants August 19, 2010 (OAAS-R-10-007)
- *Changes to the Long Term – Personal Care Services Program* recipient flyer being sent to all LT-PCS program participants August 19, 2010 (OAAS-RC-10-001)
- *Service Hour Allocation of Resources (SHARe) Guide – Long Term Personal Care Services Program (With Adult Day Health Care Waiver Services)* (OAAS-SC-10-022) –

This guide is to be used to develop plans of care based on MDS-HC assessments completed on or after September 5, 2010.

- *Single Point of Entry Assessor Checklist* (OAAS-ADM-09-015) is a step-by-step guide for assessment and care plan development meetings. It explains the use and disposition of the MDS-HC and the next two (2) forms on this list.

- *Rights and Responsibilities for Applicants/Participants of Long Term – Personal Care Services (LT-PCS)* (OAAS-RF-10-006)

- *Descriptions of Groups Used In Louisiana Long Term – Personal Care Services (LT-PCS) Program* (OAAS-RC-10-002)

- *Long Term – Personal Care Services Program Fact Sheet* with ACS contact information (OAAS-RC-09-008)*

- *Long Term – Personal Care Services Program Fact Sheet* with CAAA contact information (OAAS-RC-09-001)*

  * The "Other Service" of "Grocery Shopping" has been changed to "Shopping" on the fact sheet.

Please share this information with all assessment staff and contact the applicable OAAS representative if you have any questions.

C: OAAS State Office Staff
Medicaid Waiver Compliance Section
DHH Legal

Attachments

State of Louisiana

Department of Health and Hospitals
Office of Aging and Adult Services

Single Point of Entry (SPOE) Assessor Checklist

The *"Office of Aging and Adult Services (OAAS) Rights and Responsibilities for Applicants/Participants of Home and Community-Based Services (HCBS)"* document (OAAS-RF-08-003) has been replaced with *"Office of Aging and Adult Services (OAAS) Rights and Responsibilities for Applicants/Participants of Long Term – Personal Care Services (LT-PCS)"* document (OAAS-RF-10-006). Rights related to OAAS Service Hour Allocation of Resources methodology for Long Term Personal Care Services are included. The SPOE assessors' responsibilities for explaining use of the Minimum Data Set-Home Care (MDS-HC) assessment and the Activities of Daily Living (ADL) Index Scoring to determine number of services hours to be recommended for approval are as follows:

At the face-to-face initial or annual assessment meeting:

1. The assessor shall explain and provide the applicant/participant with a copy of the following document:
    - *"Description of Groups Used in Louisiana Long-Term Person Care Services (LT-PCS) Program"* (OAAS-RC-10-002).

2. If conducting a reassessment for a program participant, the assessor shall also explain the program changes and provide the participant with a copy of the following document:
    - *"Changes to Long Term – Personal Care Services Program"* flyer (OAAS-RC-10-001).

3. After gathering all MDS-HC information, the assessor shall review with the applicant/participant the completed MDS-HC item by item to determine if it is accurate.

4. The assessor shall explain to the applicant/participant how many hours and each type of assistance proposed to be included in the Plan of Care (POC). A part of the assessor's explanation is to include that this is only a proposed amount based on the information gathered during the face-to-face assessment and is contingent upon being entered into the data base and reviewed and approved by the assessor's supervisor.

5. The assessor shall explain that the applicant/participant has the right to request more hours, in excess of the maximum of the ADL Index Scoring group to which he/she has been assigned, if needed to avoid entering a nursing facility.

6. The assessor shall explain that the applicant/participant has the right to request more hours of service within his/her ADL Index scoring category if he/she has not been given the maximum.

7. The assessor shall explain that the applicant/participant has the right to appeal for more hours if he/she believes that the MDS-HC assessment was not completed correctly or if more hours

Single Point of Entry (SPOE) Assessor Checklist

are needed to avoid entering a nursing facility up to but not to exceed the program maximum (e.g., 32 hours per week effective September 5, 2010).

8. The assessor shall explain that the applicant/participant has the right to contact the assessor's supervisor if the assessor did not explain all of these rights to him/her. Space is provided for the assessor to add his/her supervisor's telephone number to the Rights and Responsibilities document.

9. A copy of the Rights and Responsibilities document (OAAS-RF-10-006) is to be given to the applicant/participant.

After the POC has been completed and approved by the assessor's supervisor:

The applicant/participant is to be provided with a copy of page 1 and section H of the MDS-HC along with a copy of all finalized POC documents.

Note: the applicant/participant is to be provided with a copy of any and all documents signed by the applicant/participant.

How Louisiana Determines
Long Term – Personal Care Services (LT-PCS) Hours

The Louisiana Department of Health and Hospitals uses information collected through the **Minimum Data Set for Home Care (MDS-HC)** to determine a person's level of services for home- and community-based programs.

Section H of the MDS-HC, "Physical Functioning," collects information regarding the assistance you receive with **Activities of Daily Living (ADLs).** While the form asks for information about a number of activities, there are four important ADLs that are considered in determining the maximum number of hours of LT-PCS services you can receive. These are:

- getting in or out of bed or a chair (transferring)
- going from a lying to a sitting position in bed (bed mobility)
- using the toilet, and
- eating.

The assessment looks at how much help you received in performing these activities during the three days prior to your assessment. The assessment rates the level of assistance as described in the chart below.

MDS-HC Scoring Term	What this means
Independent	No help, setup, or oversight OR help, setup, and oversight provided only 1 or 2 times (with any task or subtask)
Setup help only	Article or device provided within reach of person 3 or more times
Supervision	Oversight, encouragement or cueing provided 3 or more times during last 3 days or supervision (1 or more times) plus physical assistance provided only 1 or 2 times (for a total of 3 or more episodes of help or supervision)
Limited Assistance	Person highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times OR combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help)
Extensive Assistance	Person performed part of activity on own (50% or more of subtasks), but help of following types were provided 3 or more times: weight-bearing support OR full performance by another during part (but not all) of last 3 days
Maximal Assistance	Person involved and completed less than 50% of subtasks on own (includes 2 + person assist), received weight-bearing help or full performance of certain subtasks 3 or more times
Total Dependence	Full performance of activity by another

Based on the amount of assistance received in each of the four ADLs (transfer, bed mobility, toileting, and eating), an **ADL Index** is calculated to determine your overall level of assistance. The ADL Index determines the range of LT-PCS hours available each week.

ADL INDEX	LT-PCS HOURS PER WEEK
4 – 5	1 – 18
6 – 8	1 – 22
9 – 10	1 – 26
11 – 13	1 – 30
14 – 15	1 – 32

Once the range of hours is determined, a Plan of Care is developed. It is the care-planning process, and discussions with your assessor, that determine the actual number of hours of assistance that you will receive. The actual number cannot exceed the maximum number in the ADL Index, unless it is determined that you need additional hours to avoid entering a nursing home. However, no one can receive more than 32 hours of LT-PCS a week.

Daily Level of Service Guide

This form is to be used as a general guide in assigning recommended time allotments for ADL and IADL activities.

Independent – recipient able to perform task without assistance

Limited Assistance – recipient involved in task but received help from others some of the time

Extensive Assistance – recipient involved in task but received help from others all of the time

Total Assistance – recipient is totally dependent on others

Note: For each category of time, the recipient should not receive less than the maximum assigned time in the previous category. Time for activities should be listed in increments of 15 minutes (i.e., 15 min., 30 min., 45 min. etc.).

ADL Activities	Independent	Limited	Extensive	Total
Eating (based on 3 meals/day)	0	Up to 30 min./day	Up to 1 hr./day	Up to 1 hr.30 min./day
Bathing	0	Up to 30 min./day	Up to 45 min./day	Up to 1 hr./day
Dressing	0	Up to 15 min./day	Up to 30 min./day	Up to 1 hr./day
Grooming	0	Up to 15 min./day	Up to 15 min./day	Up to 15 min./day
Transferring	0	Up to 30 min./day	Up to 45 min./day	Up to 1 hr./day
Ambulation	0	Up to 15 min./day	Up to 30 min./day	Up to 30 min./day
Toileting	0	Up to 30 min./day	Up to 45 min./day	Up to 1 hr./day

IADL Activities	Maximum Time
Light housekeeping	Up to 1 hour/week
Food preparation and storage	Up to 30 minutes/meal
*Grocery shopping	Up to 2 hours/week
Laundry	Up to 1 hour/week
Medication reminders	1 hour/month
Assist with scheduling medical appointments	15 minutes/month
Assist recipient with accessing medical transportation	15 minutes/month
**Accompany to medical appointments when necessary due to recipient's frail condition	Up to 3 hrs. 30 min./month

**Inquiry should be made about the distance to the store (i.e., neighborhood store vs. rural area) and time appropriately assigned.*

***Verification is needed that the recipient has standing medical appointments in order to assign time in the Plan of Care that would exceed 3 hrs.30 minutes.*

Direct link to Medicaid's July 2002 *Case Management Services Provider Manual* posted to OAAS internet website:

http://www.dhh.louisiana.gov/offices/publications.asp?ID=105&Detail=1722

Exhibit 31 MDS-HC (Eley deposition Exh. 1)

MINIMUM DATA SET - HOME CARE (MDS-HC)©

• Unless otherwise noted, score for last 3 days

• Examples of exceptions include IADLs/Continence/Services/Treatments where status scored over last 7 days

SECTION AA. NAME AND IDENTIFICATION NUMBERS

1.	NAME OF CLIENT	a. (Last/Family Name) b. (First Name) c. (Middle Initial)
2.	CASE RECORD NO.	
3.	GOVERNMENT PENSION AND HEALTH INSURANCE NUMBERS	a. Pension (Social Security) Number b. Health insurance number (or other comparable insurance number)

SECTION BB. PERSONAL ITEMS *(Complete at Intake Only)*

1.	GENDER	1. Male 2. Female
2.	BIRTHDATE	Month Day Year
3.	RACE/ETHNICITY ®	*(Check all that apply)* *RACE* American Indian/Alaskan Native (a.) Asian (b.) Black or African American (c.) Native Hawaiian or other Pacific Islander (d.) White (e.) *ETHNICITY:* Hispanic or Latino (f.)
4.	MARITAL STATUS	1. Never married 3. Widowed 5. Divorced 2. Married 4. Separated 6. Other
5.	LANGUAGE ©	Primary Language 0. English 1. Spanish 2. French 3. Other
6.	EDUCATION *(Highest Level Completed)*	1. No schooling 5. Technical or trade school 2. 8th grade/less 6. Some college 3. 9-11 grades 7. Bachelor's degree 4. High school 8. Graduate degree
7.	RESPONSIBILITY/ ADVANCE DIRECTIVES	*(Code for responsibility/advance directives)* 0. No 1. Yes a. Client has a legal guardian b. Client has advance medical directives in place (for example, a do not hospitalize order)

SECTION CC. REFERRAL ITEMS *(Complete at Intake Only)*

1.	DATE CASE OPENED/ REOPENED	Month Day Year
2.	REASON FOR REFERRAL	1. Post hospital care 4. Eligibility for home care 2. Community chronic care 5. Day care 3. Home placement screen 6. Other
3.	GOALS OF CARE	*(Code for client/family understanding of goals of care)* 0. No 1. Yes a. Skilled nursing treatments d. Client/family education b. Monitoring to avoid clinical complications e. Family respite c. Rehabilitation f. Palliative care
4.	TIME SINCE LAST HOSPITAL STAY	Time since discharge from last in-patient setting (*Code for most recent instance in LAST 180 DAYS*) 0. No hospitalization within 180 days 3. Within 15 to 30 days 1. Within last week 4. More than 30 days ago 2. Within 8 to 14 days
5.	WHERE LIVED AT TIME OF REFERRAL	1. Private home/apt. with no home care services 2. Private home/apt. with home care services 3. Board and care/assisted living/group home 4. Nursing home 5. Other
6.	WHO LIVED WITH AT REFERRAL	1. Lived alone 2. Lived with spouse only 3. Lived with spouse and other(s) 4. Lived with child (not spouse) 5. Lived with other(s) (not spouse or children) 6. Lived in group setting with non-relative(s)
7.	PRIOR NH PLACEMENT	Resided in a nursing home at anytime during **5 YEARS** prior to case opening 0. No 1. Yes
8.	RESIDENTIAL HISTORY	Moved to current residence within last two years 0. No 1. Yes

SECTION A. ASSESSMENT INFORMATION

1.	ASSESSMENT REFERENCE DATE	*Date of assessment* Month Day Year
2.	REASONS FOR ASSESSMENT	*Type of assessment* 1. Initial assessment 2. Follow-up assessment 3. Routine assessment at fixed intervals 4. Review within 30-day period prior to discharge from the program 5. Review at return from hospital 6. Change in status 7. Other

SECTION B. COGNITIVE PATTERNS

1.	MEMORY RECALL ABILITY	*(Code for recall of what was learned or known)* 0. Memory OK 1. Memory problem a. Short-term memory OK — seems/appears to recall after 5 minutes b. Procedural memory OK--Can perform all or almost all steps in a multitask sequence without cues for initiation
2.	COGNITIVE SKILLS FOR DAILY DECISION-MAKING	a. How well client made decisions about organizing the day (e.g., when to get up or have meals, which clothes to wear or activities to do) 0. *INDEPENDENT*—Decisions consistent/reasonable/safe 1. *MODIFIED INDEPENDENCE*—Some difficulty in new situations only 2. *MINIMALLY IMPAIRED*—In specific situations, decisions become poor or unsafe and cues/supervision necessary at those times 3. *MODERATELY IMPAIRED*—Decisions consistently poor or unsafe, cues/supervision required at all times 4. *SEVERELY IMPAIRED*—Never/rarely made decisions b. Worsening of decision making as compared to status of **90 DAYS AGO** (or since last assessment if less than 90 days) 0. No 1. Yes
3.	INDICATORS OF DELIRIUM	a. Sudden or new onset/change in mental function over **LAST 7 DAYS** (including ability to pay attention, awareness of surroundings, being coherent, unpredictable variation over course of day) 0. No 1. Yes b. In the **LAST 90 DAYS** (or since last assessment if less than 90 days), client has become agitated or disoriented such that his or her safety is endangered or client requires protection by others 0. No 1. Yes

SECTION C. COMMUNICATION/HEARING PATTERNS

1.	HEARING	*(With hearing appliance if used)* 0. *HEARS ADEQUATELY*—Normal talk, TV, phone, doorbell 1. *MINIMAL DIFFICULTY*—When not in quiet setting 2. *HEARS IN SPECIAL SITUATIONS ONLY*—Speaker has to adjust tonal quality and speak distinctly 3. *HIGHLY IMPAIRED*—Absence of useful hearing
2.	MAKING SELF UNDERSTOOD (Expression)	*(Expressing information content—however able)* 0. *UNDERSTOOD*—Expresses ideas without difficulty 1. *USUALLY UNDERSTOOD*—Difficulty finding words or finishing thoughts BUT if given time, little or no prompting required 2. *OFTEN UNDERSTOOD*—Difficulty finding words or finishing thoughts, prompting usually required 3. *SOMETIMES UNDERSTOOD*—Ability is limited to making concrete requests 4. *RARELY/NEVER UNDERSTOOD*
3.	ABILITY TO UNDERSTAND OTHERS (Comprehension)	*(Understands verbal information—however able)* 0. *UNDERSTANDS*—Clear comprehension 1. *USUALLY UNDERSTANDS*—Misses some part/intent of message, BUT comprehends most conversation with little or no prompting 2. *OFTEN UNDERSTANDS*—Misses some part/intent of message; with prompting can often comprehend conversation 3. *SOMETIMES UNDERSTANDS*—Responds adequately to simple, direct communication 4. *RARELY/NEVER UNDERSTANDS*
4.	COMMUNICATION DECLINE	Worsening in communication (making self understood or understanding others) as compared to status of **90 DAYS AGO** (or since last assessment if less than 90 days) 0. No 1. Yes

SECTION D. VISION PATTERNS

1.	VISION	*(Ability to see in adequate light and with glasses if used)* 0. *ADEQUATE*—Sees fine detail, including regular print in newspapers/ books 1. *IMPAIRED*—Sees large print, but not regular print in newspapers/ books 2. *MODERATELY IMPAIRED*—Limited vision; not able to see newspaper headlines, but can identify objects 3. *HIGHLY IMPAIRED*—Object identification in question, but eyes appear to follow objects 4. *SEVERELY IMPAIRED*—No vision or sees only light, colors, or shapes; eyes do not appear to follow objects
2.	VISUAL LIMITATION/ DIFFICULTIES	Saw halos or rings around lights, curtains over eyes, or flashes of lights 0. No 1. Yes
3.	VISION DECLINE	Worsening of vision as compared to status of **90 DAYS AGO** (or since last assessment if less than 90 days) 0. No 1. Yes

SECTION E. MOOD AND BEHAVIOR PATTERNS

1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD (*Code for observed indicators irrespective of the assumed cause*)

0. Indicator not exhibited in last 3 days
1. Exhibited 1-2 of last 3 days
2. Exhibited on each of last 3 days

- **a. A FEELING OF SADNESS OR BEING DEPRESSED**, that life is not worth living, that nothing matters, that he or she is of no use to anyone or would rather be dead
- **b. PERSISTENT ANGER WITH SELF OR OTHERS**—e.g., easily annoyed, anger at care received
- **c. EXPRESSIONS OF WHAT APPEAR TO BE UNREALISTIC FEARS**—e.g., fear of being abandoned, left alone, being with others
- **d. REPETITIVE HEALTH COMPLAINTS**—e.g., persistently seeks medical attention, obsessive concern with body functions
- **e. REPETITIVE ANXIOUS COMPLAINTS, CONCERNS**—e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues
- **f. SAD, PAINED, WORRIED FACIAL EXPRESSIONS** — e.g., furrowed brows
- **g. RECURRENT CRYING, TEARFULNESS**
- **h. WITHDRAWAL FROM ACTIVITIES OF INTEREST**—e.g., no interest in long standing activities or being with family/friends
- **i. REDUCED SOCIAL INTERACTION**

2. MOOD DECLINE — Mood indicators have become worse as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No 1. Yes

3. BEHAVIORAL SYMPTOMS — Instances when client exhibited behavioral symptoms. If EXHIBITED, ease of altering the symptom when it occurred.

0. Did not occur in last 3 days
1. Occurred, easily altered
2. Occurred, not easily altered

- **a. WANDERING**—Moved with no rational purpose, seemingly oblivious to needs or safety
- **b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS**—Threatened, screamed at, cursed at others
- **c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS**—Hit, shoved, scratched, sexually abused others
- **d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS**—Disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smears/throws food/feces, rummaging, repetitive behavior, rises early and causes disruption
- **e. RESISTS CARE**—Resisted taking medications/injections, ADL assistance, eating, or changes in position

4. CHANGES IN BEHAVIOR SYMPTOMS — Behavioral symptoms have become worse or are less well tolerated by family as compared to **90 DAYS AGO** (or since last assessment if less than 90 days)
0. No, or no change in behavioral symptoms 1. Yes

SECTION F. SOCIAL FUNCTIONING

1. INVOLVEMENT
- **a.** At ease interacting with others (e.g., likes to spend time with others)
  0. At ease 1. Not at ease
- **b.** Openly expresses conflict or anger with family/friends
  0. No 1. Yes

2. CHANGE IN SOCIAL ACTIVITIES — As compared to **90 DAYS AGO** (or since last assessment if less than 90 days ago), decline in the client's level of participation in social, religious, occupational or other preferred activities. IF THERE WAS A DECLINE, client distressed by this fact
0. No decline
1. Decline, not distressed
2. Decline, distressed

3. ISOLATION
- **a.** Length of time client is alone during the day (morning and afternoon)
  0. Never or hardly ever
  1. About one hour
  2. Long periods of time—e.g., all morning
  3. All of the time
- **b.** Client says or indicates that he/she feels lonely
  0. No 1. Yes

SECTION G. INFORMAL SUPPORT SERVICES

1. TWO KEY INFORMAL HELPERS — Primary (A) and Secondary (B)

NAME OF PRIMARY AND SECONDARY HELPERS

a. (Last/Family Name) **b.** (First)

c. (Last/Family Name) **d.** (First)

	(A) Prim	(B) Secn
e. Lives with client 0. Yes 1. No 2. No such helper [skip other items in the appropriate column]		
f. Relationship to client 0. Child or child-in-law 2. Other Relative 1. Spouse 3. Friend/neighbor		
Areas of help: 0. Yes 1. No		
g. — Advice or emotional support		
h. — IADL care		
i. — ADL care		

1. TWO KEY INFORMAL HELPERS — Primary (A) and Secondary (B) (cont)

	(A) Prim	(B) Secn
If needed, willingness (with ability) to increase help: 0. More than 2 hours 1. 1-2 hours per day 2. No		
j. — Advice or emotional support		
k. — IADL care		
l. — ADL care		

2. CAREGIVER STATUS (*Check all that apply*)

- A caregiver is unable to continue in caring activities—e.g., decline in the health of the caregiver makes it difficult to continue — a.
- Primary caregiver is not satisfied with support received from family and friends (e.g., other children of client) — b.
- Primary caregiver expresses feelings of distress, anger or depression — c.
- *NONE OF ABOVE* — d.

3. EXTENT OF INFORMAL HELP (HOURS OF CARE, ROUNDED) — For instrumental and personal activities of daily living received over the **LAST 7 DAYS**, indicate extent of help from family, friends, and neighbors

	HOURS
a. Sum of time across five weekdays	
b. Sum of time across two weekend days	

SECTION H. PHYSICAL FUNCTIONING:
· IADL PERFORMANCE IN 7 DAYS
· ADL PERFORMANCE IN 3 DAYS

1. IADL SELF PERFORMANCE—Code for functioning in routine activities around the home or in the community during the **LAST 7 DAYS**,

(A) IADL SELF PERFORMANCE CODE (*Code for client's performance during LAST 7 DAYS*)
0. *INDEPENDENT*—did on own
1. *SOME HELP*—help some of the time
2. *FULL HELP*—performed with help all of the time
3. *BY OTHERS*—performed by others
8. *ACTIVITY DID NOT OCCUR*

(B) IADL DIFFICULTY CODE *How difficult it is (or would it be) for client to do activity on own*
0. *NO DIFFICULTY*
1. *SOME DIFFICULTY*—e.g., needs some help, is very slow, or fatigues
2. *GREAT DIFFICULTY*—e.g., little or no involvement in the activity is possible

	(A) Performance	(B) Difficulty
a. MEAL PREPARATION—How meals are prepared (e.g., planning meals, cooking, assembling ingredients, setting out food and utensils)		
b. ORDINARY HOUSEWORK—How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)		
c. MANAGING FINANCE—How bills are paid, checkbook is balanced, household expenses are balanced		
d. MANAGING MEDICATIONS—How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)		
e. PHONE USE—How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)		
f. SHOPPING—How shopping is performed for food and household items (e.g., selecting items, managing money)		
g. TRANSPORTATION—How client travels by vehicle (e.g., gets to places beyond walking distance)		

2. ADL SELF-PERFORMANCE—The following address the client's physical functioning in routine personal activities of daily life, for example, dressing, eating, etc. during the **LAST 3 DAYS**, **considering all episodes of these activities**. For clients who performed an activity independently, be sure to determine and record whether others encouraged the activity or were present to supervise or oversee the activity [*Note—For bathing, code for most dependent single episode in LAST 7 DAYS*]

0. *INDEPENDENT*—No help, setup, or oversight —OR— Help, setup, oversight provided only 1 or 2 times (with any task or subtask)
1. *SETUP HELP ONLY*—Article or device provided within reach of client 3 or more times
2. *SUPERVISION*—Oversight, encouragement or cueing provided 3 or more times during last 3 days —OR— Supervision (1 or more times) plus physical assistance provided only 1 or 2 times (for a total of 3 or more episodes of help or supervision)
3. *LIMITED ASSISTANCE*—Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times —OR— Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help)
4. *EXTENSIVE ASSISTANCE*—Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 or more times:
   — Weight-bearing support —OR—
   — Full performance by another during part (but not all) of last 3 days
5. *MAXIMAL ASSISTANCE*—Client involved and completed less than 50% of subtasks on own (include: 2+ person assist), received weight bearing help or full performance of certain subtasks 3 or more times
6. *TOTAL DEPENDENCE*—Full performance of activity by another
8. *ACTIVITY DID NOT OCCUR* (regardless of ability)

2. ADL SELF-PERFORMANCE (cont)

a. MOBILITY IN BED—Including moving to and from lying position, turning side to side, and positioning body while in bed.

b. TRANSFER—Including moving to and between surfaces—to/from bed, chair, wheelchair, standing position. [*Note—Excludes to/from bath/toilet*]

c. LOCOMOTION IN HOME—[Note—If in wheelchair, self-sufficiency once in chair]

d. LOCOMOTION OUTSIDE OF HOME—[Note—If in wheelchair, self-sufficiency once in chair]

e. DRESSING UPPER BODY—How client dresses and undresses (**street clothes, underwear**) above the waist, includes prostheses, orthotics, fasteners, pullovers, etc.

f. DRESSING LOWER BODY—How client dresses and undresses (**street clothes, underwear**) from the waist down, includes prostheses, orthotics, belts, pants, skirts, shoes, and fasteners

g. EATING—Including taking in food by any method, including tube feedings.

h. 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.

i. PERSONAL HYGIENE—Including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (EXCLUDE baths and showers)

j. BATHING—How client takes full-body bath/shower or sponge bath (**EXCLUDE** washing of back and hair). Includes how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area. ***Code for most dependent episode in LAST 7 DAYS***

3. ADL DECLINE — ADL status has become worse (i.e., now more impaired in self performance) as compared to status **90 days ago** (or since last assessment if less than 90 days)
0. No 1. Yes

4. PRIMARY MODES OF LOCOMOTION
0. No assistive device 3. Scooter (e.g., Amigo)
1. Cane 4. Wheelchair
2. Walker/crutch 8. ACTIVITY DID NOT OCCUR

a. Indoors

b. Outdoors

5. STAIR CLIMBING — In the **last 3 days**, how client went up and down stairs (e.g., single or multiple steps, using handrail as needed)
0. Up and down stairs without help
1. Up and down stairs with help
2. Not go up and down stairs

6. STAMINA

a. In a typical week, during the **LAST 30 DAYS** (or since last assessment), code the number of days client usually went out of the house or building in which client lives (no matter how short a time period)
0. Every day 2. 1 day a week
1. 2-6 days a week 3. No days

b. Hours of physical activities in the **last 3 days** (e.g., walking, cleaning house, exercise)
0. Two or more hours 1. Less than two hours

7. FUNCTIONAL POTENTIAL

a. Client believes he/she capable of increased functional independence (ADL, IADL, mobility)

b. Caregivers believe client is capable of increased functional independence (ADL, IADL, mobility)

c. Good prospects of recovery from current disease or conditions, improved health status expected

d. *NONE OF ABOVE*

SECTION I. CONTINENCE IN LAST 7 DAYS

1. BLADDER CONTINENCE

a. **In LAST 7 DAYS** control of urinary bladder function (with appliances such as catheters or incontinence program employed) [Note—if dribbles, volume insufficient to soak through underpants]

0. *CONTINENT*—Complete control; DOES NOT USE any type of catheter or other urinary collection device
1. *CONTINENT WITH CATHETER*—Complete control with use of any type of catheter or urinary collection device that does not leak urine
2. *USUALLY CONTINENT*—Incontinent episodes once a week or less
3. *OCCASIONALLY INCONTINENT*—Incontinent episodes 2 or more times a week but not daily
4. *FREQUENTLY INCONTINENT*—Tends to be incontinent daily, but some control present
5. *INCONTINENT*—Inadequate control, multiple daily episodes
8. *DID NOT OCCUR*—No urine output from bladder

b. Worsening of bladder incontinence as compared to status **90 DAYS AGO** (or since last assessment if less than 90 days)
0. No 1. Yes

2. BLADDER DEVICES (***Check all that apply in LAST 7 DAYS***)

a. Use of pads or briefs to protect against wetness

b. Use of an indwelling urinary catheter

c. *NONE OF ABOVE*

3. BOWEL CONTINENCE — In **LAST 7 DAYS**, control of bowel movement (with appliance or bowel continence program if employed)

0. *CONTINENT*—Complete control; DOES NOT USE ostomy device
1. *CONTINENT WITH OSTOMY*—Complete control with use of ostomy device that does not leak stool
2. *USUALLY CONTINENT*—Bowel incontinent episodes less than weekly
3. *OCCASIONALLY INCONTINENT*—Bowel incontinent episode once a week
4. *FREQUENTLY INCONTINENT*—Bowel incontinent episodes 2-3 times a week
5. *INCONTINENT*—Bowel incontinent all (or almost all) of the time
8. *DID NOT OCCUR*—No bowel movement during entire 7 day assessment period

SECTION J. DISEASE DIAGNOSES

Disease/infection that doctor has indicated is present and affects client's status, requires treatment, or symptom management. Also include if disease is monitored by a home care professional or is the reason for a hospitalization in **LAST 90 DAYS** (or since last assessment if less than 90 days)

[blank]. Not present
1. Present—not subject to focused treatment or monitoring by home care professional
2. Present—monitored or treated by home care professional
[If no disease in list, check **J1ac**, *None of Above*]

1. DISEASES

HEART/CIRCULATION
a. Cerebrovascular accident (stroke)
b. Congestive heart failure
c. Coronary artery disease
d. Hypertension
e. Irregularly irregular pulse
f. Peripheral vascular disease

NEUROLOGICAL
g. Alzheimer's
h. Dementia other than Alzheimer's disease
i. Head trauma
j. Hemiplegia/hemiparesis
k. Multiple sclerosis
l. Parkinsonism

MUSCULO-SKELETAL
m. Arthritis
n. Hip fracture
o. Other fractures (e.g., wrist, vertebral)

p. Osteoporosis

SENSES
q. Cataract
r. Glaucoma

PSYCHIATRIC/MOOD
s. Any psychiatric diagnosis

INFECTIONS
t. HIV infection
u. Pneumonia
v. Tuberculosis
w. Urinary tract infection (in **LAST 30 DAYS**)

OTHER DISEASES
x. Cancer—(in past 5 years) not including skin cancer
y. Diabetes
z. Emphysema/COPD/asthma
aa. Renal Failure
ab. Thyroid disease (hyper or hypo)
ac. *NONE OF ABOVE*

2. OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES
a. ____ | | | | . | |
b. ____ | | | | . | |
c. ____ | | | | . | |
d. ____ | | | | . | |

SECTION K. HEALTH CONDITIONS AND PREVENTIVE HEALTH MEASURES

1. PREVENTIVE HEALTH (PAST TWO YEARS) (***Check all that apply—in PAST 2 YEARS***)
Blood pressure measured — a.
Received influenza vaccination — b.
Test for blood in stool or screening endoscopy — c.
IF FEMALE: Received breast examination or mammography — d.
NONE OF ABOVE — e.

2. PROBLEM CONDITIONS PRESENT ON 2 OR MORE DAYS (***Check all that were present on at least 2 of the last 3 days***)
a. Diarrhea
b. Difficulty urinating or urinating 3 or more times at night
c. Fever
d. Loss of appetite
e. Vomiting
f. *NONE OF ABOVE*

3. PROBLEM CONDITIONS (***Check all present at any point during last 3 days***)

PHYSICAL HEALTH
a. Chest pain/pressure at rest or on exertion
b. No bowel movement in 3 days
c. Dizziness or lightheadedness
d. Edema
e. Shortness of breath

MENTAL HEALTH
f. Delusions
g. Hallucinations
h. *NONE OF ABOVE*

4.	PAIN	**a.** Frequency with which client complains or shows evidence of pain 0. No pain (score b-e as 0) 2. Daily - one period 1. Less than daily 3. Daily - multiple periods (e.g., morning and evening) **b.** Intensity of pain 0. No pain 2. Moderate 4. Times when pain is horrible 1. Mild 3. Severe or excruciating **c.** From client's point of view, pain intensity disrupts usual activities 0. No 1. Yes **d.** Character of pain 0. No pain 1. Localized - single site 2. Multiple sites **e.** From client's point of view, medications adequately control pain 0. Yes or no pain 1. Medications do not adequately control pain 2. Pain present, medication not taken	
5.	FALLS FREQUENCY	Number of times fell in **LAST 90 DAYS** (or since last assessment if less than 90 days) If none, code "0"; if more than 9, code "9"	
6.	DANGER OF FALL	(*Code for danger of falling*) 0. No 1. Yes	
		a. Unsteady gait	
		b. Client limits going outdoors due to fear of falling (e.g., stopped using bus, goes out only with others)	
7.	LIFESTYLE (Drinking/ Smoking)	(*Code for drinking or smoking*) 0. No 1. Yes	
		a. In the LAST 90 DAYS (or since last assessment if less than 90 days), client felt the need or was told by others to cut down on drinking, or others were concerned with client's drinking	
		b. In the LAST 90 DAYS (or since last assessment if less than 90 days), client had to have a drink first thing in the morning to steady nerves (i.e., an "eye opener") or has been in trouble because of drinking	
		c. Smoked or chewed tobacco daily	
8.	HEALTH STATUS INDICATORS	(**Check all that apply**)	
		Client feels he/she has poor health (when asked)	a.
		Has conditions or diseases that make cognition, ADL, mood, or behavior patterns unstable (fluctuations, precarious, or deteriorating)	b.
		Experiencing a flare-up of a recurrent or chronic problem	c.
		Treatments changed in **LAST 30 DAYS** (or since last assessment if less than 30 days) because of a new acute episode or condition	d.
		Prognosis of less than six months to live—e.g., physician has told client or client's family that client has end-stage disease	e.
		NONE OF ABOVE	f.
9.	OTHER STATUS INDICATORS	(**Check all that apply**)	
		Fearful of a family member or caregiver	a.
		Unusually poor hygiene	b.
		Unexplained injuries, broken bones, or burns	c.
		Neglected, abused, or mistreated	d.
		Physically restrained (e.g., limbs restrained, used bed rails, constrained to chair when sitting)	e.
		NONE OF ABOVE	f.

SECTION L. NUTRITION/HYDRATION STATUS

1.	WEIGHT	(*Code for weight items*) 0. No 1. Yes	
		a. Unintended weight loss of 5% or more in the **LAST 30 DAYS** [or 10% or more in the **LAST 180 DAYS**]	
		b. Severe malnutrition (cachexia)	
		c. Morbid obesity	
2.	CONSUMPTION	(*Code for consumption*) 0. No 1. Yes	
		a. In at least 2 of the last 3 days, ate one or fewer meals a day	
		b. In last 3 days, noticeable decrease in the amount of food client usually eats or fluids usually consumes	
		c. Insufficient fluid—did not consume all/almost all fluids during last 3 days	
		d. Enteral tube feeding	
3.	SWALLOWING	0. *NORMAL*—Safe and efficient swallowing of all diet consistencies 1. *REQUIRES DIET MODIFICATION TO SWALLOW SOLID FOODS* (mechanical diet or able to ingest specific foods only) 2. *REQUIRES MODIFICATION TO SWALLOW SOLID FOODS AND LIQUIDS* (puree, thickened liquids) 3. *COMBINED ORAL AND TUBE FEEDING* 4. *NO ORAL INTAKE (NPO)*	

SECTION M. DENTAL STATUS (ORAL HEALTH)

1.	ORAL STATUS	(**Check all that apply**)	
		Problem chewing (e.g., poor mastication, immobile jaw, surgical resection, decreased sensation/motor control, pain while eating)	a.
		Mouth is "dry" when eating a meal	b.
		Problem brushing teeth or dentures	c.
		NONE OF ABOVE	d.

SECTION N. SKIN CONDITION

1.	SKIN PROBLEMS	Any troubling skin conditions or changes in skin condition (e.g., burns, bruises, rashes, itchiness, body lice, scabies) 0. No 1. Yes	
2.	ULCERS (Pressure/ Stasis)	Presence of an ulcer anywhere on the body. Ulcers include any area of persistent skin redness (Stage 1); partial loss of skin layers (Stage 2); deep craters in the skin (Stage 3); breaks in skin exposing muscle or bone (Stage 4). **[Code 0 if no ulcer, otherwise record the highest ulcer stage (Stage 1-4).]**	
		a. Pressure ulcer—any lesion caused by pressure, shear forces, resulting in damage of underlying tissues	
		b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities	
3.	OTHER SKIN PROBLEMS REQUIRING TREATMENT	(*Check all that apply*)	
		Burns (second or third degree)	a.
		Open lesions other than ulcers, rashes, cuts (e.g., cancer)	b.
		Skin tears or cuts	c.
		Surgical wound	d.
		Corns, calluses, structural problems, infections, fungi	e.
		NONE OF ABOVE	f.
4.	HISTORY OF RESOLVED PRESSURE ULCERS	Client previously had (at any time) or has an ulcer anywhere on the body 0. No 1. Yes	
5.	WOUND/ ULCER CARE	(*Check for formal care in LAST 7 DAYS*)	
		Antibiotics, systemic or topical	a.
		Dressings	b.
		Surgical wound care	c.
		Other wound/ulcer care (e.g., pressure relieving device, nutrition, turning, debridement)	d.
		NONE OF ABOVE	e.

SECTION O. ENVIRONMENTAL ASSESSMENT

1.	HOME ENVIRONMENT [Check any of following that make home environment hazardous or uninhabitable (if none apply, check *NONE OF ABOVE*; if temporarily in institution, base assessment on home visit)]	Lighting in evening (including inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors)	a.
		Flooring and carpeting (e.g., holes in floor, electric wires where client walks, scatter rugs)	b.
		Bathroom and toiletroom (e.g., non-operating toilet, leaking pipes, no rails though needed, slippery bathtub, outside toilet)	c.
		Kitchen (e.g., dangerous stove, inoperative refrigerator, infestation by rats or bugs)	d.
		Heating and cooling (e.g., too hot in summer, too cold in winter, wood stove in a home with an asthmatic)	e.
		Personal safety (e.g., fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street)	f.
		Access to home (e.g., difficulty entering/leaving home)	g.
		Access to rooms in house (e.g., unable to climb stairs)	h.
		NONE OF ABOVE	i.
2.	LIVING ARRANGEMENT	**a.** As compared to **90 DAYS AGO** (or since last assessment), client now lives with other persons—e.g., moved in with another person, other moved in with client 0. No 1. Yes	
		b. Client or primary caregiver feels that client would be better off in another living environment 0. No 1. Client only 2. Caregiver only 3. Client and caregiver	

SECTION P. SERVICE UTILIZATION (IN LAST 7 DAYS)

1.	FORMAL CARE (Minutes rounded to even 10 minutes)	Extent of care or care management in **LAST 7 DAYS** (or since last assessment if less than 7 days) involving	(A) # of Days	(B) Hours	(C) Mins
		a. Home health aides			
		b. Visiting nurses			
		c. Homemaking services			
		d. Meals			
		e. Volunteer services			
		f. Physical therapy			
		g. Occupational therapy			
		h. Speech therapy			
		i. Day care or day hospital			
		j. Social worker in home			

2. SPECIAL TREATMENTS, THERAPIES, PROGRAMS

Special treatments, therapies, and programs received or scheduled during the **LAST 7 DAYS** (or since last assessment if less than 7 days) and adherence to the required schedule. Includes services received in the home or on an outpatient basis.

[Blank]. Not applicable
1. Scheduled, full adherence as prescribed
2. Scheduled, partial adherence
3. Scheduled, not received
[If no treatments provided, check *NONE OF ABOVE* **P2aa**]

RESPIRATORY TREATMENTS		o. Occupational therapy	
a. Oxygen		p. Physical therapy	
b. Respirator for assistive breathing		**PROGRAMS**	
c. All other respiratory treatments		q. Day center	
		r. Day hospital	
OTHER TREATMENTS		s. Hospice care	
d. Alcohol/drug treatment program		t. Physician or clinic visit	
		u. Respite care	
e. Blood transfusion(s)		**SPECIAL PROCEDURES DONE IN HOME**	
f. Chemotherapy		v. Daily nurse monitoring (e.g., EKG, urinary output)	
g. Dialysis			
h. IV infusion - central		w. Nurse monitoring less than daily	
i. IV infusion - peripheral			
j. Medication by injection		x. Medical alert bracelet or electronic security alert	
k. Ostomy care			
l. Radiation		y. Skin treatment	
m. Tracheostomy care		z. Special diet	
THERAPIES		aa. *NONE OF ABOVE*	aa.
n. Exercise therapy			

3. MANAGEMENT OF EQUIPMENT (In Last 3 Days)

Management codes:
0. Not used
1. Managed on own
2. Managed on own if laid out or with verbal reminders
3. Partially performed by others
4. Fully performed by others

a. Oxygen		c. Catheter	
b. IV		d. Ostomy	

4. VISITS IN LAST 90 DAYS OR SINCE LAST ASSESSMENT

Enter 0 if none, if more than 9, code "9"

a. Number of times ADMITTED TO HOSPITAL **with** an overnight stay

b. Number of times VISITED EMERGENCY ROOM **without** an overnight stay

c. EMERGENT CARE--including unscheduled nursing, physician, or therapeutic visits to office or home

5. TREATMENT GOALS

Any treatment goals that have been met in the **LAST 90 DAYS** (or since last assessment if less than 90 days)
0. No 1. Yes

6. OVERALL CHANGE IN CARE NEEDS

Overall self sufficiency has changed significantly as compared to status of **90 DAYS AGO** (or since last assessment if less than 90 days)
0. No change 1. Improved—receives fewer supports 2. Deteriorated—receives more support

7. TRADE OFFS

Because of limited funds, during the last month, client made trade-offs among purchasing any of the following: prescribed medications, sufficient home heat, necessary physician care, adequate food, home care
0. No 1. Yes

SECTION Q. MEDICATIONS

1. NUMBER OF MEDICATIONS

Record the number of different medicines (prescriptions and over the counter), including eye drops, taken regularly or on an occasional basis in the **LAST 7 DAYS** (or since last assessment)[*If none, code "0", if more than 9, code "9"*]

2. RECEIPT OF PSYCHOTROPIC MEDICATION

Psychotropic medications taken in the **LAST 7 DAYS** (or since last assesssment) [Note—Review client's medications with the list that applies to the following categories] 0. No 1. Yes

a. Antipsychotic/neuroleptic		c. Antidepressant	
b. Anxiolytic		d. Hypnotic	

3. MEDICAL OVERSIGHT

Physician reviewed client's medications as a whole in **LAST 180 DAYS** (or since last assessment)
0. Discussed with at least one physician (or no medication taken)
1. No single physician reviewed all medications

4. COMPLIANCE/ ADHERENCE WITH MEDICATIONS

Compliant all or most of time with **medications** prescribed by physician (both during and between therapy visits) in **LAST 7 DAYS**

0. Always compliant
1. Compliant 80% of time or more
2. Compliant less than 80% of time, including failure to purchase prescribed medications
3. *NO MEDICATIONS PRESCRIBED*

5. LIST OF ALL MEDICATIONS

List prescribed and nonprescribed medications taken in **LAST 7 DAYS** (or since last assessment)

a. Name and Dose—Record the name of the medication and dose ordered.

b. Form: Code the route of Administration using the following list:

1. By mouth (PO)
2. Sub lingual (SL)
3. Intramuscular (IM)
4. Intravenous (IV)
5. Subcutaneous (SQ)
6. Rectal (R)
7. Topical
8. Inhalation
9. Enteral tube
10. Other

c. Number taken—Record the amount of medication administered each time the medication is given

d. Freq: Code the number of times per day, week, or month the medication is administered using the following list:

PRN.	As necessary	5D.	Five times daily
QH.	Every hour	QOD.	Every other day
Q2H.	Every two hours	QW.	Once each wk
Q3H.	Every three hours	2W.	Two times every week
Q4H.	Every four hours	3W.	Three times every week
Q6H.	Every six hours	4W.	Four times each week
Q8H.	Every eight hours	5W.	Five times each week
QD.	Once daily	6W.	Six times each week
BID.	Two times daily (includes every 12 hrs)	1M.	Once every month
		2M.	Twice every month
TID.	Three times daily	C.	Continuous
QID.	Four times daily	O.	Other

a. Name and Dose	b. Form	c. Number Taken	d. Freq.
a.			
b.			
c.			
d.			
e.			
f.			
g.			
h.			
i.			
j.			
k.			

SECTION R. ASSESSMENT INFORMATION

1. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:

a. Signature of Assessment Coordinator

b. Title of Assessment Coordinator

c. Date Assessment Coordinator signed as complete — Month — Day — Year

d. Other Signatures	Title	Sections	Date
e.			Date
f.			Date
g.			Date
h.			Date
i.			Date

☐ = When box blank, must enter number or letter [a.] = When letter in box, check if condition applies

@ Country specific

Exhibit 31 Eley Deposition Exhibit 4-scoring sheet

InterRAI scales

ADL index: points are assigned for each task as described below and then summed. The scores range from 4 to 15, with a 4 being the most independent and 15 the most dependent. The algorithm is provided by InterRAI.

Late loss Activities of Daily Living

- Eating (h2g)
  - Enteral tube feeding (l2d)
- Toileting (h2h)
- Transfer (h2b)
- Bed Mobility (h2a)

Eating

MDSHC QUESTION	POINTS
If l2d = 1	3
Else	
If h2g in (.,0,1,2)	1
Else	
If h2g = 3	2
Else	
If g2g in (4,5,6,8)	3

Toileting

MDSHC QUESTION	POINTS
If h2h in (.,0,1,2)	1
Else	
If h2h = 3	3
Else	
If h2h in (4,5,6,8)	4

Transfer

MDSHC QUESTION	POINTS
If h2b in (.,0,1,2)	1
Else	
If h2b = 3	3
Else	
If h2b in (4,5,6,8)	4

Bed Mobility

MDSHC QUESTION	POINTS
If h2a in (.,0,1,2)	1
Else	
If h2a = 3	3
Else	
If h2a in (4,5,6,8)	4

IADL index: points are assigned for each of the late loss IADLs and then summed. The scores range from 0 to 3.

Late loss IADLs

- Meal Preparation (h1aa)
- Managing Medication (h1da)
- Phone Use (h1ea)

MDSHC QUESTION	MDSHC QUESTION	MDSHC QUESTION	POINTS
Meal Prep (h1aa)	**Medication (h1da)**	**Phone Use (h1ea)**	
If h1aa in (.,0,1)	If h1da in (.,0,1)	If h1ea in (.,0,1)	0
Else	Else	Else	
If h1aa in (2,3,8)	If h1da in (2,3,8)	If h1ea in (2,3,8)	1

Exhibit 33 Eley Deposition Exhibit 5 Detailed Explanation of Scoring

DETAILED EXPLANATION OF SCORING METHOD

The following address the client's physical functioning in routine personal activities of daily life, for example, dressing, eating, etc. during the **LAST 3 DAYS considering all episodes of these activities.**

For clients who performed an activity independently. be sure to determine and record whether others encouraged the activity or were present to supervise or oversee the activity.

(NOTE - For bathing, code for most dependent single episode in ***LAST 7 DAYS*** *)*

0. *INDEPENDENT* -- No help, setup, or oversight -- OR -- Help, setup, oversight provided only 1 or 2 times (with any task or subtask)

1. *SETUP HELP ONLY* -- Article or device provided within reach of client 3 or more times

2. *SUPERVISION* -- Oversight, encouragement or cueing provided 3 or more times during last 3 days -OR- Supervision (1 or more times) plus physical assistance provided only 1 or 2 times (for a total of 3 or more episodes of help or supervision)

3. *LIMITED ASSISTANCE* -- Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times -OR- Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help)

4. *EXTENSIVE ASSISTANC -E-* Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 or more times:

-- Weight-bearing support -- OR --

-- Full performance of the full task or a discrete sub-task by another during part (but not all) of last 3 days

5. *MAXIMAL ASSISTANCE* -- Client involved and completed less than 50% of subtasks on own (includes 2+ person assist), received weight bearing help or full performance of certain subtasks 3 or more times

6. *TOTAL DEPENDENCE* -- Full performance of activity by another

8. *ACTIVITY DID NOT OCCUR (*regardless of ability)

EATING	**POINTS**
Tube fed	3
If not tube fed:	
Independent or needs setup help or supervision only	1
Limited assistance	2
More than limited assistance (extensive or maximal assistance, total dependence, or did not eat	3

TOILETING. TRANSFERS, AND BED MOBILITY	**POINTS**
Independent or needs setup help or supervision only	1
Limited assistance	3
More than limited assistance (extensive or maximal assistance, total dependence, or activity did not occur	4

Exhibit 34 Letter dated March 4, 2011 from Caroline Brown to Nell Hahn

COVINGTON & BURLING LLP

1201 PENNSYLVANIA AVENUE NW
WASHINGTON, DC 20004-2401
TEL 202.662.6000
FAX 202.662.6291
WWW.COV.COM

BEIJING
BRUSSELS
LONDON
NEW YORK
SAN DIEGO
SAN FRANCISCO
SILICON VALLEY
WASHINGTON

CAROLINE M. BROWN
TEL 202.662.5219
FAX 202.778.5219
CBROWN @ COV.COM x

March 4, 2011

VIA E-MAIL
Nell Hahn
Advocacy Center
600 Jefferson Street
Suite 812
Lafayette, LA 70501

Re: Pitts v. Greenstein, No: 3-10-cv-00635 (M.D. La.)

Dear Nell:

This letter and the documents referenced below represent Defendants' responses to requests made during the deposition of Hugh Eley for additional documents or for fact stipulations. The letter also clarifies one answer provided by Mr. Eley during his deposition and certain documents produced by Defendants. Mr. Eley continues to review the transcript of his deposition and will correct any additional errors he identifies prior to certifying the transcript.

1. You requested (Tr. 49) that Defendants stipulate to the number of ADHC facilities that currently accept Medicaid. Defendants are prepared to stipulate that there are currently 38 ADHC facilities accepting Medicaid. This number represents a net increase of 8 facilities since October 6, 2010 (the date of Document #0008). There are also 22 applications pending for ADHC facilities that will accept Medicaid if their application is approved. A list of the addresses of the facilities currently accepting Medicaid is attached as Document #4007, and Defendants are preparing a map of their locations.

2. You requested (Tr. 74) the current reimbursement rate for personal assistance services and the current maximum budget for an individual EDA recipient. The current reimbursement rate for personal assistance services is $2.83 per 15 minute unit (or $11.32 per hour). The current maximum budget for an individual EDA recipient is $40,046 per year.

3. You requested (Tr. 113-114) confirmation that the Office of Aging and Adult Services ("OAAS") requested funding for additional slots in the EDA waiver in state fiscal year 2010. Document #4010 shows that OAAS requested 1000 new waiver slots for SFY 2010 when the Department of Health and Hospitals ("DHH") was preparing its budget request. DHH ultimately did not include a request for new slots in the budget it presented to the Division of

Administration, but, as shown by Documents #4008 and 4009, DHH did request new funds to annualize EDA waiver slots created in the previous fiscal year.

4. You asked Mr. Eley whether the costs of providing LT-PCS were less than nursing facility costs, and he answered that he was not sure how the provider fee might affect the calculation in terms of state general fund expenditures. You then requested (Tr. 125) a historical comparison of the average per-person cost of nursing facility services and LT-PCS in terms of state general fund expenditures (taking into account the provider fee paid by nursing facilities). We have not identified a document with the historical data, and the calculations are sufficiently complex that defendants cannot timely create a document with those calculations. However, we are willing to stipulate that currently LT-PCS costs are less than NF costs from a state general fund perspective (taking the provider fee into account).

5. You requested (Tr. 135-136) confirmation that Eley Exhibit Number 2 is the most recent version of the Level of Care Eligibility Tool ("LOCET") User Manual. Eley Exhibit Number 2 is the most recent version of the glossary of the LOCET User Manual; it is not the entire Manual. Defendants want to make clear that the LOCET User Manual is simply the guide to the LOCET software system. Eligibility for LT-PCS is set forth in regulations published in the Louisiana Register.

6. You asked (Tr. 142) whether "prior nursing home placement" on page 130 of Eley Exhibit No. 3 meant residence in a nursing home at any time during the preceding five years. Defendants are prepared to stipulate that a participant must have been resident in a nursing home some time within the five years prior to the date of the LOCET in order for the prior nursing home placement to be counted as an additional factor.

7. You asked (Tr. 146) to stipulate that page 130 of Eley Exhibit Number 3 cross references the questions on Eley Exhibit No. 1. Defendants are prepared to so stipulate.

8. You requested (Tr. 166) confirmation that Eley Exhibit Numbers 4 and 5 accurately represent how the ADL Index is scored. Defendants are willing to so stipulate.

9. You requested (Tr. 205) the URL for the MDS Quality Indicator report produced by OAAS. Defendants are sending you a draft copy of the most recent annual report, labeled as Document #4006. The period covered in the draft report is calendar year 2006 through calendar year 2009.

10. You requested (Tr. 212) the "expenditures for public nursing facilities historically if we don't already have it." You already have it. See Document #3187.

11. Defendants also believe that the following issues warrant clarification prior to the due date for your opposition to the motion for summary judgment:

- You asked Mr. Eley (Tr. 51-52) about Document #3186. Mr. Eley explained that the wait times shown on Document #3186 are not representative of the wait time for an individual in a high-priority group (i.e., those in nursing homes). Mr. Eley also stated: "I'm assuming -- I'm assuming. I don't know it to be a fact -- that this number is the average across all those different populations." (Tr. 52) In fact, the wait time shown on Document #3186 is the number of days that had passed between the "As of Date" and the corresponding "Current Offer Date." The "Current Offer Date" is the offer date applicable to individuals who are not in the lowest-priority group based on their receipt of HCBS through one of the programs specified in 50 La. Admin. Code tit. 50, § 8105.

- You asked Mr. Eley (Tr. 101-108) about the number of unduplicated HCBS recipients in state fiscal year 2009 as shown on Documents #0044 and 1188, both of which were prepared by Mandi Jones. Ms. Jones has informed defense counsel that Document #1188 does not include the PACE program in its recipient or cost statistics for HCBS. Ms. Jones can account for the remaining difference between the numbers on Documents #0044 and 1188, but her explanation cannot be recounted with reasonable brevity in this letter. Defendants believe and are prepared to stipulate that the numbers on Document #0044 accurately represent the total number of individuals served in one or more of the four programs listed over the course of each fiscal year. We can make Ms. Jones available on an informal basis if you would like.

- Defendants also wish to clarify the statistics on Document #1946, which was not discussed at Mr. Eley's deposition, but which show different figures than those on Document #0044. Specifically, Defendants note that the recipient counts for nursing homes shown here include individuals who received services at intermediate care facilities for the developmentally disabled, and the HCBS recipient counts include individuals who received only Home Health. Additionally, the data on the lower half of the page reflect only individuals who actually received services on July 1; individuals, for instance, who received services on both June 30 and July 2, but not July 1, are not included.

This letter represents Defendants' good faith effort to respond to your questions. Please let me know if any of your requests has been overlooked.

Sincerely,

Caroline M. Brown

Exhibit 35 Declaration of Emile A. Barrow, Jr., M.D.

DECLARATION OF EMILE A. BARROW, JR., MD

Emile A. Barrow, Jr., MD subscribes under penalty of perjury, pursuant to 28 U>S>C § 1746, as follows:

1. My name is Emile A. Barrow, Jr. I am a physician practicing in Monroe, Louisiana. I specialize in internal medicine, cardiovascular disease and nuclear cardiology. I am Board Certified by the Board of Cardiovascular Disease.
2. I am affiliated with St. Francis Medical Center in Monroe, Louisiana.
3. I have been treating Mary Dunn for approximately twenty-four years.
4. Ms. Dunn has a history of cardiovascular disease and has had a stroke. She has arthritis and lower lumbar disk disease, which combined with a back surgery she had many years ago, causes her to have chronic back pain.
5. Ms. Dunn also has osteoporosis. After a recent fall, which I understand was the result of her attempting to transfer to her bedside commode unattended, she has a fracture in her hip. However, due to other cardiovascular complications, surgery is not recommended at this time.
6. Ms. Dunn uses a wheelchair and needs complete assistance with moving from one surface to another, toileting, bathing, grooming, and dressing. In addition, due to the severity of her pain and her lack of movement someone else must prepare her meals, do her shopping, and take care of her laundry and other household chores.
7. It is my understanding that the maximum number of hours offered by the Long-term Personal Care Services program is thirty-two hours per week, and Ms. Dunn is receiving only thirty hours per week of assistance. I believe that it is medically necessary for Ms. Dunn to receive more than thirty-two hours per week to live safely in her home.

8. I believe that if Ms. Dunn had adequate assistance and had not had her service hours reduced, it is possible that she would have had adequate assistance to transfer to her commode and she would not have fallen.
9. It is my professional medical opinion that if Ms. Dunn's hours are not increased her condition will deteriorate quickly and she will be forced to consider nursing home services.
10. I do not think Ms. Dunn wants to live in a nursing home, and I do not think that she should have her independence taken from her when she has shown that with adequate assistance she can safely stay in her own home.

/s/ Emile Barrow, Jr. 11/7/11
Emile Barrow, Jr., MD Date

Exhibit 36 Fourth Declaration of Jeanne Abadie

FOURTH DECLARATION OF JEANNE ABADIE

Jeanne Abadie subscribes under penalty of perjury, pursuant to 28 U.S.C. § 1746, as follows:

1. My name is Jeanne Abadie. I work at the Advocacy Center and my title is Compliance Specialist.
2. I have reviewed some of the discovery documents provided to the Plaintiffs' counsel by the Defendants.
3. Defendants have provided, in response to discovery in this case, a spreadsheet listing 366 LT-PCS recipients who were receiving over 32 hours of LT-PC on September 5, 2010, and who had appealed an adverse action regarding their LT-PCS between that date and approximately September 30, 2011. I have checked this list against Advocacy Center intake records, and only 26 of the people on that list have contacted the Advocacy Center. Not all of these contacts appeared to relate to the appeals.
4. The spreadsheet referred to in ¶3 above included the dates and dispositions of the individuals' appeals of reductions in LT-PCS between September 5, 2010 and September 30, 2011. I have performed calculations on these records, and offer the following summary of my calculations: 300 appeals have been decided, and the agency took an average of 68 days to decide them. The maximum number of days a decided appeal pended was 183. Forty appeals had not been decided as of the date of the spreadsheet, and they had pended an average of 57 days. The longest an open appeal had pended was 314 days.

5. Also in response to discovery in this case, Defendants provided a spreadsheet showing the individuals who have requested emergency waiver slots under the process that was begun July 2011, and the status of those requests as of October 11, 2011. I am attaching a copy of that spreadsheet, after removing the columns for name and date of birth. As of October 11, 2011, only three emergency waiver offers had been made. Two were made within two weeks of their request dates, but one (for V.U.S., a class member discussed in Plaintiffs' Memorandum in Support of their Motion for Preliminary Injunction) was made on September 7, 2011, 43 days after it was requested.
6. Two of the three emergency waiver slot offers shown on the spreadsheet were to individuals for whom the Advocacy Center had requested the slot. In neither of their cases were waiver services started within six weeks of the request. V.U.S.'s waiver slot was requested on July 26, 2011. Her services started on October 18, 2011. E.B. requested an emergency waiver slot on August 24, 2011. His waiver services started October 22, 2011.
7. Rickii Ainey was also referred for an emergency waiver by the Advocacy Center. The referral was made on July 26, 2011. An offer for an emergency waiver slot was made to Ms. Ainey on October 27, 2011, so it is not on the spreadsheet. As of November 14, 2011, her Waiver services have not started.

/s/Jeanne Abadie
Name

11/14/11
Date

Date of Request	Region of Residence	LTPCS	Is the person approved for the maximum number of weekly	If Yes to E and F, Date sent to R.O.	Date RO Called to Schedule Home Visit	Date of Home Visit	Date R.O. sent to Service Review Panel	Decision of Service Review Panel	Date Response Letter Sent	Date of Service Review Decision	Notes
7/26/11	2	Yes	No	N.A.	N.A.	N.A.	N.A.	N.A.	10/5/11	N.A.	
7/26/11	1	Yes	Yes	8/25/11		8/30/11	9/1/11	Denied		9/7/11	
7/26/11	6	Yes	No	N.A.	N.A.	N.A.	N.A.	N.A.	10/5/11	N.A.	
7/24/11	8	Yes	No	N.A.	N.A.	N.A.	N.A.	N.A.	10/5/11	N.A.	
7/26/11	1	Yes	No	10/4/11		10/10/11					
7/26/11	4	Yes	Yes	10/4/11							
7/26/11	8	Yes	No	N.A.	N.A.	N.A.	N.A.	N.A.	10/5/11	N.A.	
7/26/11	6	Yes	No	N.A.	N.A.	N.A.	N.A.	N.A.		N.A.	accepted normal waiver slot 9/19/11
7/26/11	2	Yes	No	N.A.	N.A.	N.A.	N.A.	N.A.		N.A.	
7/26/11	1	Yes	Yes	8/25/11		8/29/11	8/30/11	Approved		9/7/11	accepted emerg waiver offer 10/4/11
8/3/11	1	Yes	Yes	8/25/11							
8/3/11	1	Yes	Yes	N.A.	N.A.	N.A.	N.A.	N.A.		N.A.	accepted normal waiver slot 9/14/11
8/5/11	1	Yes	Yes	8/25/11	8/26/11	8/29/11	8/31/11	Denied		9/7/11	
8/11/11	9	No	N/A	N.A.	N.A.	N.A.	N.A.	N.A.	10/5/11	N.A.	
8/12/11	6	Yes	Yes	8/25/11			8/29/11	Denied		9/7/11	
8/16/11	8	Yes	Yes	8/25/11	N.A.	N.A.	N.A.	N.A.		N.A.	accepted NF priority offer 9/16/11
8/17/11	8	Yes	No	N.A.	N.A.	N.A.	N.A.	N.A.	10/5/11	N.A.	
8/17/11	2	No	N/A	N.A.	N.A.	N.A.	N.A.	N.A.	10/5/11	N.A.	
8/24/11	4	Yes	Yes	8/25/11			8/31/11	Denied		9/7/11	
8/24/11	2	Yes	Yes	8/25/11	8/26/11	8/30/11	8/31/11	Approved		9/7/11	
8/25/11	6	Yes	No	N.A.	N.A.	N.A.	N.A.	N.A.	10/5/11	N.A.	
8/25/11	1	Yes	No	N.A.	N.A.	N.A.	N.A.	N.A.		N.A.	
8/25/11	9	Yes	Yes	8/29/11			9/2/11	Approved		9/7/11	
9/1/11	9	Yes	Yes	9/6/11							referred to OCDD
9/2/11	2	No	N/A	N.A.							

Date of Request	Region of Residence	LTPCS	Is the person approved for the maximum number of weekly	If Yes to E and F, Date sent to R.O.	Date RO Called to Schedule Home Visit	Date of Home Visit	Date R.O. sent to Service Review Panel	Decision of Service Review Panel	Date Response Letter Sent	Date of Service Review Decision	Notes
9/9/11	9	Yes									NF admit 8/5; now in hospital
9/12/11	2	No	N/A	N.A.							
9/15/11	1	Yes	Yes	10/4/11							
10/3/2011	8	Yes	Yes	10/4/11							
10/4/11	2	Yes	Yes								
10/5/11	8	Yes	No								
10/11/11	9	Yes	No								

Exhibit 37 Declaration of Kendra Whitney, M.D.

DECLARATION OF KEYNA WHITNEY, MD

Keyna Whitney, MD subscribes under penalty of perjury, pursuant to 28 U.S.C. § 1746, as follows:

1. My name is Keyna Whitney. I am a licensed physician practicing Family Medicine in New Iberia, Louisiana. I received my medical degree from LSU Health Sciences School of Medicine in New Orleans in 2004 and completed my residency in Family Medicine at Baton Rouge General Hospital in 2007.

2. I am affiliated with the Iberia Medical Center and have been for approximately three years.

3. As part of my practice, I work intensively with people with chronic health and disabling conditions.

4. I have been treating Kenneth Roman for approximately five years. Mr. Roman has suffered several strokes, has diabetes, congestive heart failure, peripheral vascular disease, hypertension, coronary artery disease, renal failure and irritable bowel syndrome. He has left side hemiparesis. He has had several heart attacks, most recently in 2009. As a result of these conditions he experiences a great deal of weakness and mobility limitations.

5. Mr. Roman requires personal assistance with most of his activities of daily living, including transferring from a sitting to a standing position, toileting, bathing, dressing, and personal hygiene tasks. In addition, he cannot stand for long periods of time, so he needs assistance with cooking, household chores, shopping and laundry.

He frequently falls. He is incontinent of bowel and bladder and needs assistance both in cleaning himself after and incontinence episode and in changing and cleaning his bed linen. His irritable bowel syndrome makes these needs more acute.

6. To my knowledge, Kenneth Roman is currently receiving approximately 39 hours per week of in home care personal care that provides assistance with all of his activities of daily living.

7. In my experience and based on treating numerous people with disabilities, Mr. Roman's 39 hours a week are medically necessary and minimum for Mr. Roman to live safely in his own home. .

8. Without these home care services, Mr. Roman would be a greater risk of falls. Additionally, he could incur significant skin and health related impairments if he is not cleaned regularly after incontinence episodes. It is likely that without adequate home-care personal assistance, Mr. Roman would much more often require expensive in-patient hospitalizations and expensive use of hospital emergency rooms.

9. Mr. Roman is very involved in his church and with his family.

10. In my opinion, both his community life and his health care should not be jeopardized by reducing his in-home care.

11. If Mr. Roman's hours of home-care personal assistance services are reduced, he will be at significant risk of going into a nursing facility.

12. In my experience, Mr. Roman would not receive the same level of medical/health care and attention in a nursing facility, which he receives presently. In a nursing facility, he will not receive the same one-on-one attention to his activities of daily living or his health care which he presently receives.

13. I am quite concerned that if Mr. Roman were forced to enter a nursing facility, his community life and health would both suffer and be jeopardized.

10/21/2010
Date

Keyna Whitney, MD

Exhibit 38 Declaration of Christopher Lege, M.D.

DECLARATION OF CHRISTOPHER LEGE, MD

Christopher Lege, MD subscribes under penalty of perjury, pursuant to 28 U.S.C. § 1746, as follows:

1. My name is Christopher Lege. and I practice Internal Medicine in New Orleans, Louisiana.

2. I have been affiliated with Touro Infirmary in New Orleans for approximately six years.

3. My practice includes many people who have disabilities, who require assistance with activities of daily living, and who with such assistance live in the community safely and happily.

4. I have been treating Rickii Ainey for four years for Arthrogryposis a rare congenital disorder that is characterized by multiple joint contractures and can include muscle weakness and fibrosis. Her condition is progressive.

5. Ms. Ainey has no functional use of her arms or hands. She can walk, but her legs are weak and she falls easily.

6. Ms. Ainey requires assistance with all activities of daily living. She needs assistance going from a sitting to a standing position. She requires assistance dressing. She requires assistance with toileting, including pulling her clothes on and off and help cleaning herself. She cannot bathe herself or perform personal hygiene tasks.

7. Ms. Ainey requires full assistance with meal preparation, house keeping, shopping and laundry.

8. I attribute Ms. Ainey's having remained healthy to the fact that she has had home-care assistance. Having dependable home-care has lessened stress she would place on her joints by attempting to do things on her own, which has prevented her condition from progressing as quickly as it might.

9. My understanding is that Ms. Ainey is currently receiving 41 hours of home-care assistance. This amount of assistance is required for her to live safely in her own home and such assistance is medically necessary. .

10. Any reduction in Ms. Ainey's home-care hours is likely to cause her to be institutionalized in a nursing home. In my opinion, this would be inappropriate and medically contraindicated. Ms. Ainey is a young and vibrant women who should continue to live in her own home and make her own choices about her life.

11. In my experience, Ms. Ainey would not receive the same level of medical/health care and attention in a nursing facility that she receives at home. In a nursing facility, she will not receive the same one-on-one attention to her activities of daily living.

12. I believe that if Ms. Ainey were forced to enter a nursing home, her emotional and physical health would decline rapidly and unnecessarily.

9/12/10
Date

Christopher Lege, MD

Exhibit 39 Declaration of Robert Ancira, M.D.

DECLARATION OF ROBERT ANCIRA, MD

Robert Ancira, MD subscribes under penalty of perjury, pursuant to 28 U.S.C. § 1746, as follows:

1. My name is Robert Ancira, and I practice psychiatry in New Orleans, Louisiana.
2. I have been treating Rickii Ainey since 2007 for depression.
3. In December of 2006, Ms. Ainey attempted suicide. I first saw her after that suicide attempt. Ms. Ainey's suicide attempt was motivated by uncertainty as to whether she would be able to obtain assistance with her personal care needs.
4. Ms. Ainey has Arthrogryposis, a congenital form of arthritis, which causes her to need assistance with all activities of daily living. Ms. Ainey has no functional use of her arms or hands. She walks, but her disability affects her joints and causes her gait to be unsteady.
5. Although I would classify Ms. Ainey as being clinically depressed, she has not had suicidal thoughts and her suicidal tendencies have subsided since she has had dependable Long-term Personal Care Services.
6. My understanding is that Ms. Ainey is currently approved for 41 hours of services per week, and that this amount of assistance is necessary for her to accomplish her personal care tasks such as bathing, dressing, toileting, eating and drinking, preparing meals, shopping, getting out of bed, and moving around in bed. If she were to receive less than 41 hours per week of assistance, her personal care would not be maintained and her emotional health could decline.
7. I believe that the best place for Ms. Ainey to live is her own home.

8. I do not believe she would receive the same level of one-on-one care in a nursing home that she receives at home.

9. If Ms. Ainey were forced to enter a nursing home because her personal care services were not enough for her to continue in her home, her emotional health would drastically decline.

1-10-11
Date

Robert Ancira, MD

DECLARATION OF MARK OPERARIO, MD

Mark Operario, MD subscribes under penalty of perjury, pursuant to 28 U.S.C. § 1746, as follows:

1. My name is Mark Operario. I am a physician practicing Internal Medicine and Family Medicine in Columbia, Louisiana. I received by medical degree in 1985 from the Cebu Doctors College of Medicine Philippines. I have been in practice in Columbia since 1995. I am Board Certified in Internal Medicine.

2. I have been treating Eddie M. Shaw for approximately three years. Ms. Shaw is 70 years old and has a history of arthritis and diabetes.

3. Her overall medical condition is not expected to improve. Ms. Shaw seems to be getting weaker, and due to her inactivity it is unlikely that she will lose weight, which also contributes to her lack of mobility.

4. Ms. Shaw has difficulty performing self-care tasks due to her arthritis and her weight. Her hands are significantly affected, so she cannot grip items, such as a knife, fork, hairbrush or soap, which means she needs assistance eating, bathing and performing all hygiene tasks.

5. Ms. Shaw requires assistance with transferring and toileting. She must put her weight on someone or something to go from a seating position to a standing position and vice versa. She cannot walk without holding on to something. When visiting my office, she uses a wheelchair.

6. It is my opinion that she cannot safely prepare her own meals or perform household chores, such as housekeeping and laundry.

7. Ms. Shaw has bladder incontinence episodes daily, and should be cleaned thoroughly after each episode to prevent skin breakdowns.

8. I have been monitoring Ms. Shaw's condition closely, and have been seeing her approximately once every three to four months.

9. To my knowledge, Eddie Shaw is currently receiving 38 hours per week of personal care services at home for her activities of daily living and light housekeeping tasks. The 38 hours a week of personal care service that Ms. Shaw receives in her home are medically necessary for her to continue to live in her home and the minimum amount of help that she requires to remain healthy and stable in the community.

10. If Ms. Shaw's service hours were reduced, I would expect her health to deteriorate, which would lead to institutionalization in a nursing facility. In my opinion, reducing her current in-home personal care services would jeopardize her health, safety and welfare.

11. Ms. Shaw can live in her home with the appropriate number of hours, and should be given the opportunity to do so. It is my opinion, that she can be better cared while living in her own home than if she were living in a nursing home.

9-29-11
Date

/s/ Mark Operario, M.D.
Mark Operario, MD

Exhibit 41 36 La Reg 2217-20

C. The federal share of expenditures for payments to GNOCHC providers shall be calculated based upon the applicable federal medical assistance percentage rate for the year in which the expenditures were incurred.

D. The department may make an urgent sustainability payment to any eligible GNOCHC clinic that meets the criteria of this Chapter 67 and requires financial support to maintain clinical operations while the department seeks CMS approval for the funding and reimbursement protocol for this waiver program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:

§6903. Reimbursement Methodology

A. Urgent Sustainability Payments

1. For each clinic requiring an urgent sustainability payment, the department shall determine the average payment based upon the clinic's three-year historical grant award received under the PCASG program.

2. The sustainability payment shall be no more than 25 percent of the average annual payment determined for that clinic during the PCASG period. Prior approval from CMS shall be required for sustainability payments in excess of 25 percent of the clinic's average PCASG payment. The department may disburse the payment in the first quarter of demonstration year one.

3. Upon CMS approval of the payment methodology, the department shall reconcile the amount of sustainability payments made to clinics during the period of October 1, 2010 through December 31, 2010 against the actual payments that would have been made to the clinics under the approved payment methodology.

a. Any overpayments made to a clinic shall be recouped from the clinic's payments due in the quarter following the reconciliation.

b. Any underpayments made to a clinic shall be made in the quarter following the reconciliation.

4. The total of all sustainability payments made during the first quarter in demonstration year one shall not exceed $7.5 million. Any sustainability payments made shall be applied to the $30 million total computable annual allotment for demonstration year one.

B. Reimbursement for services rendered during phase one and phase two of the demonstration shall be made according to the rate methodology established by the department and approved by CMS in the funding and reimbursement protocol for this waiver program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce Greenstein
Secretary

1010#002

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing and
Office of Aging and Adult Services

Home and Community-Based Services Waivers
Elderly and Disabled Adults
Personal Assistance Services
(LAC 50:XXI.8101, 8105, 8107, 8301, and 8503)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amends LAC 50:XXI.8101, §8105, §8107, §8301 and §8503 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

To assure compliance with federal requirements regarding the cost-effectiveness of the Elderly and Disabled Adults (EDA) Waiver Program, the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amended the provisions governing the EDA Waiver to: 1) change the allocation priority of waiver opportunities; 2) implement uniform needs-based assessments to determine the level of support needs and establish an individual cost cap based on need; 3) clarify the service cap for environmental accessibility adaptation services; 4) add shared supports to companion services; and 5) mandate that personal representatives cannot be the paid companion care worker (Louisiana Register, Volume 35, Number 11). The department promulgated an Emergency Rule which amended the provisions governing the EDA Waiver to implement a new service that incorporated the current functions of companion services and further clarified the provisions governing responsible representatives and discharge criteria (Louisiana Register, Volume 36, Number 6). The July 4, 2010 Emergency Rule also reorganized the provisions governing covered services in a more clear and concise manner in the Louisiana Administrative Code.

The department now proposes to amend the provisions of the July 4, 2010 Emergency Rule to: 1) adopt provisions that address requests for services; 2) revise the provisions governing the allocation of waiver opportunities and the resource assessment process; 3) clarify the provisions governing restrictions for paid direct care staff and the place of service; and 4) revise the provisions governing provider responsibilities. This action is being taken to avoid federal sanctions for noncompliance with waiver cost-effectiveness requirements and to ensure long-term financial viability for the Elderly and Disabled Adults Waiver.

Effective October 20, 2010, the Department of Health and Hospitals, Office of Aging and Adult Services amends the provisions of the July 4, 2010 Emergency Rule governing the Elderly and Disabled Adults Waiver.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXI. Home and Community-Based Services Waivers
Subpart 7. Elderly and Disabled Adults Waiver
Chapter 81. General Provisions

§8101. Introduction

A. - B. …

C. Requests for EDA waiver services shall be accepted from the following individuals:

1. an individual who wants to receive EDA Waiver services;

2. an individual who is legally responsible for a participant who may be in need of EDA Waiver services; or

3. a responsible representative designated by the participant to act on his/her behalf in requesting EDA Waiver services.

D. Each participant who requests EDA Waiver services has the option to designate a responsible representative. For purposes of these provisions, a responsible representative shall be defined as the person designated by the participant to act on his/her behalf in the process of accessing and/or maintaining EDA Waiver services.

1. The appropriate form authorized by OAAS shall be used to designate a responsible representative.

a. The written designation of a responsible representative does not give legal authority for that individual to independently handle the participant's business without his/her involvement.

b. The written designation is valid until revoked by the participant. To revoke the written designation, the revocation must be submitted in writing to OAAS or its designee.

2. The functions of a responsible representative are to:

a. assist and represent the participant in the assessment, care plan development and service delivery processes; and

b. to aid the participant in obtaining all necessary documentation for these processes.

3. The participant's responsible representative shall not be reimbursed for providing services to the participant.

4. An owner or employee of a EDA Waiver services agency may not be designated as a responsible representative for any recipient who receives services from an agency he/she owns or is employed by.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:1698 (August 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Division of Long Term Supports and Services, LR 32:1245 (July 2006), amended by the Department Of Health and Hospitals, Office of Aging and Adult Services, LR 34:1029 (June 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:2447 (November 2009), amended LR 36:

§8105. Programmatic Allocation of Waiver Opportunities

A. …

B. EDA Waiver opportunities shall be offered to individuals on the registry according to the following needs-based priority groups. The following groups shall have priority for EDA Waiver opportunities, in the order listed:

1. individuals with substantiated cases of abuse or neglect with Adult Protective Services or Elderly Protective Services who, absent EDA Waiver services, would require institutional placement to prevent further abuse and neglect;

2. individuals diagnosed with Amyotrophic Lateral Sclerosis (ALS);

3. individuals presently residing in nursing facilities for 90 or more continuous days;

a. - e.NOTE. Repealed.

4. individuals who are not presently receiving home and community-based services under another approved waiver program including, but not limited to the:

a. Adult Day Health Care Waiver;

b. New Opportunities Waiver;

c. Supports Waiver; and

d. Residential Options Waiver;

5. all other eligible individuals on the Request for Services Registry (RFSR), by date of first request for services.

C. - D. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:1699 (August 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Division of Long Term Supports and Services, LR 32:1245 (July 2006), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:1030 (June 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:2447 (November 2009), amended LR 36:

§8107. Resource Assessment Process

A. - C.1. …

2. The applicant/recipient may qualify for an increase in the annual services budget amount upon showing that:

a. one or more answers are incorrect as recorded on the MDS-HC (with the exception of the answers in Sections AA, BB, A, and R of the MDS-HC); or

C.2.b. - D. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:2447 (November 2009), amended LR 36:

Chapter 83. Covered Services

§8301. Service Descriptions

A. Support Coordination is services that will assist recipients in gaining access to necessary waiver and State Plan services, as well as needed social, educational and other services, regardless of the funding source for these services. Support coordinators shall be responsible for ongoing monitoring of the provision of services included in the recipient's approved CPOC.

B. Transition Intensive Support Coordination is services that will assist recipients who are currently residing in nursing facilities in gaining access to necessary waiver and State Plan services, as well as needed social, educational and other services, regardless of the funding source for these services. Support coordinators will initiate and oversee the process for assessment and reassessment, as well as be responsible for ongoing monitoring of the provision of services included in the recipient's approved CPOC.

C. Environmental Accessibility Adaptation is necessary physical adaptations made to the home to ensure the health, safety, and welfare of the recipient, or enable the recipient to function with greater independence in the home. Without these necessary adaptations, the recipient would require institutionalization. These services must be provided in accordance with state and local laws governing licensure and/or certification.

1. There is a lifetime cap of $3,000 per recipient for this service.

D. Personal Emergency Response System (PERS). This is an electronic device which enables the recipient to secure help in an emergency. PERS services are limited to specific recipients.

5. - 5.e. Repealed.

E. Personal Assistance Services (PAS) provides assistance to participants in performing the activities of daily living and household chores necessary to maintain the home in a clean, sanitary and safe environment, based on their CPOC.

1. PAS may also include the following services based on the CPOC:

a. protective supervision provided solely to assure the health and welfare of a participant with cognitive/memory impairment and/or physical weakness;

b. supervising or assisting, as approved in the CPOC, a participant with functional impairments with health related tasks (any health related procedures governed under the Nurse Practice Act) if he/she is unable to do so without supports according to applicable delegation/medication administration;

c. supervising or assisting the participant, who has no supports and is unable to do so without supports or has no available natural supports, to socialize in his/her community according to the desired outcomes included in the CPOC;

d. escort services, which are used to accompany the individual outside of the home during the performance of tasks related to instrumental activities of daily living and health maintenance, and to provide the same assistance as would be rendered in the home; and

e. extension of therapy services.

i. For purposes of these provisions, extension of therapy services may include instances where licensed practitioners may provide instruction to the worker so he/she is able to better assist the participant.

ii. Licensed therapists may choose to instruct the workers on the proper way to assist the participant in follow-up therapy sessions. This assistance and support provides reinforcement of instruction and aids in the rehabilitative process.

iii. A registered nurse may instruct a worker to perform basic interventions with participants that would increase and optimize functional abilities for maximum independence in performing activities of daily living, such as range of motion exercises.

2. PAS is provided in the participant's home unless the participant requests to receive PAS outside of the home.

a. PAS shall not duplicate the services provided to a participant who resides in an assisted living facility.

b. The participant must be present while PAS services are being provided in the home.

3. Service Restrictions

a. PAS shall not be provided during the same designated hours or time period that a participant receives Adult Day Health Care services.

b. Participants who receive PAS cannot receive Long-Term Personal Care Services.

4. PAS services may be provided by one worker for up to three waiver participants who live together and who have a common direct service provider.

a. Waiver participants may share PAS service staff when it is agreed to by the participants and health, safety and welfare can be assured for each individual.

b. Shared PAS services will be reflected on the plan of care of each participant.

5. The following individuals are prohibited from being reimbursed for providing services to a participant:

a. the participant's spouse;

b. the participant's curator;

c. the participant's tutor;

d. the participant's legal guardian;

e. the participant's responsible representative; or

f. the person to whom the participant has given Representative and Mandate authority (also known as power of attorney).

6. Participants are not permitted to receive PAS while living in a home or property owned, operated, or controlled by a provider of services who is not related by blood or marriage to the participant.

F. Transition Services. These services assist an individual, who has been approved for an EDA Waiver opportunity, to leave a nursing facility and return to live in the community.

1. Service Limit. Funds are available one time per lifetime for specific items as approved in the recipient's CPOC.

G. Adult Day Health Care (ADHC). ADHC services are a planned, diverse daily program of individual services and group activities structured to enhance the recipient's physical functioning and to provide mental stimulation. Services are furnished for five or more hours per day (exclusive of transportation time to and from the ADHC facility) on a regularly scheduled basis for one or more days per week, or as specified in the plan of care. An adult day health care facility shall, at a minimum, furnish the following services:

1. individualized training or assistance with the activities of daily living (toileting, grooming, eating, ambulation, etc.);

2. health and nutrition counseling;

3. an individualized, daily exercise program;

4. an individualized, goal directed recreation program;

5. daily health education;

6. medical care management;

7. one nutritionally balanced hot meal and two snacks served each day;

8. nursing services that include the following individualized health services:

a. monitoring vital signs appropriate to the diagnosis and medication regimen of each recipient no less frequently than monthly;

b. administering medications and treatments in accordance with physicians' orders;

c. monitoring self-administration of medications while the recipient is at the ADHC facility; and

NOTE: All nursing services shall be provided in accordance with acceptable professional practice standards.

d. transportation to and from the facility.

NOTE: If transportation services that are prescribed in any participant's approved CPOC are not provided by the ADHC facility, the facility's reimbursement rate shall be reduced accordingly.

H. Providers of EDA Waiver services must have a valid, current license for their respective service program, if applicable, and furnish services in accordance with the applicable licensing and/or certification requirements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:1699 (August 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Division of Long Term Supports and Services, LR 32:1245 (July 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:2448 (November 2009), amended LR 36:

Chapter 85. Admission and Discharge Criteria

§8503. Admission Denial or Discharge Criteria

A. Admission shall be denied or the participant shall be discharged from the EDA Waiver Program if any of the following conditions are determined.

1. - 7. …

8. It is not cost effective or appropriate to serve the individual in the EDA Waiver.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:1699 (August 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Division of Long Term Supports and Services, LR 32:1246 (July 2006), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:1030 (June 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 36:

Chapter 89. Provider Responsibilities

§8901. General Provisions

A. Any provider of services under the EDA Waiver shall abide by and adhere to any federal or state laws, rules, policy, procedures, or manuals issued by the department. Failure to do so may result in sanctions.

B. The provider agrees to not request payment unless the participant for whom payment is requested is receiving services in accordance with the EDA Waiver Program provisions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:1700 (August 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Division of Long Term Supports and Services, LR 32:1247 (July 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 36:

§8903. Reporting Requirements

A. Support coordination and direct service providers are obligated to report changes to the department that could affect the waiver participant's eligibility including, but not limited to, those changes cited in the denial or discharge criteria.

B. Support coordination and direct service providers are responsible for documenting the occurrence of incidents or accidents that affect the health, safety and welfare of the recipient and completing an incident report. The incident report shall be submitted to the department with the specified requirements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 36:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein
Secretary

1010#023

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing

Inpatient Hospital Services—Major Teaching Hospitals
Qualifying Criteria
(LAC 50:V.1301-1309)

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to adopt LAC 50:V.1301-1309 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopted a rule that established the reimbursement of major and minor teaching hospitals as peer groups under the prospective reimbursement methodology for hospitals (*Louisiana Register*, Volume 20, Number 6). The department amended the June 20, 1994 Rule to adopt new criteria for the reimbursement of graduate medical education (GME) pursuant to Section 15 Schedule 09 of Act 19 of the 1998

Exhibit 42 Doc. 2482 Email from Steven Buco to Rick Henley

From: Steven Buco <sbuco@statres.com>
Sent: Wednesday, January 12, 2011 9:31 AM
To: Rick Henley <Rick.Henley@LA.GOV>
Cc: Candace Ricard <Candace.Ricard@LA.GOV>; Randy Davidson <Randy.DAVIDSON@LA.GOV>
Subject: Pitts et al. vs Greenstein - Request for Production of Documents - Item 24

The number of individuals on the EDA registry as of 1/11/11 is 19,156.
The number of individuals on the ADHC registry as of 1/11/11 is 666.

Steve
225.767.0501
President
Statistical Resources, Inc.

225.767.0501

Exhibit 43 Declaration of Gregory Ward, M.D.

DECLARATION OF GREGORY WARD, MD

Gregory Ward, MD subscribes under penalty of perjury, pursuant to 28 U.S.C. § 1746, as follows:

1. My name is Gregory Ward and I am a licensed physical medicine and rehabilitation physician practicing in Baton Rouge, Louisiana since 1990. I received by medical degree from the Medical College of Ohio in 1986. I completed my residency in physical medicine and rehabilitation in Chicago, Illinois at Rush Presbyterian Hospital. I have been Board Certified by the American Board of Physical Medicine & Rehabilitation since May 15, 1991.

2. I have been affiliated with Our Lady of the Lake Regional Medical Center in Baton Rouge since 1990.

3. As part of my practice, I specialize in treating people with disabilities, including people who have conditions that cause chronic pain and fatigue.

4. I have been treating Helen Pitts more than ten years. Ms. Pitts has rheumatoid arthritis, osteoporosis, osteoarthritis, lymphedema, gait instability, emphysema, congestive heart failure, and fibromyalgia. Her overall medical condition is not expected to improve. The fact that she suffers from a combination of these diseases puts her in a precarious situation.

5. Due to Ms. Pitts' medical conditions, she experiences extreme fatigue and pain on a daily basis, both of which affect her ability to perform her own personal care.

Her arthritis and fibromyalgia have caused her to have only very limited use of her hands, arms and legs.

6. Ms. Pitts requires assistance with numerous activities of daily living, including transferring, toileting, bathing, personal hygiene tasks, and dressing. In addition, she cannot safely prepare her own meals or perform household chores, such as housekeeping and laundry.

7. Ms. Pitts is incontinent and needs assistance cleaning herself after her frequent incontinent episodes.

8. To my knowledge Ms. Pitts, has no family or friends who can assist with her personal care needs, so she depends exclusively on her paid assistance.

9. To my knowledge, Helen Pitts is currently receiving 39 hours per week of personal care services at home for her activities of daily living. These hours of service are medically necessary for her to live and are minimally what she requires. In my opinion, she cannot reside in the community with less assistance with her activities of daily living.

10. I have many patients with less severe impairments who require more hours a week of personal care assistance than Ms. Pitts.

11. In the latter part of 2008 or early 2009, Ms. Pitts lost her home personal care assistance services and greatly deteriorated. For example:Ms. Pitts can no longer stand except for very short periods of time, her episodes of incontinence are more frequent, her ability to walk with a walker has diminished, and her overall health has declined. She is currently receiving the amount of assistance which is both medically necessary and minimally required for her to reside in the community. If her service

hours are reduced, I would expect her to deteriorate again, and require institutionalization in a nursing facility.

12. In my opinion, reducing her current in-home personal care services would jeopardize Helen Pitts' community life and her health care.

13. If Ms. Pitt's hours of personal care services are reduced to 32 hours per week or less, she will be at significant risk of going into a nursing facility. This reduction is medically inappropriate.

14. In my experience, Ms. Pitts would not receive the same level of medical/health care and attention in a nursing facility, which she receives presently in the community In a nursing facility, she will not receive the same one-on-one attention to her activities of daily living, which she presently receives.

15. I am quite concerned that if Ms. Pitts were forced to enter a nursing facility, her physical, emotional and cognitive health would deteriorate rapidly and unnecessarily.

9-20-10
Date

Gregory Ward, MD

Exhibit 44 37 La Reg 1113 (April 20, 2011)

outpatient hospital services rendered by non-rural, non-state hospitals designated as major teaching hospitals.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part V. Hospital Services
Subpart 5. Outpatient Hospitals
Chapter 65. Teaching Hospitals
Subchapter B. Reimbursement Methodology
§6533. Major Teaching Hospitals

A. Effective for dates of service on or after October 1, 2009, a quarterly supplemental payment shall be issued to qualifying non-rural, non-state acute care hospitals for outpatient services rendered during the quarter. These payments shall be used to facilitate the development of public-private collaborations to preserve access to medically necessary services for Medicaid recipients. Aggregate payments to qualifying hospitals shall not exceed the maximum allowable cap for the state fiscal year.

1. Qualifying Criteria. In order to qualify for the supplemental payment, the non-rural, non-state acute care hospital must:

a. be designated as a major teaching hospital by the department in state fiscal year 2009;

b. have provided at least 25,000 Medicaid acute care paid days for state fiscal year 2008 dates of service;

c. have provided at least 4,000 Medicaid distinct part psychiatric unit paid days for state fiscal year 2008 dates of service; and

d. provided at least 20,000 Medicaid outpatient paid visits for state fiscal year 2008 dates of service.

2. Payments shall be distributed quarterly based on Medicaid paid claims data from service dates in state fiscal year 2009.

3. Payments are applicable to Medicaid service dates provided during each quarter and shall be discontinued for the remainder of the state fiscal year in the event that the maximum payment cap is reached or by June 30, 2011, whichever occurs first.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to all inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein
Secretary

1104#059

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing
and
Office of Aging and Adult Services

Personal Care Services—Long-Term
Policy Clarifications and Service Limit Reduction
(LAC 50:XV.12901-12909 and 12911-12915)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amend LAC 50:XV.12901-12909 and §§12911-12915 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

Senate Resolution 180 and House Resolution 190 of the 2008 Regular Session of the Louisiana Legislature directed the department to develop and implement cost control mechanisms to provide the most cost-effective means of financing the Long-Term Personal Care Services (LT-PCS) Program. In compliance with these legislative directives, the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amended the provisions governing the LT-PCS Program to: 1) implement uniform needs-based assessments for authorizing service units; 2) reduce the limit on LT-PCS service hours; 3) mandate that providers must show cause for refusing to serve clients; and 4) incorporate provisions governing an allocation of weekly service hours (*Louisiana Register,* Volume 35, Number 11).

The department promulgated an Emergency Rule which amended the provisions governing long-term personal care services to: 1) establish provisions that address requests for services; 2) revise the eligibility criteria for LT-PCS; 3) clarify the provisions governing restrictions for paid direct care staff and the place of service; and 4) reduce the maximum allowed service hours (*Louisiana Register*, Volume 36, Number 8). The department promulgated an Emergency Rule which amended the provisions of the September 5, 2010 Emergency Rule to clarify the provisions of the Rule (*Louisiana Register*, Volume 36, Number 12). The department now proposes to amend the provisions of the December 20, 2010 Emergency Rule to further clarify the provisions of the Rule. This action is being taken to ensure that these provisions are promulgated in a clear and concise manner.

Effective April 20, 2011, the Department of Health and Hospitals, Bureau of Health Services Financing and the

Office of Aging and Adult Services amend the provisions of the December 20, 2010 Emergency Rule governing long-term personal care services.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XV. Services for Special Populations
Subpart 9. Personal Care Services
Chapter 129. Long Term Care
§12901. General Provisions

A. The purpose of personal care services is to assist individuals with functional impairments with their daily living activities. Personal care services must be provided in accordance with an approved service plan and supporting documentation. In addition, personal care services must be coordinated with the other Medicaid and non-Medicaid services being provided to the recipient and will be considered in conjunction with those other services.

B. Each recipient requesting or receiving long-term personal care services (LT-PCS) shall undergo a functional eligibility screening utilizing an eligibility screening tool called the Level of Care Eligibility Tool (LOCET), or a subsequent eligibility tool designated by the Office of Aging and Adult Services (OAAS).

C. Each LT-PCS applicant/recipient shall be assessed using a uniform assessment tool called the Minimum Data Set-Home Care (MDS-HC) or a subsequent assessment tool designated by OAAS. The MDS-HC is designed to verify that an individual meets eligibility qualifications and to determine resource allocation while identifying his/her need for support in performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The MDS-HC assessment generates a score which measures the recipient's degree of self-performance of late-loss activities of daily living during the period just before the assessment.

1. The late-loss ADLs are eating, toileting, transferring and bed mobility. An individual's assessment will generate a score which is representative of the individual's degree of self-performance on these four late-loss ADLs.

C.2. - C.7. Repealed.

D. Based on the applicant/recipient's uniform assessment score, he/she is assigned to a level of support category and is eligible for a set allocation of weekly service hours associated with that level.

1. If the applicant/recipient disagrees with his/her allocation of weekly service hours, the applicant/recipient or his/her responsible representative may request a fair hearing to appeal the decision.

2. The applicant/recipient may qualify for more hours if it can be demonstrated that:

a. one or more answers to the questions involving late-loss ADLs are incorrect as recorded on the assessment; or

b. he/she needs additional hours to avoid entering into a nursing facility.

E. Requests for personal care services shall be accepted from the following individuals:

1. a Medicaid recipient who wants to receive personal care services;

2. an individual who is legally responsible for a recipient who may be in need of personal care services; or

3. a responsible representative designated by the recipient to act on his/her behalf in requesting personal care services.

F. Each recipient who requests PCS has the option to designate a responsible representative. For purposes of these provisions, a responsible representative shall be defined as the person designated by the recipient to act on his/her behalf in the process of accessing and/or maintaining personal care services.

1. The appropriate form authorized by OAAS shall be used to designate a responsible representative.

a. The written designation of a responsible representative does not give legal authority for that individual to independently handle the recipient's business without his/her involvement.

b. The written designation is valid until revoked by the recipient. To revoke the written designation, the revocation must be submitted in writing to OAAS or its designee.

2. The functions of a responsible representative are to:

a. assist and represent the recipient in the assessment, care plan development and service delivery processes; and

b. to aid the recipient in obtaining all necessary documentation for these processes.

F.3 - F.4. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:911 (June 2003), amended LR 30:2831 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 32:2082 (November 2006), LR 34:2577 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:2450 (November 2009), LR 37:

§12902. Participant Direction Option

A. The Office of Aging and Adult Services implements a pilot program, the Louisiana Personal Options Program (La POP), which will allow recipients who receive long term personal care services (LT-PCS) to have the option of utilizing an alternative method to receive and manage their services. Recipients may direct and manage their own services by electing to participate in La POP, rather than accessing their services through a traditional personal care agency.

1. La POP shall be implemented through a phase-in process in Department of Health and Hospitals administrative regions designated by OAAS.

A.2. - B.1. ...

2. With the assistance of a services consultant, participants develop a personal support plan based on their approved plan of care and choose the individuals they wish to hire to provide the services.

C. - E.1. ...

2. Change in Condition. The participant's ability to direct his/her own care diminishes to a point where he/she can no longer do so and there is no responsible representative available to direct the care.

3. Misuse of Monthly Allocation of Funds. The LA POP participant or his/her responsible representative uses