IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF WISCONSIN

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GERALD NELSON, by his legal guardian and next friend, JANE PRENTICE; JOAN BZDAWKA, by her legal guardian and next friend, RICHARD MILLER; SANDRA EHRLICHMAN, by her legal guardian and next friend, NANCY STEEVES; MARILYN BERDIKOFF, by her legal guardian and next friend, LOIS DEGNER; LENORE CZARNECKI, by her agent and next friend, CAROLYN CETNAROWSKI; and JOHN GORTON, by his agent and next friend, DEBORAK BRUNK, each on their own behalf and on behalf of a class of persons similarly situated,

Plaintiffs,

v. Case No. 04-C-0193

MILWAUKEE COUNTY; WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES; and HELENE NELSON, in her official capacity as Secretary of DHFS,

Defendants.

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# STATE DEFENDANTS' BRIEF IN SUPPORT OF MOTIONS TO DISMISS FOURTH AMENDED COMPLAINT

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## STATEMENT OF THE CASE

This is an action for declaratory, injunctive and retroactive monetary relief based on the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12101, *et seq.*, and § 504 of the Rehabilitation Act, 29 U.S.C. § 794; together with a statutory civil rights claim, 42 U.S.C. § 1983, based on the federal Medical Assistance ("MA" or "Medicaid") statute, § 1396a(a)(30)(A). Plaintiffs claim that their rights under the ADA, Rehabilitation Act and Medicaid statute, § 1396a(a)(30)(a) ("(a)(30)(A)"), are being violated by the manner in which the

State of Wisconsin and Milwaukee County administer Family Care, a statutory Wisconsin MA waiver program designed to serve physically and developmentally disabled persons and the elderly. Family Care is now operating in a limited number of Wisconsin counties, including Milwaukee County, and is designed to provide long-term community-based managed care to covered individuals who choose to enroll in the county "care management organization" ("CMO"). Plaintiffs, six individual recipients of Family Care in Milwaukee County and their guardians or authorized representatives, currently assert nine counts on behalf of themselves and a putative class. The primary focus of plaintiffs' claims is the allegedly inadequate per member-per month (or "capitated") rates paid by the State to the Milwaukee CMO and Milwaukee County's attempts to limit the contracted rates it pays to providers of certain residential and day program services to the plaintiffs and the class they seek to represent.

The defendants include Milwaukee County, which administers the Milwaukee County CMO; the Wisconsin Department of Health and Family Services ("DHFS"), which administers the Wisconsin Medical Assistance program, including Family Care; and Helene Nelson, the DHFS Secretary, sued in her official capacity (collectively, the "State defendants"). After filing answers incorporating grounds for dismissal as defenses, both the County and the State defendants have formally moved to dismiss the Fourth Amended Complaint. This brief is submitted in support of the State Defendants' Motions to Dismiss.

## QUESTIONS PRESENTED

1. Must certain counts be dismissed for lack of jurisdiction because the plaintiffs lack standing or because particular claims are not ripe for adjudication?

2. Must plaintiffs' claim for retroactive declaratory and monetary relief against the State defendants be dismissed because, with the exception of the Rehabilitation Act, such relief is barred based on sovereign immunity and the Eleventh Amendment to the U.S. Constitution?

3. Must the complaint be dismissed because the nine assorted counts fail to state claims on which relief can be granted, F.R.C.P. 12(b)(6) and 12(c)?

## STATEMENT OF FACTS

Family Care is a managed care MA waiver program currently operated by DHFS as a pilot program through which elderly persons with long-term care needs and adults who have physical or developmental disabilities may receive comprehensive community-based services.[1] Services available under Family Care include both some of the services that would otherwise be provided under Wisconsin's regular State Medicaid Plan, as well as services that would otherwise be available only under a Home and Community-Based Services (HCBS) Waiver obtained from the federal government under § 1915(c) of the Social Security Act, 42 U.S.C. § 1396n(c).[2]

[1]General descriptive information regarding Family Care is available on the DHFS website at http://dhfs.wisconsin.gov/LTCare/Generalinfo/Index.htm (Exhibit 2001*). *As more fully described later in this brief, the State defendants request that the Court take judicial notice of basic documentary materials related to the Family Care waiver that are posted on the DHFS website. Hard copies of the documents have been marked as exhibits and are being mailed to the Court and other counsel simultaneously with the filing of this brief. An index to these exhibits is attached to this brief as well.

[2]For a complete listing of long-term care services provided through Family Care, see the Health and Community Supports Contract for 2005 ("the CMO Contract") at pp. 15-16, available on the DHFS website at: http://dhfs.wisconsin.gov/LTCare/StateFedReqs/CY05HCSContract.pdf (Exhibit 2002).

Family Care is authorized by federal Medicaid authorities pursuant to two types of waivers,[3] and an approved prepaid health plan that authorizes DHFS to contract for State Plan long-term care services on a prepaid basis.[4] The waivers permit Wisconsin to deliver services in a manner that is exempt from some otherwise-applicable federal Medicaid requirements. One type of waiver, the HCBS or "1915(c)" waiver, permits Wisconsin to use federal Medicaid funds for HCBS services instead of only institutional care for people who would qualify for Medicaid in a nursing home. *See* 42 USC §1396n(c). The other type of waiver, the managed care or "1915(b)" waiver, permits Wisconsin to limit the services in the Family Care benefit to people who enroll in a CMO. This waiver also limits participants' freedom of choice of provider. *See* 42 USC §1396n(b) ("Waivers to promote cost-effectiveness and efficiency").

Family Care is currently being operated on a pilot basis in several counties.[5] In Milwaukee County, Family Care is available only for elderly individuals (60 years of age and older), including those with physical disabilities and those with developmental disabilities. In other counties in which Family Care is operating, it is available for elderly individuals and adults

[3]The waiver applications and terms and conditions of approval are available on the DHFS website at: http://dhfs.wisconsin.gov/LTCare/Waiver/Index.htm (*see* Exhibit 2003, which includes some of the primary materials marked as Ex. 2003-A through 2003-D(3)).

[4]The federal government approves DHFS' contracts with CMOs as Prepaid Health Plans. *See* n.2, CMO contract, p. 121, ¶ (18), (Ex. 2002). *See* also June 1, 2001, waiver approval letter from Center for Medicaid and State Operations, ¶ 1, available on the DHFS website at http://dhfs.wisconsin.gov/LTCare/Waiver/HCFAApprovalLetter-1915b.pdf (Ex. 2003-D(1)).

[5]See "Wisconsin Family Care Counties," a map posted on the DHFS website at: http://dhfs.wisconsin.gov/LTCare/Generalinfo/FCMap.htm (Ex. 2004).

of any age with physical or developmental disabilities.[6] (In Milwaukee County, physically or developmentally disabled persons under the age of 60 continue to receive community-based long term care services via pre-existing HCBS waivers, including the Community Options Program ("COP") waiver, Community Integration Program ("CIP") and Brain Injury ("BI") waivers. *See* Am. Comp. ¶ 32.)

Organizationally, Family Care consists of two components in each county in which the program is fully implemented: an aging and disability resource center ("resource center") and a CMO. *See* Wis.Stat. §§ 46.283 and 46.284.[7]

The resource center provides information to elderly people and people with disabilities about resources available to them in their local communities, Wis. Stat. § 46.283(4)(e). An individual who wants to receive long-term care services through the Family Care program is screened for eligibility by the resource center and the county Economic Support unit. Wis. Stat. § 46.283(4)(f) and (g). If the individual is eligible and is considering enrollment, the person is contacted by an independent "enrollment consultant" who determines whether the person is making an informed decision to enroll in the CMO. The CMO has no part in the eligibility or enrollment decision.

The CMO manages and delivers the Family Care benefit. Wis. Stat. § 46.284. After a participant enrolls, the CMO assesses the participant's needs for health care and long-term care

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[6]See June 1, 2001, waiver approval letter from Center for Medicaid and State Operations, par. 1, available on the DHFS website at: http://dhfs.wisconsin.gov/LTCare/Waiver/HCFAApprovalLetter-1915b.pdf (Ex. 2003-D(1)).

[7]See also "Family Care Program Operations Information" posted on the DHFS website at: http://dhfs.wisconsin.gov/LTCare/ProgramOps/Index.htm (Ex. 2005).

services, Wis. Stat. § 46.284(4)(b).[8] The CMO delivers those services in the Family Care benefit package that are identified as necessary to meet the individual's long-term care needs through the CMO's network of providers, Wis. Stat. § 46.284(4)(d).[9] A contract between DHFS and the CMO requires that the CMO, in exchange for the capitated payments, manage and provide a combination of HCBS waiver services and long-term care Medicaid State Plan services. In Milwaukee County, the CMO is the Milwaukee County Department on Aging ("MCDA").[10]

A CMO enrollee has a right to a contested case hearing to challenge certain actions or inactions on the part of the CMO. These include failure to provide timely services included in the enrollee's care plan, reduction of such services, or a care plan that requires the enrollee to live in a place unacceptable to the enrollee.[11]

Several important features of Family Care distinguish it from the Medicaid State Plan and the HCBS Waivers:

- Family Care pays on a capitated[12] rather than a fee-for-service basis. Under both the State Plan and traditional HCBS Waivers, providers are usually paid on a "fee-for-service"

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[8] *See* also n.2, CMO contract at pp. 30 *et seq.*, (Ex. 2002).

[9] *See* n.2, CMO Contract at p. 15 *et seq*., (Ex. 2002)

[10] See "Resource Center and CMO Contacts," posted on the DHFS website at: http://dhfs.wisconsin.gov/LTCare/Generalinfo/Where.htm (Ex. 2006).

[11] See CMO contract at 54-55, (Ex. 2002).

[12] "Capitation refers to the prospective payment of a fixed sum per period for each patient under the care of a selected provider, regardless of the actual costs incurred by the provider in treating the patient." Andrew Ruskin, "Capitation: The Legal Implications of Using Capitation to Affect Physician Decision-Making Processes," 13 J. Contemp. Health L. & Policy 391 (Spring 1997). *See also* Gary R. Ilminen, *Consumer Guide to Long-Term Care* (Madison, WI 1999) at 49 (capitation is "[t]he practice in managed care of paying a fixed amount to a provider or entity to cover the cost of providing care to members of a health plan for a set period of time").

basis: the provider renders a service to a Medicaid recipient, submits a claim to Medicaid, and is paid at a pre-established rate for the service. In contrast, under Family Care, the CMO agrees by contract with the State Medicaid Program to provide the services from the Family Care benefit package that most cost-effectively meet each participant's assessed long-term care needs, in exchange for a capitated, per member-per month payment from the State Medicaid Program. Wis. Stat. §§ 46.28(4)(d) and (5).

- Under applicable federal regulations, DHFS is required to set these capitated payment rates at a level that is "actuarially sound," subject to annual review and approval by the Centers for Medicare and Medicaid Services ("CMS"), *see* 42 CFR §§ 438.1(a)(1) and 438.6(c)(2). The capitated rates paid to the CMOs by DHFS have increased at an average of more than 8 percent each year, ranging from $1,466.64 in CY 2000 to $2,055.01 in CY 2005 in Milwaukee County for enrollees at the comprehensive level.[13] The rates are developed by an actuarial firm under contract with DHFS.[14]
- Family Care is a Medicaid entitlement program. Unlike other HCBS waiver programs (COP, CIP and BI), an individual who is eligible for Medicaid and is functionally eligible for Family Care may not be placed on a waiting list to await either participation in the program or receipt of any part of the services for which the individual has an assessed need. Wis. Stat. § 46.286(3)(a). A Family Care CMO is required to provide all services

[13]See "Family Care CMO Capitation Rates," 2000-2005, posted on the DHFS website at: http://dhfs.wisconsin.gov/LTCare/StateFedReqs/CapitationRates.htm (Ex. 2007).

[14]See Actuary Report, "Family Care Capitated Rates, CY 2005" (November 22, 2004), posted on the DHFS website at: http://dhfs.wisconsin.gov/LTCare/StateFedReqs/RateReport2005.pdf (Ex. 2008).

necessary to cost-effectively meet the participant's assessed needs, in exchange for the monthly capitated payment for that individual.[15]

- DHFS, as the state Medicaid agency, does not make direct payments to the providers who render Family Care services. Instead, DHFS pays the respective CMO the capitated rate based on the total number of Family Care enrollees the CMO serves per month. The Family Care CMO pays its providers, and is responsible for setting payment rates at a level that will attract a sufficient number of qualified providers to provide services to all entitled persons who seek enrollment in the CMO.[16]

The plaintiffs include six individual Milwaukee County Family Care recipients and their respective guardians or authorized representatives. All of the plaintiff recipients are aged 60 or over and each is disabled as a result of a developmental disability or because of disabilities associated with aging. Plaintiffs Nelson, Bzdawka, Ehrlichman and Berdikoff are legally incompetent (Am. Comp. ¶¶ 5-10). Plaintiffs Czarnecki and Gorton both have significant disabilities that affect their ability to make decisions (*id.*).

The Amended Complaint alleges that providers servicing MA recipients in conventional HCBS waiver programs (COP, CIP and BI waivers) have been given more favorable rates and have been granted increases in their rates more readily than Milwaukee County Family Care providers (Am. Comp. ¶¶ 56-57). Plaintiffs also allege that the ability of Family Care recipients to select specific day programs and residential placements is more limited than that of participants in the COP, CIP and BI waiver programs (Am. Comp. ¶ 52).

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[15] *See* n.2, CMO contract at pp. 15 *et seq.,* (Ex. 2002).

[16] *See* n.2, CMO contract at pp. 60-61, (Ex. 2002).

In 2004, Dr. Kallas, an executive officer of Senior Residential Care of America, Inc., which owns the facilities where plaintiffs Czarnecki and Gorton currently reside, allegedly conducted a mail survey of Wisconsin Family Care providers around the state (Am. Comp. ¶ 59). The Amended Complaint alleges that 80% of the respondents stated they were being paid below "their cost of care as determined by an audit," while 8.5% of the respondents indicated they were being paid the equivalent of their cost of care and 5.7% said they were being paid more than their cost of care (*id.*).

Plaintiffs allege that the capitated rates for Family Care set by DHFS for the years 2000 through 2004 were "insufficient to provide appropriate services to persons with disabilities in Milwaukee County and were a substantial factor in causing the Milwaukee County Family Care program to operate at a deficit" during the same period (Am. Comp. ¶ 60). Plaintiffs also allege that the capitated rates were a substantial factor in causing numerous adult family homes ("AFHs"), community-based residential facilities ("CBRFs") and day programs for AFH and CBRS residents "to operate at a loss and either cease operation or be at a substantial risk of ceasing operation" (*id.*).

According to plaintiffs, Milwaukee County's residential rates for 2005 "will lead to significant numbers of residential providers either leaving the Family Care program or declaring bankruptcy" (Am. Comp. ¶ 61). Plaintiffs further allege that the capitated rate set by DHFS for the 2005 calendar year is insufficient to provide appropriate services to persons with disabilities in Milwaukee County and, at the same time, eliminate Milwaukee County's Family Care deficit and provide reimbursement to AFHs, CBRFs and day programs sufficient to support their continued operation (Am. Comp. ¶ 63). Plaintiffs predict that the failure to provide reasonable rates and cost of living increases will cause numerous providers either to cut the level of services

they provide or refuse to serve disabled Milwaukee County residents, forcing them to move from their homes, lose their day services and cause substantial numbers to be admitted to institutions such as nursing homes (Am. Comp. ¶ 64).

Plaintiffs Nelson, Bzdawka, Ehrlichman and Berdikoff are developmentally disabled persons (Am Comp. ¶¶ 65, 80, 91, 101). Each resides at either an adult family home or a CBRF operated by Homes for Independent Living ("HIL") and all four attend a day program operated by HIL as well (Am. Comp. ¶¶ 67, 82, 93 and 102). Plaintiffs Czarnecki and Gorton each reside in CBRFs operated by a different provider, Senior Residential Care of America (Am. Comp. ¶¶ 111, 121). Plaintiffs Nelson and Bzdawka are both under the supervision of the Milwaukee County Probate Court and in each case, their placements have been determined to be appropriate to their needs (Am. Comp. ¶¶ 70, 84). In the case of Berdikoff, Ehrlichman, Czarnecki and Gorton, their agents or family members all approve of their placements and prefer that each individual continue in his or her current placement (Am. Comp. ¶¶ 94, 104, 113 and 123).

HIL, the residential and day services provider for Nelson, Bzdawka, Berdikoff and Ehrlichman, has been negotiating with the Milwaukee County CMO for several years in an unsuccessful attempt to obtain a higher contract rate for the provision of services to all four plaintiffs as well as other Family Care clients (Am. Comp. ¶¶ 73, 90, 97 and 106). The rates that the CMO has been willing to approve for HIL placements are lower than rates paid by the Milwaukee County Disability Services Division ("MCDSD") for conventional HCBS waiver services and by other counties for serving persons with similar needs, but the CMO has refused to approve a "cost of living increase" for Family Care services to the plaintiffs or for other clients (Am. Comp. ¶¶ 72-74, 86-87, 96-97 and 105-06). HIL brought the situation to a head by notifying the Milwaukee CMO that it would terminate its Family Care contract and that the

funding dispute was the only reason for the contract termination (Am. Comp. ¶¶ 75-76). Although the CMO reacted to the contract termination notice by seeking to move Nelson, Bzdawka, Ehrlichman and Berdikoff to different group homes or CBRFs and different day programs over their guardians' objections, HIL and the CMO have agreed that all four will stay in their present placements pending resolution of this case or further order of the Court (*id.* ¶¶ 77, 88, 98 and 107).

In the cases of plaintiffs Czarnecki and Gorton, their provider, Senior Residential Care, has also attempted without success to obtain a rate increase from the Milwaukee CMO for the provision of services to Family Care clients (*id.* ¶ 114). The Family Care rate authorized for Senior Residential Care's CBRF's in Milwaukee County is substantially less than the COP waiver program rate authorized by Waukesha County for identical services at a Waukesha County Senior Residential Care facility (*id.* ¶ 115). Senior Residential Care has issued public statements that it is losing money under its current Family Care rates (*id.* ¶¶ 116, 124). According to the Amended Complaint, it is probable that in the "foreseeable future" Senior Residential Care will refuse to accept Family Care clients or will be forced to close its residential facities (*id.* ¶¶ 117, 125).

In the case of each of the plaintiffs, the complaint alleges, it would be "very traumatic and harmful" to each of them to be removed from their current placements (*id.* ¶¶ 81, 89, 99, 108, 118 and 126). In each case, the complaint further alleges, because of the severity of the disabilities of each one, it is likely that moving him or her "would worsen his [or her] condition and lead to placement in a nursing home or similar situation" (*id.* ¶¶ 82, 90, 100, 109, 119 and 127).

## ARGUMENT

### I. ALL NINE COUNTS MUST BE DISMISSED BECAUSE PLAINTIFFS LACK STANDING OR BECAUSE THEY ARE NOT RIPE FOR ADJUDICATION.

#### A. Standing and ripeness implicate the essential constitutional requirement that a "case or controversy" must exist between the parties.

Under article III of the United States Constitution, federal courts only have jurisdiction over "cases and controversies." *Smith v. Wisconsin Dept. of Agriculture*, 23 F.3d 1134, 1141 (7th Cir. 1994). "Standing to sue or defend is an aspect of the case-or-controversy requirement." *Arizonans for Official English v. Arizona*, 520 U.S. 43, 64 (1997) (citations omitted). In order to qualify as a person with standing to litigate, a person must show, first and foremost, "'an invasion of a legally protected interest' which is 'concrete and particularized' and '"actual or imminent, not 'conjectural' or 'hypothetical.'" *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992) (internal citations omitted); *see also Raines v. Byrd*, 521 U.S. 811, 818, (1997). Plaintiffs have the burden of proving the existence of standing. *Cf. Valley Forge, Etc. v. Americans United, Etc.*, 454 U.S. 464, 473 (1982).

To have standing, a party must show: (1) a direct and palpable injury; (2) that the injury can be fairly traced to the challenged action of the defendant; and (3) that the injury is likely to be redressed if the relief sought is granted. *See Valley Forge, Etc.*, 454 U.S. at 472; *Oak Ridge Care Center v. Racine County, Wis.*, 896 F. Supp 867, 871 (E.D. Wis. 1995). These three components comprise "the core" of Article III's case or controversy requirement. *See Steel Co. v. Citizens for a Better Environment*, 523 U.S. 83, 103-04 (1998).

A plaintiff must have a personal stake in the outcome, which requires both a "distinct and palpable injury" to the plaintiff and a "fairly traceable" causal connection between the claimed

injury and the challenged conduct. *See Banks v. Secretary of Indiana Family & Soc. Serv.*, 790 F. Supp. 1427, 1434 (N.D. Ind. 1992); *cf. U.S. ex rel. Hall v. Tribal Development Corp.*, 49 F.3d 1208 (7th Cir. 1995).

> A plaintiff has standing to sue—that is, he can invoke the jurisdiction of the court—if he is tangibly, materially, injured by the conduct of the defendant that he claims is unlawful and if the relief he seeks would redress the injury in whole or in part and thus confer a material benefit upon him.

*Bruggeman v. Blagojevich*, 324 F.3d 906, 909 (7th Cir. 2003). In other words, each plaintiff must demonstrate "an individuated harm impacting specifically upon him [or her] and of a tangible, concrete nature." L. Tribe, *American Constitutional Law*, § 3-16 at 114 (2d ed. 1988).

In order to establish standing for purposes of declaratory or injunctive relief, the injury need not already have occurred. A state agency that has "'plainly indicated' an intent to enforce an act that would affect the rights" presented a present and concrete controversy within the meaning both of the Declaratory Judgment Act and Article III of the Constitution. *California v. LaRue*, 409 U.S. 109, 112 n.3 (1972) (quoting from *Public Utilities Comm'n of California v. United States*, 355 U.S. 534, 539 (1958)). *Also see Warth v. Seldin*, 422 U.S. 490, 499 (1975) (a federal court's jurisdiction can be invoked only when the plaintiff himself has suffered "some *threatened* or actual injury," quoting from *Linda R.S. v. Richard D.*, 410 U.S. 614, 617 (1973) (emphasis added).

> Where, as here, the challenged conduct is only threatened, "[t]he plaintiff must show that 'he has sustained or is immediately in danger of sustaining some direct injury' as the result of the challenged official conduct and the injury or threat of injury must be both 'real and immediate,' not 'conjectural' or hypothetical.'"

*United States ex rel. LeBlanc v. Raytheon Co.,* 729 F. Supp. 170, 172 (D. Mass. 1990), *aff'd*, 913 F.2d 17 (1st Cir. 1990) (quoting *Los Angeles v. Lyons*, 461 U.S. 95, 101-02 (1983)).

In *Adarand Constructors, Inc. v. Pena*, 515 U.S. 200 (1995), the Court held that construction contractors could sue to challenge affirmative action requirements on future jobs they

had not yet bid upon. The Court said the test is whether the injury is concrete and particularized and actual or imminent, not conjectural or hypothetical. *Id*. at 211. Adarand was not required to demonstrate that it had been, or would be, the low bidder. *Id*. The injury to Adarand from a discriminatory classification lay in being prevented from competing on an equal footing. The imminence test was met because the agency was likely to let contracts involving guardrail work containing the disqualifying clause at least once per year; the plaintiff was very likely to bid on each such contract; and the plaintiff often had to compete for such contracts against small disadvantaged businesses. *Id*. at 212.

For a declaratory judgment to issue, however, "there must be a dispute which 'calls, not for an advisory opinion upon a hypothetical basis, but for an adjudication of present right upon established facts.'" *Ashcroft v. Mattis*, 431 U.S. 171, 172 (1977), quoting *Aetna Life Ins. Co. v. Haworth*, 300 U.S. 227, 242 (1937). Even when the jurisdictional prerequisites for standing are satisfied, the district court has wide discretion in deciding whether declaratory relief is appropriate. *See Nationwide Ins. v. Zavalis*, 52 F.3d 689, 692 (7th Cir. 1995).

The doctrine of ripeness is based on both constitutional and prudential grounds. *Koehring Co. v. Adams*, 605 F.2d 280, 282 (7th Cir. 1979). Under Article III, federal courts may only adjudicate "cases or controversies" and may not render advisory opinions. *Wisconsin's Environmental Decade, Inc. v. State Bar of Wisconsin*, 747 F.2d 407, 410 (7th Cir. 1984), *cert. denied*, 471 U.S. 1100 (1985). Ripeness is a jurisdictional prerequisite. *Smith*, 23 F.3d at 1142. Cases are unripe when the parties point only to hypothetical, speculative, or illusory disputes as opposed to actual, concrete conflicts. In this regard, ripeness is closely related to its justiciability cousins, the doctrines of finality and standing.

In *Abbott Laboratories v. Gardner*, 387 U.S. 136 (1967), the Court explained that the rationale of ripeness

> is to prevent the courts, through avoidance of premature adjudication, from entangling themselves in abstract disagreements over administrative policies, and also to protect the agencies from judicial interference until an administrative decision has been formalized and its effects felt in a concrete way by the challenging parties.

*Id.* at 148. The Court elaborated a two-part standard for evaluating the ripeness of claims. A court must first weigh the fitness of the issues for judicial decision. It must then evaluate the hardship to the parties of withholding court consideration. Id. at 149. As stated in *United Public Workers of America v. Mitchell*, 330 U.S. 75, 89-90 (1947):

> The power of courts, and ultimately of this Court to pass upon the constitutionality of acts of Congress arises only when the interests of litigants require the use of this judicial authority for their protection against actual interference.

For example, in the *Smith v. Wisconsin Department of Agriculture* case, the court held that a suit by dairy farmers claiming that procedures for suspension of milk permits violated due process was not ripe, and the district court lacked subject matter jurisdiction, where the farmer was under no present threat of suspension even though he would be subject to regulatory inspections. *Id.,* 23 F.3d at 1142.

B. Plaintiffs lack standing to seek retroactive declaratory or monetary relief for actions of either the State defendants or Milwaukee County for the period prior to the filing of this lawsuit because they fail to allege any direct or tangible injury to themselves that this court can redress for that period of time.

The Fourth Amended Complaint sets forth nine counts against both the State defendants and Milwaukee County. The first eight counts are paired counts under the ADA and Rehabilitation Act so that each ADA claim (Counts 1-4) is accompanied by a twin Rehabilitation Act claim (Counts 5-8) which are essentially identical to each other in substance, but are based

on the respective statutes. In general, these eight counts seek declaratory and injunctive relief because "Family Care policies, procedures and *rates related to funding*" for Adult Family Homes, Community-Based Residential Facilities and day programs "have in the past and continue to" discriminate against the plaintiffs in various alleged ways based on their disabilities (*cf.* Am. Comp. ¶¶ 143, 148, 153, 156, 162, 166, 171, and 174) (emphasis supplied).

Count 9 alleges a private right of action under the Civil Rights Act, 42 U.S.C. § 1983, based on what are often called the "quality of service" and "equal access provisions" of the Medicaid statute, 42 U.S.C. § 1396a(a)(30)(A), and is a direct challenge to the adequacy of the capitated rates set by DHFS and paid to the Milwaukee County CMO for the years 2000 through 2004 (Am. Comp. ¶ 183) and during year 2005 as well (Am. Comp. ¶ 184). The complaint seeks a declaratory judgment to the effect that the defendants have violated and continue to violate the ADA, the Rehabilitation Act and (a)(30)(a), and prospective injunctive relief related to the funding for Family Care (Am. Comp. at 34). In addition, the complaint demands retroactive monetary relief requiring that "future rates set by the State defendants include an amount sufficient to alleviate the shortfall in Milwaukee County's Family Care program caused by inadequate capitated rates from 2000 through the present" (*id.*, ¶¶ (F) and (G)).

The problem with every one of these claims based on past actions of the State defendants and Milwaukee County is that plaintiffs fail to allege any "direct and palpable injury" to themselves during the period from 2000 to the present that is "likely to be redressed by a favorable decision." *See Valley Forge, Etc.*, 454 U.S. at 472.

The complaint contains no allegations that the plaintiffs have not been entirely satisfied with the residential and day program placements each has had during the period each has been enrolled in the Family Care program from the time of their enrollment to the present time (*see*

*gen.* Am. Comp. ¶¶ 65-127). Accordingly, none of the plaintiffs claims any past violation of the integration, least restrictive setting and reasonable accommodation requirements of the ADA and Rehabilitation Act, nor any violation of (a)(30)(a), with regard to themselves personally.

The complaint does allege that, when HIL, the residential and day services provider for plaintiffs Nelson, Bzdawka, Berdikoff and Ehrlichman served notice on the Milwaukee CMO that HIL intended to terminate its contract, the CMO reacted by planning to move the plaintiffs to different facilities (Am.Comp. ¶¶ 77, 88, 98 and 107). But a simple "move," a mere change in placement alone, whether the change is threatened or actual, is not an injury that "is likely to be redressed by a favorable decision" under the statutes plaintiffs seek to invoke. *See Valley Forge, Etc.*, 454 U.S. at 472.

Under the ADA and Rehabilitation Act, the court has jurisdiction to insure that plaintiffs are placed in the most integrated setting appropriate to their needs and that they be reasonably accommodated. *See gen. Olmstead v. L.C. by Zimring*, 527 U.S. 581, 590-02, 607 (1999). Under (a)(30(A), which plaintiffs also seek to invoke, the MA statute requires that the state MA plan provide methods and procedures "as may be necessary . . . to assure that payments are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent such care and services are available to the general population in the geographic area." Furthermore, the Court is empowered to remedy past violations of plaintiffs' rights under these statutes. None of these statutes, however, protects plaintiffs against simply being moved to a different residential placement, nor do they confer on this court the authority to remedy individual placement decisions absent a cognizable injury to plaintiffs. *See Valley Forge, Etc.*, 454 U.S. at 472.

In essence, applying the standing analysis set forth above, plaintiffs lack standing to pursue claims for retroactive declaratory or monetary relief for the period from year 2000 to the present because none of them alleges any past or current injury—neither past disability discrimination nor past deprivation of MA services—that this Court is empowered to remedy. Accordingly, plaintiffs lack standing to litigate any of their claims to the extent they seek relief for any period prior to the filing of this litigation. *Cf. Id.*; *Bruggeman*, 324 F.3d at 909. Applying *Bruggeman*, the plaintiffs cannot invoke the jurisdiction of the court because they have not been "tangibly, materially, injured" by the past conduct of either set of defendants and because the relief they seek would not "redress the injury . . . and thus confer a material benefit" upon them. *Id.*

C. Plaintiffs' speculative predictions of future disastrous consequences to providers and, in turn, to themselves are insufficient to establish ripeness necessary to litigate either their ADA and Rehabilitation Act discrimination claims or their Medicaid claim.

While plaintiffs certainly attempt to assert claims of past injury to their rights under the ADA, Rehabilitation Act and (a)(30)(A), the primary focus of their latest amended complaint continues to be allegations that the cumulative effect of the State defendants' and Milwaukee County's alleged violations of the statutes will result in *future* injuries to themselves that this Court should remedy through injunctive or declaratory relief.

Plaintiffs allege that the capitated rates for Family Care paid by DHFS to Milwaukee County have caused the Milwaukee County CMO to operate at a deficit and that the capitated rates were a substantial factor in causing "numerous" AFHs, CBRFs and day programs to operate at a loss and either cease operation already or to be at a substantial risk of ceasing operation in the future (Am. Comp. ¶ 60). They further allege that the rates paid by the Milwaukee County

CMO to providers "will lead to significant numbers of residential providers either leaving the Family Care program or declaring bankruptcy" (Am. Comp. ¶ 61). They predict that the County CMO's failure to provide reasonable rates and cost of living increases "will cause" numerous providers of residential services either to cut services or refuse to serve disabled Milwaukee County residents, "forc[ing them] to move from their homes and to lose their day services" and, in turn, "cause substantial numbers of these residents to be admitted to institutions such as nursing homes" (Am. Comp. ¶ 64).

As to the plaintiffs personally, HIL, the residential and day program provider for plaintiffs Nelson, Bzdawka, Ehrlichman and Berdikoff, has sought to terminate its Family Care contract, thus forcing the Milwaukee County CMO to initiate the process of seeking different placements for those plaintiffs (Am. Comp. ¶¶ 75-77, 88, 98 and 107). As to plaintiffs Czarnecki and Gorton, their residential service provider, Senior Residential Care, has issued public statements that it is losing money because of its current Family Care contract rates and that it will not be able to sustain these losses much longer (Am. Comp. 116, 124). As a result, plaintiffs allege that Senior Residential Care will refuse to accept Family Care clients or will be forced to close its residential facilities "in the foreseeable future" (Am. Comp. ¶¶ 117, 125), presumably requiring plaintiffs Czarnecki and Gorton to move to a different facility if they wish to remain enrolled in Family Care. Plaintiffs allege that these forced future moves, if they occur, will be very traumatic and harmful to each and will, in turn, likely cause their individual disabilities to worsen, thus leading to their individual "placement in a nursing home or similar situation" (Am. Comp. ¶¶ 82, 90, 100, 109, 119 and 127).

Clearly, although plaintiffs allege threatened harm, they do not claim to have sustained, nor are they "'immediately in danger of sustaining some direct injury.'" *Cf. U.S. ex rel. LeBlanc*,

729 F. Supp. at 172. Plaintiffs' claims of threatened future injury are entirely "conjectural or hypothetical"; they are neither direct nor "real and immediate" *id.*, rendering claims based on such injuries unripe for adjudication. In one sense at least, "ripeness is about *when* [plaintiffs] can sue"; a matter of whether they can sue "*yet*" rather than whether they can ever sue. *See Smith*, 23 F.3d at 1141 (emphasis in original). Regardless of whether plaintiffs can sue at all, the State defendants respectfully suggest that they clearly cannot sue "yet" to redress claims that they may, some day, be forced to move and that, as a result of such a move, they will eventually end up in residential placements that violate rights protected by the ADA, the Rehabilitation Act or (a)(30)(A). *Id.*

The threatened future injuries, if they occur at all, are not direct violations of plaintiffs' statutory rights nor direct injuries to themselves. The claimed threats of future injury are based on allegations that the rates paid to residential providers in the future will result in sufficient numbers of providers refusing to provide Family Care services so that, as a result, plaintiffs allege, they will be forced to relocate to different residential placements and, ultimately, to nursing homes. Moreover, these threats of future indirect injury are significantly dependent on the assumption that the Milwaukee County CMO will violate its obligations under both the CMO contract and the statutes themselves to assure that plaintiffs are placed consistently with their needs and protected rights. Yet plaintiffs have not alleged any facts to support a claim that the Milwaukee County CMO is currently placing Family Care enrollees without due regard for their needs and protected rights and there is no basis whatever for a presumption that it will do so in the future. Furthermore, each has available an immediate administrative remedy in the form of a grievance and fair hearing process, should they be dissatisfied with any potential future change of placement. *See* n.2, CMO Contract at 54-55 (Ex. 2002).

The danger of any potential future injury to plaintiffs is remote indeed. In short, because plaintiffs' claims of threatened future injury are entirely hypothetical and speculative, they are not ripe for adjudication and must be dismissed as a result. *See Smith*, 23 F.3d at 1141-1142.

### D. Plaintiffs lack standing to challenge the capitated rates DHFS pays to the Milwaukee County CMO under the terms of the Family Care contract.

As indicated above at 4, Family Care is authorized by federal Medicaid authorities pursuant to two types of waivers and an approved prepaid health plan authorizing DHFS to contract for State Plan long-term care services on a prepaid basis. *See* nn. 3 and 4 (Exhibits 2003 and 2004). The managed care aspect of Family Care permits DHFS to limit services in the Family Care benefit to those persons who enroll in a CMO. *See gen.* 42 U.S.C. § 1296n(b) and Wis. Stat. §§ 46.281, 46.284 and 46.286. The CMO manages and delivers the Family Care benefit. Wis. Stat. § 46.284. DHFS provides funding on a capitated basis for the provision of services under Family Care. Wis. Stat. § 46.284(5). In exchange for the capitated payments, the CMO is required by the terms of the CMO contract to manage and provide all services necessary to meet a participant's assessed needs in a cost-effective manner. *See* n.2, above, CMO contract at 1, 15 (Exhibit 2002).

Although all nine of plaintiffs' current counts focus on funding for AFHs, CBRFs and day programs, Counts 4, 8 and 9 focus directly and exclusively on the adequacy of "the fixed capitation rate" paid by DHFS to the Milwaukee County CMO and on the "methods used to determine provider rates" employed by Milwaukee County (Am. Comp. ¶¶ 156, 174, 183 and 184). Indeed, via their Amended Response to State Defendants' First Interrogatories, plaintiffs have recently confirmed their claim that "deficiencies in any services provided to Milwaukee Family Care recipients, including assessment and evaluation methods, are the result

of the state defendants' failure to set an adequate capitated rate for calendar years 2000 through 2005." *See* Exhibit 2009 at 2, attached to State Defendants' Motions to Dismiss. It appears, therefore, that should the court reject the standing and ripeness arguments set forth in Secs. I.B and I.C, above, the justiciability of this entire case turns on whether plaintiffs' have standing to attack the capitated rates DHFS pays the Milwaukee County CMO, as they plainly seek to do.

In addition to the general objections to plaintiffs' standing argued above, the State defendants specifically submit that plaintiffs lack standing to attack the capitated rates paid by DHFS to the Milwaukee County CMO under the CMO contract. In return for accepting the capitated rates—and regardless of their claimed adequacy or inadequacy in plaintiffs' eyes—the CMO has obligated itself under the contract to provide Family Care enrollees, including the plaintiffs, with the full range of Family Care services the individual enrollee needs under his or her plan of care. *See* n.2, CMO Contract at pp. 15 *et seq*. (Ex. 2002). The CMO contracts with service providers who, in turn, provide the Family Care services needed by individual enrollees.

The State defendants neither negotiate nor contract with the providers, nor do they provide the services to which plaintiffs are entitled under Family Care. Although plaintiffs complain that the capitated rates are inadequate, they are not parties to the CMO contracts. The Milwaukee County CMO, which is a party to the CMO contract, is obligated to manage and provide for the Family Care services plaintiffs need in return for the capitated rates set by the State defendants.

The Fourth Amended Complaint simply fails to allege facts showing how the capitated rates directly injure the plaintiffs, since Family Care recipients or beneficiaries are entitled to Family Care services regardless of the level or adequacy of the capitated rates. *See* Wis. Stat. §§ 46.284(4)(d) and (5). With regard to the capitated rates, therefore, plaintiffs have failed to

demonstrate the second essential component of standing or justiciability: they have failed to allege how any injury to themselves "can be fairly traced to" the capitated rates set by DHFS. *See Valley Forge, Etc.*, 454 U.S. at 472.

## II. PLAINTIFFS' CLAIMS FOR RETROACTIVE DECLARATORY AND MONETARY RELIEF BASED ON § 1983 AND THE MEDICAID STATUTE, AND TITLE II OF THE ADA MUST BE DISMISSED BECAUSE SUCH RELIEF AGAINST THE STATE DEFENDANTS IS BARRED BY SOVEREIGN IMMUNITY AND THE ELEVENTH AMENDMENT.

The Complaint includes a demand for retroactive monetary relief of a decidedly unusual sort, requesting that the State defendants reimburse Milwaukee County for allegedly inadequate capitated payments sufficient to "alleviate the shortfall" allegedly caused by the State defendants' "inadequate capitated rates from the year 2000 to the present" (Am. Comp. at 34, Conclusion F). Apart from the obvious question of plaintiff Family Care recipients' standing to advance such a claim,[17] addressed above, the State defendants contend that the Court lacks jurisdiction to entertain such a claim because, except for counts based on § 504 of the Rehabilitation Act, sovereign immunity and the Eleventh Amendment bar such retroactive monetary relief against them.

The Constitution recognizes a state's sovereign immunity from suit. *See College Savings Bank v. Florida Prepaid Postsecondary*, 527 U.S. 666, 684 (1999). The Eleventh Amendment to the Constitution provides, "The Judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by

[17]On its face, at least, the demand for relief is framed simply as an attempt to recoup from the State defendants money for the county treasury.

Citizens of another State, or by Citizens or Subjects of any Foreign State." This Amendment

> is convenient shorthand but something of a misnomer, for the sovereign immunity of the States neither derives from, nor is limited by, the terms of the Eleventh Amendment. . . . [T]he States' immunity from suit is a fundamental aspect of the sovereignty which the States enjoyed before the ratification of the Constitution, and which they retain today (either literally or by virtue of the admission into the Union upon an equal footing with the other States) except as altered by the plan of the Convention or certain constitutional Amendments.

*Alden v. Maine*, 527 U.S. 706, 713 (1999). The Eleventh Amendment "does not define the scope of the States' sovereign immunity; it is but one particular exemplification of that immunity." *Federal Maritime Commission v. S.C. State Ports Authority*, 535 U.S. 743, 753 (2002).

It is jurisdictional "in the sense that it is a limitation on the federal court's judicial power, and therefore can be raised at any stage of the proceedings." *Calderon v. Ashmus*, 523 U.S. 740, 745 n.2 (1998). *See Kimel v. Florida Board of Regents*, 528 U.S. 62, 73 (2000) (it "does not provide for federal jurisdiction over suits against non-consenting States"). "This withdrawal of jurisdiction effectively confers an immunity from suit." *Puerto Rico Aqueduct & Sewer Auth. v. Metcalf & Eddy*, 506 U.S. 139, 144 (1993).

There are "only two circumstances in which an individual may sue a State. First, Congress may authorize such a suit in the exercise of its power to enforce the Fourteenth Amendment. . . . Second, a State may waive its sovereign immunity by consenting to suit." *College Savings Bank*, 527 U.S. at 670.

Sovereign immunity bars federal court "suits against the States and their agencies . . . regardless of the relief sought." *Puerto Rico Aqueduct & Sewer Auth.*, 506 U.S. at 146. *See Seminole Tribe of Florida v. Florida*, 517 U.S. 44, 72 (1996) (the relief sought "is irrelevant to the question whether the suit is barred"); *Pennhurst State School & Hospital v. Halderman*, 465 U.S. 89, 100-01 (1984) (this jurisdictional bar applies "regardless of the nature of the relief

sought"). Accordingly, sovereign immunity bars an action for money damages against a state agency, *Edelman v. Jordan*, 415 U.S. 651, 666-67 (1974); injunctive relief, *Seminole Tribe of Florida*, 517 U.S. at 58, and *Alabama v. Pugh*, 438 U.S. 781 (1978); and declaratory relief. *Benning v. Board of Regents of Regency Universities*, 928 F.2d 775, 778 (7th Cir. 1991).

The rule against retrospective monetary relief cannot be circumvented by labeling it equitable restitution: it is a retrospective claim against the treasury. *Edelma,* 415 U.S. at 663, 665-68. The bar applies "if the relief is tantamount to an award of damages for a past violation of federal law, even though styled as something else." *Papasan v. Allain*, 478 U.S. 265, 278 (1986). "Relief that in essence serves to compensate a party injured in the past by an action of a state official in his official capacity that was illegal under federal law is barred when the state official is the named defendant." *Papasan,* 478 U.S. at 278 (footnote omitted).

To be distinguished are actions for prospective declaratory and injunctive relief against state officials. Sovereign immunity does not "preclude actions against state officials sued in their official capacity for prospective injunctive or declaratory relief." *Thiokol Corp. v. Department of Treasury*, 987 F.2d 376, 381 (6th Cir. 1993) (citing *Ex Parte Young*, 209 U.S. 123 (1908). *Also see Benning*, 928 F.2d at 778 (sovereign immunity precludes declaratory relief against the state because *Ex Parte Young's* "authority-stripping fiction" is limited to actions against public officials).

"Congress can abrogate state sovereign immunity *only* when it legislates to enforce the Fourteenth Amendment." *College Savings Bank*, 527 U.S. at 671 (emphasis added). "*Seminole Tribe* makes clear that Congress may not abrogate state sovereign immunity pursuant to its Article I powers." *Florida Prepaid Postsecondary v. College Savings,* 527 U.S. 627, 636 (1999). *See Seminole Tribe of Florida*, 517 U.S. at 72 ("Even when the Constitution vests in Congress

complete lawmaking authority over a particular area, the Eleventh Amendment prevents congressional authorization of suits by private parties against unconsenting States").

Whether the abrogation arises from an act of Congress or a state waiver, the language purporting to do so must be expressed with unmistakable clarity. *Welch v. State Dept. of Highways and Public Transp.*, 483 U.S. 468, 474 (1987); *Atascadero State Hosp. v. Scanlon*, 473 U.S. 234, 239-40 (1985). 42 U.S.C. § 1983 is not such a waiver. *See Will v. Michigan Dept. of State Police*, 491 U.S. 58 (1989). In this case, based on *Edelman*, *Will* and many other cases, it is clear that plaintiffs cannot seek retroactive monetary relief against the State defendants based on their § 1983-Medicaid claim. *Id.*[18]

The Supreme Court recently held that Title II of the ADA, under which plaintiffs sue the defendants here, constitutes a valid exercise of Congress' enforcement power under the Fourteenth Amendment. *Tennessee v. Lane*, 124 S. Ct. 1978, 1993 (2004). However, *Lane* expressly refrained from addressing Eleventh Amendment immunity as a defense to Title II ADA claims outside "the class of cases implicating the fundamental right of access to the courts." *Id.*

Following *Lane*, therefore, whether retroactive monetary relief is available in suits against states under Title II of the ADA outside the context of access to the courts remains an open question which the Court pointedly did not address, even though the plaintiff had asked for damages as well as equitable relief. *Id.*, at 1983. Furthermore, the majority opinion emphasized that the primary ADA remedy of "reasonable modifications"—a form of prospective injunctive relief—is "a

[18]In *Atascadero*, the court held that Congress did not abrogate the State's Eleventh Amendment immunity in adopting the Rehabilitation Act. *See id.*, 473 at 247. However, Congress subsequently enacted 42 U.S.C. § 2000d-7 in response to *Atascadero* and the Supreme Court subsequently recognized § 2000d-7 as a valid and unambiguous waiver of states' Eleventh Amendment immunity. *See Lane v. Pena*, 518 U.S. 187, 200 (1996).

reasonable prophylactic measure, reasonably targeted to a legitimate end." *Id.*, at 1994. The State defendants respectfully submit that, given the Court's rationale and limited holding in *Lane*, that retroactive monetary relief is not available as a remedy in a suit against the State based on Title II of the ADA. *See also Walker v. Snyder*, 213 F.3d 344, 346-47 (7th Cir. 2000).

## III. THE COMPLAINT MUST BE DISMISSED BECAUSE THE NINE ASSORTED COUNTS FAIL TO STATE CLAIMS ON WHICH RELIEF CAN BE GRANTED.

### A. A complaint must allege facts sufficient to support the elements of the claim: factual and legal conclusions are not sufficient.

In considering a motion to dismiss under F.R.C.P. 12(b)(6), the court must accept as true all well-pleaded factual allegations in the complaint, drawing all reasonable inferences in favor of the plaintiff. *Hishon v. King & Spalding*, 467 U.S. 69, 72 (1984); *Yeksigian v. Nappi*, 900 F.2d 101, 102 (7th Cir. 1990). *Cf.* F.R.C.P. 12(c); *City of Waukesha v. Viacom International, Inc.*, 362 F. Supp.2d 1025, 1028 (E.D.Wis. 2005) (same standard applies under Rule 12(c)). The court may dismiss a complaint for failure to state a claim under Fed. R. Civ. P. 12(b)(6) only if "'it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitled him to relief.'" *Strauss v. City of Chicago*, 760 F.2d 765, 767 (7th Cir. 1985) (quoting *Conley v. Gibson*, 355 U.S. 41, 45-46 (1957)). Although all reasonable inferences are to be drawn in favor of the plaintiff, the complaint must set forth factual allegations sufficient to establish the elements that are crucial to recovery under plaintiff's claim. *Sutliff, Inc. v. Donovan Cos.,* 727 F.2d 648, 654 (7th Cir. 1984). Legal conclusions without factual support are not sufficient. *Benson v. Cady*, 761 F.2d 335, 338 (7th Cir. 1985).

Moreover, even the liberal notice pleading standards have their limits. If there is no "reasonable prospect" that the plaintiff can make out a valid claim from the facts narrated in the

complaint, the court should grant the motion to dismiss. *Sutliff, Inc.,* 727 F.2d at 654; *see also Chaveriat v. Williams Pipe Line Co.,* 11 F.3d 1420, 1430 (7th Cir. 1993) (plaintiff may not "fumble around searching for a meritorious claim within the elastic boundaries of a barebones complaint"); *Matter of Wade*, 969 F.2d 241, 249 (7th Cir. 1992) (inferences plaintiffs asked court to draw from alleged facts were not reasonable), *cert. denied*, 510 U.S. 870 (1993); 5C Charles A. Wright & Arthur R. Miller, *Federal Practice and Procedure*, § 1368 at 248 (2004) (inferences drawn in favor of non-moving party must be reasonable and "cannot be indulged in when they are . . . inconsistent with matters that fall within the judicial notice doctrine"). The court "need not accept as true allegations that contradict facts which may be judicially noticed." *Westlands Water District v. U.S. Department of the Interior*, 850 F. Supp. 1388, 1399 (E.D. Cal. 1994).

Plaintiffs have a responsibility to include allegations of fact sufficient to establish the crucial elements of their claims. *Forest County Potawatomi Community v. Doyle,* 828 F. Supp. 1401, 1405 (W.D.Wis. 1993), *aff'd*, 45 F.3d 1079 (7th Cir. 1995). If they file complaints that assert legal conclusions without making adequate factual allegations to support those conclusions, their complaints may be dismissed on Rule12 grounds. *Panaras v. Liquid Carbonic Industries Corp.,* 74 F.3d 786, 792 (7th Cir. 1996); *Strauss*, 760 F.2d at 767-68. A complaint must contain either direct or inferential allegations respecting all the material elements necessary to sustain a recovery under some viable theory. *Car Carriers, Inc. v. Ford Motor Co.*, 745 F.2d 1101, 1106 (7th Cir. 1984), *cert. denied*, 470 U.S. 1054 (1985).

Since a court can take judicial notice of a document at any stage of the proceedings under Fed. R. Evid. Rule 201(f), it can do so on a motion to dismiss without converting it to a motion for summary judgment. *See Menominee Indian Tribe of Wisconsin v. Thompson*, 161 F.3d 449, 455-56

(7th Cir. 1998), *cert. denied*, 526 U.S. 1066 (1999); *MGIC Indem. Corp. v. Weisman*, 803 F.2d 500, 504 (9th Cir. 1986). Under Fed. R. Evid. Rule 201(b), documents judicially noticed must be "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." Public records and other documents filed in public offices are judicially noticeable. *Mass. v. Westcott*, 431 U.S. 322, 323 n. 2 (1977); *Green v. Warden, U.S. Penitentiary,* 699 F.2d 364, 369 (7th Cir.)*, cert. denied*, 461 U.S. 960 (1983); *Reiner v. Washington Plate Glass Co., Inc.*, 711 F.2d 414, 416 (D.C. Cir. 1983). A court may also refer to contention interrogatories in deciding a motion to dismiss. *See Sperling v. Hoffmann-LaRoche, Inc.*, 924 F. Supp. 1396, 1401-2 (D.N.J. 1996) (treating contention interrogatories as though included within the complaint itself).[19]

B. Counts 1-8 must be dismissed because the complaint fails to state claims based on the ADA or the Rehabilitation Act.

1. Summary of the showings necessary to state claims for which relief may be granted under Title II of the ADA and § 504 of the Rehab Act.

The ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity. 42 U.S.C. § 12132. Under Title II of the ADA, a "qualified individual with a disability" is someone who, with or without reasonable modifications, meets the essential eligibility requirements to receive public services or participate in a public program. 42 U.S.C. § 12131(2). The ADA defines

[19]Based on the Fed. R. Evid. Rule 201(b) and (d) and the precedent cited in the text, the State defendants request that the court take judicial notice of the Family Care waiver documents posted on the DHFS website and cited, with electronic links, at nn 1-16 above. A listing of the documents to which this request for judicial notice is directed, with exhibit numbers, is attached to this brief. *See* n.1, above. A copy of Plaintiff's Amended Response to State Defendants' First Set of Interrogatories is attached to the State defendants Motions to Dismiss as Exhibit 2009.

"disability" as a "physical or mental impairment that substantially limits one or more of the major life activities of the individual." 42 U.S.C. § 12012(2)(A). A "public entity" includes any special purpose district or other instrumentality of the state or local government. 42 U.S.C. § 12131(1).

To establish a violation of Title II of the ADA, a plaintiff must show that (1) he or she is a qualified individual with a disability; (2) he or she is being excluded from participation in or denied the benefits of some service, program or activity by reason of his or her disability, or subjected to discrimination by reason of his or her disability; and (3) that the entity providing the service, program or activity is a public entity. *Wisconsin Cmty Serv. v. City of Milwaukee*, 309 F. Supp. 2d 1096, 1103 (E.D. Wis. 2004).

The Rehab Act provides that "[n]o otherwise qualified individual with a disability in the United States, as defined in [29 U.S.C. § 706(8)], shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance[.]" 29 U.S.C. § 794(a). *See also Branham v. Snow*, 392 F.3d 896, 904 (7th Cir. 2004), *reh'g denied* (2005) (Rehab Act prohibits discrimination based solely on a person's disability). The Rehab Act defines "disability" similarly to definition of the same term in the ADA. 29 U.S.C. § 794(a). "Otherwise qualified" means, for purposes of the Rehab Act, that if an individual were not disabled, he or she would have qualified for the program or treatment allegedly denied because of the individual's disability. *Grzan v. Charter Hosp. of Northwest Indiana*, 104 F.3d 116, 120 & n.4 (7th Cir. 1997).

To survive a motion to dismiss a Rehab Act claim, the plaintiff's prima facie case must show that (1) he or she is an "individual with a disability" under the Act, (2) he or she is

"otherwise qualified" for the benefit sought, (3) he or she was excluded from participation, denied benefits, or discriminated against solely by reason of his or her disability, and (4) the program or activity in question receives federal financial assistance. *Grzan*, 104 F.3d at 119 & n.4; *Wisconsin Cmty Serv.*, 309 F. Supp. 2d at 1103; *Branham*, 392 F.3d at 902.

Relevant provisions of the ADA and the Rehab Act are similar. *Wisconsin Cmty. Serv.*, 309 F. Supp. 2d at 1103. Title II of the ADA was modeled on § 504 of the Rehab Act, and elements of claims under the two provisions are nearly identical. *Washington v. Indiana High Sch. Athletic Assoc.*, 181 F.3d 840, 845 n.6 (7th Cir. 1999). Standards and precedent applicable to one act also are applicable to the other. *Washington*, 181 F.3d at 845 n.6; *Wisconsin Cmty. Serv.*, 309 F. Supp. 2d at 1103.

One key difference is that while the Rehab Act requires exclusion solely by reason of disability, the ADA requires only that exclusion be by reason of the disability. *Washington*, 181 F.3d at 845 n.6. Section 504 of the Rehab Act therefore prohibits discrimination against a person with a disability only if the individual's disability is unrelated to and improper to consideration of the services in question. When medical treatment is the issue, typically the disability itself creates or contributes to the need for services. The term "otherwise qualified" consequently cannot be applied in the context of medical treatment decisions without distorting its plain meaning. Similarly, denial of treatment "solely by reason of disability" also does not fit allegations of discriminatory medical treatment. Section 504 prohibits discrimination between persons with disabilities and persons without disabilities; it does not create absolute substantive rights to treatment, and is ill suited for bringing claims of discriminatory medical treatment in which the plaintiff compares his or her treatment (medical or non-medical) to the treatment afforded other persons with disabilities. *Grzan*, 104 F.3d at 120-22.

2. Failures to state claims for which relief may be granted common to Counts One-Eight of the Amended Complaint.

Counts One through Eight against Secretary Nelson must be dismissed outright. The Amended Complaint fails to allege any involvement or conduct whatsoever by Secretary Nelson in developing and implementing policies, procedures and rates relating to funding for AFHs, CBRFs and day programs for persons in AFHs and CBRFs (collectively, "services"). The Amended Complaint further fails to allege any involvement or conduct whatsoever amounting to intentional discrimination by Secretary Nelson in the manners alleged in the Amended Complaint or in any other manner. Instead, the Amended Complaint alleges only that Secretary Nelson is responsible for the overall operation of DHFS and has the powers and duties of the head of a state agency specified in Wis. Stat. § 15.04(1) (Am. Comp. ¶ 13). That single conclusory allegation amounts to neither a direct factual allegation nor an inferential factual allegation linking Secretary Nelson to development and implementation of policies, procedures and rates relating to funding for the services. *Cf. Car Carriers*, 745 F.2d at 1106. Furthermore, as to Counts One, Three, Five and Seven alleging ADA violations, Secretary Nelson is an individual and not a "public entity" for purposes of the ADA. *Cf.* 42 U.S.C. § 12131(1). For all these reasons, Counts One-Eight fail to state claims against Secretary Nelson for which relief can be granted and must be dismissed.

Similarly, Counts One through Eight all allege that reasonable modifications or reasonable accommodations can be made to the Family Care program to serve plaintiffs in the manner they advocate (Am. Comp.¶¶ 142, 147, 151, 155, 161, 165, 170, 173). Counts One through Eight all fail to state claims under either the ADA or the Rehab Act in which a reasonable accommodation or modification is possible, however.

Regulations implementing the ADA require a public entity to make reasonable modifications in policies, practices or procedures, "'when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program or activity.'" 28 C.F.R. § 35.130(b)(7), quoted in *Wisconsin Cmty. Serv.*, 309 F. Supp. 2d at 1104. The Rehab Act requires reasonable accommodation unless it creates undue financial or administrative burdens, or requires a fundamental alteration in the nature of the program. *Wisconsin Cmty. Serv.*, 309 F. Supp. 2d at 1104. The Seventh Circuit has framed the fundamental alteration inquiry as "to ask whether waiver of the rule in the particular case at hand would be so at odds with the purposes behind the rule that it would be a fundamental and unreasonable change." *Washington*, 181 F.3d at 850.

Plaintiffs already are participating in the Family Care program. Plaintiffs' proposed reasonable accommodation or modification consists of essentially requiring fee-for-service payments to providers serving Family Care members in the same way that fee-for-service payments are made to providers serving participants in the other waiver programs. To require alteration of Family Care from a capitated rate to a fee-for-service system would eviscerate the entire purpose for the program and change it so fundamentally that it would no longer exist as a managed care capitated rate system. Because that change so clearly would constitute a fundamental alteration of the entire Family Care program, no reasonable accommodation or modification is possible. Counts One-Eight therefore fail to state claims for which relief can be granted.

Finally, Counts Five-Eight fail to state claims for which relief may be granted because the Amended Complaint fails to allege that the plaintiffs were discriminated against solely on the

basis of their disabilities as required by the Rehab Act. The specific variations of discrimination alleged in Count Five distinguish between classes of persons with disabilities on the basis of (1) age, (2) county of residence, and (3) degree of disability (Am. Comp. ¶ 143). The specific variations of discrimination alleged in Counts Seven and Eight distinguish among classes of persons with disabilities on the basis of age—whether they are sixty years of age or older. None of these are distinctions between persons with disabilities and persons without disabilities. Rather than alleging that the plaintiffs were discriminated against solely on the basis of their disability, Count Six instead attacks the treatment decisions made by and for Family Care enrollees. The Rehab Act does not create substantive rights to treatment, however, and cannot be applied in the context of comparative treatment decisions. The plaintiffs therefore fail to allege that they are persons with disabilities otherwise qualified for the benefits allegedly denied them. *Grzan*, 104 F.3d at 120-22. Counts Five-Eight consequently all fail to state claims for which relief can be granted under the Rehab Act.

3. Counts One and Five fail to state claims for which relief can be granted.

Counts One (ADA) and Five (Rehab Act) allege that Milwaukee County residents with disabilities aged 60 and older whose services are funded by Family Care receive substantially inferior treatment regarding payment for services compared to (1) Milwaukee County residents under age 60 whose services are funded by the COP, CIP and BI programs; (2) residents of non-Family Care counties with disabilities of any age whose services are funded by the COP, CIP and BI programs; and (3) Milwaukee County residents with less significant disabilities served by Family Care (Am. Comp. ¶ 138-43, 157-62.)

Neither the ADA nor the Rehab Act establish any obligation to meet a disabled persons' particular needs vis-à-vis the needs of other disabled persons. *Doe v. Pfrommer*, 148 F.3d 73, 83 (2nd Cir. 1998). Plaintiffs' alleged distinction from the other groups alleged in Counts One and Five therefore affords no cognizable grounds for relief under the ADA or the Rehab Act.

There is no allegation anywhere in the Amended Complaint of any facts demonstrating or implying intentional discrimination by the State defendants against the plaintiffs on grounds of the plaintiffs' disabilities or any other grounds. Counts consequently fail to state any intentional discrimination claim for which relief can be granted.

Also, as to both Counts One and Five, none of the plaintiffs are being excluded from or denied the benefits of some service, program or activity by reason of their disabilities. It is participation in services, programs and activities that the ADA and Rehab Act protect—not access to any specific funding stream to pay for those services, programs and activities, and not any universal, objective funding level for those services, programs and activities. All of the plaintiffs are receiving residential and other services through the Family Care program in which they are enrolled, by reason of their disabilities (Am. Comp. ¶¶ 71, 85, 95, 103, 112, 122).

Certain providers of services to the plaintiffs might want to be paid more money for providing those services, but that does not amount to any kind of discrimination against the plaintiffs who indisputably have been and continue to receive services through their participation in the Family Care program. Family Care is not about writing blank checks to service providers; it is about providing effective, coordinated, appropriate services to Family Care members in an efficient and cost-effective manner. Appropriate coordination and delivery of services to Family Care enrollees is guaranteed and protected by the state's contract with the CMO, as explained in sections I.C. and I.D. above, not by the level of the capitated rate paid to the CMO. Because the

providers' complaints about the rates they are paid by the CMO do not amount to discrimination against the plaintiffs who have been and continue to receive services and other benefits of participating in the Family Care program, Counts One and Five fail to state claims for which relief can be granted under the ADA or the Rehab Act.

4. Counts Two and Six fail to state claims for which relief may be granted.

Count Two (ADA) and Count Six (Rehab Act) allege that the State defendants Family Care policies, procedures and rates prevent persons with disabilities from obtaining the same result, gaining the same benefit, or reaching the same level of achievement in the most integrated setting appropriate to their needs. Count Two further alleges that those polices, procedures and rates have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the Family Care and Medicaid programs (Am. Comp. ¶¶ 144-48, 163-66).

Counts Two and Six fail to state claims for which relief can be granted because they make no sense. They allege that Family Care policies, procedures and rates relating to funding for services prevent persons with disabilities from obtaining the same result, gaining the same benefit or reaching the same level of achievement in the most integrated setting appropriate to their needs—without identifying any comparison group against which to gauge attainment of the same result, the same benefit and the same level of achievement. There can be no discrimination against persons with disabilities absent another group of persons without disabilities treated differently.

Nor are plaintiffs' conclusory allegations about deprivation of the same results, benefits and achievements in the most integrated setting supported by evidentiary facts in the Amended Complaint. None of the plaintiffs has claimed that he or she is not placed in the most integrated

setting, and any possibility that a plaintiff's residential placement might change in the future is not equivalent to alleging deprivation of most integrated setting—all as explained above in Sections I.C. and I.D. And, even if the plaintiffs had alleged sufficient supporting facts, neither the ADA nor the Rehab Act establish any obligation to meet a disabled persons' particular needs vis-à-vis the needs of other disabled persons. *Doe*, 148 F.3d at 83.

Relatedly, the State defendants' role concerning direct care and decisions regarding the most integrated settings for individual Family Care enrollees is non-existent as a matter of law. Under the Family Care contract, it is the county CMO—not the State defendants—that is legally responsible for direct care service provision and decisions regarding the most integrated settings for individual Family Care enrollees (*see* n.2 above, Exhibit 2002, pages 15-20, 26-42).

For these reasons, Counts Two and Six fail to state claims for which relief can be granted under Title II of the ADA and § 504 of the Rehab Act.

5. Counts Three and Seven fail to state claims for which relief can be granted.

Counts Three (ADA) and Seven (Rehab Act) allege that Family Care policies, procedures and rates relating to funding for services as developed and implemented by DHFS and Secretary Nelson violate integration requirements of the ADA and the Rehab Act because they substantially increase the probability that Milwaukee County residents with disabilities aged 60 or older will be placed in more restrictive, less integrated settings despite their preference for less restrictive, more integrated settings (Am. Comp. ¶¶ 149-53, 169-70).

Plaintiffs' conclusory claims are totally speculative and unsupported by evidentiary facts concerning any of the named plaintiffs. As explained in Sections I.C. and I.D. above, plaintiffs have not alleged any facts to support a claim that the CMO has in the past or is currently placing

Family Care enrollees without due regard for their needs and protected rights, and there is no basis whatever for a presumption that it will do so in the future. No claim for which relief can be granted is stated.

6. Counts Four and Eight fail to state claims for which relief can be granted.

Count Four (ADA) and Count Eight (Rehab Act) allege that the fixed capitation rate and the methods used to determine provider rates fail to provide an individualized determination of services needed to place and maintain Milwaukee County residents aged 60 or older with disabilities in appropriate and integrated residential services of their choice (Am. Comp. ¶¶ 154—56, 172-74).

The essence of these claims seems to be that the State defendants' policies, procedures and rates related to Family Care funding will not result in plaintiffs' future placement in (1) appropriate and integrated residential services (2) of their unrestricted choice. As to point (1), please see Arguments I.C. and I.D. above. As to point (2), there is no basis in law for plaintiffs to claim injury based on a purported unilateral right to choose their own residential settings. Section 1396n(c)(2)(C) of the Medicaid statute requires that all similarly situated waiver participants be "informed of the feasible alternatives, if available under the waiver, at the choice of such individuals, to provision of inpatient hospital services, nursing facility services or services in an intermediate care facility for the mentally retarded." As a matter of law neither Family Care nor other waiver recipients have a protected, unlimited right to choose residential facilities. The plaintiffs therefore fail to allege any actionable discrimination.

Also, the Amended Complaint sets forth only generalized and conclusory allegations regarding failure to provide individualized determination of services needed for placement of

Family Care members. These speculative claims are not supported by facts relating to individualized determination of service needs for any of the plaintiffs in this lawsuit, as further explained in Section I.C. above.

Furthermore, the State defendants' responsibility for providing Milwaukee County with actuarially sound capitation rates does not include either setting provider rates or making an individualized determination of services needed by participants, both of which are the responsibility of the Milwaukee County CMO pursuant to the CMO contract (Exhibit 2, page 15). Plaintiffs' complaints about allegedly inadequate provider rates or individual service determinations therefore fail to state any claim for relief against the State defendants.

### C. Count 9 fails to state a claim based on 42 U.S.C. § 1396(a)(30)(A).

Count 9 attempts to set forth a claim based on the Medicaid statute, 42 U.S.C. § 1396a(a)(30)(A), which provides:

> [A state plan for Medical Assistance must] provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of care and services and *to assure that payments are consistent with efficiency, economy, and quality of care and 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*.

*Id.* (emphasis supplied). In Count 9, plaintiffs refer to the italicized language of the statute as the "adequate rate and equal access" provisions[20] of (a)(30)(A) (*see* Am. Comp. ¶ 182). In the two

[20]There seems to be no common shorthand for describing the provisions of (a)(30)(A) to which plaintiffs refer although, for the sake of brevity, the cases most commonly refer to these provisions together as simply to the "equal access" provisions. *See, e.g., Clark v. Richman*, 339 F. Supp.2d 631, 638 (M.D. Pa. 2004). When broken into two concepts, the first is often referred to as the "quality of care" provision. *See Pennsylvania Pharmacists Assn. v. Houstuon*,

succeeding paragraphs, plaintiffs set forth conclusory allegations that the capitated rates set by the State defendants and paid to Milwaukee County for the years 2000 through 2005 have been inadequate to assure that payments to Family Care AFH and CBRF providers and to providers of day services to residents of such facilities are adequate and sufficient, tracking the italicized language of the statute almost word for word (*id.* ¶¶ 183-184).

Count 9, together with the rest of the amended complaint, fails to state a claim for relief based on the quality of care and equal access provision of (a)(30)(A) for several reasons. First, for purposes of retroactive monetary relief, neither DHFS nor Secretary Nelson in her official capacity are "persons" who are subject to suit under 42 U.S.C. § 1983. *See Arizonans for Official English*, 520 U.S. at 69-70 n. 24; *Will*, 491 U.S. at 71.

Secondly, there is significant room for debate as to whether the provisions of (a)(30)(A) are sufficient to create a statutory right in favor of either recipients or providers which is enforceable under § 1983, based on the requirements articulated by the Supreme Count most recently in *Gonzaga University v. Doe*, 536 U.S. 273, 279-286 (2002); *see also Blessing v. Freestone*, 520 U.S. 329, 340-343 (1997). Cases following *Gonzaga* acknowledge that pre-*Blessing* cases recognizing that MA recipients or providers have a private right of action under § 1983 are open for re-examination. *See Westside Mothers, et al. v. Olszewski*, *et al.*, 2005 WL 1027987 *4-*15, __ F. Supp.2d __ (E.D.Mich. 2005) (re-examining prior decisions recognizing private right in light of *Gonzaga*; finding no right of action for recipients); *Sanchez v. Johnson*, 301 F. Supp.2d 1060, 1063 (N.D. Cal. 2004) (on reconsideration following *Gonzaga*, holding that recipients did not have private right of action); *OKAAP, et al. v. Fogarty, et al.*,

283 F.3d 531, 538-44 (3rd Cir. 2002)(*en banc*). This argument will refer to the "quality of care" and "equal access" provisions.

366 F. Supp.2d 1050, 1102-04 (N.D. Ok. 2005) (analyzing cases; holding that recipients but not providers have right of action under (a)(30)(A)); *cf. Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 56-58 (2004) (re-examines prior precedent; held: providers do not have private right of action, but rationale may affect recipients as well); *In re. NYAHSA Litigation*, 318 F. Supp.2d 30, 39-40 (N.D.N.Y. 2004) (recipients are intended beneficiaries; no private right of action for providers).

The question of whether recipients have a private right of action under (a)(30)(A) and § 1983 is noted to the court here, however, primarily for purposes of preserving the issue for review. Because the State defendants presume that this court will consider itself bound by Seventh Circuit precedent pre-dating *Blessing*, which expressly recognized a private right of action for providers based on (a)(30)(A),[21] they will not challenge in this Court plaintiffs' claim that plaintiffs have a private right of action based on the equal access provisions of (a)(30)(A).

Assuming, *arguendo*, that MA recipients have a private right of action under (a)(30)(A) however, it is highly unlikely that plaintiffs can rely on (a)(30)(A) alone as the basis to state a claim challenging the adequacy of the Family Care capitated rates, as plaintiffs seek to do in Count 9. *Cf. Clayworth v. Bonta*, 295 F. Supp. 1110, 1124-1126 (E.D. Cal. 2003) (despite finding private right of action benefiting recipients under (a)(30)(A), the court concluded that neither MA recipients nor providers had private right of action to challenge capitated rates under the managed care waiver provisions of 42 U.S.C. § 1396n(b) and the applicable federal

[21] *See Methodist Hospitals v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir. 1996) (held: providers have a private right of action to enforce "equal access" provision of (a)(30)(A)); *see also American Society of Consultant Pharmacists, et al. v. Garner*, 180 F. Supp.2d 953, 969, 977 (N.D. Ill. 2001) (post-*Blessing*; following *Methodist Hospitals*; suggesting that providers' right of action is derivative of patients' rights to quality of services).

regulation, 42 C.F.R. § 438.(6)(c)).[22] After all, the components of Family Care are approved as a managed care program under the waiver provisions of § 1396n(b), "waivers to promote cost-effectiveness and efficiency," *and* as a prepaid health plan as well as a HCBS waiver under § 1396n(c). *See* nn. 3 and 4, above and citations therein, including the CMO Contract (Ex. 2002) at 121, ¶ 18 and Ex. 2003-D(1). Plainly, applying fundamental principles of statutory construction, the Court must strive to interpret *all* of the requirements of the federal statutes and interpretative rules that apply to Family Care, including (a)(30)(A), in harmony with one another.

Most importantly for present purposes, the Family Care capitated rates, on which plaintiffs focus their primary attack, must comply with the "actuarial soundness" requirements of 42 C.F.R. § 438.6, which imposes various requirements on contracts for managed care and pre-paid health plans. *See* 42 C.F.R. § 438.6(a). Among the central requirements of that rule applicable to Family Care are the requirements of § 438.6(c) that the payments by DHFS to CMO providers, including the Milwaukee County CMO, must comply with the detailed standards for "actuarially sound capitation rates" as defined in subsec. 438.6(C)(1)(i) and set forth in succeeding provisions of that rule, including subsecs. 438.6(c)(2) and (3). Subsec. (c)(2)(i) provides unequivocally that "[a]ll payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound," while subsec. (3) contains the specific requirements that the "actuarially sound" DHFS rates must meet.

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[22]Because plaintiffs assert a private right of action based solely on (a)(30)(A) and ignore the managed care waiver requirements of 42 U.S.C. § 1396n(b) as well as the actuarial soundness requirements of the federal regulations governing capitated rates, the State defendants will address plaintiffs' claim in the context of arguing that they do not state a claim for relief concerning the capitated rates under (a)(30)(A). *Clayworth*, however, is clear well-reasoned precedent addressing why the waiver provisions of § 1396n(b) are relevant *and* why MA recipients do not have enforceable rights to attack managed care capitated rates based on § 1396n(b). *See Clayworth*, 295 F. Supp.2d at 1124-26.

Because the detailed requirements for actuarial soundness of 42 C.F.R. § 438.6 govern the capitated rates DHFS pays CMO providers, the State defendants submit that, *at a minimum*, in order to state a claim under (a)(30)(A) directly attacking the capitated rates of a managed care waiver, as plaintiffs seek to do, the complaint must set forth facts alleging that the rates are not "actuarially sound." Yet Count 9 of the Fourth Amended Complaint—indeed, the complaint as a whole—completely ignores the applicable, detailed requirements of § 438.6(c) and does not allege, even in conclusory fashion, that the DHFS capitated rates are *not* actuarially sound.

Furthermore, if one construes the actuarial soundness requirements in conjunction with the "quality of care" language of (a)(30)(A), on which plaintiffs rely, plaintiffs must adequately allege that the capitated rates "are [in]consistent with efficiency, economy, and quality of care" as well as "[in]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" *see id.* Count 9 should be dismissed for failure to state a claim for that reason alone.

In any event, assuming one can ignore the federal standards the DHFS capitated rates must meet for purposes stating a claim that the rates are inadequate under (a)(30)(A), the utterly conclusory allegations of the complaint fail to set forth *facts* that are even minimally sufficient to state a claim under that statute.

With regard to the requirement that the payments be consistent with "quality of care," plaintiffs do not allege any deficiencies in the quality of the care they are currently receiving. The bald assertions to the effect that Family Care rates may at some point in the future allegedly become inadequate to assure quality of care is nothing more than conclusory speculation, insufficient to support an inference that, in fact, this will come to pass.

In an apparent attempt to support a claim under the final "equal access" requirement of (a)(30)(A), plaintiffs do allege that some providers have threatened to stop providing Family Care services and, in the case of HIL, one of the providers serving the plaintiffs, the provider actually did serve the Milwaukee County CMO with notice that it intended to terminate its Family Care contract. But the termination of a single provider contract is a far cry from—and not remotely the equivalent of—alleging facts sufficient to demonstrate that so many providers will terminate their services (*and* will not be replaced with other willing providers) that plaintiffs and their putative class will not have access to community-based residential long term care services "at least to the extent that such care and services are available to the general population in the geographic area," as the statute requires. While ¶¶ 183 and 184 of the Amended Complaint repeat the statutory language in conclusory fashion, there are simply no facts anywhere in the complaint to support the conclusory allegations.

As the Seventh Circuit indicated in *Methodist Hospitals, Inc.*, any rights enforceable under (a)(30)(A) are substantive rather than procedural; the statute "requires each state to produce a *result*, not to employ any particular methodology for getting there." *Id.* at 1030. Count 9 of the Fourth Amended Complaint does not adequately allege that the *results* required of Family Care—that the payments be consistent with quality of care and sufficient to insure access to Family Care services by recipients to the extent that such care and services are available to the general population in the geographic area—will not be delivered. In short, Count 9 fails to state a claim actionable under (a)(30)(A).

## CONCLUSION

For the reasons discussed above, the Fourth Amended Complaint must be dismissed for lack of jurisdiction because plaintiffs lack standing or because the claims are not ripe for

adjudication. In the alternative, the complaint must be dismissed because it fails to state claims for relief under the ADA, the Rehabilitation Act or the Medicaid statute, 42 U.S.C § 1396(a)(30)(A) enforceable under § 1983. In addition, claims for retroactive declaratory and monetary relief against the State defendants, other than claims based on the Rehabilitation Act § 504, are barred by sovereign immunity and the Eleventh Amendment.

Dated this 15th day of June, 2005.

Respectfully submitted,

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