Matter No. 797175/SMPuiszis

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

EDWARD BOUDREAU, by and through his parents, Edwin and Ann Boudreau, BRIAN BRUGGEMAN, by and through his parents, Kenneth and Carol Bruggeman, FRANCES CORSELLO, by and through her parents, Vincent and Agnes Corsello, ANGELA MOORE, by and through her parents, James and Brenda Moore, LINDA SEMPREVIVO, by and through her parents, Richard and Ruth Semprevivo, individually and on behalf of a class,

Plaintiffs,

vs.

GEORGE H. RYAN, in his official capacity as Governor of the State of Illinois, ANN PATLA, in her official capacity as Director of the Illinois Department of Public Aid, LINDA RENEE BAKER, in her official capacity as Secretary of the Illinois Department of Human Services, MELISSA WRIGHT, in her official capacity as Associate Director of the Office of Developmental Disabilities,

Defendants.

No. 00 C 5392

JUDGE GRADY

MAGISTRATE DENLOW

NOTICE OF FILING

TO: Robert H. Farley, Jr., Robert H. Farley, Jr., Ltd., 1155 S. Washington, Naperville, IL 60540
Thomas G. Morrissey, Thomas G. Morrissey, Ltd., 10249 S. Western Avenue, Chicago, IL 60643

PLEASE TAKE NOTICE that on January 11, 2002 we will file with the Clerk of the Circuit Court of Cook County, Illinois, Defendants' Memorandum of Law on Statewideness and Medicaid Recipients' Right to Placement in Close Geographic Proximity to Family, a copy of which is attached hereto and herewith served upon you.

HINSHAW & CULBERTSON

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PROOF OF SERVICE

I, Diane Barnes, a non-attorney, being first duly sworn on oath depose and state that I served the foregoing Notice on all counsel of record by mailing a copy of same from the U.S. Mail located at 222 North LaSalle Street, Chicago, Illinois on January 11, 2002.

Diane Barnes

SUBSCRIBED AND SWORN TO
before me this 11th day of
January, 2002.

Geraldine A. Cochran
Notary Public

OFFICIAL SEAL
GERALDINE A COCHRAN
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES:03/26/05

797175/1007022.1-HC01_DS1A

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Plaintiffs,	)	
vs.	)	**No. 00 C 5392**
GEORGE H. RYAN, in his official capacity as Governor of the State of Illinois, *et al.*,	)	**Judge Grady** **Magistrate Denlow**
Defendants.	)	

DEFENDANTS' MEMORANDUM OF LAW ON STATEWIDENESS AND MEDICAID RECIPIENTS' RIGHT TO PLACEMENT IN CLOSE GEOGRAPHIC PROXIMITY TO FAMILY

After ten days of hearing and twenty-three witnesses, Plaintiffs have completed their evidence in support of the motion for class certification. Through lay and expert witnesses, they have articulated a claim, purportedly on behalf of a class of persons with mental retardation and developmental disabilities eligible for and denied Medicaid services. The claim is that the Illinois Medicaid Plan does not provide for them to receive "active treatment" as required by the Medicaid Act and regulations thereunder because, they claim, there are not sufficient vacancies in ICF/MR facilities for persons in the nine-county area to receive services within an unspecified close geographic proximity to their families.

This claim was first asserted two weeks into the hearing on November 28, 2001, by the addition of a paragraph to the expert report of Dr. Susan Parish, which was faxed to the offices of Defendants' counsel at 2:22 PM, the day before her testimony. This newly articulated theory does not appear in any of the Plaintiffs' pleadings, nor is it contained in Plaintiffs' memorandum of law

submitted in support of the motion for class certification. Defendants have objected to the assertion of this new claim.[1]

There is no legal basis for the claim that the Medicaid Act requires services in an ICF/MR to be made available at a location that serves the convenience of the recipient's family. This is a far cry from the argument advanced to defeat Defendants' motion to dismiss the Amended Complaint, which was that the five plaintiffs whose claims were then being presented had received no response from the State of Illinois to their requests for residential placement, despite waiting up to seven years.[2]

Plaintiffs' core argument is simply that an ICF/MR placement in close geographical proximity to the family residence makes such good sense that it *must* be required by some legal mandate. Justice Blackmun once observed that, "Sometimes, the intuitively sensed obviousness of a case induces a rush to judgment, in which a convenient rationale is too readily embraced without full consideration of its internal coherence or future ramifications." *O'Bannon v. Town Court Nursing Center,* 447 U.S. 773, 804, 100 S.Ct. 2467, 65 L.Ed.2d 506, 530 (1980)(concurring opinion). The palpable need of the Plaintiffs and other Illinois citizens with mental retardation or developmental disabilities induces just such a rush to judgment; the wide discretion Congress conferred on the States in providing Medicaid benefits and vital institutional concerns such as

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[1]Because the claim being asserted now is materially different from the claim that was considered by the court in the original motion to dismiss, the points made and case law cited in this memorandum are also submitted in support of the motion to dismiss the Third Amended Complaint. These points also bear on class certification because the would-be class representative Plaintiffs must demonstrate that they possess a colorable claim, which is required to establish standing to sue as a class representative. It was in a memorandum in support of the motion for class certification that Plaintiffs first asserted the theory that their rights were violated by an allegedly disproportionate concentration of private ICF/DD facilities located in the State's other 93 counties. The shifting sands on which Plaintiff base their claims are responsible for the fact that the court must consider the present legal issues for the first time in the context of class certification, rather than on a motion to dismiss.

[2]This was false in two respects. First, the original five Plaintiffs were all provided with PAS Agent services—to the extent they sought them and followed up on efforts of the PAS Agent—and were provided with appropriate information. Second, all but one of the Plaintiffs sought placement in a CILA and all demanded that they be provided with placement with a particular provider, and to have new vacancies created for them, and the remaining Plaintiff sought placement only in one specific ICF/MR that would not accept him.

sovereign immunity and Constitutional limits on federal power must not be overlooked simply because they require more careful reflection.

Plaintiffs' Active Treatment Theory As Articulated During The Hearing

We address Plaintiffs' present theory without attempting to catalog the shortcomings in evidence presented to support it. Plaintiffs' claim, as counsel now articulates it, is that if ICF/MR services are provided in a location close to the recipient's family, it will be convenient for the family to visit the recipient and participate in his or her habilitation or treatment.[3] Plaintiffs assert that such proximity is required because:

(1) The regular presence of family members is needed to provide "active treatment" to assist in the development and improvement of skills. This cannot happen unless the family lives nearby.[4]

(2) Persons with mental retardation and developmental disabilities desire frequent contact with family members, and family relationships can help to overcome the limited social network of a developmentally disabled individual as well as the disruption caused by staff turnover.[5]

(3) Persons with mental retardation and developmental disabilities are especially subject to abuse and neglect by the staff of provider agencies. The frequent presence of family members is important as a form of program oversight and quality assurance. Families who are actively involved are much more likely to be able to detect and report problems.

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[3]The term "habilitation," rather than "treatment," is technically the correct term with respect to persons with mental retardation or developmental disabilities, since these disabilities are not illnesses, as, for example, is the case with mental illness. Since the Supreme Court has noted this distinction but has chosen to use both terms interchangeably, *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 6, 101 S.Ct. 1531, 67 L.Ed2d 694, 701 n. 1(1981), Defendants will do so here as well.

[4]If this is the theory Plaintiffs rely upon, then the class definition must be revised accordingly. Persons whose family members are no longer alive, or who are not willing or able to commit the time and expense required to actually be providing "active treatment" to the ICF/MR resident sufficient to justify accommodating their convenience should be excluded from the Class.

[5]Plaintiffs do not offer a legal basis for an entitlement to optimal "well-being." There is none.

Plaintiffs insist that the State is obligated to ensure that there is a vacancy in a facility close to each Medicaid recipient's family residence in the nine-county area. Plaintiffs claim it has not done so.

Plaintiffs' Statewideness Theory As Articulated During The Hearing

Plaintiffs have argued variously that (1) the State is required to have an ICF/MR in every county of the state;(2) ICF/DD's are not distributed evenly across the state; and (3) there allegedly are not enough vacancies in ICF/DD's located in the northeastern nine counties of the State to serve everyone who lives in that area and who is seeking an ICF/DD placement.

Plaintiffs' "Small Size" ICF/MR Claim

Defendants offered testimony that the developmental disabilities service system is presently in a transition stage from institutional to community-based care. In arguing against Defendants' position that ICF/MR services in a facility of any size are "institutional" services, Plaintiffs have articulated a theory that they are entitled to receive ICF/MR services in facilities of a particularly small size. Just as they provide no identifiable benchmark for what geographical proximity is necessary to satisfy the Medicaid Act, they provide no specification of what the required threshold ICF/MR size is. Two possibilities are suggested by the testimony: (1) the reference to a State regulatory designation of "ICF/DD 16 and under" facilities; and (2) those ICF/DD's having four to six persons (which Plaintiffs claim are identical, for habilitation purposes, to a Community Integrated Living Arrangement ("CILA")[6]. Plaintiffs contend that ICF/MR services should be provided in a community-based setting, which, it will be seen below, is a contradiction in terms.

Necessity of A Clear and Unambiguous Legal Standard

This memorandum is intended to assist the Court's inquiry into whether there is a legal standard that satisfies the requirements of both the law governing sovereign immunity under the Eleventh Amendment and 42 U.S.C. §1983.

Unambiguous Obligation Required By Section 1983. The only basis for any of the statutory claims being presented here is the State's receipt of Medicaid funding from the federal government. The federal authority to regulate the delivery of Medicaid services by the State of Illinois is premised

[6]Defendants accept the court's unequivocal statement that CILA and other waiver services are not a part of the claim being asserted herein, since waiver services are statutorily subject to numerical limitations.

on the Spending Clause. The theory is that this otherwise purely state function—how Illinois chooses to spend its tax money to provide free services for persons with mental retardation and developmental disabilities—is brought within the federal purview by acceptance of federal financial support in exchange for a voluntary, contract-like agreement by the State to follow federal requirements in providing medical assistance.

Pennhurst State School v. Halderman, 451 U.S. 1, 101 S.Ct. 1531, 67 L.Ed.2d 694 (1981) and its progeny illustrate the line between an obligation that is clear and unambiguous and one that is either aspirational or otherwise insufficient to create federal rights. The crux of the matter is this: Spending Clause legislation is in the nature of a contract between the federal government, and States cannot be bound by hidden conditions. "Thus, if Congress intends to impose a condition on the grant of federal monies, it must do so unambiguously." *Pennhurst,* 451 U.S. at 17, 24-25, 67 L.Ed.2d at 707, 712:

> The legitimacy of Congress' power to legislate under the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.' There can, of course, be no knowing acceptance if the State is unaware of the conditions or is unable to ascertain what is expected of it.
> . . .
> That canon applies with greatest force where, as here, a State's potential obligations under the Act are largely indeterminate . . . The crucial inquiry . . . [is] whether Congress spoke so clearly that we can fairly say that the State could make an informed choice.

In *Pennhurst,* the Court found that a Medicaid "bill of rights" provision declaring that "persons with developmental disabilities have a right to appropriate treatment, services and habilitation...[which] should be provided in the setting that is least restrictive of the person's personal liberty..." did not give rise to enforceable rights. Because other provisions of the law were more specific in nature, and because the obligation was so far-reaching that Congress would not have imposed such a sweeping and expensive obligation without being more explicit, the Court concluded, the provisions in question were "general statements of federal policy, not newly created legal duties." 451 U.S. at 23, 67 L.Ed.2d at 711.

The next three decisions in this line of cases all addressed the status of statutory mandates

clothed in the word "reasonable."[7] In *Wright v. Roanoke Redevelopment and Housing Authority,* 479 U.S. 418, 107 S.Ct. 766, 93 L.Ed.2d 781 (1987), the Court again focused on the statutory context and concluded that a ceiling on utility charges to residents of federally supported housing projects did create such rights because it specifically defined how the charges were to be calculated. In *Wilder v. Virginia Hospital Ass'n,* 496 U.S. 498, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990), the requirement of "reasonable and adequate" payment rates for Medicaid providers (see discussion of 42 U.S.C. §1396a(a)(30) *infra.*) was held to give rise to enforceable rights because the statute and implementing regulations set forth in detail the factors to be considered and the methods for calculation of rates.

The plaintiff in *Suter v. Artist M.*, 503 U.S. 347, 112 S.Ct. 1360, 118 L.Ed.2d 1 (1992), sought to enforce a provision of the federal Adoption Act requiring a state to make reasonable efforts to prevent a child from being removed from his home and to reunite the family when that could not be prevented. Because there was no further guidance on how "reasonable efforts" were to be measured, and because the meaning of the requirement necessarily varied with the individual case, the court concluded, the manner in which this provision was to be enforced was left up to the individual State to work out. *Suter,* 503 U.S. at 360, 118 L.Ed.2d at 14. The enforcement mechanism allowed for reduction or elimination of payments by the Secretary of Health & Human Services where there was a substantial failure to comply with this provision. The administrative regulations were general in nature, and did not provide notice to the State that anything other than submission of a Plan complying with the regulations was a condition of federal funding. Thus, the Court concluded, the provision imposed only a generalized duty on the State, to be enforced by the Secretary, rather than a legal right enforceable by private individuals, 503 U.S. at 360-363, 118 L.Ed.2d at 14-16.

Thus, in reviewing the measures on which Plaintiffs rely in seeking to make out a judicially enforceable obligation to provide an ICF/MR placement in close geographical proximity to the recipient's family (or of a particular size), the court should consider the following factors to

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[7]The Court noted in *Suter v. Artist M.*, 503 U.S. 347, 112 S.Ct. 1360, 118 L.Ed.2d 1 (1992) that the use of the word "reasonable" was not decisive, 503 U.S. at 357, 118 L.Ed.2d at 12.

distinguish privately enforceable enactments from hortatory declarations and administrative directives:

> (1) whether or not the condition would impose an indeterminate burden on the State;
>
> (2) whether the mandate announces directly what is required or is said to impose an obligation on the basis of a syllogism;
>
> (3) whether the mandate includes particulars about the requirement or is general in nature;
>
> (4) whether the mandate calls for a different analysis for each individual case or can apply to discrete and defined classes of situations;
>
> (5) whether the enforcement mechanism applicable to the provision suggests that private actions are contemplated; and
>
> (6) whether or not the mandate specifically states that federal funding is contingent on what is demanded.

Not one of these factors weighs in favor of recognizing a federally enforceable right with respect to either the active treatment or the statewideness provisions on which Plaintiffs rely to create an obligation to provide services in close geographic proximity to the family home.

In *Harris v. James*, 127 F.3d 993 (11th Cir. 1997), the plaintiffs sought to enforce a transportation requirement that did not appear explicitly in the Medicaid Act, but only in a federal regulation. 127 F.3d at 1005. The Court addressed 42 U.S.C. §1396a(a)(19), which requires that a State plan for medical assistance must:

> Provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined and such care and services will be provided in a manner consistent with simplicity of administration in the best interest of the recipients.

It held that Section1396a(a)(19) does not provide a right enforceable under 42 U.S.C. §1983. In concluding that §1396a(a)(19) was "insufficiently specific to confer any particular right to the plaintiffs," the Court in *Harris* also noted in Footnote 24 of its opinion:

> In addition to our concern that the provision is insufficiently specific to confer enforceable rights on the plaintiff, we also suspect that such

> an obligation is "too vague and amorphous" to be capable of judicial enforcement. To ask a court to determine whether a state practice complies with the broad, and sometimes competing, goals of "simplicity of administration" and "the best interests of the recipients" would likely strain judicial competence.

Accord, Bumpus v. Clark, 681 F.2d 679, 683 (9th Cir. 1982) *opinion withdrawn as moot*, 702 F.2d 826 (9th Cir. 1983); *Stewart v. Bernstein*, 769 F.2d 1088, 1093 (5th Cir. 1985); *Cook v. Hariston*, No. 90-3437, 948 F.2d 1288 (6th Cir. November 26, 1991) (*unpublished decision*) ("[T]he district court did not error in finding that the [provisions] in question were not sufficiently specific and definite to permit enforcement through §1983."); *Graus v. Kaladjian*, 2 F. Supp.2d 540, 543 (S.D.N.Y. 1998) ("this Court, however, is in agreement with those courts that have concluded that this amorphous provision [42 U.S.C. §1396a(a)(19)] does not itself create a federal right privately enforceable under §1983").

These decisions establish that a court's notion of what in the "best interests" of a particular person with a developmentally disability seeking ICF/DD placement is not enough to create a legal right.

Sovereign Immunity Waiver Must Be By "Unmistakably Clear Language."

This standard applies with even greater force in this case, where in the absence of a clear and specific mandate, this action may not be brought in this court by virtue of the Eleventh Amendment and the doctrine of sovereign immunity. Congress may require a waiver of sovereign immunity as a condition of the State's participation in a federal program, but it must express its intent to impose such a condition on the State unambiguously, *Marie O. v. Edgar,* 131 F.2d 610, 615 (7th Cir. 1997). The Court in *MCI Corp. v. Illinois Commerce Commission,* 168 F.3d 315, 321 (7th Cir. 1999) acknowledged that a waiver may be implied in a Spending Clause case from acceptance of the federal assistance, but that implied consent can only be found when Congress has spoken in "unmistakably clear language." *Id., citing Welch v. Texas Dep't of Highways & Public Transp.,* 483 U.S. 468, 477-478, 107 S.Ct. 2941, 97 L.Ed.2d 389 (1987). The only circumstance that could give rise to an implied waiver of sovereign immunity here would be the presence of an obligation creating rights enforceable under 42 U.S.C. §1983. Thus, for Plaintiffs to be able to proceed with this action, the statutory language (or, if the court concludes that regulations can be considered, the regulatory

language) must not only be "clear and unambiguous" to come within §1983, the obligation must be created by "unmistakably clear language."

This is the only path remaining to Plaintiffs to avoid dismissal of the action based on sovereign immunity, as recent case law holds that the integration claim under either the Americans With Disabilities Act (which has already been dismissed) and the Rehabilitation Act (which has not) are barred by the analysis of the Supreme Court's recent decision in *Board of Trustees of the University of Alabama v. Garrett,* 531 U.S. 356, 121 S.Ct. 955, 148 L.Ed.2d 866 (2001). In *Reickenbacker v. Foster,* 2001 WL 1540102 (5th Cir. Dec. 3, 2001), the Fifth Circuit reached this conclusion. *Accord, Garcia v. S.U.N.Y. Health Sciences Center of Brooklyn,* 2001 WL 1159970 (2d Cir. Sept. 25, 2001)(recognizing exception for actions only where a showing of discriminatory *animus* on the basis of a disability could be made out).

Necessity of Showing Non-Compliant State Plan Under Section 1983. The court has already recognized that under *Mallett v. Wisconsin Div. of Vocational Rehabilitation,* 130 F.3d 1245 (7th Cir. 1997), Section 1983 limits the scope of what may be asserted in a claim seeking to enforce the Medicaid Act. Specifically, the claim cannot be one in which an individual complains of not receiving services that should be provided. The claim must be that the Illinois Medicaid Plan does not comply with federal requirements, and that as a result, the Plaintiff has not received the benefits to which she is entitled. Memorandum Opinion and Order of May 1, 2001, at 17-18. An isolated violation or a failure to follow the Plan itself is not sufficient to make out a claim.

Plaintiffs do not point to any specific provision of the Plan. Rather, they seek to establish that it is a *de facto* provision of the Plan that there will not be sufficient ICF/MR vacancies to enable the putative Plaintiff class members to receive services within some unidentified geographic proximity to their family homes as they claim is required. Assuming *arguendo* that a *de facto* theory is permitted, it must be shown that (1) the State has intentionally created the alleged lack of availability, and (2) that the lack of availability means that a majority of individuals are unable to obtain services to which they are entitled. Defendants also contend that the reason that this matter is not addressed in the Illinois Medicaid Plan is because the Act does not require or even contemplate that a State Plan will address the subject of geographical proximity of ICF/MR facilities to Medicaid recipients seeking services.

Applicable Provisions of the Medicaid Act

Definition of Medical Assistance

Required "Medical Assistance" Means Payment For ICF/MR Services. The Medicaid Act requires that States provide "medical assistance," 42 U.S.C. §1396a(a). Medical assistance "means payment of part or all of the cost of the following care and services...for individuals...whose income and resources are insufficient to meet all of such cost...."

Provisions on ICF/MRs

Medicaid Act Defines ICF/MR's As Providing Active Treatment. An "intermediate care facility for the mentally retarded" "means an institution...for the mentally retarded or persons with related conditions if...the primary purpose of such institution...is to provide health or rehabilitative services for mentally retarded individuals and the institution meets such standards as may be prescribed by the Secretary" and "the mentally retarded individual with respect to whom a request for payment is made under a plan approved under this subchapter is receiving active treatment under such a program..." 42 U.S.C. §1396d(d)

Medicaid Act Requires ICF/MR's To Develop Written Plan of Care. The Medicaid Act further requires that "with respect to services in an intermediate care facility for the mentally retarded (where the State plan includes medical assistance for such services) the ICF/MR provide, with respect to each patient receiving such services, for a written plan of care, prior to admission to or authorization for benefits in such facility...and for a regular program of independent professional review (including medical review) which shall periodically review his need for such services" 42 U.S.C. §1396a(a)(31).

Medicaid Act Authorizes Federal Certification of ICF/MR's. The Medicaid Act provides for certification of ICF/MR facilities by the Secretary of the Department of Health & Human Services, (Subpart C of 42 CFR 442.100 *et seq.*) and for decertification where standards are not maintained, 42 U.S.C. §1396i(b)(1).

Statewideness

Medicaid Act Mandates a Plan In Effect in All Political Subdivisions. The "statewideness" requirement of the Medicaid Act simply states that the State Plan must "provide that it shall be in

effect in all political subdivisions of the State and, if administered by them, be mandatory upon them." 42 U.S.C. §1396a(a)(1).

Comparability

Medicaid Mandates Comparable Services To Eligible Recipients. The "comparability" requirement of the Medicaid Act states that the State Plan must "provide...that the medical assistance made available to any [categorically needy] individual...(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 [medically needy] individuals." 42 U.S.C. §1396a(a)(10)(B).

Medicaid Act Requires Availability of Services Comparable to Private Market. The Medicaid Act provides that a State Plan "must provide for such methods and procedures relating to the utilization of, and the payment for, care and services under the plan...as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area..." 42 U.S.C. §1396a(a)(30).

Reasonable Promptness

"Medical Assistance" Must Be Provided With Reasonable Promptness. The reasonable promptness requirement of the Medicaid Act states only that the State Plan must "provide that all individuals wishing to make application for medical assistance under the plan shall have the opportunity to do so and that such assistance shall be provided with reasonable promptness to all eligible individuals." 42 U.S.C. §1396a(a)(8).

Community Based Services

Medicaid Act Provides That "Community-Based Services" Are Waiver Services. Community-based services are by definition waiver services like CILA, unlike ICF/MR services: "The Secretary may by waiver provide that a State plan approved under this subchapter include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services...with respect to whom there has been a determination that but for provision of such services the individuals would require a level of care provided in a[n]...intermediate care facility for the

mentally retarded the cost of which could be reimbursed under the State plan." 42 USC §1396n(c)(1).

Medicaid Act Limits Availability of Home and Community-Based Services. It is undisputed that the Medicaid Act provides that a waiver program may limit the number of persons to be served under the waiver. It further provides that waiver programs provide that "such individuals who are determined to be likely to require the level of care provided in a[n]...intermediate care facility for the mentally retarded are informed of the feasible alternatives, *if available under the waiver*, at the choice of such individuals..." 42 U.S.C. §1396n(c)(2)(C)(emphasis added).

Applicable Regulations

Amount, Duration and Scope Regulation. The regulations provide, on the one hand, that the service the State Plan provides shall be "sufficient in amount, duration and scope to reasonably achieve its purpose." 42 C.F.R. §440.230(b). The regulation also provides that the State "may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures." 42 C.F.R. §440.230(d)

Active Treatment Plan Regulation. The Medicaid Act provisions pertaining to the services to be provided by ICF/MR's are enforced by regulations adopted pursuant to the Secretary's authority to prescribe standards for such facilities, 42 C.F.R. § 483.400. It is in this set of regulations—addressed not to the States but to ICF/MR's that wish to be eligible for Medicare funding—where the so-called "active treatment" regulation appears. This regulation is referred to under Subpart C as a "condition for participation," meaning that if it is not complied with, the facility will lose certification for Medicare funding. The standard is set forth in 42 C.F.R. §483.440(a):

> (a) *Standard: Active Treatment.* (1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward—
>
> > (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and

(ii) The prevention or deceleration of regression or loss of current optimal functional status.

(2) Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous treatment program.

Statewideness. The only provision of the regulations that amplifies the "statewideness" requirement is the provision that a State Plan must provide that it "will be in operation statewide through a system of local offices, under equitable standards for assistance and administration that are mandatory throughout the State." 42 C.F.R. §431.50(b).

Reasonable Promptness. There are two regulations dealing with reasonable promptness. First is the requirement for "time standards for determining eligibility" of "ninety days for applicants who apply for Medicaid on the basis of disability." 42 C.F.R. §435.912(a)(1). The regulation requires that the standard be met "except in unusual circumstances," which include, "for example, delays attributable to the applicant or an examining physician." 42 C.F.R. § 435.912(c)(1). The time period in question runs "from the date of application to the date the agency mails a notice of determination." 42 C.F.R. §435.912(b).

The second regulation is the only one addressing the requirement for actually providing medical assistance: "The agency must— (a) Furnish Medicaid promptly to recipients without any delay caused by the agency's administrative procedures." 42 C.F.R. § 435.930. Thus, the ninety-day time limitation applies only to eligibility determinations, and not to actually furnishing Medicaid benefits.

Comparability Regulation. The regulations provide that the services available to the categorically needy be "not less in amount, duration and scope than those services available to a medically needy recipient." 42 C.F.R. §440.240(a) It further provides that the services available to all categorically needy recipients be comparable to one another, and that services available to recipients in each medically needy group by comparable to one another. 42 C.F.R. §440.240(b).

ARGUMENT

I. Necessity of Statutory Obligation As Distinguished From Administrative Regulations.

For Illinois to be subject to federal mandates arising from the Medicaid Act, the requirement should be plain from the statute itself, since regulations are subject to constant revision and new obligations may be added without Congressional approval. Administrative agencies may be authorized by Congress to issue at least two types of regulations. *Interpretive* regulations, which purport to elaborate on and clarify ambiguities in federal statutes, are typically regarded as persuasive by courts in construing federal statutes unless they do not reflect a reasonable interpretation of the statutory provision they are construing. *Substantive* regulations, by contrast, represent a delegation by Congress of authority to legislate on a specific subject, guided by a policy directive contained in a statute.

The court in *Harris v. James,* 127 F.3d 993, 1006-1007 (11th Cir. 1997) noted that four justices of the Supreme Court are already on record that "federal rights" enforceable through 42 U.S.C. §1983 *cannot* derive from valid regulations *of either type* issued by an administrative agency, citing *Wright v. Roanoke Redevelopment and Housing Authority,* 479 U.S. 418, 437-438, 107 S.Ct. 766, 93 L.Ed.2d 781 (1987)(O'Connor, J.)(dissenting opinion). Concluding that the position expressed in the dissent in that case was not rejected by the majority, the Eleventh Circuit held that while an interpretive regulation might assist in construction of a statute, the existence of a federal right enforceable under §1983 must be determined without consulting anything other than what is contained in the provision adopted by Congress, *Harris,* 127 F.3d at 1006-1009. See also *Garcia v. Brownsville Housing,* 105 F.3d 1053, 1057 (5th Cir. 1997); *Smith v. Kirk,* 821 F.2d 980, 984 (4th Cir. 1987).

II. The Active Treatment Plan Regulation Does Not Contain A Clear, Specific Mandate Requiring ICF/MR Placement Within A Reasonable Proximity of Family

Plaintiffs have cited no case law to date supporting their contention that the active treatment plan regulation requires that a state ensure that there are ICF/MR placements within some geographic proximity of the recipient's family residence. Neither the statute nor the regulations mention any such right, directly or implicitly. Each is concerned with what happens within the walls of the ICF/MR facility: treatment focused on skills development and maintenance.

The absurdity of finding the requirement Plaintiffs seek to impose in this provision is that it is not even directed towards the State and the State Plan. Rather, it is a standard that must be met by an ICF/MR to be eligible to receive Medicaid funding. The statute mandates that treatment in an ICF/MR take place under a written plan of care, and it specifically authorizes the Secretary of the Department of Health and Human Services to establish standards for certification of ICF/MR's. The active treatment regulation is simply a condition for participation in the Medicaid program. It addresses what happens post-placement, not where an individual is to be placed. So the first point is that the regulation requiring an active treatment plan does *not* regulate where ICF/MR facilities must be located, or what the State, as opposed to an ICF/MR provider, is required to do.

The regulations do speak to the role of parents and family in the ICF/MR. They establish a standard for providers to comply with to promote *communication* between parents, legal guardians and residents in the ICF/MR. They provide that the facility must "promote participation of parents and legal guardians in the process of providing active treatment unless their participation is unobtainable or inappropriate." 42 C.F.R. § 483.420(c)(1) Facilities are required to "promote visits by individuals with a relationship to the client (such as family, close friends, legal guardians and advocates) at any reasonable hour, without prior notice..." 42 C.F.R. § 483.420(c)(3) They are to "promote frequent and informal leaves from the facility for visits, trips or vacations..." 42 C.F.R. § 483.420(c)(5) These regulations are also conditions for ICF/MR participation in Medicaid entitled "Standard: Communication with clients, parents and guardians." 42 C.F.R. § 483.420(c).

These provisions represent all that the Medicaid regulations have to say about the participation of parents and family members in the treatment of ICF/MR residents. While it may be

true that geographical proximity of the facility to the family home might in some, or even many, instances help ICF/MRs promote more frequent family involvement, the regulations do not say what Plaintiffs would like them to say: that the State is required to ensure that Medicaid recipients are placed so that family members are within a certain distance or travel time in order that their relationship with the Medicaid recipient is made reasonably convenient. So the second point is that the regulations specifically addressed the role family may play in active treatment, encourage frequent communication, but do not mandate geographical proximity. It is unreasonable to infer any geographical proximity requirement from the regulations that Plaintiffs rely upon.

The third point is the most basic: Plaintiffs' argument seeks to tease out of plain language something that is not there. Whatever merit there might be in other cases to judicial policymaking or simply liberal construction of a statute, it is improper in this case. The relief requested by Plaintiffs must be supported by a requirement that is crystal clear. A requirement that is nowhere in the statute, and that must be teased out of a regulation, cannot satisfy Plaintiffs' burden.

As the court observed in *Bumpus v. Clark*, 681 F.2d 679, 684 ((9th Cir. 1982), "The Medicaid program is not intended to meet all the medical needs of recipients. Rather, the goal is to provide medical assistance 'as far as practicable under the conditions in [each] State.'" In that case, the court noted with chagrin that "Plaintiffs are infirm, elderly, and variously afflicted with heart disease, stroke disorders, chronic brain syndrome and other disabilities. They allege that the closure of Edgefield Manor, and the resulting involuntary transfers and destruction of interpersonal relationships, will cause irreparable emotional and physical injuries.... One expert has testified that 'a transfer of the patients at Edgefield [nursing home for the elderly] will quite probably result in the deaths of a substantial number of those patients.'" 681 F.2d at 683. Nevertheless, the court concluded that neither the regulation creating the right to a hearing before termination of medical services nor the regulation mandating "such safeguards as may be necessary to assure that ...services will be provided in...the best interests of the recipients" meant that the facility could not be closed or that a hearing was required before it could be closed. 681 F.2d at 683.

III. The Statewideness Provision of the Medicaid Act, And Statewideness Regulations, Do Not Contain A Clear, Specific Mandate Requiring ICF/MR Placement Within A Reasonable Proximity of Family

The provision of the Medicaid Act calling for statewide application of the State Plan contains no hint that the State must maintain, as Plaintiffs contend, an equal geographical distribution of vacancies[8] across the State, much less a requirement that the *number* of vacancies be such that any Medicaid recipient may readily be placed at a location within reasonable geographical proximity to the family[9].

It would require clairvoyance to find such a requirement in the simple statutory command directing that the State Plan "shall be in effect in all political subdivisions of the State." Plaintiffs articulate no clear standard of what the State is required to do. If Illinois was required to ensure that facilities are constructed so as to provide adequate ICF/MR vacancies near the families of the recipients, the statute would have to prescribe some specific method by which State administrators could determine whether the system of private and public providers was or was not in compliance with this unstated requirement. Congress cannot be presumed to leave the States with a standard that varies according to the daily fluctuations in supply and demand for ICF/MR placements. If this had been something the Medicaid Act intended to ensure, Congress would have required the State to maintain some kind of geographical distribution of beds within a particular range; provided for a safe harbor against loss of compliance due to demographic shifts; authorized rate adjustments on a geographic basis to create incentive for development in under-served areas; and so on.

The requirements would apply beyond ICF/MR's. All residents of all States would have to have equal access to all hospital, nursing home, physician and other services. Rural hospitals would

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[8]Plaintiffs' claim is more than that there must be an equal distribution of ICF/MR facilities or beds. It would require that the State constantly ensure that *vacancies* are available; even where the facilities were perfectly distributed in proportion to the eligible population, the State could be out of compliance under Plaintiffs' theory if vacancies were not also proportional.

[9]The claim asserted by Plaintiffs here is also that there must be *enough* vacancies so that the geographical proximity requirement could be satisfied. As such, it goes beyond the statewideness requirement and would also mandate that the State ensure that facilities exist or are built to satisfy each Medicaid recipient's needs. This stands in stark contrast to the language of the statute, which with one exception not applicable here (see below) requires the State only to provide "medical assistance," which is defined as "money."

have to be more numerous to assure residents in rural areas would have the same access to acute care services as residents of Chicago and its metropolitan area. As a last resort, the Act would require the State to build facilities and employ physicians to assure uniform availability of health care services throughout the State. There is *nothing at all* in the Medicaid Act requiring States to ensure that providers be available to provide the services the program finances other than the provision on rate levels addressed in the next section of this memorandum.

The Medicaid regulations require only that the Plan be "in operation statewide through a system of local offices, under equitable standards for assistance and administration that are mandatory throughout the State." Local "offices" plainly refers to administration of the program, and in this case there is no dispute that the PAS Agencies are located throughout the State, covering each political subdivision in the State. Something so basic as where providers must be located would not be left to the imagination if Congress intended to cover it. Moreover, there is no question that ICF/MR's *are* located throughout the State. If the requirement intended was "proportional geographical distribution of providers," the drafters of the statute and regulations would not have expressed so important an obligation in such opaque language.

The court has posed the hypothetical question of whether it would be permissible if all ICF/MR's were located south of Springfield. The answer to this question is that Congress did not consider this to be a problem likely enough to arise that it made sense to establish any standard for the State. It relied upon the marketplace operation to address this, as is described in the next section.

The Medicaid Act provision requiring the plan to "be in effect in all political subdivisions of the State and where administered by them, be mandatory upon them" means that the plan must *apply* in all political subdivisions, that is, that the Plan covers the same services without regard to geographical area within the state where the resident lives. The provision addresses the relationship between the plan and local governments and by its terms provides: (1) that the plan be in effect in all political subdivisions and (2) that if the local government administers the plan, the plan is mandatory on the local government. The only thing that is *clear* from this sentence is that no one may be found ineligible for Medicaid benefits based on where s/he lives within the state. The provision ensures that no resident of any political subdivision may be carved out of the coverage of the Medicaid plan, either directly by a place of residence limitation on eligibility, or indirectly by

delegating administration to a local agency that is free to ignore the plan. Placing this provision at the very beginning of the statute suggests a focus on administration and structure, rather than a standard describing the benefit being provided.

This interpretation is supported by the Supreme Court's decision in *Suter v. Artist M.,* 503 U.S. 347, 112 S.Ct. 1360, 118 L.Ed.2d 1 (1992). In *Suter,* the plaintiffs argued that they were entitled to enforce any provision of the Adoption Act in court because of an identical provision in that statute: "This section states that the state plan shall 'provide that the plan shall be in effect in all political subdivisions of the State and, if administered by them, be mandatory upon them.'" Rejecting this construction, the Court concluded: "we think that 'in effect' is directed to the requirement that the plan apply to all political subdivisions of the State, and is not intended to otherwise modify the word 'plan.'" 503 U.S. at 359, 118 L.Ed.2d at 13.

By describing the statewideness obligation as requiring that "the plan apply to all political subdivisions of the State," the Court specifically accepted the construction Defendants advocate here. By stating that the words "in effect" do not otherwise modify the word "plan," the Court rejected any additional obligation—and that necessarily includes any implied obligation to provide that services be available on a uniform basis.

The Eleventh Circuit could not have been more plain in endorsing this construction in *Harris v. James,* 127 F.3d 993 (11th Cir. 1997). The *Harris* plaintiffs contended that unless transportation was provided to and from providers, the plan could not truly be "in effect" in all areas of the State. This argument was emphatically rejected: "The Court's conclusion that the 'shall be in effect' provision of the Adoption Act requires only that the plan apply to all political subdivisions would seem to foreclose arguments (such as the plaintiffs') that attempt to use the 'shall be in effect' provisions of other State-plan legislation as a bootstrap for enforcing requirements imposed on such plans by other statutory provisions." 127 F.3d at 1011. There is no principled difference between the contention that a plan is not truly "in effect" because providers are so situated that Medicaid recipients must travel great distances to be placed in ICF/MR's, and the argument made in *Harris* claiming that without a right to transportation, benefits are not "in effect" throughout the State.

The Second Circuit indicated acceptance of this construction as well, plainly articulating it as the "better analogy," without definitively resolving the issue, in *Concourse Rehabilitation &*

Nursing Center, Inc. v. Wing, 150 F.3d 185, 189 (2d Cir. 1998). The court first articulated the plaintiffs' view that the statewideness provision contained a substantive component (that the State Plan provide that it will be "in effect") and a procedural component (that the plan is in fact "in effect" and "mandatory if administered by a political subdivision of the State"), and was therefore enforceable under §1983. But after reviewing what the court stated in *Suter,* the court said, "...a better analogy to *Wilder* is that the right conferred by Section 1396a(a)(1) has a procedural component—that the plan must provide that it applies statewide—and a substantive component—that the plan is in fact applied statewide even if administered by a political subdivision." 150 F.3d at 189.

The remaining decisions pertaining to the statewideness requirement are District Court decisions that either predate *Suter*[10] or do not address what *Suter* has to say about the construction of "in effect in all political subdivisions of the State," except for *Sobky v. Smoley*, 855 F.Supp. 1123 (E.D. Cal. 1994). *Sobky* found a statewideness violation where California allowed counties to opt out of covering methadone maintenance services, and all but 12 counties did so. Its discussion of *Suter* distinguished the Court's statements about the "shall be in effect" provision by pointing out that in *Suter,* the Plaintiff was attempting to use the "in effect" language to support enforcement of a different provision of the statute, 855 F.Supp. at 1134 n. 29. But the court ignored the other aspect of what *Suter* said about the provision, which was that "in effect" did not modify the word "plan" other than to express that the plan was to apply to all political subdivisions. Perhaps that is because in that case, all but 12 counties of the State did not subscribe to the methadone maintenance program in issue there, which meant that the *Suter* standard was indeed satisfied.

The *Sobky* court did go on to say that under the statewideness provision, *services* were to be provided throughout the State. It relied on a clarifying comment in the statewideness regulation allowing providers to provide services to limited geographical areas, 855 F.Supp. at 1134-1135. To

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[10] *e.g., Smith v. Vowell,* 379 F.Supp. 139 (W.D. Tex. 1974); *Clark v. Kinzer,* 758 F.Supp. 572 (E.D. Cal. 1990); *Morgan v. Cohen,* 665 F.Supp. 1164 (E.D. Pa. 1987); *Turner v. Heckler,* 573 F.Supp. 867, 873 (S.D. Ohio 1983). These decisions cite and rely on one another, in most instances accepting statewideness as a basis for the decision along with one or more other provsions. Each traces its conclusions back to *Smith,* in which the District Judge described as "preposterous" the proposition that there could be merely rhetorical conditions within the Medicaid scheme, a proposition that has since become law. *Smith* articulated and relied on the same construction of "in effect" that was specifically rejected in *Suter.*

the extent that the decision asserts this negative pregnant analysis proves that State Medicaid obligations include provision of services, as opposed to funding, it is simply wrong. First, the cited exception in the regulation does not necessarily imply that ensuring services are available statewide is part of the regulation's command. For instance, if a State Plan designates one or more providers for each specific geographical area and states that a provider who renders services to a recipient outside its area will not be reimbursed, this part of the regulation ensures that the plan will not found to lack of statewideness, so long as there is at least one provider in each area. Second, the regulation says only how the regulation should *not* be construed, and this does not imply that another interpretation unsupported by the principal section of the regulation *is* correct. At a minimum, the obligation cannot be clear if the regulation does not affirmatively state that the other interpretation *is* correct.

To the extent that the decision is based on the fact that each county had its own local plan, and that the majority of those plans omitted an entitlement service, the decision is correct. Indeed, that is precisely what the Second Circuit concluded the case stood for in *Concourse Rehabilitation & Nursing Center, Inc.*, 150 F.3d at 189. In this case, the State Plan covering persons with mental retardation and developmental disabilities is operated through local PAS Agents whose coverage is not limited, and services are provided in facilities in virtually every county of the State[11]. To the extent *Sobky* goes beyond this, the opinions of the Supreme Court in *Suter,* of the Eleventh Circuit in *Harris* and of the Second Circuit in *Concourse Rehabilitation & Nursing Center, Inc.* should govern instead.

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[11]In addition to *Smith v. Vowell,* which is addressed in the preceding footnote, the court identified *Carr v. Wilson,* 203 F.R.D. 66 (D. Conn. March 30, 2001)(class certification ruling). One of the several related claims asserted was that the failure to pay dental provider market rates resulted in a violation of 42 U.S.C. §1396a(a)(1) and 42 C.F.R. §431.50(b)(1), "which require that Medicaid covered dental services be available to Medicaid recipients throughout Connecticut," 203 F.R.D. at 69. The court in *Carr* concluded that its determination was to be made "solely on the allegations of the complaint,"203 F.R.D. at 72 and that it "may not consider the validity of the plaintiff's claims." 203 F.R.D. at 69. The only argument concerning the standing of the individual plaintiffs was a mootness argument. 203 F.R.D. at 76. Because the *Carr* decision disclaimed any consideration of whether the claim was actionable, it can tell us nothing at all about statewideness except that the attorney representing plaintiffs in that case considered the claim to be worth including along with half a dozen others.

IV. The Medicaid Act's Only Mandate To States Concerning Providing Services, As Opposed To Financing, Is The Requirement To Provide Market Rates of Payment

If Congress had intended to require States to provide *services,* as opposed to financing, there would be a collection of requirements in the statute describing what States are required to do to ensure that services be available, and directing that they provide the services themselves if the private market fails to do so. No such provisions are in the statute. Congress rejected that approach in favor of reliance on private market mechanisms. A statute whose principal purposes and mandates have to do with financing of covered services can be expected to rely on a financial device to ensure that those services are available. The Medicaid Act provides that *payments* for Medicaid services must be "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area," 42 U.S.C. §1396a(a)(30).[12]

It was within the province of Congress to determine that the private market is superior to state control over ICF/MR and other providers as a mechanism for ensuring that there are adequate providers. Providers of ICF/MR services have sound reasons for not developing new facilities, and to presume that the market has operated in an irrational fashion would be folly. Plaintiffs may find fault with how the private marketplace has distributed the facilities and vacancies, but that is a quarrel with the statute and cannot form the basis for relief in this court.

V. The "Amount, Duration and Scope" Requirement Is Not A Clear, Specific Mandate Requiring ICF/MR Placement Within An Unspecified Close Proximity to Family

The court has mentioned the "medical necessity" standard in passing, and Defendants have reminded the court of *Alexander v. Choate*, 469 U.S. 287, 105 S. Ct.. 712 (1984). Although

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[12]As noted in *HCMF Corp. v. Gilmore,* 26 F.Supp. 873, 876 (W.D. Va. 1998), this portion of the statute has been revised since it was held to be enforceable by private suit in *Wilder.* The provision was not entirely repealed; the specific federal requirements for calculating rates were turned over to the States, which had the effect of establishing sovereign immunity over disputes by providers against States relating to the rates, 26 F.Supp.2d at 878-880..

Plaintiffs have neither cited nor made reference to the "amount, duration and scope" regulation, it requires attention here.

In *Alexander v. Choate,* 469 U.S. 287, 105 S.Ct. 712, 83 L.Ed.2d 661 (1985), the Court confronted a challenge based on handicap discrimination to Tennessee's decision to limit Medicaid payment for hospital stays to fourteen days. Plaintiffs presented evidence that persons with handicaps have longer hospital stays, and contended that the Plan could not lawfully impose such a limitation. In rejecting both a claim of discrimination through "denial of meaningful access" and a disparate impact argument that saving money through shorter hospital stays necessarily imposes disadvantages on persons with handicapped, the Court looked to the basic structure and purpose of the Act:

> ...Medicaid programs do not guarantee that each recipient will receive that level of health care precisely tailored to his or her particular needs. Instead, the benefit provided through Medicaid is a particular package of health care services, such as 14 days of inpatient coverage. That package of services has the general aim of assuring that individuals will receive necessary medical care, but the benefit provided remains the individual services offered—not 'adequate health care.'
>
> ...The Act gives the States substantial discretion to choose the proper mix of amount, scope and duration limitations on coverage, as long as care and services are provided in 'the best interests of the recipients.'
>
> *Alexander v. Choate,* 469 U.S. at 303, 83 L.Ed.2d at 673.

The package of Medicaid funded free ICF/MR services made available to Illinois residents is necessarily limited to those facilities that the private marketplace has established. The Plan serves thousands of persons, and according to Plaintiffs' calculations, fully one-third of them are in the nine-county northern Illinois area. While new entrants to the system are confronted with more vacancies at downstate facilities than in the nine-county area, this does not mean that the package of ICF/MR services represent a legally inadequate benefit.

In *King v. Sullivan,* 776 F.Supp. 645 (D. R.I. 1991), a case with significant similarities to this one, the plaintiffs claimed that the State did not expend sufficient funds on community residential

services. Plaintiffs in that case had been offered the opportunity for placement in a large state-operated ICF/MR, but claimed the right to placement in "community-based," group home ICF/MR facilities. The court concluded that it was proper for the State to limit access to such settings to persons in "emergency" situations, just as Illinois limits CILA group home placement to community emergencies and other priority populations. Rejecting this claim, the court held that Medicaid only mandates that "any medical assistance service provided be adequate to reasonably achieve the purposes of the medical assistance service that the state offers in its State Plan." *King,* 776 F.Supp. at 652. The court went on to point out that "When a State obligates itself to providing Medicaid services...the state need not meet its obligations perfectly. A service is sufficient in amount, duration and scope if it adequately meets the needs of most individuals eligible for Medicaid assistance to pay for that service. [citations omitted]" Reasonable promptness did not require provision of one particular type of ICF/MR, 776 F.Supp. at 651-652, nor did the "amount, duration and scope regulation, 776 F.Supp. at 652-653. Plaintiffs' comparability argument was rejected because a careful reading of the statute showed that "nothing in the statute prohibits a state from offering different services to persons in different categories of medical need or with different degrees of medical necessity." 776 F.Supp. at 654. A claim of inadequate funding failed because plaintiffs could not identify any ICF/MR providers who refused to serve Medicaid recipients, 776 F.Supp. at 655. Finally, the court rejected a "freedom of choice" argument, saying: "By demanding a literal 'choice' of ICF-MRs, Plaintiffs are essentially asking this Court to compel Rhode Island to expand its State Plan so that vacancies always exist to give applicants a selection among several different facilities. Such a ruling would go well beyond the requirements of the Medicaid statute, both in letter and in spirit. Rhode Island's treasury is not limitless, as the Medicaid Act emphatically recognizes." 776 F.Supp. at 656-657.

The holding of *King* was recently supported by the Second Circuit in *CERCPAC v. Health and Hospitals Corporation,* 147 F.3d 165 (2nd Cir. 1998). In that case, the complaint asserted that a municipal agency's closing of a specialized health care facility would eliminate or reduce some services needed by disabled children and would inconveniently relocate other services that those children required. The court addressed the right to equal access of services, and citing *Alexander*

v. Choate, held that there was no guarantee of any particular level of medical care for disabled persons, and no assurance of maintenance of service previously provided.

In *Cherry v. Tompkins*, 1995 W.L. 502403 (S.D. Ohio), the defendant State of Ohio changed the level of care criteria set forth in the Ohio Administrative Code to determine if individuals qualified for nursing facility services for Ohio's home and community based services, or for nursing facility services during pre-admission screening. The plaintiffs claimed that the amended level of care criteria violated the amount, duration and scope provisions set forth in 42 C.F.R. § 440.230(c) restricting the scope of necessary medical services based on plaintiff's diagnoses, type of illness and conditions. The court rejected this claim and held: "The Medicaid Act leaves such fiscal related policy decisions to defendant as long as they are reasonable and in the best interests of Medicaid recipients. Plaintiffs did not demonstrate either unreasonableness in the amended criteria or that the amended criteria failed to meet the best interests of the Ohio Medicaid applicants and recipients as a whole."

In *Doe v. Bush*, 261 F.3d 1037 (11th Cir. 2001), the court considered not only the amount, duration and scope regulation but various other regulations under the Medicaid Act, some of which are relevant here and concluded: "What all of those statutory provisions and regulations mean is that the defendants were free to limit the provision of ICF/DD services to only those applicants for whom ICF/DD services were deemed medically necessary." The Medicaid Act and regulations permit a state to define medical necessity in a way tailored to the requirements of its own Medicaid program.

Plaintiffs' argument that they are entitled to be placed in an ICF/MR which is geographically convenient to the family home is much weaker than the claims asserted by the plaintiffs in the various cases cited herein. Plaintiffs' claim ignores the State's wide discretion to administer Medicaid in a manner that is fiscally responsible and in the best interests of Medicaid recipients *as a whole*. The State is faced with limited resources with which to fund services offered by providers under the Medicaid program. Plaintiffs' theory and argument, if supported, would allow recipients of Medicaid throughout the State to demand a certain level and placement of services which would require allocation of funds under the Program that should be left to the Executive and Legislative branches of the State.

Thus, even if Plaintiffs are correct that the Medicaid recipient's "well-being" and skill development/maintenance are best served where the family is close by, even if they are correct that the treatment is not as optimal where that is not the case, and even if they are correct that abuse and neglect are more effectively monitored when the family is nearby,[13] Illinois is not required to meet any particular "geographical proximity" standard. Certainly it cannot be said in light of the discretion the Act confers on States that Illinois was on notice of such a requirement when the Medicaid Plan was adopted.

In this case, the Plaintiffs do not challenge a specific, explicit limitation contained in the Illinois Medicaid Plan, but seek to make out a *de facto* provision that they claim fails to comply with the Act. They describe the unarticulated provision in the negative: "individuals in the nine-county area will not receive ICF/MR placements in close geographical proximity to their existing family homes." But in light of the affirmative right of the State to place limits on the services to be provided, an explicit statement in the State Plan that "ICF/MR services may be provided anywhere in the state without regard to geographical proximity to the previous family home" would be permitted under this line of decisions.

VI. The Reasonable Promptness Provisions of the Act and Regulations Do Not Amount To A Clear, Specific Mandate Requiring ICF/MR Placement Within A Reasonable Proximity of Family

Reasonable promptness is only an issue if one assumes that family convenience in ICF/MR placement is an entitlement . Plaintiffs' argument that there are insufficient ICF/MR vacancies to serve persons in the nine-county northern Illinois area because the ICF/MR vacancies are concentrated in southern Illinois effectively concedes that there are sufficient vacancies statewide to accommodate all persons seeking such placements. Plaintiffs' evidence does not support a claim that there are not enough ICF/MR beds in the State as a whole.

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[13]There are a host of other provisions within the Act and Regulations designed to prevent abuse and neglect, 42 C.F.R. §483.420(a)-(d) (Conditions of Participation for ICF/MR: Client Protection).Other than general statements, Plaintiffs provide no specific proof that these measures are inadequate where they are not supplemented by an increased level of family involvement resulting from close geographical proximity.

The reasonable promptness regulation does not say what Plaintiffs have repeatedly asserted that it says. There is no mandate, either in the statute or the regulations, requiring that placements be made within any defined period of time. The Act speaks of permitting everyone to apply for assistance and provides that such assistance "shall be provided with reasonable promptness to all eligible individuals." Plaintiffs seek to alter the meaning of "assistance" from financing to the actual provision of services. This is not what the Act says, however. There is no contention in this case that approval for funding has not been provided promptly to persons seeking such approval. Any holdup is in selection of a suitable facility, not in approval of payment.

The regulations expand this requirement beyond what the Act provides, but the result is the same. There are two regulations. The first mandates eligibility determinations within a fixed time period of ninety days, and provides for exceptions where the delay is caused by the applicant or treating physician, 42 C.F.R. §435.922. Plaintiffs have made no showing of undue delay in approving applications for Medicaid eligibility. The evidence shows, moreover, that because the PAS agents assist Medicaid applicants to locate services from the very start of the process, no cognizable harm would occur from a delay in providing approval.

The second requirement is that the agency's procedures not delay furnishing of Medicaid. The regulation obviously refers to funding approval, but even if it was construed to apply to the provision of the services of an ICF/MR, there is no contention that any delay in providing such services is attributable to administrative delay by the PAS Agent. The Plaintiffs generally praise the PAS Agents for their responsiveness, and counsel blames not the efficiency of the PAS Agents, but an alleged shortage of ICF/MR beds, for the fact that Plaintiffs and the supposed members of the putative class have not been placed in ICF/MR's.

VII. There Is No Right Under the Medicaid Act To Community Based Services Or Any Limit On The Size of an ICF/MR To Be Provided

Plaintiffs have asserted that services in a small ICF/MR are virtually identical to those provided in a CILA. Defendants have vigorously disputed this contention because it is simply untrue, and because their effort to transition the delivery system from a primarily institutional system relying on large State operated developmental centers and ICF/DD facilities of varying sizes to a system emphasizing home and community based services is under attack by Plaintiffs. Plaintiffs'

argument seems mainly to be that persons seeking CILA services should be included by the court as also seeking services in an ICF/MR.[14]

The Medicaid Act specifically uses the expression "institution" with reference to all ICF/MR's, 42 U.S.C. §1396d(d), and specifically references "community based services" only in the context of waiver services, which include CILA as an alternative to treatment in an ICF/MR, 42 USC §1396n(c)(1). The evidence will show that these distinctions are not just a matter of statutory nomenclature.

What is significant is that nowhere in any part of the Medicaid Act or regulations is there anything suggesting that there is a distinction among ICF/MR's based on size. There is nothing that Plaintiffs have offered to the court that would provide any clear and specific standard for determining the size of the ICF/MR in which an individual is entitled to be placed. Insofar as Plaintiffs are claiming that they have a right to a particular size of ICF/MR because skills development/maintenance will be superior, or because it will benefit their "well-being," this is not only contradicted by their own evidence, it suffers from the same deficiency as their arguments about proximity to family.

Conclusion

The Plaintiffs have articulated two claims in support of their effort to force Illinois to provide them with ICF/MR placements within close geographical proximity of their family homes: active treatment and Statewideness. They appear to assert a right to an ICF/MR of some unidentified small size. The legal grounds on which they rely do not give rise to federal rights because each relies on a syllogism rather than on a specific command in the positive law, and none of the critical factors affecting the outcome in the Supreme Court cases on this subject suggests that such a legal right exists. The necessity for a clear mandate is made more urgent by the fact that recognition of a right effectively abrogates sovereign immunity.

If one simply looks to the Medicaid Act itself, or even to the regulations, this is plain. The active treatment regulation is directed to providers, not States, and addresses what is to happen after,

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[14]This may also represent an effort by Plaintiffs to justify the isolated, but apparently improper imposition of a facility size requirement by Ms. Prunier-King in her handling of the Wilsman request for services.

not before, a placement. The regulations call for ICF/MR's to facilitate family communication and involvement, but do not call for facilities to be near to the family. If that obligation was intended, it would have been expressly stated. The statewideness mandate as Plaintiffs assert it is equally absurd, and would turn the entire health care system upside down, requiring massive State intervention in the private market, if one accepted Plaintiffs' theory that the State was responsible for ensuring that the market provided a selection of ICF/MR vacancies close to home for every person with mental retardation or a developmental disability. The Supreme Court and two Courts of Appeal have recently addressed the correct interpretation of the "statewideness" requirement, and each has rejected the construction of that provision on which Plaintiffs rely.

As a statute based on the expenditure of pubic funds to accomplish social objectives, the Medicaid Act also relies on market forces to ensure that there are adequate providers. This is why the statute does not contain any provisions dealing with this important subject that give rise to a right to a nearby ICF/MR placement. The statute, rather, provides the State with broad discretion to define what package of benefits it will provide, and requires only that the package be designed to benefit the beneficiaries of the program as a whole. It is within the discretion of the State officials charged with administration of the Illinois Medicaid Plan to seek to increase the number of true community residential placements, CILA's, and to limit access to that service, at least for the immediate future, to persons with no home or community based alternative. Even if, as Plaintiffs claim, individuals outside that category who insist on receiving a residential placement may be inconvenienced by having to select a distant ICF/MR; and even if the placement is less beneficial, they are able to receive that service, and that is all that the Medicaid Act demands of the Illinois State Plan. Even if the *de facto* approach Plaintiffs advocate could be employed here, the provision they would inject into the Illinois Medicaid Plan would be perfectly permissible.

The court's function here is limited to following the law. In so doing, it will enable the officials charged with responsibility for the Illinois Medicaid Plan covering persons with mental retardation and developmental disabilities to exercise their responsibilities with the interests of the entire population of such persons in mind, rather than devoting resources to constructing new facilities that will be obsolete before they are completed and that the putative class members and those who represent their interests have always opposed. Plaintiffs' expert, Dr. Braddock, praised

Ms. Wright for her courage and leadership even as he said that leadership was what was restraining Illinois from improving its system. The law commands that she be permitted to perform that role without interference.

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Respectfully submitted,

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