UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

JOANNA DYKES; DAVID WALKER, by and through his next friend, Michele Beauregard; **LORETTA DAVIS,** by and through her next Friend, Trish Mlekodaj; **HEATHER YOUNG**, by and through her next friend Robert Stark; **MICHELLE CONGDEN; AMANDA PIVINSKI; JOSHUA WOODWARD; ALYSSA FERRARO,** by and through her next friend, Sharon Ferraro and **DISABILITY RIGHTS FLORIDA, Inc.**, a Florida non-profit corporation,

Plaintiffs,

v. **Case No. 4:11-cv-00116-RS -WCS**

ELIZABETH DUDEK in her official capacity as Secretary of the Florida Agency for Health Care Administration, and **BRIAN VAUGHAN** in his official capacity as (Interim) Director of the Florida Agency for Persons with Disabilities, and **RICK SCOTT** in his official capacity as Governor of the State of Florida.,

Defendants.
_____/

DEFENDANTS' MOTION TO DISMISS AMENDED COMPLAINT

The Defendants, Elizabeth Dudek, in her official capacity as Secretary of the Florida Agency for Health Care Administration ("AHCA"), and Brian Vaughan, in his official capacity as Interim Director of the Florida Agency for Persons with Disabilities,

hereby file this their Motion to Dismiss Plaintiffs' Amended Complaint and state as follows[1]:

MEMORANDUM OF LAW

Defendants move to dismiss Plaintiffs' Amended Complaint for failure to state a cause of action. Fed. R. Civ. P. 12(b)(6). In deciding a motion to dismiss, Courts ordinarily assume that the material allegations of the complaint are true. Bell Atlantic Corp. v. Twombly, 127 S.Ct. 1955, 1965 (2007). If, however, a plaintiff fails to make plausible factual allegations that would support his cause of action, the court should dismiss the case. Sibley v. The Florida Bar, 2008 WL 4525395 (N.D. Fla. 2008) (citing Twombly). A plaintiff must provide more than mere labels and conclusions, and formulaic recitations of the elements of a cause of action will not suffice. Twombly, 127 S.Ct. at 1964-65. A plaintiff's factual allegations must be enough to raise his right to relief beyond the speculative level. Davis v. Coca-Cola Bottling Co. Consol., 516 F.3d 955, 974 (11th Cir. 2008) (citing Twombly).

ARGUMENT

I. Medicaid Overview

A. Statutory Framework

Medicaid is a joint federal and state program for the funding of medical services for certain defined categories of low income recipients established by Title XIX of the Social Security Act of 1965. 42 U.S.C. § 1396 *et seq*. (the "Medicaid Act"). In order to

[1] As explained in a separate filing, Governor Scott is not a proper defendant in this action pursuant to Eleventh Amendment immunity, and has therefore moved to be dismissed as a defendant. Should the Court deny the Governor's motion, he joins in this motion. The other Defendants do not waive any of their immunity defenses under the Eleventh Amendment.

participate in Medicaid, a state must submit to the federal government a plan outlining its program to fund medical services for the poor and needy in accordance with the federal Medicaid Act. This is referred to as the Medicaid State Plan. If the federal government approves the plan, it "then subsidizes a certain portion of the financial obligations which the state has agreed to bear." Harris v. James, 127 F.3d 993, 996 (11th Cir. 1997) (citing Silver v. Baggiano, 804 F.2d 1211 (11th Cir. 1986)).

Congress passed the Medicaid Act pursuant to its spending power under Article I, § 8, Clause 1 of the U.S. Constitution. See Pharm. Research & Mfrs. Of Am. v. Walsh, 538 U.S. 644, 682-3 (2003). When Congress exercises its spending power, the States that accept Federal funds enter a "quasi-contractual" relationship with the Federal government. Pennhurst State School and Hospital v. Halderman, 451 U.S. 1, 17 (1981). In this quasi-contractual relationship, states must be made aware of the conditions attached to federal funds to ensure they have "voluntarily and knowingly accept[ed] the terms of the ‚contract.'" Id.

The federal Medicaid Act defines "medical assistance" to mean payment for all or part of a variety of health care services listed in the Act. See e.g. 42 U.S.C. § 1396a(a)(10)(A) and 42 U.S.C. § 1396d(a)(1)-(29). There are three main categories of Medicaid services: (1) mandatory services; (2) optional services; and (3) "waiver" services. Each category of services gives rise to different state rights and obligations.

1. Mandatory Medicaid Services

The federal Medicaid statute lists all of the mandatory and optional services in 42 U.S.C. § 1396d(a)(1) through (29). Of the 29 listed services, eight are mandatory,

meaning that a state must include these eight services in its state plan to participate in Medicaid. 42 U.S.C. § 1396a(a)(10)(A). Mandatory services include inpatient hospital services, outpatient hospital services, laboratory and x-ray services, **nursing facility services**, nurse-midwife services, certified nurse practitioner services, and freestanding birth center services. See 42 U.S.C. § 1396a(a)(10)(A) (requiring state plans to provide at least the services listed in § 1396d(a)(1) through (5), (17), (21) and (28)). In providing for these mandatory services Medicaid-participating states must make these services available in every political subdivision in the state, which is referred to as the program's "statewideness" requirement. 42 U.S.C. § 1396a(a)(1). Additionally, the state must make all mandatory services available in equal amount, duration, and scope to every Medicaid-eligible person in the state. 42 U.S.C. § 1396a(a)(10)(B)(i). For example, this requirement (which is known as Medicaid's "comparability" requirement) means that a state cannot ordinarily pay for 45 days of inpatient hospitalization per year for Medicaid recipients in Tallahassee, but only 35 days per year for recipients in Pensacola. Similarly, a state cannot pay for 45 days of hospitalization for someone with HIV/AIDS, but only 35 days for someone with cerebral palsy. All Medicaid recipients then, generally speaking, have access to the exact same package of mandatory services.

2. Optional Medicaid Services

In addition to the eight mandatory services, the federal Medicaid statute lists 21 other services that Medicaid-participating states **may** provide payment for through the state Medicaid program. These other 21 listed services are referred to as "optional services," with the states having the discretion whether to include these services in their

Medicaid State plans. Optional services include **services in an intermediate care facility for the mentally retarded** ("ICF/DD")[2], physical therapy services, prescription drug coverage, dental services, vision services, and several others. 42 U.S.C. § 1396d(a)(6)-(16), (18)-(20), and (22)-(29). As with mandatory services, once a state decides to include an optional service in its Medicaid program, it must make the service available statewide and give all Medicaid-eligible persons access to the same amount, duration, and scope of the service. Doe 1-13 By & Through Doe, Sr. 1-13 v. Chiles, 136 F.3d 709, 721 (11th Cir. 1998).

3. Federal Requirements for State Medicaid Programs

Each state's Medicaid program must conform to the standards set forth in the Medicaid Act and its implementing regulations. Two significant requirements, statewideness and comparability, are described above. Two other significant standards to which state Medicaid programs must adhere are the "reasonable promptness" requirement and the "freedom of choice" requirement. The reasonable promptness provision requires that each state plan "provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals." 42 U.S.C. § 1396a(a)(8). The freedom of choice provision, in turn, requires that each Medicaid state plan provide that "any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which

[2] While the federal Medicaid Act uses the term "mentally retarded," the State of Florida prefers "developmentally disabled." Hence the abbreviation "ICF/DD."

provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services." 42 U.S.C. § 1396a(a)(23). As demonstrated below in sections II and III of this Motion, neither of these provisions entitles the Plaintiffs to the relief they seek in the Amended Complaint.

Another requirement of the Medicaid Act relevant to this lawsuit is related to the provision of fair hearings. Each Medicaid State Plan must "provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness." 42 U.S.C. § 1396a(a)(3). The federal regulations implementing the Medicaid Act go further. Each state's Medicaid program must inform recipients of their right to fair hearings and how to obtain such hearings. 42 C.F.R. § 431.206.

4. Medicaid Waiver Services.

In addition to the mandatory and optional services offered under a state's Medicaid State Plan, a state may also enter into an agreement with the federal government to offer services under a waiver program, such as a Home and Community-Based ("HCBS") waiver program. See 42 U.S.C. § 1396n(c). With "waiver" services, the state has requested (and the federal government has agreed) to "waive" certain requirements of the Medicaid Act without jeopardizing federal financial participation. 42 U.S.C. § 1396n(c)(3). In this way, the Medicaid Act allows states to provide an enhanced benefit package to certain populations within the state.

The Medicaid Act allows the states to enhance their benefit package in waiver programs in two ways. First, a state can provide more of a Medicaid-covered service to a

waiver recipient than to a non-waiver Medicaid recipient. Thus, even though a non-waiver Medicaid recipient can only receive 45 days of inpatient hospitalization per year, a waiver recipient might be able to receive significantly more days. Second, a state can provide services to waiver recipients that are not listed among the 29 mandatory and optional Medicaid services, including respite care, homemaker and companion services, and habilitation services. 42 U.S.C. § 1396n(c)(4)(B). As a result of this waiver authority, Florida has created waiver programs with enhanced benefit packages targeted to Medicaid-eligible persons with HIV/AIDS, traumatic brain injuries, spinal cord injuries, cystic fibrosis, autism, spina bifida, and cerebral palsy, among others. These waiver programs, with explicit federal knowledge and approval, exclude and deny these enhanced benefits to persons who do not have the specific disabling condition targeted by the waiver program.

Additionally, the Medicaid Act explicitly permits the federal government to waive Medicaid's customary "statewideness" and "comparability" requirements, allowing states to limit the number of people who receive waiver services, to limit waiver programs to certain areas of the state, and to provide an enhanced benefit package only to this limited population. federal law specifically allows states to "cap" the number of persons receiving waiver services. 42 U.S.C. § 1396n(c)(9)-(10). Federal law also allows the states to limit their waiver programs to certain parts of the state as opposed to persons living throughout the state. 42 U.S.C. § 1396n(c)(3). Thus, Medicaid can deny waiver services to persons are not under the cap or who do not live in the specified area of the state where the waiver is in effect.

It is important to note that while the federal Medicaid Act permits states to create HCBS waiver programs, it does not require states to do so. As the Medicaid Act states, "a State plan approved under this subchapter ***may*** include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by" the federal government. 42 U.S.C. § 1396n(c)(1) (emphasis added). Nor does the Medicaid Act require the federal government to approve states' HCBS waiver programs. The Secretary of the Department of Health and Human Services "***may*** by waiver" allow states to create HCBS programs. Id. (emphasis added).

B. The Florida Medicaid Developmental Disabilities Waiver Program

The Florida Medicaid Developmental Disabilities Waiver program ("DD Waiver") was implemented in 1982 as a combined waiver with aged and disabled adult services. These populations were split into separate waivers in 1985. The purpose of the DD Waiver is "to promote, maintain and restore the health of eligible recipients with developmental disabilities; to minimize the effects of illness and disabilities through the provision of needed supports and services in order to delay or prevent institutionalization; and to foster the principles of self-determination as a foundation for services and supports." Florida Medicaid Developmental Disabilities Waiver Services Coverage and Limitations Handbook[3], p. 1-8. The DD Waiver offers additional state plan services as well as waiver services such as personal care assistance and companion services to individuals with developmental disabilities such as mental retardation, autism, cerebal

[3] Incorporated by reference by AHCA as an administrative rule by Rule 59G-13.083, Florida Administrative Code.

palsy, spina bifida, or Prader-Willi Syndrome. Id., at 2-3. The DD Waiver is operated by Florida's Agency for Persons with Disabilities.

In 2007, the Florida Legislature mandated the implementation of a four-tier system in the DD Waiver. See § 393.0661, Florida Statutes. Recipients are placed in tiers based upon assessments of their needs. For example, tier one "is limited to clients who have service needs that cannot be met in tier two, three, or four for intensive medical or adaptive needs and that are essential for avoiding institutionalization, or who possess behavioral problems that are exceptional in intensity, duration, or frequency and present a substantial risk of harm to themselves or others." § 393.0661(3)(a), Florida Statutes.

II. With Regard to Reasonable Promptness, the Plaintiffs Have Failed to State a Claim Upon Which Relief Can be Granted

The Plaintiffs allege that their placement on the wait list for the DD Waivers violates the reasonable promptness requirement found in 42 U.S.C. § 1396a(a)(8) and 42 C.F.R. § 435.930. Amended Complaint ¶¶ 161-177. This claim is unfounded. The Medicaid Act requires that State plans for medical assistance "provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals." 42 U.S.C. § 1396a(a)(8). Likewise, the administrative regulations implementing the Medicaid Act require that a state Medicaid agency:

> (a) Furnish Medicaid promptly to recipients without any delay caused by the agency's administrative procedures;
>
> (b) Continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible; and

> (c) Make arrangements to assist applicants and recipients to get emergency medical care whenever needed, 24 hours a day and 7 days a week.

42 C.F.R. § 435.930. As demonstrated below, neither of these provisions operates to guarantee Plaintiffs placement on the DD Waiver.

Section 1396a(a)(8) guarantees reasonable promptness only to "eligible individuals." The cap on waiver services operates as a "constraint on eligibility." Boulet v. Cellucci, 107 F. Supp. 2d 61, 77 (D. Mass. 2000). Only those individuals who are "under the cap" are eligible pursuant to § 1396a(a)(8). See Id. ("eligible individuals under the cap are entitled to waiver services.") Only "[t]hose patients who are on the waiting list and for whom slots are available" are "eligible." Bryson v. Shumway, 308 F.3d 79, 88 (1st Cir. 2002). The District Court for the Middle District of Alabama offered a cogent analysis of this issue in Susan J. v. Riley, 616 F. Supp. 2d 1219 (M.D. Ala. 2009):

> "Only those persons who both (1) meet the preliminary eligibility requirements for participation in the Waiver program, as indicated by their presence on the waiting lists, and (2) are entitled to one of the few Waiver slots are entitled to the provision of medical assistance with reasonable promptness….The many persons who are on the waiting list, who evidently meet the preliminary eligibility requirements, but who are not entitled to one of the few available Waiver slots are not entitled to the provision of medical assistance with reasonable promptness"

at 1241.

It is thus clear that the Plaintiffs on the waiting list for the DD Waiver are only entitled to enrollment onto the DD Waiver with "reasonable promptness" if there are available slots. The Plaintiffs have failed to allege that there are any available slots and

thus have failed to state a claim upon which relief can be granted. Thus, Count One of Plaintiffs' Complaint should be dismissed pursuant to Rule 12(b)(6), Fed. R. Civ. P.

III. With Regard to Freedom of Choice, the Plaintiffs Have Failed to State a Claim Upon Which Relief Can be Granted

Plaintiffs claim that Defendants' conduct "violates statutory freedom of choice requirement" under 42 U.S.C. § 1396n(c)(2). Amended Complaint, at ¶181. In fact, no such requirement exists. The only provision in § 1396n(c)(2) that in any way relates to recipient choice is subparagraph (C), which requires a state to assure that:

> "such individuals who are determined to be likely to require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded are informed of the feasible alternatives, if available under the waiver, at the choice of such individuals, to the provision of inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded;"

42 U.S.C. § 1396n(c)(2)(C). Several points are of note regarding this provision as it relates to this case. First, it does not require states to provide alternatives. It only requires states to *inform* recipients of alternatives *to the extent they exist* ("if available under the waiver"). A state could only violate this provision by failing to inform individuals regarding alternatives, not by failing to provide alternatives that are not available at the time. Second, the Defendants would not violate § 1396n(c)(2) by failing to inform individuals regarding services in the DD Waiver because, to the extent there are no open slots in the DD Waiver, such alternatives are neither "feasible" nor "available." To the extent that there are no available slots in the DD Waiver for individuals on the waiting list, "the waiver services are not „feasible' for them until the cap has risen to include them." Boulet, at 77 (citing 42 U.S.C. § 1396n(c)(2)(C)). Likewise, a waiver

"program is not ‚available' under the statute when the slots available" have been filled. Makin ex rel. Russell v. Hawaii, 114 F. Supp. 2d 1017, 1028 (D. Haw. 1999) (citing 42 U.S.C. § 1396n(c)(2)(C)). Because services in the DD Waiver are neither "feasible" nor "available," the Plaintiffs have failed to state a claim under § 1396n(c)(2) upon which relief can be granted.

The other provision cited by Plaintiffs in the Amended Complaint regarding freedom of choice is § 1396a(a)(23). Amended Complaint, at ¶¶ 16, 118. This provision states that state plans for medical assistance must provide that

> "any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services"

42 U.S.C. § 1396a(a)(23). The issues raised in part II above regarding reasonable promptness apply to this freedom of choice provision as well. Individuals on the waiting list for the DD Waiver are not "eligible" for services in the waiver and § 1396a(a)(23) therefore does not apply to them. As one court explained, "[i]ndividuals who apply [for a Medicaid waiver program] after the cap has been reached are not eligible" for services in the waiver program. Boulet, at 77. As Plaintiffs are not "eligible," they have failed to state a claim under § 1396a(a)(23) upon which relief can be granted.

Regardless, the provisions of the Medicaid Act Plaintiffs cite in their Amended Complaint do not give rise to private rights of action, particularly § 1396n(c)(2). According to the Eleventh Circuit and the Supreme Court, there are three requirements that must be met before a federal statute will be read to confer a private cause of action

under §1983: (1) the provision in question must benefit the plaintiff; (2) the plaintiff must demonstrate that the right assertedly protected by the statute is not so vague and amorphous that its enforcement would strain judicial resources; and (3) the provision giving rise to the asserted right must be couched in mandatory, rather than precatory, terms. Id. at 1269, citing Blessing v. Freestone, 520 U.S. 329, 340-1 (1997) (calling the three part analysis the "Blessing test"). A plaintiff can only sue under §1983 to protect unambiguously conferred rights, and cannot sue to protect mere benefits or interests created in a federal statute. Id. at 1269, citing Gonzaga Univ. v. Doe, 536 U.S. 273 (2002).

In Gonzaga v. Doe, the Supreme Court noted that only twice in history has it recognized a federal right in a spending clause statute – and both times the statutory provision in question created a specific monetary entitlement in the plaintiff. Gonzaga v. Doe, 536 U.S. 273, 280-1 (2002). Medicaid is found in a spending clause statute. The provisions Plaintiffs cite, however, do not create specific monetary entitlements. For example, § 1396n(c)(2) involves information that the state must pass along to a Medicaid recipient – an administrative requirement that is best enforced by the federal administrative agency that governs the Medicaid program and not by the courts.

As Plaintiffs have failed to state a claim upon which relief can be granted with regard to freedom of choice, this Court should dismiss Count Two pursuant to Rule 12(b)(6), Fed. R. Civ. P.

IV. Plaintiffs' Claims Under Count Four of the Amended Complaint Should be Dismissed Because Plaintiffs Have Failed to State a Claim Upon Which Relief Can be Granted

Section 1 of the Fourteenth Amendment of the U.S. Constitution states that "[n]o state shall… deprive any person of life, liberty, or property." After citing this provision in their Amended Complaint, Plaintiffs assert that they "have a constitutionally protected property interest in Medicaid benefits." Amended Complaint, at ¶ 227. Plaintiffs have no protected property interest in the DD Waiver program, because, as explained in parts II and III above, Plaintiffs are not "eligible" for these programs.

While Plaintiffs are not eligible for the DD Waiver, they are entitled to an opportunity for a fair hearing under § 1396a(a)(3) of the Medicaid Act and to notice of such right under the federal regulations. 42 C.F.R. § 431.206. However, the right to such notice in the regulation is not enforceable by private right of action pursuant to 42 U.S.C. § 1983. Neither the right to a hearing nor the right to notice constitutes a specific monetary entitlement. See Gonzaga, at 280-1.

This Court should note that Plaintffs do not allege that they were never notified as to the denial of DD Waiver services. Rather, Plaintiffs Dykes, Walker, Davis, Young, and Congden assert that they were not notified as to their categorization on the waitlist.[4] Amended Complaint, ¶¶ 23, 32, 39, 47, 54. The Medicaid Act does not create any enforceable right to be placed on a waiting list for services for which an individual is not currently eligible. Therefore, there is no right to a fair hearing pursuant to § 1396a(a)(3) regarding *wait list categorization*. There is only a right to a fair hearing when an

[4] Plaintiffs do not allege any failure of Defendants to inform Plaintiffs Ferraro, Pivinski, or Woodward.

application is *denied* or is *not acted upon with reasonable promptness*. 42 U.S.C. § 1396a(a)(3). Plaintiffs do not allege either of these things.[5]

V. Plaintiffs' Claims Under the Americans with Disabilities Act and Section 504 of the Rehabilitation Act Should be Dismissed Because Plaintiffs Have Failed to State a Claim Upon Which Relief Can be Granted

A. Statutory, Regulatory, and Case Law Framework

The Americans with Disabilities Act ("ADA") became law in 1990. 42 U.S.C. § 12101, *et seq*. Title II applies to public entities, the definition of which includes the Defendants. 42 U.S.C. § 12131(1). The Title II provision most relevant to this lawsuit, provides that "no 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." 42 U.S.C. § 12132.

Section 504 of the Rehabilitation Act of 1973 ("Section 504") includes a prohibition of discrimination substantially identical to the one in § 12131(1) of the ADA. 29 U.S.C. § 794(a). The ADA and Section 504 can be analyzed together as "[t]here is no significant difference in analysis of the rights and obligations created by the ADA and the Rehabilitation Act." Zukle v. Regents of Univ. of California, 166 F.3d 1041, 1045, n.11 (9th Cir. 1999).

The regulations implementing Title II of the ADA require a public entity to "make reasonable modifications in policies, practices, or procedures when the

[5] Plaintiffs do not allege such facts because none exist. The Florida Agency for Persons with Disabilities notifies recipients when they are denied enrollment in the DD Waiver and provides an opportunity for a fair hearing.

modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." 42 C.F.R. § 35.130(b)(7). Thus, where a modification would constitute a fundamental alteration to the service, program, or activity at issue, it is not required under the ADA.

In Olmstead v. L.C. ex rel Zimring, 527 U.S. 581 (1999), the Supreme Court was faced with the question of whether the proscription of discrimination found in Title II of the ADA may require placement of persons with mental disabilities in community settings rather than institutions. See Olmstead, at 587. The Court held that the answer is "a qualified yes." Id. The Court found that the ADA requires the placement of a person with a disability in community settings rather than institutions when (1) the State's treatment professionals have determined that community placement is appropriate, (2) the transfer from the institution to the community is not opposed by the individual, and (3) the placement can be reasonably accommodated, taking into account (a) the resources available to the State, and (b) the needs of others with disabilities. Id. Reading Olmstead together with Title II's implementing regulations, it is clear that the question of whether a modification constitutes a fundamental alteration must necessarily take into account the resources available (e.g., funding) and the needs of others with disabilities (e.g., the number of persons who must be served with those resources).

Justice Ginsburg's opinion in Olmstead suggests that a fundamental alteration would lie where a Court is asked to disrupt a State's "comprehensive, effectively working" plan of deinstitutionalization. "If, for example, the State were to demonstrate

that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met." Id., at 605-606. Note that only three other justices joined Justice Ginsburg in Part III-B, so this passage is not part of the Court's holding. Nor has the Eleventh Circuit Court of Appeals adopted the substance of this provision in any case. As such, while this provision may be instructive, it does not constitute binding law that this Court must follow. Even if Part III-B were part of the Supreme Court's opinion, it still remains that this passage does not **require** a showing of a comprehensive, effectively working plan in order to demonstrate that a requested modification would constitute a fundamental alteration. Rather, a comprehensive, effectively working plan is *one example* of a showing of fundamental alteration.[6]

Like the provision of Title II of the ADA which it interprets, Olmstead is about non-discrimination and does not create an absolute prohibition against institutionalization. Nor does Olmstead, or the ADA, create an absolute right for persons with disabilities to remain in the community and avoid institutionalization. As the Second Circuit has noted, "*Olmstead* does not…stand for the proposition that states must provide disabled individuals with the opportunity to remain out of institutions." Rodriguez v. City of New York, 197 F.3d 611, 619 (1999).

B. Interplay of the ADA and the Medicaid Act

[6] It should also be noted that the "comprehensive, effectively working plan" described in Olmstead is one of *deinstitutionalization*, not a plan for ensuring that no individual with a disability ever has to enter an institution.

1. The ADA Neither Abrogates Nor Amends the Medicaid Act

Plaintiffs' claims would require the Court to find that the ADA has invalidated one or more provisions of the Medicaid Act. For example, the Court would have to invalidate the Medicaid Act's provision in 42 U.S.C. § 1396n(c)(1) declaring that HCBS waiver programs are optional for states and that states can cap enrollment in such programs.

An inherent assumption of Plaintiffs' lawsuit is that the Medicaid Act has been impliedly amended by the ADA. However, the criteria for statutory amendment by implication are not met here. The Supreme Court has held that "[a]mendments by implication, like repeals by implication, are not favored." United States v. Welden, 377 U.S. 95, 103 (U.S. 1964). In a case where "two statutes are capable of co-existence, it is the duty of the courts, absent a clearly expressed congressional intention to the contrary, to regard each as effective." Morton v. Mancari, 417 U.S. 535, 551 (U.S. 1974). The Medicaid Act and the ADA are capable of co-existence, and the ADA contains no clear congressional intent to amend the Medicaid Act.

Moreover, the Medicaid Act is a more specific statute than the ADA. Indeed, the ADA generally prohibits discrimination, while the Medicaid Act ordinarily prohibits discrimination but waives this prohibition in a specific, public health policy context. According to the U.S. Supreme Court, "it is a basic principle of statutory construction that a statute dealing with a narrow, precise, and specific subject is not submerged by a later enacted statute covering a more generalized spectrum." Radzanower v. Touche

Ross & Co., 426 U.S. 148, 153 (U.S. 1976). The more specific statute controls "regardless of the priority of enactment." Morton, at 551.

2. Constitutional Implications

The Plaintiffs' assumption that the Medicaid Act has been impliedly amended by the ADA raises grave constitutional concerns. Congress passed the Medicaid Act pursuant to its spending authority under Article I, section 8 of the U.S. Constitution. See Ball v. Rodgers, 492 F.3d 1094, 1105 n.15 (9th Cir. 2007). To be constitutional, a spending clause statute must meet certain criteria. One of these is that *Congress must clearly and unambiguously state the conditions that come with receiving federal money*. Congress must do this so that states can decide whether to accept the money knowingly, "cognizant of the consequences of their decision." Pennhurst State School and Hospital v. Halderman, 451 U.S. 1, 17 (1981); South Dakota v. Dole, 483 U.S. 203, 207 (1987).

In the Medicaid Act, Congress requires states that participate in Medicaid to provide for nursing facility services for all Medicaid recipients who need them. 42 U.S.C. § 1396a(a)(10)(A); 42 U.S.C. § 1396d(a)(4). Put another way, Congress requires states to provide nursing facility services as a condition of receiving federal Medicaid dollars. Likewise, Congress requires states that, like Florida, have decided to include ICF/DDs in their Medicaid State Plans to provide services in ICF/DDs for all Medicaid recipients who need them as a condition of receiving federal Medicaid dollars. Id.

The Medicaid Act does not require states to provide HCBS waiver services in lieu of nursing facility and ICF/DD services. 42 U.S.C. § 1396n(c)(1) and (2). Instead, Congress has made these waiver services optional. Id. Stated another way, Congress

does not require states to provide waiver services as a condition of receiving federal Medicaid dollars.

Plaintiffs' legal theory holds that by virtue of their providing nursing facility services and ICF/DD services in the Florida Medicaid program, the Defendants have obligated themselves to provide services in the more "integrated setting" of the community through the DD Waiver. As this obligation is not clearly and unambiguously stated in the Medicaid Act, the Plaintiffs' theory raises grave concerns regarding the Medicaid Act's constitutionality under the Spending Clause.

C. Count Three Plaintiffs' Amended Complaint

Count Three of Plaintiffs' Amended Complaint would require a finding that the Medicaid Act has been impliedly amended by the ADA. However, as demonstrated above, the criteria for amendment by implication has not been met here. Moreover, such amendment would effectively render the Medicaid Act unconstitutional. As such, Count Three of Plaintiffs' Amended Complaint fail to state a claim upon which relief can be granted and should be dismissed pursuant to Rule 12(b)(6), Fed. R. Civ. P.

VI. Nursing Home Residents Have Failed to State a Claim Under the Americans with Disabilities Act

A. Plaintiff Heather Young is a Member of a Certified Statewide Class on Same Issues

The matter of Lee, et al. v. Dudek, et al., Case No. 4:08cv26-RH/WCS, a statewide class action lawsuit, is currently pending before this Court. The Honorable Robert L. Hinkle, U.S. District Court Judge, presided over a trial in the matter from February 7, 2011, through February 16, 2011, and a final order is still forthcoming.

The class in Lee v. Dudek consists of "any Florida Medicaid-eligible adult who, at any time while this litigation has been pending, has resided in a nursing home that receives Medicaid funding, and who could and would reside in the community with appropriate community based services." Lee v. Dudek Docket Entry 136. The Defendants in the Lee v. Dudek matter are AHCA and the Florida Department of Elder Affairs. The class in Lee v. Dudek claims that "Defendants have required that Named Plaintiffs and class members be confined unnecessarily in institutions, *i.e.*, nursing facilities, rather than permit them to reside in the community in order to obtain long-term care services in violation of the ADA's integration mandate." Lee v. Dudek Amended Complaint (Docket Entry 13).

Plaintiff Heather Young and the 115 putative class members identified in ¶ 157 of the Amended Complaint in the instant matter are members of the Lee v. Dudek class. Moreover, the issues, at least with respect to the ADA and Section 504, are the same in the instant case as in Lee v. Dudek. The same parties and the same claims are before the same Court in a different matter. Even if this Court disagrees with Defendants' arguments below, it would be an unnecessary waste of judicial resources to permit Plaintiff Young's claims, and those of the 115 putative class members in nursing homes, under the ADA and Section 504 to proceed in this matter.[7]

While the principle of res judicata would not strictly apply until a final order issues in Lee v. Dudek, allowing the ADA and Section 504 claims of Plaintiff Young and the 115 putative class members in nursing homes to proceed would also be contrary to

[7] As shown in Parts II and III above, all claims under the Medicaid Act should also be dismissed.

the purposes of Rule 23, Fed. R. Civ. P., the procedural rule which permitted the class members in Lee v. Dudek to join together in a single class action. The purposes of Rule 23 "are to **avoid a multiplicity of suits**, provide **common binding adjudication**, and **prevent inconsistent or varying adjudications**." Mungin v. Florida E. Coast Ry. Co., 318 F. Supp. 720, 730 (M.D. Fla. 1970) aff'd, 441 F.2d 728 (5th Cir. 1971) (emphasis added).

In Schrader v. Selective Serv. Sys. Local Bd. No. 76 of Wis., 329 F. Supp. 966, 967 (W.D. Wis. 1971), the District Court for the Western District of Wisconsin narrowed the purposes of Rule 23 down to one: "to reduce **multiple litigation** of the same issues" (emphasis added). Plaintiff Young and the 115 putative class members in nursing homes are attempting to re-litigate claims brought in a case that was only just tried before this Court. Their claims under the ADA and Section 504 should be dismissed. Alternatively, Plaintiff Young should be dropped as a party pursuant to Rule 21, Fed. R. Civ. P.

B. Nursing Home Residents Have Other Community-Based Options

To the extent that an ADA violation could lie under the facts alleged in the Plaintiffs' Complaint, such violation would arise solely from a failure of Defendants to provide services in the "most integrated setting appropriate." 28 C.F.R. § 35.130(d). The Plaintiffs claim that this violation has occurred because the Defendants have not "provide[d] the plaintiffs with appropriate community services through the DD Waivers in order to avoid institutionalization." Amended Complaint, ¶ 6. Plaintiffs ignore the fact that the Defendants have other Medicaid home and community-based waiver programs for which Plaintiff Young and the 115 putative class members in nursing

homes would likely be eligible and which could provide the services necessary for these individuals to transition to the community[8]. The Plaintiffs fail to allege whether Ms. Young and any of the 115 putative class members in nursing homes have even applied for the Medicaid Aged and Disabled Adult Waiver, the Nursing Home Diversion Waiver, the Assisted Living Waiver, or the Traumatic Brain Injury / Spinal Cord Injury Waiver. Unless the Plaintiffs have applied for the waiver programs for which they are eligible and been wait-listed, they have not adequately explored the resources available to them to be able to claim that the Defendants are unjustifiably institutionalizing them. Indeed, to the extent these individuals reside in nursing homes, they would not be wait-listed if they applied for these waivers. The Florida Medicaid Program's Nursing Home Transition Program allows AHCA to transfer funds from the Medicaid nursing home budget to the budgets of any of these four waiver programs. Laws of Florida, Chapter 2011-69, Specific Appropriation 208; Laws of Florida, Chapter 2010-152, Specific Appropriation 219. As a result, any budgetary constraints within a given home and community-based waiver program would not prevent the transition of an eligible Medicaid recipient from a nursing home into that program. Thus, there is no wait list nursing home transition.

VII. Plaintiffs Dykes, Walker, and Davis and the Putative Class Members in ICF/DDs Will Now Have Similar Options as Those in Nursing Homes

Plaintiffs Joanna Dykes, David Walker, and Loretta Davis currently reside in ICF/DD facilities. Amended Complaint, at ¶¶ 17, 25, 34. Plaintiffs also allege that there are 198 putative class members currently residing in private ICF/DDs, 69 putative class

[8] While these waiver programs do not provide behavioral services, Medicaid nursing home residents also do not receive such services.

members residing in state-run ICF/DDs, and 1,136 putative class members in settings defined as "other." Id., at ¶ 153-155. As a result of legislation passed in the 2011 session of the Florida Legislature, Medicaid recipients in ICF/DDs will now have similar options as those for nursing home residents described in part VI.B. above. AHCA now has authority to transfer funds from the budgets for ICF/DDs to the DD Waiver budget. Laws of Florida, Chapter 2011-69, Specific Appropration 206. As a result, budgetary constraints in the DD Waiver would not prevent an eligible Medicaid recipient from transitioning into that waiver from an ICF/DD.

VIII. Plaintiffs Congden, Pivinski, Ferraro, and Woodward Have Failed to State a Claim Under the ADA or Section 504

Even if this Court disagrees with the Defendants' arguments in Part V above, Plaintiffs Michelle Congden, Amanda Pivinski, Alyssa Ferraro, and Joshua Woodward have failed to state a claim upon which relief can be granted under the ADA or Section 504. None of these individuals is currently institutionalized, nor have they alleged that they are in any serious risk of being institutionalized. As such, the Defendants have not violated the ADA or Section 504 with respect to these Plaintiffs. Count Three refers to unnecessary institutionalization and the integration mandate, but Plaintiffs Congden, Pivinski, Ferraro, and Woodward have not alleged any facts to indicate that they fall within the allegations in these Counts.

Plaintiff Congden resides with her sister in the community. Amended Complaint, at ¶ 50. While the Amended Complaint does allege that Plaintiff Congden's sister is "in

need of respite in order to avoid institutionalizing her," it is not alleged that any institutionalization is, in fact, imminent. Id., at ¶ 51.

Plaintiff Pivinski resides with her parents in the community. Id., at ¶ 57. Plaintiffs allege that Ms. Pivinski "needs employments supports to maintain her in the community." Id., at 63. However, the Plaintiffs allege no facts sufficient for the Court to include that the lack of "employment supports" places Plaintiff Pivinski at risk of institutionalization.

Plaintiff Ferraro lives with her mother in the community. Id., at 71. Plaintiffs allege that Plaintiff Ferraro's mother "cannot meet FERRARO's needs without assistance" and that she "is faced with moving from her current apartment in order to pay for FERRARO's services on her own or institutionalizing" her daughter. Id., at 75-76. However, the Plaintiffs provide no facts as to why Ms. Ferraro is suddenly at risk of institutionalization after having resided with her mother for years.

Plaintiff Woodwad lives with his father and stepmother in the community. Id., at 65. The facts alleged regarding Plaintiff Woodward do not allege any plausible risk of institutionalization, imminent or otherwise. The Amended Complaint states that he "seeks competitive employment" and "does not need much assistance with activities of daily living." Id., at 67. The only needs the Amended Complaint identifies for Plaintiff Woodward are "assistance with speech therapy, an employment coach, and behavior assistance." Id. The Plaintiffs fail to explain how or why the lack of these things would force Plaintiff Woodward out of the community and into an institution.

It is clear that the ADA claims in this case are brought pursuant to the integration mandate. See e.g., Amended Complaint, at ¶ 2. The integration mandate states: "[a] public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d). It is also clear that the Plaintiffs' ADA claims all relate to "unjustified institutional isolation" which the Supreme Court has found to violate the ADA. Olmstead, at 600. See e.g., Amended Complaint, at ¶¶ 3, 5, 6, 12. Indeed, the very purpose of the integration mandate is "avoid unduly segregating the disabled," Radaszewski ex rel. Radaszewski v. Maram, 383 F.3d 599, 607 (7th Cir. 2004).

In addition, the purpose of Medicaid waiver programs, including the DD Waiver, is to permit states to offer home and community-based services "only to individuals who need them in order to avoid institutionalization." Radazewski, at 601-02. Requiring a state to provide waiver services to individuals who do not need them in order to avoid institutionalization would clearly constitute a "fundamental alteration" of the waiver program which is not required by the ADA. See 28 C.F.R. § 35.130(b)(7).

It is true that institutionalization is not a prerequisite to bringing an action under the ADA and the integration mandate. See Fisher v. Oklahoma Health Care Auth., 335 F.3d 1175, 1181 (10th Cir. 2003) (Integration mandate "would be meaningless if plaintiffs were required to segregate themselves by entering an institution before they could challenge an allegedly discriminatory law or policy that threatens to force them into segregated isolation"). However, in every case plaintiffs in the community have been permitted to bring claims under the integration mandate of the ADA, the plaintiffs

have been "imperiled with segregation." Fisher, at 1182. See also, Michele Haddad v. Thomas Arnold, et al., Case 3:10-cv-00414-UAMH-TEM (M.D. FL, July 9, 2010) (Without the requested services "Plaintiff would be forced to leave the community and enter a nursing home in order to receive the care she requires."); Luis Cruz, et al., v. Thomas Arnold et al., Case 1:10-cv-23048-UU (S.D. Fl, November 24, 2010) ("Plaintiffs are at risk of institutionalization if they do not receive services available under the [waiver program].")

Plaintiffs Congden, Pivinski, Ferraro, and Woodward all currently live in the community. Not one of them is institutionalized. Nor has any alleged facts sufficient for the Court to conclude that she or he is at substantial *risk* of being institutionalized. They are already in the most integrated setting appropriate for their needs.[9] Therefore, Plaintiffs Congden, Pivinski, Ferraro, and Woodward have failed to state a claim under the ADA upon which relief can be granted. Plaintiffs Congden, Pivinski, Ferraro, and Woodward's claims in Count Three should be dismissed pursuant to Rule 12(b)(6), Fed. R. Civ. P. Alternatively, these Plaintiffs should be dropped as parties pursuant to Rule 21, Fed. R. Civ. P.

IX. Conclusion

For the foregoing reasons, the Defendants respectfully request that the Plaintiffs' Amended Complaint be DISMISSED.

[9] In the Preamble to the Notice of Final Rule for the regulation including the integration mandate, the Department of Justice defines "most integrated setting" as "a setting that enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 56 FR 35694-01(July 26, 1991). By this definition, a recipient's parents' home is no less integrated a setting than her own apartment would be.

Respectfully submitted this 22nd day of July, 2011.

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been served by the Notice of Electronic Filing, and was electronically filed with the Clerk of the Court via the CM/ECF system, which generates a notice of the filing to all attorneys of record, on this the 22nd day of July 2011.

/s/ Andrew T. Sheeran

Andrew T. Sheeran