IN THE UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

Case No. 05-1148 & 05-1150

MANDY R., by and through her parents and guardians, Mr. and Ms. R., et al.,
Plaintiffs-Appellants,

JODI F., et al.,
Plaintiffs-Intervenors-Appellants,
and

COLORADO ASSOCIATION OF COMMUNITY CENTERED BOARDS,
Plaintiffs-Intervenors-Appellants,
v.

BILL OWENS, Governor of the State of Colorado, in his official capacity, et al.,
Defendants-Appellees.

On Appeal from the United States District Court for the District of Colorado
(Matsch, R.), District Court Case No. 00-M-1609

REPLY BRIEF OF COLORADO ASSOCIATION OF COMMUNITY CENTERED BOARDS

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Colorado Association of Community Centered Boards ("CCACB") through its undersigned counsel, respectfully submits the following *Reply Brief:*

I. INTRODUCTION

The evidence at trial conclusively established that the State of Colorado was intentionally not providing Medicaid services to hundreds of eligible persons for budgetary reasons. The State Defendants ignore this critical fact in their Answer Brief, and attempt to turn this case into a debate over whether Medicaid is a "payment" scheme or one involving "services."

The State Defendants essentially concede that the district court erred below – offering token support for the district court's opinion. Instead, the State Defendants attempt to fashion an alternative rationale for affirming the result below, an alternative rationale which also involves refashioning CACCB's and Plaintiffs' claims.

To resolve this case, this Court need only apply well established law and hold the State responsible for what it has agreed to do in its State Medicaid Plan. The budgetary reasons underlying the district court's refusal not only are not a sufficient defense, they have been substantially mitigated by the recent vote approving Referendum C.[1]

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[1]CCACB asks this Court to take judicial notice of the recent vote in Colorado approving Referendum C, which will allow the State of Colorado to retain an estimated $3.1 billion over the next five years that would otherwise have had to be returned to Colorado taxpayers under Colorado's

II. The State Defendants Concede That the District Court Erred in Relying Upon the State's budget Constraints in Refusing to Award Relief to Plaintiffs and CACCB

The State Defendants do not even attempt to defend the district court's decision until page 40 of their brief, and then, their defense involves essentially a re-write of what the district court held. The district court unquestionably dismissed the Plaintiffs' and CACCB's claims based upon a misstatement of law that it was wrong to make the State of Colorado appropriate additional funds to afford a remedy for the State's violation of the Medicaid Act:

> The level of funding for Medicaid in Colorado is determined by the Colorado General Assembly. The funds to be spent are those collected by taxation and the Colorado electorate has imposed constitutional constraints on the power of the legislature to impose taxes and the purposes for which public funds can be spent.
> . . .
>
> In summary, the declaratory relief requested by the plaintiffs and Intervenor must be declined because such a judgment would intrude into the authority and responsibility of those who are accountable to the electorate. There is no more fundamental principle of democratic government than that which reserves to the people the power to tax and spend. It is therefore
>
> ORDERED, that judgment will enter for the dismissal of the plaintiffs' and Intervenor's claims with the defendants' costs to be taxed.

Taxpayer Bill of Rights (TABOR), Colo. Const. art. X, §20 See Fed. R. Evid. 201(f) (judicial notice can be taken at any stage of the proceedings).

CACCB's Opening Brief, **Attachment A** at 13, 20. The State Defendants' assert that CACCB and Plaintiffs are "mischaracterizing" what the district court held, and that "read fairly," all the district court did was consider the "practical ramifications" of any relief it was asked to award. *Answer Brief* at 40. The State Defendants fail to assert, however, how such "practical ramifications" of any award can legally afford a legitimate basis for dismissing CACCB's and Plaintiffs' claims.

CACCB respectfully submits that the district court's decision speaks for itself. "Read fairly," the district court squarely held that the Medicaid claims against the State of Colorado must be dismissed because of the State's budgetary constraints.

The leading case in this Circuit for the proposition that budgetary constraints cannot afford a defense to compliance with the Medicaid Act is Amisub (PSL), Inc. v. Colorado Dept. of Social Services, 879 F.2d 789 (10th Cir. 1989), cert. denied, 496 U.S. 935 (1990). CACCB relied upon Amisub for this proposition, yet, the State Defendants failed to mention Amisub in the relevant part of their brief.[2]

The key evidence at trial proved that hundreds of persons who are eligible for residential services – and who need them today – are being denied them because the State is maintaining a waiting list because of then-existing budgetary constraints.

---

[2] The State Defendants cite Amisub only once, and then for a different proposition. See *Answer Brief* at 35. The part of their brief attempting to recast the district court's reliance upon its budget-constraints rationale appears at 40-44.

See,e.g., App.1171-73 (Colorado General Assembly Joint Budget Committee briefing document); App.251 (cross-examination of Colorado Director of Division for Developmental Disabilities, acknowledging no attempt by State of Colorado in 2004-2005 to reduce waiting list because of budgetary constraints). This Court held in Amisub that the State of Colorado cannot do this. The State Defendants' wholesale failure to even address this point can only be considered an admission that the district court erred.

III. The Medicaid Act Involves More than a "Payment Scheme"

The State Defendants principal defense is to rely upon dicta in a Seventh Circuit opinion, Bruggeman v. Blagojevich, 324 F.3d 906 (7th Cir. 2003), for the proposition that Medicaid is a "payment scheme," and, under it, the State is only obligated to pay for services, not provide them. The State Defendants essentially urge this Court to fashion its own rationale to dismiss Plaintiffs' and CACCB's claims, and suggest that this Court can accomplish the task by adopting the Bruggeman dicta. This Court should decline the State Defendants' invitation for a host of reasons.

First, the State's argument is belied by the plain language of the Medicaid Act and Colorado's State Plan implementing the Act in Colorado. Colorado's State Plan unequivocally contains the promise from the State of Colorado to the federal government that it will "provide" "[i]ntermediate care facility ***services***" with "no

limitations." App.912.

The State Defendants scoff at this language as mere verbiage on a "preprinted form," and they assert that "there is no basis to conclude that the language of the form overrides the pertinent statutes and regulations." *Answer Brief* at 19. There are two problems with this tactic. First, it represents an attempt to persuade this Court to ignore the plain language of the State Plan, a document other federal courts have found binding, see,e.g., Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 502 (1990)(a Medicaid state plan "contains a comprehensive statement describing the nature and scope of the State's Medicaid program.); Amisub, 879 F.2d at 794 (discussing binding effect of Boren Amendment as a state-plan requirement); King by King v. Sullivan, 776 F.Supp. 645, 648 (D.R.I. 1991) ("The character and details of the state's obligations arise from the commitments the state makes in its State Plan, which, through the Medicaid Act and its regulations, binds the state as a matter of federal law.").

Second, the State of Colorado's ICF/MR "no limitations" promise does not only not override the applicable statutes and regulations, it effectuates them. CACCB covers the applicable statutes and regulations at length in its *Opening Brief*. CACCB respectfully submits that they are consistent in all respects with the State Plan, "preprinted form" or otherwise. CACCB would add here that the requirement to

provide ICF/MR "services" to all eligible persons with "no limitations" is particularly grounded in the comparability requirement, 42 U.S.C. § 1396a(a)(10). That section of the Medicaid Act, regulating state-plan requirements, provides that a State Plan "must":

> (10) provide –
>
> > (A) for making medical assistance available, ***including at least the care and services*** listed in paragraphs (1) through (5), (17) and (21) of [42 U.S.C. § 1396(d)(a)] to
> >
> > > (i) all individuals [covered by a host of various programs and conditions]
> >
> > . . .
> >
> > (B) that the medical assistance made available to any individual described in Subparagraph (a) –
> >
> > > (i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and
> > >
> > > (ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (a)[.]

42 U.S.C. § 1396a(a)(10) (emphasis added). The implementing regulation for the comparability section of the Act even more directly addresses that a state plan must insure the availability of services:

> § 440.240 Comparability of ***services*** for groups.

Except as limited in § 440.250 –

(a) The plan must provide that the ***services*** available to any categorically needy recipient under the plan are not less in amount, duration, and scope than those services available to a medically needy recipient; and

(b) The plan must provide that the ***services*** available to any individual in the following groups are equal in amount, duration, and scope for all recipients within the group:

(1) The categorically needy.

(2) A covered medically needy group.

42 C.F.R. § 440.240 (emphasis added).[3]

The "preprinted form" language in Colorado's State Plan scoffed at by the State which contains the promise that the State will provide ICF/MR services with "no limitations" appears under the heading: "Amount, Duration and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy." See Sabree v. Richman, 367 F.3d 180, 192 (3d. Cir. 2004)(42 U.S.C. § 1396a(a)(10) creates enforceable rights under § 1983); see also Sanchez v. Johnson, 416 F.3d 1051, 1061-62 (9th Cir. 2005)(agreeing with Sabree). A comparison of the "preprinted form" which is part of Colorado's State Plan to 42 U.S.C. § 1396a(a)(10) and 42 C.F.R. § 440.240, which govern the "amount, duration and scope" of services that must be

[3] The regulations cited by the State Defendants at page 16 of their brief provide no support for their assertion that Medicaid is simply a "payment" scheme.

provided in all state plans, demonstrates complete consistency, not some unfounded ultra vires obligation as claimed by the State Defendants.

As noted by Plaintiffs in their *Reply Brief*, 42 U.S.C. § 1396a(a)(2) expressly requires the State of Colorado and all other States participating in Medicaid to insure that any lack of local funds "will not result in lowering of the amount, duration, scope, or quality of care and services available under the plan." Again, the focus of this state-plan requirement is on the availability (and, notably, also quality) of "care and services," not simply payment.

The Bruggeman dicta offers no support for the State Defendants here. Bruggeman must be considered in light of its context. The plaintiffs in that case had available to them the residential services they sought, but they were located in the southern part of the State of Illinois. The plaintiffs in that case claimed that the Medicaid Act required that services be provided to them closer to their home in the Metropolitan Chicago area. The Seventh Circuit, in almost summary fashion, discounted the plaintiffs' claims, observing that the Medicaid Act's reference to "assistance" "***appears*** to have reference" to financial assistance rather than services. 324 F.3d at 910 (emphasis added). There is no analysis of Illinois' State Plan, nor does there appear to be any consideration of the Medicaid Act other than a cursory look at the the reasonable promptness provision. Indeed, the Seventh Circuit appears

to have raised its "payment" observation concerning the scope of the Medicaid Act sua sponte. The case came before it with the district court having ruled that the plaintiffs lacked standing to bring their claims in the first instance. There is no indication that this "payment" issue was even one raised in the briefs or addressed by the plaintiffs. This Court should weigh these factors when considering the State Defendants' claim that "[t]he decision in Bruggeman appears to be the only court to have squarely ruled on the issue," in contrast to the multitude of cases cited by CACCB, *Opening Brief* at 39-41, addressing the issue after briefing by both sides.

As noted above, the record in this Case shows that hundreds of persons, otherwise eligible for services, are being denied them because the State of Colorado has failed to appropriate sufficient funds. This is not a situation where persons are being denied services because they live in a different part of the State than where they desire to receive services. While undoubtedly some of the persons needing and wanting services today may choose to wait for a more desirable situation, there are hundreds of persons, otherwise eligible, who are officially waiting for services today, who greatly need them, and would take advantage of them with "reasonable promptness" if the State would simply appropriate sufficient funds today to make services available to them.

In determining a claim based upon the Americans with Disabilities Act, the Supreme Court in Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581 (1999) observed that a State could avoid having to make alterations to its waiver program under the ADA if it "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." Id. at 605-06. The State of Colorado's plan, while perhaps arguably comprehensive, is not effectively working when hundreds of eligible and needy persons are being denied services for budgetary reasons, nor does Colorado have "a waiting list that move[s] at a reasonable pace." Indeed, the evidence shows that many persons and their families have waited many years for services and suffered significant hardships in the process.

CACCB respectfully urges this Court to reject the State's "payment" defense based upon the Bruggeman dicta.

IV. The State's "Cap" Defense Does Not Protect the State from Living Up to Its Entitlement Obligation to Provide an ICF/MR Level of Care to All Individuals Who are Eligible for Medicaid Residential Services

Colorado, in its State Plan, promised the federal government that it would provide "Intermediate care facility ***services*** . . . for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of ***such care***." App.755 (emphasis added). In its State Plan, Colorado promised the federal government that

it would provide such services with "no limitations." Id. This part of Colorado's State Plan was approved in 1991. Id.

ICF/MR services have been available under the Medicaid Act since 1971.[4] They were considered at the time an improvement over the warehouse-like situations in which many persons received what could only loosely be defined as services. ICFs/MR, nevertheless, were themselves institutions, and a movement developed to get persons with developmental disabilities out of institutions and into community settings. "Since the mid-1970s, there has been a national trend toward deinstitutionalization and institution closure."[5]

In response to this deinstitutionalization trend, Congress enacted changes to the Medicaid Act that allowed States to provide services in non-institutional settings through the granting of waivers to some of the more demanding regulations that are necessary in an institutional setting. The change that is at issue here is the statute that allows for waiver of the requirements for ICF/MR institutions so that services can be provided in a community setting – the program known as Home and Community

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[4] Gary A. Smith, *Status Report: Litigation Concerning Home and Community Services for People with Disabilities* (available at http://www.hsri.org/docs/litigation050205.PDF (May 2, 2005).

[5] Research and Training Center on Community Living, Institute on Community Integration, "Status of Institutional Closure Efforts in 2005" (Sept. 2005).

Based Services - Developmental Disability ("HCBS-DD"). This statute, 42 U.S.C. § 1396n(c)(1), provides, in part:

> The Secretary may by waiver provide that 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 Secretary which are provided pursuant to a ***written plan of care*** to individuals with respect to whom there has been a determination that ***but for the provision of such services*** the individuals would require the ***level of care*** provided in a hospital or a nursing facility ***or intermediate care facility for the mentally retarded*** the cost of which could be reimbursed under the State plan.

(Emphasis added.) The correct interpretation of this statute, its implementing regulations, and the State's approved waiver application, rests at the heart of CACCB's reasonable promptness and comparability claims.

The State of Colorado is attempting to avoid compliance with the Medicaid Act by relying upon the historical fact that as a result of deinsitutionalization, the vast majority of residential services are provided in HCBS-DD settings as opposed to ICF/MR settings. The State is asserting that the only entitlement is to "payment" for ICF/MR services, a service delivery model that is now used very sparingly because of deinstitutionalization. The State is also relying upon the fact that the waiver provisions of the Medicaid Act can be capped. See 42 U.S.C. §§ 1396n(c)(9), (10);

42 C.F.R. § 441.303(f)(6).

The gist of the State's defense is as follows: it concedes ICFs/MR are an entitlement, but there are very few of them today, so the State has virtually no exposure for failing to provide ICFs/MR, particularly under its theory that it need only "pay" for ICFs, not actually provide them. HCBS-DD, the overwhelmingly predominant model,[6] is not an entitlement, the State argues, because, under the Medicaid Act, HCBS-DD can be capped. Thus, the State Defendants argue that they have no obligation whatsoever to actually provide Medicaid residential services, either in ICFs (because there are very few of them, and they are full) or in HCBS-DD settings (because they are capped).

The starting point in demonstrating the fallacy of the State Defendants' argument is the waiver statute itself, 42 U.S.C. § 1396n(c)(1). The statute provides that "but for the provision of such [waiver] services," an eligible person "would require the level of care" in an ICF/MR. In other words, the waiver statute is directly linked to a State's obligation to otherwise provide an ICF/MR "level of care" to an eligible individual.

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[6] Most of the state-run residential services provided for persons with developmental disabilities are provided under HCBS-DD, not ICF/MR.

This requirement is mirrored in the regulations. Section 441.302 of 42 C.F.R. contains the necessary assurances that States must provide the federal government to participate in the waiver program. Section 441.302(c)(1)(ii) requires that the State of Colorado assure "[t]hat the recipient, but for the provision of waiver services, would otherwise be institutionalized in such a [ICF/MR] facility." Similarly, section 441.302(g), captioned "institutionalization absent waiver," requires assurances from the State of Colorado that "absent the waiver, recipients in the waiver ***would receive*** the appropriate type of Medicaid funded institutional ***care*** (hospital, NF, or ICF/MR) that they require." (Emphasis added.)

The State of Colorado's Waiver Application, App.856, tracks these essential federal requirements. Paragraph 2 states: "This waiver is requested in order to provide home and community-based ***services*** to individuals who, ***but for*** the provision of ***such services***, would require the following ***levels (s) of care***, the cost of which could be reimbursed under the approved Medicaid State plan." (Emphasis added.) Subparagraph b, describing ICF/MR care, is then checked. Consistent with 42 C.F.R. §§ 441.302(g) and 441.302(c)(ii), the State's Waiver Application contains the assurance that: "Absent the waiver, persons served in the waiver ***would receive*** the appropriate type of Medicaid-funded ***institutional care*** that they require, as

indicated in item 2 of this request." Paragraph 16g, App.864 (emphasis added).[7]

In short, the waiver statute, its implementing regulations, and the State of Colorado's Waiver Application, all show that the HCBS-DD waiver is simply an alternative vehicle created by Congress to allow the States that offer ICF/MR services as part of their state plans the option of providing an ICF/MR "level of care" to eligible persons in a "home and community based" setting.[8] The fact that a State can expand or contract the size of the HCBS-DD program as it sees fit does not mitigate in any way the overarching obligation that the State has to all persons eligible for services – so long as the State chooses to "provide" ICF/MR "services" to all eligible persons with "no limitations" in its State plan.

In their brief, the State Defendants posit a straw-man argument and then, not surprisingly, strike it down by observing that "we must reject CACCB's argument

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[7] Portions of the State Medicaid Manual placed in evidence by the State further explain that the waiver merely provides "an alternative to institutionalization," App.915, and does not relieve the State from providing services to persons eligible under the State Plan. As the State Medicaid Manual describes: "A home and community-based services waiver offers you [the State] broad discretion not generally afforded under the State plan ***to address the needs*** of individuals who would otherwise ***receive*** costly ***institutional care*** provided under the State Medicaid plan." Id. (emphasis added).

[8] The State Defendants, in their Statement of the Facts, acknowledge: "One of these waivers allows Colorado to offer HCBS to persons with DD ***who would otherwise need services in an ICF/MR***." *Answer Brief* at 8-9 (emphasis added).

that there can be no cap for HCBS-DD services." *Answer Brief* at 26. As shown, CACCB makes no such argument.

The State Defendants get a little closer by stating that "CACCB argues that Colorado has a generalized obligation to provide services to persons who need ICF/MR level of services, and that Colorado could choose to meet this obligation by offering more HCBS-DD." *Answer Brief* at 26. The State Defendants then assert that they can defeat this argument by refuting that "Colorado has an obligation to provide ICF/MR services." Id. at 27.

The State Defendants then proceed to attempt to refute that Colorado has an obligation to provide ICF/MR services, not by analyzing the Medicaid Act, the implementing regulations, Colorado's State Plan, or its Waiver Application – discussed above – but by completely recasting CACCB's case into something far more manageable from their perspective:

> [CACCB's and Plaintiff's] arguments seem to take two forms. First, they argue that any waiting list for any non-waiver Medicaid service, of itself, is a violation of Medicaid law, and the State must do whatever is necessary to end the waiting list. Under this form of the argument, it does not matter why there is a waiting list. Second, they argue that Colorado has violated Medicaid law because it does not encourage the development of any new ICFs/MR. Under this form of the argument, they must prove that Colorado has caused the absence of ICFs/MR
> . . . .

Answer Brief at 28. CACCB respectfully would like to point out the following flaws with the State Defendants' assertions. First, the "two forms" of arguments asserted by the State Defendants have nothing to do with the point that the State does indeed have a "a generalized obligation to provide services to persons who need an ICF/MR level of services," *Answer Brief* at 26, under the Medicaid Act and waiver statute, so long as Colorado's State Plan and Waiver Application say what they say.

Second, it ***does*** matter why there is a waiting list. If there were legitimate programmatic reasons why persons were waiting for services, that would be entirely different from the situation in this case. CACCB asserts in this Court that a waiting list, intentionally maintained and managed by the State of Colorado, consisting of hundreds of eligible persons, many of whom have waited years for service, solely for budgetary reasons, is a violation of the Medicaid Act's reasonable promptness and comparability requirements.

Third, CACCB and the Plaintiffs do not have to prove that Colorado has caused the absence of ICFs/MR, although they did so in the trial court below. CACCB's and Plaintiffs' ICF/MR availability evidence was merely introduced in the trial court below to help show the district court that the payment defense was a pretense. To establish a violation of reasonable promptness and comparability, CACCB and Plaintiffs need only demonstrate that the Medicaid Act, the waiver statute, Colorado's

State Plan and its Waiver Application, all obligate the State to provide an ICF/MR level of care, either in an ICF/MR or in an HCBS-DD setting, and that the State is denying eligible persons of these services for budgetary reasons. In any event, the fact-intensive nature of the State Defendant's defense was never even addressed by the district court below, because it ruled, as a matter of law, that CACCB and Plaintiffs could not be awarded relief that would require the State to appropriate additional funds for residential services.

The State Defendants' attempts to completely redefine the playing field should be rejected along with any defense resting upon the non-contested principle that the waiver program is capped.

V. CACCB Does Indeed Have a Private Cause of Action for Pursuing Its Rates Claim and This Court Should Remand This Claim for a Determination on the Merits

As noted in CACCB's *Opening Brief*, CACCB acknowledges that there is a split in the circuits on this issue. The State Defendants's *Answer Brief* does little more than cite the jurisdictions that go their way. What is readily apparent after reading the State Defendants' brief is that the question of whether CACCB can assert a claim under 42 U.S.C. § 1983 for a violation of 42 U.S.C. § 1396a(a)(30)(A) hinges upon this Court's interpretation of Wilder v. Va. Hosp. Ass'n, 496 U.S. 498 (1990).

In its *Opening Brief*, CACCB demonstrated why Wilder controls this case. In response, the State – like the jurisdictions that have ruled that § 1396a(a)(30)(A) is not actionable under § 1983 – tries to distinguish the Boren Amendment, formerly 42 U.S.C. § 1396a(a)(13)(A), which the Supreme Court considered in Wilder, from § 1396a(a)(30)(A). The State Defendants' attempt, however, falls short of warranting a result different from the result in Wilder.

The State Defendants concede that the Boren Amendment "bears a superficial resemblance" to § 1396a(a)(30)(A), *Answer Brief* at 34, but then assert that, in actuality, they are "really quite different." The first major difference, the State Defendants assert, is that the Boren Amendment involved a State making "findings and assurances" to the federal government, while § 1396a(a)(30)(A) involves only "methods and procedures."

The Supreme Court in Wilder analyzed the Boren Amendment at length in concluding that it created enforceable rights under § 1983. The Supreme Court noted in its analysis that the legislative history of the Boren Amendment included an earlier amendment that gave the States additional discretion to determine, in the first instance, what rates were appropriate by employing their own "methods and standards" for calculating rates in the first instance. 496 U.S. at 505-06. This change afforded the States additional flexibility to determine what rates were "reasonable."

Id. at 506. The flexibility afforded by allowing the States to define for themselves the appropriate "methods and standards," embodied in the later Boren Amendment, did not make this provision unenforceable under § 1983, as the Court found in Wilder. CACCB submits that "methods and procedures" and "methods and standards" are a distinction without a difference.

Second, the State Defendants state that under the Boren Amendment, "there was a specific and objective . . . measure of quality of care, i.e. the care must conform to applicable laws, regulations, and quality standards," while § 1396a(a)(30)(A) "contains ***no definition*** or standard for 'quality of care.'" *Answer Brief* at 35 (emphasis added). The Supreme Court in Wilder noted that, under the Boren Amendment, rates had to be:

> "reasonable and adequate" to meet the costs of "efficiently and economically operated facilities." The State must also assure the Secretary that individuals have "reasonable access" to facilities of "adequate quality." ***The Act does not define these terms, and the Secretary has declined to adopt a national definition***, concluding that ***States should determine the factors*** to be considered in determining what rates are "reasonable and adequate" to meet the costs of "efficiently and economically operated facilit[ies]."

496 U.S. at 507 (emphasis added). The Boren Amendment and § 1396a(a)(30)(A) both permit the States, in the first instance, to define what are appropriate rates. This substantial discretion, however, did not make § 1396a(a)(30)(A) inactionable under

§ 1983. As noted by the Supreme Court:

> That the amendment gives the States substantial discretion in choosing among reasonable methods of calculating rates may affect the standard under which a court reviews whether the rates comply with the amendment, but it does not render the amendment unenforceable by a court. While there may be a range of reasonable rates, there certainly are ***some*** rates outside that range that no State could ever find to be reasonable and adequate under the Act. Although some knowledge of the hospital industry might be required to evaluate a State's findings with respect to the reasonableness of its rates, such an inquiry is well within the competence of the Judiciary.

Id. at 519-20 (emphasis in original). The State Defendants' argument that the Boren Amendment provided "definition" where § 1396a(a)(30)(A) does not, does not withstand even a cursory reading of Wilder.

The critical language, per the Court, was the "must" language that appears in the introductory language of § 1396a(a), and the "payment" language in the Boren Amendment:

> The Boren Amendment is cast in mandatory rather than precatory terms: The state plan "***must***" "provide for payment . . . of hospital[s]" according to rates the State finds are reasonable and adequate.

Id. at 512 (emphasis in original). Similarly, § 1396a(a)(30)(A), necessarily contains the same "must" language of § 1396a(a), and virtually identical "payment" language. The State Defendants' attempt to distinguish Wilder is unavailing.

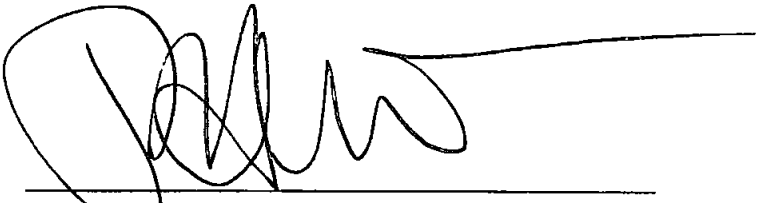
The State Defendants make a number of other representations that warrant a brief response. First, the State Defendants appear to suggest that CACCB's rates claim must be limited to an allegation that low rates have harmed quality. That is not true. There are four standards set forth in § 1396a(a)(30)(A): efficiency, economy, quality of care, and access to services. As discussed in CACCB's *Opening Brief* at 50, 53, CACCB asserts that all four standards are violated under the existing rates, and CACCB introduced evidence relating to all four standards. *Opening Brief* at 21-27. Second, the State Defendants argue that the efficiency and economy standards cannot be at issue because CACCB seeks to raise rates. *Answer Brief* at 32. The State Defendants fail to grasp that rates can be so low that they are inefficient and/or uneconomical. For example, as noted in CACCB's *Opening Brief*, when rates are so low that Community Centered Boards are incapable of paying sufficient wages, high turnover occurs, which significantly harms efficiency and economy. Third, the State Defendants seek to avoid this obvious conclusion by asserting that CACCB's member CCBs are "free to" increase salaries if they think it will minimize turnover. If the rates the State pays will not support higher salaries, the CCBs are not "free to" raise salaries.

Finally, the State Defendants assert that even if CACCB can bring a § 1396a(a)(30)(A) claim under § 1983, this Court should defer to the "finding" by the district court that addressed "quality of care." The district court did not make any findings of fact or conclusions of law in dismissing all of the claims before it, save for the one conclusion that all claims then-pending should be dismissed because they called for a remedy the district court found inappropriate. Any allusion the district court made to virtually irrelevant evidence concerning lack of enforcement actions against Community Centered Boards or their service agencies by the Colorado Department of Health should in no way be construed as a finding of fact warranting deference by this Court.

CONCLUSION

The Court should reverse the district court, remand with instructions to the district court to enter judgment in favor of CACCB and the Plaintiffs on the reasonable promptness and comparability claims, order the State to develop a plan to eliminate the waiting list, and conduct further proceedings and address the merits of CACCB's rates claim taking into consideration the effects of eliminating the waiting list.

Dated: November 23, 2005.



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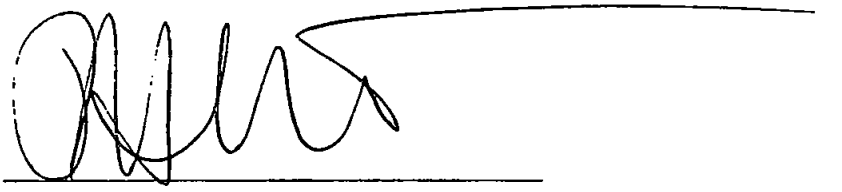
CERTIFICATE OF COMPLIANCE PURSUANT TO RULE 32(a)(7)

As required by Fed. R. App. P. 32(a)(7)(C), I certify that this brief complies with Fed. R. App. P. 32(a)(7)(B) as follows: this *Reply Brief* is proportionally spaced and contains 6056 words, exclusive of the corporate disclosure statement, table of contents, table of authorities, the statement with respect to oral argument, and this certificate of compliance, which are excluded by virtue of Fed. R. App. P. 32(a)(7)(B)(iii), as computed by WordPerfect 9.0.



CERTIFICATE OF SERVICE

I certify that on this 23rd day of November, 2005, the foregoing **REPLY BRIEF OF COLORADO ASSOCIATION OF COMMUNITY CENTERED BOARDS** were served on all parties and other interested persons by depositing a correct copy of the same in the United States mail, first-class postage prepaid, addressed to the following:

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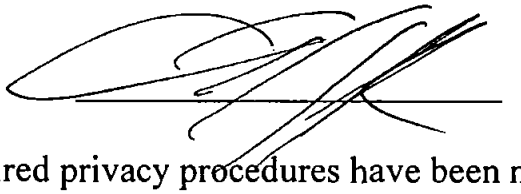

In addition, I certify that all required privacy procedures have been made and, with the exception of those redactions, every document submitted in Digital Form or scanned PDF format is an exact copy of the written document filed with the Clerk. The digital submissions have been scanned for viruses with the most recent version of a virus scanning program and, according to the program, are free of viruses.

\s\Richard A. Westfall, Esq.