

No. 02-3657

IN THE  
UNITED STATES COURT OF APPEALS  
FOR THE SEVENTH CIRCUIT

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|                                 |   |                                         |
|---------------------------------|---|-----------------------------------------|
| DONNA RADASZEWSKI, Guardian,    | ) | On Appeal From the United States        |
| on behalf of ERIC RADASZEWSKI,  | ) | District Court for the Northern         |
|                                 | ) | District of Illinois, Eastern Division. |
| Plaintiff-Appellant,            | ) |                                         |
|                                 | ) |                                         |
| v.                              | ) | No. 01 C 9551                           |
|                                 | ) |                                         |
| BARRY MARAM, Director, Illinois | ) |                                         |
| Department of Public Aid,       | ) | The Honorable                           |
|                                 | ) | JOHN W. DARRAH,                         |
| Defendant-Appellee.             | ) | Judge Presiding.                        |

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**BRIEF OF DEFENDANT-APPELLEE**  
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## **JURISDICTIONAL STATEMENT**

Plaintiff's Jurisdictional Statement is not complete and correct.

Plaintiff filed a complaint in the Circuit Court of DuPage County, Illinois, against Anna Patla in her capacity as then-Director of the Illinois Department of Public Aid, alleging the Department violated various state laws in connection with services covered through Medicaid for her son Eric and seeking injunctive relief. Doc. 1 at Ex. A. On November 15, 2001, Plaintiff was granted leave to file a supplemental complaint, which added allegations that the Department violated Title II of the Americans with Disabilities Act (42 U.S.C. § 12132) and Section 504 of the Rehabilitation Act (29 U.S.C. § 794) and state law. Doc. 1 at Ex. E, D.

On December 14, 2001, Defendant filed a notice of removal pursuant to 28 U.S.C. §§ 1441 and 1446(b) based on the supplemental complaint's alleged violations of federal law. Doc. 1. Plaintiff moved to remand (Docs. 3, 4), but the district court remanded only the state law claims, finding that it lacked supplemental jurisdiction over them under Pennhurst State School & Hosp. v. Halderman, 465 U.S. 89 (1984) (Doc. 8). Under 28 U.S.C. § 1331, the district court had jurisdiction over the federal claims for injunctive relief. 42 U.S.C. § 2000d-7(a)(1) (Rehabilitation Act); Bruggeman v. Blagojevich, 324 F.3d 906 (7th Cir. 2003) (Eleventh Amendment does not bar ADA claims for injunctive relief).

On September 11, 2002, the district court entered an order granting Defendant's motion for judgment on the pleadings. Doc. 16. On October 9, 2002, Plaintiff filed a notice of appeal. Doc. 17. This Court therefore has jurisdiction over the appeal pursuant to 28 U.S.C. § 1291.

## **ISSUE PRESENTED**

Whether Plaintiff can plead any set of facts to support her claim that the Director of the Department of Public Aid's decision that the Home Services Program cannot cover the cost of 2 or 3 shifts of private duty nursing for her adult son in their home constitutes disability discrimination under the Americans with Disabilities Act or Section 504 of the Rehabilitation Act of 1973.



## **STATEMENT OF THE CASE**

Federal law requires the Department of Public Aid to include necessary in-home private duty nursing for children in its Medicaid plan but not for adults. The Department covers such care for disabled adults only through the Home Services Program (HSP), for which the cap is the cost of care in a nursing facility.

Plaintiff's son Eric lives at home, where he receives care from his parents, who were specially trained to meet his complex medical needs. Before he turned 21 and "aged out" of a children's program for which the cap is the cost of hospitalization, the Department covered 2 shifts of daily private duty nursing for him. When he applied for the HSP, the Department determined he was eligible for "exceptional care" services in a nursing facility, so it agreed to cover the cost of his in-home care up to the cost of that level of care in a facility. Because this amount would cover at most 5 hours of private duty nursing daily, he appealed to the Director. At the hearing, his witnesses testified he needed 24-hour skilled clinical nursing and that no nursing facility would provide it. The Director concluded the HSP rules did not permit the Department to pay more than the "exceptional care" cap for in-home care.

Plaintiff sued the Director in state court, alleging that the nondiscrimination provisions of the Americans with Disabilities Act (42 U.S.C. § 12132) and Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) required the Department to cover 2 or 3 shifts of in-home private duty nursing so that Eric could live at home. After removal, the district court granted the Director's Rule 12(c) motion. It found the Eleventh Amendment barred the ADA claim. It also found the Rehab Act did not require the Department to add and fund private duty nursing services for adults.

## STATEMENT OF FACTS<sup>1</sup>

### Background

Though Congress decided that the States' Medicaid plans must cover certain services, such as nursing home care, it made other services optional, such as private duty nursing and home health care. 42 U.S.C. §§ 1396a(10)(A), 1396d(a)(4)(A), 1398d(a)(7), (8). Generally, the Illinois Medicaid plan does not cover shift private duty nursing except when short-term and intermittent. 89 Ill. Admin. Code §§ 140.435, 140.346, 140.472. For children, however, Congress mandated that the States' Medicaid plans must cover all necessary medical services, even those not generally covered under a State's plan, under the "early and periodic screening, diagnostic, and treatment" (EPSDT) program. 42 U.S.C. §§ 1396d(a)(4)(B), 1396d(r). Illinois does so. 305 ILCS 5/5-19(a).

Moreover, though Medicaid generally covers long-term medical care only in hospitals and nursing facilities, the States may cover in-home care, including certain services not covered in a State's Medicaid plan, through waiver programs if approved by the federal Department of Health and Human Services (HHS). 42 U.S.C. § 1396n(c). Such programs must be "cost neutral," that is, the average per capita cost of in-home care under the program cannot exceed the average cost of comparable

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<sup>1</sup> Under Rule 12(c) of the Federal Rules of Civil Procedure, like a Rule 12(b)(6) motion, this Court, like the district court, accepts as true all well-pleaded factual allegations and draws all reasonable inferences in the plaintiff's favor. Midwest Gas Services, Inc. v. Indiana Gas Co., Inc., 317 F.3d 703, 709 (7th Cir. 2003). On such motions, in addition to the complaint, courts may take judicial notice of documents in the public record and reports of administrative bodies. Menominee Indian Tribe of Wisconsin v. Thompson, 161 F.3d 449, 456 (7th Cir. 1998).

facility-based care. Id. In Illinois, the Department of Public Aid (the Department), which administers Medicaid and the EPSDT program, has obtained HHS approval for a number of waiver programs to cover in-home care for those who otherwise would require facility-based care. See [www.state.il.us/dpa/home\\_and\\_community\\_based\\_serv.htm](http://www.state.il.us/dpa/home_and_community_based_serv.htm) (accessed 5/15/03).

One of these programs covers all medically necessary in-home care for "medically fragile [and] technology dependent" children up to age 21 who would otherwise be in a facility, regardless of their parents' financial abilities, so long as the "service cost maximum" (SCM) for that care does not exceed the cost of care in a hospital or a skilled pediatric nursing facility. 89 Ill. Admin. Code § 140.645; see also [www.state.il.us/dpa/html/technology\\_dependent\\_medically.htm](http://www.state.il.us/dpa/html/technology_dependent_medically.htm) (accessed 5/15/03). For disabled adults who would otherwise be in a nursing facility, the Home Services Program (HSP) covers in-home care so long as the SCM for such care does not exceed the cost of care in a nursing facility. 89 Ill. Admin. Code §§ 676.10, 676.30(j), 682.100(g), (h) (individual cannot require in-home services that are expected to cost more than the cost of care in a facility for an individual with a similar determination of need (DON) score); see also [www.state.il.us/dpa/html/waiver\\_for\\_the\\_disabled.htm](http://www.state.il.us/dpa/html/waiver_for_the_disabled.htm) (accessed 5/15/03).

Before he turned 21, Eric Radaszewski, the son of Plaintiff Donna Radaszewski, received in-home care through the EPSDT program and the children's waiver program after he was diagnosed with and treated for brain cancer and later suffered a stroke. Doc. 1 at Ex. D at 2 (AT Appendix at A11). Due to special training,

Eric's parents were able to care for him about 8 hours a day, while the children's waiver program covered 2 shifts of private duty nursing daily as well as certain other services. Id. Sometime before his 21st birthday in August 2000, when Eric would "age out" of the children's waiver program, Department officials advised Plaintiff about applying to the Office of Rehabilitation Services (ORS) for the HSP. Id. at 4. In February 2000, ORS determined that Eric's complex medical diagnosis made him eligible for "exceptional care"<sup>2</sup> in a nursing facility and thus he was eligible for an SCM of \$4,593 per month for in-home services instead of the standard SCM of \$1,857 allowed for a DON score of 70. Doc. 13 at Ex. A at 2 (AT Appendix at A41).

On administrative appeal with the Department, the parties agreed that the only issue was whether the HSP should be required to pay more than the cost of a nursing facility at the "exceptional care" SCM to cover in-home services for Eric. Id. at 1 (AT Appendix at A40). At the hearing, Eric's treating physician testified he needed "substantial one-on-one nursing care" and would be at risk if placed in a nursing facility, the registered nurse in charge of his care testified his medical needs required constant surveillance, and an expert testified that no nursing facility would provide the level of care he required, which she said was skilled clinical nursing 24 hours per day. Id. at 2-3 (AT Appendix at A41-42). According to his witnesses, he needed \$15,000 to \$20,000 a month to provide for his in-home care. Id. at 3 (AT Appendix at A41).

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<sup>2</sup> The Department defines "exceptional care" as "the level of care with extraordinary costs related to services" for head-injured or ventilator-dependent persons, among others. 89 Ill. Admin. Code 140.569(a).

In August 2000, Ann Patla, the then-Director of the Department, issued a final administrative decision affirming the ORS determination. Id. at 1 (AT Appendix at A40). She reasoned that the Department's rules governing the HSP permitted participation only when the cost of in-home services does not exceed the cost of a nursing facility. Id. at 4 (AT Appendix at A43). She also noted that Eric had raised 2 issues that could not be heard in the appeal process: (1) a failure to provide services sufficient for his needs, when the failure was based on state law, regulations, and federal government approval, and (2) a challenge to the legality of the HSP rules as applied to him. Id. Nothing in the record indicates that judicial review was sought for the Director's decision.

### **Plaintiff's First Suit**

On September 1, 2000, Plaintiff filed an action in federal court against then-Director Anna Patla, seeking to compel the Department to continue to cover shifts of private duty nursing for Eric and alleging violation of his rights under the Illinois Medicaid plan, federal Medicaid law (42 U.S.C. § 1396 et seq.), and due process. Doc. 1 at Ex. D at 10 (Radaszewski v. Patla, No. 00-5391 (N.D. Ill.)). Though the district court granted Plaintiff's motion for a temporary restraining order against the Director, it denied her motion for a preliminary injunction. Doc. 1 at Ex. D at 10. Plaintiff appealed, but this Court held the appeal was moot in light of an amendment to the Illinois Medicaid plan eliminating private duty nursing for adults.<sup>3</sup> Doc. 3 at

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<sup>3</sup> In February 2001, HHS approved the amendment to the Illinois Medicaid plan. Doc. 10 at Ex. A. The Department filed a certified copy of the amended rule with the office of the Illinois Secretary of State in September 2001. Doc. 1 at Ex. D at

Ex. F (Radaszewski v. Patla, No. 00-3929 (7th Cir., March 8, 2001)).

### **Plaintiffs Second Suit**

Meanwhile, in December 2000, approximately 1 month after the district court denied Plaintiff's motion for a preliminary injunction, she filed another suit against the Director, this time in the Circuit Court of DuPage County, alleging violations of state law based on the same facts and seeking injunctive relief. Doc. 1 at Ex. A.

Within a few weeks, the state court issued a temporary restraining order against the Director. Id. at Ex. B. Plaintiff subsequently was granted leave to file a supplemental complaint, which added allegations that private duty nursing for Eric was required under the nondiscrimination requirement of Title II of the Americans with Disabilities Act (ADA) (42 U.S.C. § 12132) and Section 504 of the Rehabilitation Act of 1973 (the Rehab Act) (29 U.S.C. § 794) and challenged the amendment to the Illinois Medicaid plan on state law grounds. Id. at Ex. E, D. The Director answered. Doc. 3 at Ex. E.

The Director then filed a notice of removal pursuant to 28 U.S.C. §§ 1441 and 1446(b). Doc. 1. After removal, Plaintiff moved to remand (Docs. 3, 4), but the district court granted the motion only as to the state law claims<sup>4</sup> (Doc. 8).

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11.

<sup>4</sup> The state court subsequently dismissed the case. Radaszewski v. Garner, No. 00-CH-1475 (DuPage County Circ. Ct., Nov. 22, 2002). Plaintiff appealed, and the appeal remains pending. Radaszewski v. Maram, No. 2-02-1276 (Ill. App. Ct., 2d Dist.).

### **The District Court Judgment**

The Director then moved for judgment on the pleadings as to the federal claims under Rule 12(c) of the Federal Rules of Civil Procedure. Doc. 10. On the ADA claim, the Director argued that the Director could not be named as a defendant, citing Walker v. Snyder, 213 F.3d 344 (7th Cir. 2000). Id. at 4. She also argued that neither the ADA nor the Rehab Act required the Department to cover 24-hour private duty nursing in Eric's home. Id. at 4-14. Plaintiff responded (Doc. 12), and the Director replied (Doc. 13). Plaintiff asked the district court to defer its ruling on the motion until this Court issued its opinion in a pending appeal that challenged Walker, and the Director objected. Docs. 15, 14.

The district court entered an order denying Plaintiff's motion to defer and granting the Director's motion for judgment on the pleadings. Doc. 16 (AT Appendix at A5). The court dismissed the ADA claim on Eleventh Amendment grounds, finding that Walker was controlling. Id. at 4. Noting that the Rehab Act does not require the States to create and fund new programs and that private duty nursing is not presently covered for any adults, it found the Department did not have to create and fund long-term private duty nursing for Eric. Id. at 5.

Plaintiff appealed. Doc. 17. The district court subsequently entered the remand order a second time. Doc. 22.

## **SUMMARY OF ARGUMENT**

The United States Supreme Court held in Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581 (1999) that the Americans with Disabilities Act prohibits discrimination only with regard to the services the States "in fact provide." Here, Plaintiff wants the Department of Public Aid to cover 2 or 3 shifts of private duty nursing daily for her son so that he can live at home. The Medicaid plan for Illinois, however, does not cover private duty nursing for adults, the Department of Public Aid covers it only for children up to age 21, and the Department has determined that her son is eligible under the Home Services Program (HSP) for disabled adults only at the "exceptional care" level, which is the equivalent of at most 5 hours of private duty nursing a day.

Plaintiff can plead no set of facts that would support a disability discrimination claim under the ADA or Section 504 of the Rehabilitation Act of 1973. She cannot allege that an existing Department program will cover 2 or 3 shifts of private duty nursing a day for her son: the Medicaid plan covers no private duty nursing, the HSP would cover at most 5 hours a day, and the children's program is unavailable to adults. Plaintiff also cannot allege any facts to show that her son meets the eligibility requirements for the HSP, because she has alleged that the cost of his in-home care would exceed the HSP cap for the level of care the Department has determined he needs. Lastly, she cannot allege that the program modifications needed to cover 2 or 3 shifts of private duty nursing are reasonable: the children's program would have to be extended to adults, or the HSP cap would have to be raised at least 400%. Either modification is patently unreasonable. Thus, the Director was entitled to judgment.



## ARGUMENT

### **I. The Director Was Entitled to Judgment as a Matter of Law on Plaintiff's ADA and Rehab Act Claims.**

The district court dismissed Plaintiff's ADA claim on the ground that Walker was controlling, but this Court recently abrogated Walker in Bruggeman v. Blagojevich, 324 F.3d 906, 912-13 (7th Cir. 2003). Nevertheless, as Plaintiff acknowledges, an ADA claim is materially identical to, and subject to the same standard as, a claim under Section 504 of the Rehab Act, with the sole difference being that the latter applies only to federally funded programs. AT Brf. at 9. As demonstrated below, however, application of that standard to Plaintiff's claims mandates their dismissal.

#### **A. The Grant of a Rule 12(c) Motion Should Be Affirmed When, as Here, a Plaintiff Cannot Plead a Set of Facts to Support Her Claim.**

The grant of a motion to dismiss under Rule 12(c) of the Federal Rules of Civil Procedure, like a Rule 12(b)(6) motion, is reviewed de novo. Midwest Gas Services, Inc. v. Indiana Gas Co., Inc., 317 F.3d 703, 709 (7th Cir. 2003). Thus, this Court accepts as true all well-pleaded factual allegations and draws all reasonable inferences in the plaintiff's favor. Id. at 709. In addition to the complaint, courts may take judicial notice of documents in the public record and reports of administrative bodies. Menominee Indian Tribe of Wisconsin v. Thompson, 161 F.3d 449, 456 (7th Cir. 1998).

As Plaintiff recognizes (AT Brf. at 6), a Rule 12(c) motion should be granted if

it appears beyond doubt that she cannot plead any set of facts that would support her claims. Midwest Gas Services, 317 F.3d at 709. Moreover, even if the district court improperly considered extrinsic documents, as Plaintiff implies (AT Brf. at 8), the judgment may be affirmed if dismissal would be proper without considering them. Menominee Indian Tribe, 161 F.3d at 456. Here, it is plain that Plaintiff's complaint was subject to dismissal because she did not and cannot plead any set of facts that would support her claims.

**B. The Director Was Entitled to Judgment Because Neither the ADA Nor the Rehab Act Requires the Department to Add Private Duty Nursing for Adults to Its Medicaid Plan or to Increase the SCM for the HSP by 400-600% to Cover Shifts of Private Duty Nurses in the Home.**

Plaintiff attacks the district court's decision reasoning, as do Amici. AT Brf. at 21-24, Amici Brf. at 14, 16. As demonstrated below, dismissal was proper.

**1. The ADA and Section 504 of the Rehab Act Require the States to Make Only "Reasonable Modifications" to Programs the States "in Fact Provide."**

To determine whether Plaintiff did or can allege a set of facts that would support her claim requires this Court to determine Congress's intent when enacting the ADA and Section 504 of the Rehab Act. To do so requires looking first at the language of the statutes to determine their plain meaning; legislative history is examined only if necessary to determine whether the language of the statutes is contrary to that intent. Grzan v. Charter Hospital of Northwest Indiana, 104 F.3d 116, 122 (7th Cir. 1997) (affirming dismissal of a Rehab Act claim). Thus, though

Plaintiff's brief addresses the legislative history of the ADA and Section 504 of the Rehab Act at some length (AT Brf. at 13-14 & n.4), doing so was unnecessary unless the wording of the statutes at issue here is ambiguous (Eldred v. Ashcroft, \_\_ U.S. \_\_\_, \_\_\_, 123 S. Ct. 769, 783 n.16 (2002)). Plaintiff does not argue that either statute's language is ambiguous. She is correct not to do so.

Section 504 of the Rehab Act prohibits the denial of federally funded benefits to a "qualified individual with a disability" "solely by reason of" that disability. 29 U.S.C. § 794(a). The Supreme Court has explained that Congress's intent in enacting Section 504 was only "to assure evenhanded treatment" of handicapped individuals in administration of federally-funded benefits. Alexander v. Choate, 469 U.S. 287, 304 (1985). The Court cautioned that Section 504 was not intended to "guarantee that each [benefit] recipient will receive that level of health care precisely tailored to his or her needs." Id. at 303. Indeed, the Court held that nothing in the Rehab Act indicates Congress intended "to make major inroads on the States' longstanding discretion to choose the proper mix of amount, scope, and duration limitations on services covered by state Medicaid . . . ." Id. at 307. Moreover, the Court has held that the Rehab Act does not require extending to all disabled people a benefit accorded to one set of disabled individuals. Traynor v. Turnage, 485 U.S. 535, 549 (1988). In short, through Section 504, Congress intended only to prohibit disability discrimination, not to set national health care policy.

Like Section 504, the ADA prohibits public entities from discriminating

against a "qualified individual with a disability" "by reason of such disability" in their programs, but unlike Section 504, it is not limited to federally funded programs. 42 U.S.C. § 12132. The ADA defines "qualified individual with a disability" to include only those who, with or without reasonable modifications, meet "the essential eligibility requirements" for participating in a public entity's programs. 42 U.S.C. § 12131(2). It also required the Attorney General of the United States to issue rules implementing it that would be consistent with those promulgated under Section 504 of the Rehab Act. 42 U.S.C. § 12134. Congress explicitly expressed its intent that the ADA be interpreted consistently with Alexander. H.R. Rep. No. 101-485(II), 101st Cong., 2d Sess. 84 (1990) (reprinted in 1990 U.S.C.C.A.N. 267, 303, 367 (1990)).

Under one of the ADA rules, called the "reasonable accommodation regulation," public entities may be required to make only "reasonable modifications" to their policies and practices, and only when necessary to avoid disability discrimination. 28 C.F.R. § 35.130(b)(7). Moreover, a public entity may resist making such modifications by demonstrating they would "fundamentally alter" a program. Id. Another rule, the "integration regulation," requires public entities to administer their programs and services "in the most integrated setting appropriate to the needs of qualified handicapped persons. 28 C.F.R. § 35.130(d).

**2. The Supreme Court Has Explicitly Limited the ADA's Nondiscrimination Requirement to Programs and Services the States Already Provide.**

Plaintiff and Amici Access Living et al. appear to believe that the ADA requires

the States to cover any and all services needed to allow the disabled to live at home. AT Brf. at 10-23, Amici Brf. at 14-19. Not so. Indeed, not long ago, the United States Supreme Court gave only a "qualified yes" when asked if the ADA's nondiscrimination provision requires transferring a disabled person from a facility to a community setting. Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581 (1999).

In Olmstead, the mentally disabled plaintiffs argued that Georgia violated the ADA by not transferring them from its psychiatric hospitals to its community-based programs even though its treatment professionals had determined they were eligible for such placements. Id. at 593. Georgia countered that inadequate funding, not disability discrimination, prevented the transfers. Id. at 594. Alternatively, it argued, to require immediate transfers would fundamentally alter its activities given that it was using all available funds for others with disabilities. Id. The Court<sup>5</sup> concluded that the States must provide community-based treatment for the mentally disabled if the State's treatment professionals have determined such placement is appropriate, the disabled person is not opposed, and the placement can be reasonably accommodated, unless the State can demonstrate that the placement would fundamentally alter the nature of its programs. Id. at 597-03, 607. The Court then remanded the matter for further proceedings. Id. at 607.

In reaching its conclusions, the Court first held that "unjustified institutional isolation" of the disabled constitutes disability discrimination for ADA purposes. Id.

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<sup>5</sup> Though Plaintiff attributes this statement to the plurality (AT Brf. at 13), it appears to be part of the majority's decision.

at 600. The Court then found that requiring the mentally disabled to give up community life, even when community placement could be reasonably accommodated, in order to receive medical services constituted disability discrimination, given that others could receive the same services while living in the community. Id. at 601. The Court emphasized, however, that the ADA prohibits discrimination only against "qualified individuals," that is, those who the State's professionals have reasonably determined meet the essential eligibility requirements for the services sought. Id. at 601-02. Absent a State's determination that an individual meets the relevant requirements, the Court held, placing him in the community would be "inappropriate" within the meaning of the "integration regulation." Id. at 602. Though Plaintiff appears to view "reasonable modification" and "fundamental alteration" as 2 sides of the same coin (AT Brf. at 20-21), the Court further indicated that an ADA plaintiff has the burden of demonstrating that the modification she seeks is "reasonable," a question the plurality distinguished from that of the public entity's "fundamental alteration" defense. 527 U.S. at 587; id. at 603 (plurality) (distinguishing between questions of "reasonable modification" and "fundamental alteration"); id. at 613 (Kennedy, J., concurring) (same).

Though Plaintiff argues that whether the service sought is an existing program "may be a factor" in ADA analysis (AT Brf. at 22), she ignores the Court's explicit holding that whether the service at issue exists is the key factor: "the States must adhere to the ADA's nondiscrimination requirement with regard to the services they

in fact provide," not with regard to services the State does not provide. 527 U.S. at 603 n.14 (emphasis added). Indeed, the Court stressed it was not holding that the ADA affirmatively imposes on the States a "standard of care" for whatever medical services they render, or . . . requires States to 'provide a certain level of benefits to individuals with disabilities.'" Id. As Justice Kennedy observed in his concurrence, the ADA does not require a State to create a non-facility-based program where none exists, and a State's judgments on the "hard decisions" about how to allocate its resources in the treatment of diseases and disabilities is a political one that is not within the ADA's ambit. Id. at 612-13 (Kennedy, J., concurring in part). Indeed, Justice Kennedy emphasized that "[i]t is not reasonable to read the ADA to permit court intervention" in a State's decision to create, or to decline to create, a new service. Id. at 613 (Kennedy, J., concurring in part).

Addressing the "fundamental alteration" defense in the "reasonable accommodation regulation," the Court<sup>6</sup> held that courts should consider not only the cost of providing non-facility-based care to the plaintiffs but also the range of services the States provide to others with similar disabilities and its obligation "to mete out those services equitably." Id. at 597. A plurality of the Court likened the defense to the "undue burden" standard of the rules promulgated under Section 504 of the Rehab Act. Id. at 603-07 & n.16 (plurality opinion) (citing 28 C.F.R. §§ 41.53, 42.511(c) and 45 C.F.R. § 84.12(c)).

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<sup>6</sup> Though Plaintiff attributes this statement to the plurality (AT Brf. at 12-13), it appears in the majority's opinion.

Since Olmstead, courts have given the same "qualified yes" when asked to decide whether the ADA requires a State to provide a disabled plaintiff with an existing benefit that would allow him not to live in a facility. In Townsend v. Quasim, \_\_\_ F.3d \_\_\_, 2003 WL 1989623 (9th Cir., May 1, 2003), for example, the court concluded that because the State offered community-based long-term care to the categorically needy, it had to offer it to the medically needy too unless it could demonstrate that extending care to the latter group would fundamentally alter its Medicaid program. In Pennsylvania Protection and Advocacy, Inc. v. Dept. of Public Welfare, 243 F. Supp. 2d 184, 193-95 (M.D. Penn. 2003), the court granted the State's motion for summary judgment, rejecting claims that it had violated the ADA and Section 504 of the Rehab Act by not providing community-based living programs after it had demonstrated it lacked the resources to do so. The court stressed that how officials had decided to allocate funds within their budget for those qualified for community placement was not a proper subject for judicial scrutiny. Id. at 195 & n.9.

\_\_\_\_\_ By contrast, when asked the different question of whether the benefit sought would require a State to create a new service, courts have given an unqualified "no," as footnote 14 of Olmstead requires. Perhaps most instructive on this question is Rodriguez v. City of New York, 197 F.3d 611 (2d Cir. 1999), in which the court held that the ADA did not require the defendant to create a new service (a caregiver for safety-monitoring), which the plaintiffs alleged would allow them to live at home. In Rodriguez, the court first found that the crux of the claim was that by providing



certain services to one group of disabled people, the defendant discriminated against those who needed different services. Id. at 618. Because the defendant did not provide safety-monitoring caretakers to either the mentally disabled or the physically disabled, moreover, the court concluded that the plaintiffs were challenging the substance of the services rather than discrimination against the disabled, noting that the ADA does not forbid denying a benefit that is provided to no one. Id. The court also held that the plaintiff could not meet the "essential eligibility requirements" for safety monitoring caretakers, given that there were no such requirements. Id. The court also rejected the plaintiffs' reliance on Olmstead, which it read as addressing only where the State had to provide an existing service, not whether it had to provide a new service. Id. at 619. The court stressed that footnote 14 in Olmstead explicitly limited the ADA to prohibit discrimination in services the State actually provides and to not require that the States provide a certain level of benefits to the disabled. Id.

Here, Plaintiff insists that Rodriguez is inapposite because the Department already covers "nursing services." See, e.g., AT Brf. at 22-23. The service Plaintiff seeks here, however is not just "nursing services." Instead, she wants private duty nursing, up to 24 hours a day. As Plaintiff acknowledges, the State's Medicaid plan does not include this service for adults. AT Brf. at 23 n.6. According to the complaint, the HSP does not cover it either within the "exceptional care" SCM. Doc. 1 at Ex. A at 4. In fact, Plaintiff tacitly acknowledges that she cannot obtain the service she seeks unless the Department either raises the age limit for the children's

waiver program or raises the level of care covered by the HSP, from "exceptional care" in a nursing facility to hospitalization. AT Brf. at 18-19. Because the case at bar concerns a benefit that the Department does not offer now, it is like Rodriguez, not like Olmstead. As in Rodriguez, the question here is whether private duty nursing should be covered, not where it should be provided, given that it is not provided now. 197 F.3d at 619 (distinguishing Olmstead on this ground).

**3. Plaintiff Did Not and Cannot Allege Any Set of Facts That Would State a Claim Under the ADA or Section 504 of the Rehab Act.**

Plaintiff gives short shrift to the facts needed to state a claim under the ADA, summarily contending she has done so with allegations that (1) Eric needs and wants private duty nursing in his home; (2) his home is the "most integrated setting appropriate" for his needs; (3) the cost of round-the-clock (or at least 2 shifts of) private duty nursing is less than the cost of hospitalization; (4) he is eligible for participation in the HSP but for its funding level; and (5) the modifications she seeks for the waiver programs (waiving the age cap for the children's waiver program for those who reach 21 and whose in-home care costs less than hospitalization or increasing the SCM for the HSP from nursing facility to hospitalization) are "very little." AT Brf. at 17-19. She also argues that dismissal under Rule 12(c) is premature until the Department presents evidence to support a "fundamental alteration" defense. AT Brf. at 18-21. Amici do the same. Amici Brf. at 16 n.12. The first, and only, question here, however, is whether Plaintiff did or can allege a set of

facts stating a prima facie case under the ADA or Section 504 of the Rehab Act. The answer is no.

As a threshold matter, Plaintiff appears to underestimate the elements of her prima facie case. Under Olmstead, they include (1) a disabled person who wants to live in the community and (2) could do so with a service the public entity "in fact provides" and (3) for which the public entity's professionals have determined he is eligible, when (4) the service is offered in a facility and (5) extending that service to him outside the facility would require only a "reasonable modification" to the State's programs. See, e.g., Martin v. Taft, 222 F. Supp. 2d 940, 972 (S.D. Ohio 2002) (citing Olmstead). A careful comparison between the elements of the prima facie case and the complaint reveals that Plaintiff did and can allege a set of facts that satisfies only a few of the essential elements of her prima facie case. Moreover, as explained below, Plaintiff may have pled herself out of court.

Plaintiff's next problem is that the service she wants (2 or 3 shifts of private duty nursing daily) is not one the Department "in fact provide[s]" even though the Olmstead Court explicitly held this is an essential element of an ADA discrimination claim. 527 U.S. at 603 n.14. Plaintiff contends that the Illinois Medicaid plan covers "nursing services" and that the HSP covers "skilled nursing services" (AT Brf. at 17, 22), implying that private duty nursing are covered in a nursing facility (under Medicaid) or in the home (under the HSP). Likewise, Amici call the service at issue just "nursing" and argue that the Department must cover "appropriate nursing

services," implying that it would cover private duty nursing for Eric in a nursing facility. Amici Brf. at 16-18. The 2001 amendment to the Department's rules, however, makes plain that the Medicaid plan does not cover private duty nursing for any adult anywhere, unless short-term and intermittent. Moreover, individuals may use HSP funds to cover in-home services that cost no more than the SCM, which Plaintiff admits will cover no more than the equivalent of 5 hours of private duty nursing daily. AT Brf. at 19. Thus, the service Plaintiff seeks is not one the Department "in fact provide[s]" now under either Medicaid or the HSP. Under these circumstances, Plaintiff and Amici are challenging the substance of the service the Department covers, just like the plaintiffs in Rodriguez. 197 F.3d at 618. As the court there indicated, a disability discrimination claim cannot be based on the denial of a benefit that is denied to all. Id.

Plaintiff also contends that Eric is eligible for the HSP even though she admits that his needs exceed the HSP's essential eligibility requirements, which she dismisses as just "a formula that capped the funding he could receive." AT Brf. at 19. Plaintiff cannot allege that the Department's professionals have determined Eric presently meets the essential eligibility requirements for 2 or 3 shifts of private duty nursing daily, given that, as Rodriguez explained, it is impossible to allege facts showing that one meets the essential eligibility requirements for a service that does not exist and thus has no requirements. 197 F.3d at 618. Thus, Amici's argument that it is irrelevant that the service sought is not provided to anyone (Amici Brf. at

16) must be rejected. On the contrary, that the service does not exist is the most relevant fact of all, according to footnote 14 of Olmstead. Another reason Plaintiff cannot allege Eric is eligible for 2 or 3 shifts of private duty nursing daily is that she has alleged the State's professionals determined he is eligible only for "exceptional care" in a nursing facility, which does not include any private duty nursing.

Plaintiff complains that the cap for the HSP is too low to allow him to remain in the community. AT Brf. at 19. Apparently, she does not realize that this means she in effect has pled that he cannot meet the essential eligibility requirements of the HSP for in-home services, one of which is that the cost of in-home services be no more than the cost of exceptional care in a nursing facility. Because she has alleged that the cost of the services Eric wants exceeds the cost of "exceptional care" in a nursing facility, one of her own authorities teaches, she has pled herself out of court on this essential element of her case. Cramer v. Chiles, 35 F. Supp. 2d 1324, 1348 (S.D. Fla. 1999) (individual is not eligible for waiver program if the cost of in-home services exceeds the cost of comparable care in a facility).

Also, Plaintiff repeatedly insists that 2 or 3 shifts of private duty nursing daily would cost less than "the cost of Medicaid[-]covered services he would need in the institutional setting appropriate for him." See, e.g., AT Brf. at 24, 18. She has alleged, however, that the Department has determined that the institutional setting appropriate for Eric is "exceptional care" in a nursing facility, and she also has alleged that the cost of 2 or 3 shifts of private duty nursing daily is far more than the cost of

that care, which she has alleged is at most the equivalent of 5 hours of private duty nursing daily. Amici make the opposite mistake, arguing that the cap for the children's waiver program was the cost of care in a nursing facility so the cost of 2 shifts of private duty nursing could not have been more than the cost of a nursing facility. Amici Brf. at 16 n.12. As explained above, the cap for the children's waiver program was hospitalization.

Plaintiff also summarily insists that Eric's home is the "most integrated setting for the [nursing] services" Eric needs (AT Brf. at 17, 18), but the wording of the regulation requires that a setting be the "most integrated [one] appropriate to [his] needs," not to the services. 28 C.F.R. § 35.130(d) (emphasis added). Under Olmstead, it is not "appropriate" within the meaning of this regulation to place a patient in the community unless the State's professionals have determined he meets the essential eligibility requirements for participation in a program that would allow the placement. 527 U.S. at 602. Here, in effect, Plaintiff has alleged that Eric does not meet the essential eligibility requirements for in-home care under the HSP because, as she alleges, the State's professionals have determined he is eligible only for "exceptional care" in a nursing home or its cost-equivalent for in-home services, which she further alleged is insufficient to cover the care he needs to remain at home. Under these circumstances, Olmstead teaches, Plaintiff did not and cannot allege that Eric's home is the "the most integrated setting appropriate to [his] needs" within the meaning of the integration regulation.

Even if the complaint could be construed as alleging a set of facts meeting all the above essential elements of Plaintiff's prima facie case, it nevertheless was subject to dismissal unless she could also allege a set of facts showing that the modifications she seeks for the State's Medicaid plan or the HSP are reasonable. She cannot. Though Plaintiff characterizes the modifications that would be needed as "very small" or "very little" (AT Brf. at 18, 19), she grossly understates them.

For example, the modification Plaintiff seeks for the children's waiver program is to extend it to a class of adults of an unspecified number. AT Brf. at 19. Such a "modification" is facially unreasonable because it would completely change the program's focus and purpose, which is to cover services for a class of children with very special medical needs, who would otherwise have to be in a hospital or a skilled pediatric nursing facility, regardless of their parents' financial eligibility for Medicaid. Similarly, the "modification" that Plaintiff seeks for the HSP to raise its cap by 400-600%. Doing so would completely change the HSP's modest focus and purpose, which is to cover a modest mix of homemaking and personal care services for disabled individuals who would otherwise have to be in a nursing facility, regardless of their financial eligibility for Medicaid. Neither program is intended to cover adults whose medical needs require 2 or 3 shifts of private duty nursing daily. As Justice Kennedy observed in Olmstead, a State's decisions about how to allocate its resources simply not subject to judicial review. 527 U.S. at 612-13 (Kennedy, J., concurring in part); see also Pennsylvania Protection and Advocacy, 243 F. Supp. 2d at 195 & n.9.

In sum, though Plaintiff complains that the Director's decision not to cover a service for which Eric is not eligible "[t]urn[s] Olmstead on its head" (AT Brf. at 17), it is Plaintiff who wants to turn the ADA on its head. The Department's professionals have determined that Eric meets the essential eligibility requirements for "exceptional care" in a nursing facility and it has offered to cover in-home services for him up to the cost of that care, but Plaintiff rejected its offer. Instead, she demands that the Department cover up to 24 hours of private duty nursing for Eric even though the Department does not cover any private duty shift nursing for any adult under any existing program and cannot do so unless it makes facially unreasonable changes to the Medicaid plan or the HSP. Because Plaintiff did not and cannot plead a set of facts that would support a claim under the nondiscrimination requirements of the ADA and Section 504 of the Rehab Act require, the Director was entitled to judgment.

**C. Plaintiffs and Amici's Authorities Are Inapposite or Unpersuasive.**

None of Plaintiff's and Amici's authorities requires reversal.

Plaintiff mistakenly views her claim as turning on where the Department must offer "nursing services" for Eric (AT Brf. at 8), as do Amici (Amici Brf. at 15). Thus, it is not surprising that most of their post-Olmstead string-cited authorities address that issue rather than whether the State must provide it, the true question raised here and in Rodriguez. AT Brf. at 17 and Amici Brf. at 15 (citing Frederick L. v. Dept. of Public Welfare, 217 F. Supp. 2d 581, 591-93 (E.D. Pa. 2002) (entering



judgment for State, which demonstrated that to assure 60 community placements of mentally disabled would deprive others of health care and thus would be fundamental alteration in programs); Bryson v. Shumway, 177 F. Supp. 2d 78, 101 (D.N.H. 2001) (questions of fact on reasonableness of pace of waiting list and effectiveness of plan for transfer from facility barred summary judgment), rev'd in part on other grounds, vacated in part on other grounds, and remanded in part on other grounds, 308 F.3d 79 (1st Cir. 2002); Williams v. Wasserman, 164 F. Supp. 2d 591, 627-38 (D. Md. 2001) (granting defendant's summary judgment motion based on demonstration that State's progress in placing disabled in community was acceptable and that more immediate shift of resources plaintiffs sought would have fundamentally altered State's programs); Henrietta D. v. Giuliani, 81 F. Supp. 2d 425 (E.D. N.Y. 2000) (denying motion for summary judgment on question of equal access to existing benefits).

The other authorities Plaintiff and Amici cite decline to rule on a defendant's "fundamental alteration" defense due to the lack of evidence at that stage in the litigation. Id. (citing Lewis v. New Mexico Dept. of Health, 94 F. Supp. 2d 1217, 1238-39 (D. N.M. 2000) (denying 12(b)(6) motion as premature given that cost analysis was needed to assess State's fundamental alteration defense), aff'd on other grounds 261 F.3d 970 (10th Cir. 2001); Makin v. Hawaii, 114 F. Supp. 2d 1017, 1033-36 (D. Hawai'i 1999) (denying State's motion for summary judgment due to questions of fact about whether the plaintiffs were "qualified individuals" absent a state determination on level of care, whether the modifications sought were reasonable,

and if so, whether they would fundamentally alter the program)). That affirmative defense, however, need not be addressed unless and until a plaintiff sets for a prima facie case. As explained above, Plaintiff has failed to do so in her complaint.

Though Plaintiff faults the district court for citing pre-Olmstead authorities (AT Brf. at 21), she herself string-cites a number of them (id. at 15). She also relies heavily on one of them, which likewise concerned the question of where the State must offer existing services rather than whether the State must provide it. Id. at 15-17 (citing Helen L. v. DiDario, 46 F.3d 325 (3d Cir. 1995)). Furthermore, Helen L. is inapposite because the plaintiff there wanted fewer services at home than were provided at the nursing facility, whereas Plaintiff wants far more services than a nursing facility will provide, according to the complaint. Moreover, Plaintiff appears to rely on the Helen L. court's criticism of how officials had allocated funds within the Department's budget for those qualified for community placement (AT Brf. at 16-17), and she appears to challenge the Department's decision not to cover private duty nursing under the Medicaid plan (id. at 23 n.6). As Pennsylvania Protection and Advocacy noted, however, Helen L.'s criticism did not survive Olmstead because a State's decisions about how to allocate its resources are not a proper subject for judicial scrutiny. 243 F. Supp. 2d at 195 & n.9.

**D. Amicus United States Is Silent on Whether Plaintiff Can Plead Any Set of Facts to Support Her ADA Claim, While the Other Amici Misunderstand Both the Law and the Facts.**

Though the Attorney General for the United States promulgated the ADA

regulations at issue here, the brief of Amicus United States does not mention them and addresses only the Eleventh Amendment issue. Its silence on the question is deafening.

The other Amici make a number of legal and factual errors in their arguments. For example, though courts may take judicial notice of documents in the public record and reports of administrative bodies (Menominee Indian Tribe of Wisconsin v. Thompson, 161 F.3d 449, 456 (7th Cir. 1998)), Amici rely in part on an internal Department memo. Amici at 16 n.12 and Appendix. They also rely on extrinsic material from sources not in the public record. Amici Brf. at 16 n.12, 17-18. They offer no authority for considering such information on a Rule 12(c) motion, however, so the memo and the references to it should be stricken, as should the other items.

Amici further argue that Eric is "eligible for more extensive nursing care" than the Department will provide under the HSP but he must enter a nursing facility to receive it, which they call a "Hobson's choice." Amici Brf. at 4, 14. According to the complaint, however, the Department has determined that Eric is eligible only for "exceptional care," not for "more extensive nursing," and he may choose to receive that level of care in a nursing facility or to receive services in his home up to the same dollar amount. No private duty nursing is covered in a nursing facility under the "exceptional care" program (89 Ill. Admin. Code § 140.569), so Eric would not receive 2 or 3 shifts of private duty nursing if he is in a nursing facility.

## **CONCLUSION**

For the reasons stated above, Defendant-Appellee Barry Maram, Director of the Illinois Department of Public Aid, respectfully requests that this Court affirm the judgment entered in his favor.

Respectfully submitted,

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## PROOF OF SERVICE

The undersigned, being first duly sworn upon oath, deposes and states that two (2) copies of the foregoing Brief of Defendant-Appellee were served upon the below-named party by depositing such copies in the United States mail at 100 West Randolph Street, Chicago, Illinois 60601 in an envelope bearing sufficient postage on May 16, 2003, before 5:00 p.m.

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SUBSCRIBED and SWORN to before me  
this 16th day of May, 2003.

NOTARY PUBLIC