UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

MICHELE HADDAD,

Plaintiff

v. Case No: 3:10-cv-414-J-99MMH-TEM

THOMAS W. ARNOLD, in his official Capacity as Secretary, Florida Agency for Health Care Administration, and

DR. ANA VIAMONTE ROS, in her official capacity as Surgeon General, Florida Department of Health,

Defendants

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DEFENDANTS' MOTION TO DISMISS COMPLAINT

The Defendants, THOMAS W. ARNOLD, in his official capacity as the Secretary of the Florida Agency for Health Care Administration, and DR. ANA VIAMONTE ROS, in her official capacity as Surgeon General, Florida Department of Health, by and through undersigned counsel, hereby move pursuant to Rule 12(b)(1) and (6), Fed. R. Civ. P., to dismiss this cause for lack of subject matter jurisdiction and for failure to state a claim upon which relief can be granted. As grounds therefore, Defendants state as follows:

1. On May 13, 2010, Plaintiff Michele Haddad (Haddad) filed her Complaint, which was served on Defendants on May 17, 2010. The Complaint alleges that Defendants violate Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132 (ADA), and Section 504 of the Rehabilitation Act, 29 U.S.C. § 794(a) (Rehab Act) by denying in-home health services to Plaintiff.

2. This Court should dismiss the Complaint pursuant to Rule 12(b)(1) and (6), Fed. R. Civ. P., because Plaintiff lacks standing to bring this action, Plaintiff fails to allege an clear violation of the ADA, Rehab Act, or the Medicaid Act, the implementing regulations of the ADA which form the basis of Plaintiff's claim are not enforceable by private right of action, the claim for provision of personal care services exceeds the scope of the ADA, the ADA neither abrogates nor amends the Medicaid Act, and Plaintiff's requested relief would constitute a fundamental alteration of the Florida Medicaid Program, which the ADA does not require.

3. As further support for this Motion, the Defendants submit the following Memorandum of Law, which is attached hereto and incorporated herein by reference

MEMORANDUM OF LAW

I. The Complaint Should be Dismissed Because Plaintiff Lacks Standing.

Plaintiff lacks standing in this case because Plaintiff fails to allege discriminatory conduct. To state a claim under Title II of the ADA, a plaintiff must allege: (1) that she is a "qualified individual with a disability;" (2) who was "excluded from participation in or . . . denied the benefits of the services, programs, or activities of a public entity" or otherwise "discriminated [against] by such entity;" (3) "by reason of such disability." Shotz v. Cates, 256 F.3d 1077, 1079 (11th Cir. 2001). Plaintiff does not allege facts from which this Court could conclude that Plaintiff has been excluded from participation, denied benefits, or otherwise discriminated against by a public entity "by reason of …. disability." Id. In fact, Plaintiff's Complaint takes special note that individuals just like Plaintiff receive services in the community for the same types of disabilities. (Complaint, p. 5.) The fact that persons

just like Plaintiff are being served in the community shows that any disparate treatment is **not** "by reason of…disability."

Plaintiff also fails to allege discriminatory treatment. Plaintiff is not a member of a suspect class so disparate treatment is analyzed using a rational basis test.[1] Under such a test, disparate treatment is upheld if there is a rational basis for it; that is, "if any state of facts reasonably may be conceived to justify it." D. W. v. Rogers, 113 F.3d 1214 (11th Cir. 1997). Here, Plaintiff fails to allege discriminatory treatment applying rational basis review, because Plaintiff fails to allege facts from which this Court could conclude that there is no rational basis for Defendants' actions.[2] Because of the omission of critical elements necessary to maintain Plaintiff's action – an allegation of a violation of Title II of the ADA– Plaintiff does not have standing to maintain this lawsuit.

Plaintiff further lacks standing because she is a member of the class certified in Dubois v. Levine, Case No. 4:03-CV-107-SPM, in which the Federal District Court for the Northern District of Florida addressed a claim on behalf of a statewide class of persons with brain and spinal cord injuries that the State Defendants (the same defendants in the case sub judice) engaged in a "systemic and continuing failure to provide the named Plaintiffs and alleged class members (Plaintiffs) with medically necessary home and community based services" in violation of the ADA and Rehab Act. See Dubois Complaint, attached as

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[1] An equal protection claim predicated on disparate treatment of individuals with disabilities is subject to only rational basis review. City of Cleburne v. Cleburne Living Ctr., 473 U.S. 432, 446, 105 S. Ct. 3249, 87 L. Ed. 2d 313 (U.S. 1985); and Board of Trustees of the University of Alabama v. Garrett, 531 U.S. 356, 366-68, 121 S. Ct. 955, 148 L. Ed. 2d 866 (2001).

[2] Plaintiff may argue that Title II of the ADA modifies the analysis of what constitutes "discriminatory treatment," because of the interpretation of DOJ of a state's responsibilities thereunder as described in 28 C.F.R. § 35.130(b)(7). However, the provisions of 28 C.F.R. § 35.130(b)(7), exceed Congressional intent pertaining to the scope of Title II, as is discussed further below in Part III.

Exhibit A. The Court certified as a class "all individuals with traumatic brain or spinal cord injuries who the state has already determined **or will determine** to be eligible to receive services from Florida's Medicaid Waiver Program for persons with traumatic brain and spinal cord injuries and have not received such services." (Emphasis added.) See Dubois Settlement, attached as Exhibit B. This Settlement was approved by the Court and the Court dismissed the action with prejudice pursuant to the Settlement's terms. See Order of Dismissal with Prejudice, attached as Exhibit C. The law is clear that the doctrine of issue preclusion (or collateral estoppel) bars a party from what is tantamount to a collateral attack on a settlement issued in a prior class action asserting essentially the same claims or issues. Reyn's Pasta Bella, LLC v. Visa USA, Inc., 442 F. 3d 741 (9th Cir. 2006); Carter v. Rubin, 14 F. Supp. 2d 22 (D.C. D.C. 1998). There are four issues that are addressed in applying issue preclusion or collateral estoppel: (1) identity of issues; (2) prior adjudication resulting in a final judgment on the merits; (3) whether Plaintiff here was a party or in privity with a party to the prior adjudication; and (4) whether that party had a full and fair opportunity to litigate the issue in the prior proceeding. 47 Am. Jur. 2d, Judgments, sec. 489. In the case at bar, the issues are identical. The prior adjudication in Dubois resulted in a final judgment on the merits. Further, the parties are identical because Plaintiff here is necessarily included as a future member in the definition of the class in Dubois. Federal courts generally follow a three-step process in determining whether issue preclusion applies: (1) the identification of issues in the two actions to determine whether the issues are sufficiently similar and material in both actions to justify invoking the doctrine; (2) the examination of the record of the prior case to decide whether the issue was litigated in the first case; and (3) the examination of the

record in the prior proceeding to ascertain whether the issue was necessarily decided in the first case. Id. Here, the issues are sufficiently similar and material; and the issues were both litigated and decided in Dubois. Accordingly, the doctrine of issue preclusion (or claim preclusion or collateral estoppel) applies to bar this action. Based upon the lack of standing, the Complaint should be dismissed pursuant to Rule 12(b)(1), Fed. R. Civ. P.

II. Plaintiff Fails to State a Claim Upon Which Relief Can be Granted Because She Fails to Allege a Clear Violation of the ADA, Rehab Act, and Medicaid Act and Defendants' Alleged Conduct Does Not Constitute Discrimination Under the ADA.

A. Haddad does not allege a clear violation of the Medicaid Act or the ADA.

Plaintiff does not and cannot point to any violation of the Medicaid Act or of the ADA in bringing her claim. As will be shown, the federal Medicaid Act specifically makes the type of service Haddad seeks here, personal care assistance (PCA), an optional Medicaid service. The federal Medicaid Act also makes home and community-based waiver services (HCBS) (which can include PCA) optional, and allows states that opt to provide these services to cap the number of persons served. Thus, Florida has unquestionably followed federal Medicaid law in choosing not to provide PCA through its Medicaid program, and has followed the law in providing HCBS to a limited number of persons.

In addition, Plaintiff does not point to any statutory provision of the ADA that supports her cause. Title II of the ADA, which pertains to public programs and services, generally states that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42

U.S.C. § 12132. The regulations to the ADA, moreover, state that the ADA "does not require a public entity to provide to individuals with disabilities … services of a personal nature including assistance in eating, toileting, or dressing." 42 C.F.R. § 35.135. Accordingly, the Defendants' decision to generally exclude PCA services from Medicaid coverage complies with the black letter of the ADA and its implementing regulations.

B. Defendants' Alleged Conduct Does Not Constitute Discrimination Under the ADA

Rather than point to the text of the federal Medicaid Act or the ADA, Plaintiff bases her case on the ADA implementing regulations. First, Plaintiff asks this court to enforce what is known as the ADA's "integration mandate" which is found at 28 C.F.R. § 35.130(d), and which states: "[a] public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." See Complaint, e.g., ¶¶ 49, 52, 74, Relief Requested. Second, Plaintiff essentially asks this Court to ignore the ADA's explicit exclusion of PCA services from its purview. This Court should reject both arguments. The ADA's implementing regulations do not create a private right of action, and this Court cannot ignore the plain meaning of the regulation excluding PCA from the ADA's reach.

Because Plaintiff does not allege violations of the ADA, Rehab Act, or Medicaid Act, and the Defendants' alleged conduct does not constitute discrimination under the ADA, Plaintiff fails to state a claim upon which relief can be granted and the Complaint should be dismissed pursuant to Rule 12(b)(6), Fed. R. Civ. P.

III. Plaintiff Fails to State a Claim Upon Which Relief Can be Granted Because the Regulations Implementing Title II of the ADA, Including the "Integration Mandate", are Not Enforceable by Private Right of Action

The "integration mandate" in Title II of the ADA does not create a private right of action. As the Eleventh Circuit held in a recent decision, "[w]hile the ADA directed the Attorney General to promulgate regulations implementing Part II, 42 U.S.C. § 12134, the purpose of those 22 regulations is to provide standards for compliance with the ADA, id. § 12134(c), **not to give individuals a right to sue if compliance with those standards is not met**." Am. Ass'n of People with Disabilities v. Harris, 2010 U.S. App. LEXIS 9615, at 28 (11th Cir. Fla. May 11, 2010) (emphasis added). Here, Haddad alleges that compliance with the "integration mandate" has not been met and that this confers on her the right to bring an action against the Defendants. As Am. Ass'n of People with Disabilities demonstrates, this is not the case.

Plaintiff may argue that she is not seeking to independently enforce the "integration mandate," but is rather attempting to enforce the ADA itself, the scope of which is interpreted and defined by the "integration mandate" regulation. However, the technical violation of the "integration mandate" that Plaintiff alleges here **cannot** constitute a violation of § 12132, as Plaintiff alleges. Section 12132 provides: "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" (emphasis added). Here, the program from which the Plaintiff alleges she has been "excluded from" or "denied the benefits of" (the TBI/SCI Waiver program) is **only available** to individuals with the same disability as the Plaintiff. By definition, therefore, any exclusion, denial, or discrimination **cannot be** "by reason of such disability." Any such exclusion, denial, or discrimination would have to be for some

other reason. The Plaintiff has therefore failed to allege a violation of § 12132, and cannot enforce the "integration mandate." Because the "integration mandate" is not enforceable by private right of action, Plaintiff's Complaint fails to state a claim upon which relief can be granted and should be dismissed pursuant to Rule 12(b)(6), Fed. R. Civ. P.

Additionally, had Congress intended to make the integration mandate part of Title II of the ADA, it knew how to do so. Title III of the ADA contains an express statutory integration mandate at 42 U.S.C. § 12182(b)(1)(B). Had Congress intended to provide similar coverage in Title II as it did in Title III, Congress could have included an integration mandate in the statutory body of Title II. It did not. The express integration mandate in Title III calls into question whether the integration mandate in Title II constitutes a valid exercise of delegated legislative authority. The U.S. Supreme Court in Olmstead did not answer this question, instead noting that "we cite [Title II's regulations, including the integration mandate] with the caveat that we do not here determine their validity." Olmstead, 427 U.S at 592. The Eleventh Circuit issued this same caveat in Bircoll v. Miami-Dade County, 480 F.3d 1072, 1082 n.13 (11th Cir. 2007). Congress did not explicitly authorize any federal agency to create a privately enforceable integration mandate. To the extent the Department of Justice (DOJ) attempted to do so with respect to Title II, its actions were not authorized by Congress. Moreover, even if the regulation were somehow valid, a regulation cannot invalidate the provisions of a separate Congressional enactment, and the integration mandate thus cannot modify the Medicaid Act. The Complaint therefore fails to state a claim upon which relief can be granted and should be dismissed pursuant to Rule 12(b)(6), Fed. R. Civ. P.

IV. Plaintiff's Claims for Community-Based Personal Care Services under the ADA and the Rehab Act Fail to State a Claim Upon Which Relief Can Be Granted Because the ADA Does Not Require a Public Entity to Provide Services of a Personal Nature

In this case, Plaintiff seeks assistance transferring from her bed to her wheelchair and from her wheelchair back to her bed, and assistance dressing, grooming, toileting, and with other activities of daily life. Complaint, ¶ 21-22. Plaintiff contends that the ADA requires the provision of such PCA. This is not the case. The ADA regulations specifically exclude PCA services from the ADA's purview.

Section 35.135 of the ADA's implementing regulations states that the ADA "does not require a public entity to provide to individuals with disabilities…**services of a personal nature including assistance in eating, toileting, or dressing**" (emphasis added). In its Statement of Interest in this case, the DOJ argues that 28 C.F.R. § 35.135 "affords no defense here." Statement of Interest of the United States of America, p. 13. The DOJ contends that § 35.135 "simply makes clear that Title II does not require a State to provide personal services *in a program that does not include such services*. (For example, the Department of Motor Vehicles need not provide wheelchairs to those who wait in line for a driver's license.)" Id (emphasis in original). The DOJ implies that, because Florida allegedly provides PCA services to Medicaid recipients in the nursing home, it must also provide these services in the community under the "integration mandate." Id. This is made clear, the DOJ contends, by its own "authoritative interpretation" of 28 C.F.R. § 35.135. Id. This "interpretation," however, is entitled to no deference.

Simply stated, the DOJ's "interpretation" of 28 C.F.R. § 35.135 is not an interpretation at all. It is an attempt to carve out an exception to this regulation that is not

present in the text. The DOJ wants this Court to say that the regulation contains an exception for public entities that provide PCA services. This is an improper attempt to **amend** the regulation without complying with the requirements of the federal Administrative Procedures Act.

Section 35.135 has a plain meaning and is unambiguous. It is not subject to "interpretation" as Courts cannot and do not interpret regulations that have a plain meaning. Nor do courts defer to agency "interpretations" of unambiguous regulations. As the United States Court of Appeals for the Eleventh Circuit stated in Charter Fed. Sav. & Loan Ass'n v. Office of Thrift Supervision, 912 F.2d 1569, 1580-1 (11th Cir. 1990), "where the language selected by the drafters is clear and unequivocal, the courts are bound to give effect to the plain meaning of the chosen words [of a regulation] and no duty of interpretation arises." Id., (citing KCMC, Inc. v. FCC, 600 F.2d 546, 549 (5th Cir. 1979)).

Likewise, the United States Supreme Court has held that "deference is warranted only when the language of the regulation is ambiguous." Christensen v. Harris County, 529 U.S. 576, 588 (U.S. 2000). This regulation is not ambiguous. "To defer to the agency's position would be to permit the agency, under the guise of interpreting a regulation, to create *de facto* a new regulation." Id.

Section 35.135 could not be clearer: "This part does not require a public entity to provide to individuals with disabilities personal devices, such as wheelchairs; individually prescribed devices, such as prescription eyeglasses or hearing aids; readers for personal use or study; **or services of a personal nature including assistance in eating, toileting, or dressing**" (emphasis added). There is no ambiguity or need for interpretation, and there is

no exception for public entities that provide PCA services. Indeed, the DOJ cannot identify a single ambiguous term or phrase in the regulation – and in the absence of ambiguity, federal courts prohibit interpretation.

In its Statement of Interest, the DOJ cites the ADA Title II Technical Assistance Manual, § II-3.6200, which, in reference to the provision in § 35.135, states: "Of course, if personal services or devices are customarily provided to the individuals served by a public entity, such as a hospital or nursing home, then these personal services should also be provided to individuals with disabilities." This statement, which is not itself a regulation, says nothing about the provision of PCA *in the community*. On its face, it is clearly referring to the provision of PCA to individuals with disabilities in a context where such services are "customarily provided to the individuals served by a public entity, *such as a hospital or nursing home*" (emphasis added). The plain meaning of this provision is that a **hospital** or **nursing home** should not take § 35.135 to mean that they can deny PCA to individuals with disabilities who are in their custody.

Thus, § 35.135 and the Guidance that accompanies it exempt public entities from having to provide PCA outside of a custodial context such as a nursing home or hospital. The DOJ then employs a classic piece of circular logic. According to the DOJ, once a public entity follows its Guidance and provides PCA in a nursing home, its "interpretation" of § 35.135 takes effect and the public entity is required to provide personal care assistance in the community as well. Section 35.135 and its interpretive Guidance thus become a tautological trap. The Guidance requires nursing homes to provide PCA, but once they do

the DOJ will "interpret" its regulations to require personal care in the community. This Court should not allow such games to be played with an unambiguous regulation.

This Court should also note that PCA services are not among the essential "services, programs, and activities" that the Florida Medicaid Program provides in nursing facilities. 42 C.F.R. § 35.130(d). The Florida Medicaid Program pays for "24-hour-a-day **nursing** and **rehabilitative** services for a recipient in a nursing facility licensed under part II of chapter 400." § 409.905(8), Florida Statutes (emphasis added). No doubt, personal care services are provided in nursing facilities. However, nursing facilities provide these services *incidentally* from the custodial relationship between the nursing facility and the Medicaid recipient, in order to keep the residents in optimum health. Meals and snacks are also incidentally provided in nursing facilities. Under the DOJ's "interpretation" of its regulation, the "integration mandate" would mean that the Florida Medicaid Program has to provide meals and snacks to disabled Medicaid recipients in the community. The Florida Medicaid Program requires nursing facilities to provide "a clean comfortable mattress, pillows, clean linens and bedding appropriate to the weather and climate, towels and washcloths, functional furniture appropriate to the resident's needs, and individual closet space with clothes racks and shelves." Florida Medicaid Nursing Facilities Coverage and Limitations Handbook, p. 2-9. The tautological interpretation of the "integration mandate" that the Plaintiff and DOJ espouse would require the Florida Medicaid Program to assure that all disabled Medicaid recipients in the community have these items in the community; including the requirement for adequate closet space. This clearly goes too far, but it is the same absurd logic that lies behind the Plaintiff and DOJ's claim that the "integration

mandate" requires the provision of PCA in the community simply because it can be received in a nursing facility.

The regulations implementing Title II of the ADA are clear. Florida is required to administer its services "in the most integrated setting appropriate," but this cannot be read to require the Florida Medicaid Program to provide "services of a personal nature," which is precisely what Plaintiff is requesting here. The ADA does not require the provision of PCA services. Plaintiff's Complaint therefore fails to state a claim upon which relief can be granted and should be dismissed pursuant to Rule 12(b)(6), Fed. R. Civ. P.

V. The ADA Neither Abrogates nor Amends the Black Letter Provisions of the Medicaid Act

The fundamental question that lies at the heart of this lawsuit relates to the relationship between the ADA and the Medicaid Act. To resolve this case, this Court will need an understanding of both laws.

1. Medicaid

Medicaid is a joint federal-state venture created by federal statute, Title XIX of the Social Security Act of 1965, as amended. 42 U.S.C. § 1396 *et seq*. In order to participate in Medicaid, a state must submit a plan to the federal government outlining its program to fund medical services for the poor and needy in accordance with the federal Medicaid Act. If the federal government approves the plan, it then subsidizes the costs. Currently, with the addition of stimulus funds pursuant to the American Recovery and Reinvestment Act of 2009, the federal government provides approximately 68% of the money in Florida's Medicaid Program.

The federal Medicaid Act defines "medical assistance" to mean payment for all or part of the services listed in 42 U.S.C. § 1396d(a)(1) through (28). 42 U.S.C. § 1396d(a). Only seven of the twenty-eight services listed are mandatory, meaning that a state must provide these seven services to participate in Medicaid. 42 U.S.C. § 1396a(a)(10)(A). Mandatory services for adults over the age of 21 include inpatient hospital services, outpatient hospital services, laboratory and x-ray services, **nursing facility services**, nurse-midwife services, and certified nurse practitioner services. See 42 U.S.C. § 1396a(a)(10)(A) (requiring state plans to provide at least the services listed in § 1396d(a)(1) through (5), (17) and (21)). Thus, Florida is **required** by federal law to make nursing facility services available and, if these services are medically necessary for Plaintiff, she is entitled to them as a matter of federal law. See e.g., Goldberg v. Kelly, 397 U.S. 254 (1970).

Florida **may** include any of the other twenty-one services listed in 42 U.S.C. § 1396d(a), including PCA services. However, it is essential to note that Florida is **not required** to provide such services to comply with the Medicaid Act, and, to the extent that Florida opts not to provide any of these twenty-one other services, Florida's Medicaid recipients to do not have an entitlement to those services.

In addition to the Medicaid services offered under a state's Medicaid State Plan, a state may also enter into an agreement with the federal government to offer services under a waiver program, such as the HCBS waivers. See 42 U.S.C. § 1396n(c). Under waiver programs such as the TBI/SCI Waiver, the federal government agrees to "waive" certain requirements of the Medicaid Act without jeopardizing federal financial participation. 42 U.S.C. § 1396n(c)(3). Most importantly for the purposes of this case, the Medicaid Act

permits waiver of the comparability requirement of 42 U.S.C. § 1396a(a)(10)(B). Id. This provision requires state plans to offer the services in 42 U.S.C. § 1396d(a) to all Medicaid recipients in the same amount, duration and scope. 42 U.S.C. § 1396a(a)(10)(B). By providing for a waiver of the comparability requirement, the Medicaid Act permits states to discriminate on the basis of disability. Indeed, as a result of the various waivers, the Florida Medicaid Program currently provides increased services to persons with certain disabilities while simultaneously offering no enhanced services to persons with other types of disabling conditions.

The Medicaid Act also permits waiver of Medicaid requirements with respect to limiting the number of persons receiving waiver services and eliminating the statewideness requirement. While a state must provide services under its State Plan to everyone who meets the state's Medicaid eligibility requirements, the waiver law specifically allows states to "cap" the number of persons receiving waiver services. 42 U.S.C. § 1396n(c)(9)-(10). Waiver of statewideness means that states can limit the provision of HCBS services to certain parts of the state as opposed to persons living throughout the state. 42 U.S.C. § 1396n(c)(3).

While the federal Medicaid Act permits states to create HCBS waiver programs, it does not require states to do so. As the Medicaid Act states, "a State plan approved under this subchapter ***may*** include as „medical assistance' under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by" the federal government. 42 U.S.C. § 1396n(c)(1) (emphasis added). Neither does the Medicaid Act require the federal government to approve states' HCBS waiver programs.

The Secretary of the Department of Health and Human Services "***may*** by waiver" allow states to create HCBS programs. Id. (emphasis added).

It is not disputed that the Florida Medicaid program does not provide in-home PCA for adults like Plaintiff. While Florida does provide in-home PCA through its TBI/SCI Waiver, Florida has opted to place a cap on the number of persons enrolled in this program. The TBI/SCI Waiver program had no available opening at the time Plaintiff applied and she was thus placed on a waiting list. In the Complaint, Plaintiff does not allege that Florida has violated the Medicaid Act by failing to provide her with in-home PCA. However, Plaintiff is requesting the Court to order Defendants to provide her with such services. Such an order would effectively nullify one or more provisions of the Medicaid Act.

2. Analysis of Interplay Between the ADA and the Medicaid Act

To grant the relief requested in the Complaint, the Court will have to hold that the ADA has invalidated one or more provisions of the Medicaid Act. For example, the Court would have to invalidate the Medicaid Act's explicit statement that the only mandatory services are those found at 42 U.S.C. § 1396d(a)(1) through (5), (17), and (21) by converting PCA from an optional service to a mandatory service. 42 U.S.C. § 1396a(a)(10)(A). In the alternative, an injunction order would invalidate the provision in 42 U.S.C. § 1396n(c)(1) declaring that HCBS waiver programs are optional for states and that states can cap enrollment in such programs.

As such, the only way that Plaintiff's claims could be sustained is if the ADA were interpreted to amend (or partially repeal) the Medicaid Act by implication, by either amending/repealing 42 U.S.C. § 1396a(a)(10)(A), or by converting "may" in 42 U.S.C. §

1396n(c)(1) to "shall" . It is clear that an inherent assumption of Plaintiff's claim is that the Medicaid Act has been impliedly amended by the ADA. However, the criteria for statutory amendment by implication are not met here. The Supreme Court has held that "[a]mendments by implication, like repeals by implication, are not favored." United States v. Welden, 377 U.S. 95, 103 (U.S. 1964). In a case where "two statutes are capable of co-existence, it is the duty of the courts, absent a clearly expressed congressional intention to the contrary, to regard each as effective." Morton v. Mancari, 417 U.S. 535, 551 (U.S. 1974). The Medicaid Act and the ADA are clearly capable of co-existence, and the ADA contains no clear congressional intent to amend the Medicaid Act.

Moreover, as to the administration of the Medicaid program, the Medicaid Act is a more specific statute than the ADA. The ADA generally prohibits discrimination, while the Medicaid Act ordinarily prohibits discrimination but waives this prohibition in a specific, public health policy context. According to the Supreme Court, "it is a basic principle of statutory construction that a statute dealing with a narrow, precise, and specific subject is not submerged by a later enacted statute covering a more generalized spectrum." Radzanower v. Touche Ross & Co., 426 U.S. 148, 153 (U.S. 1976). The more specific statute controls "regardless of the priority of enactment." Morton, at 551. See also Ardestani v. United States Dep't of Justice, INS, 904 F.2d 1505, 1513 (11th Cir. 1990) ("Where there is no clear intention otherwise, a specific statute will not be controlled or nullified by a general one").

The ADA does not amend the Medicaid Act. In fact, however, the Plaintiff is not even alleging that the ADA has amended the Medicaid Act, but rather that a DOJ *regulation*

has amended the Medicaid Act. Essentially Plaintiff is arguing that the "integration mandate" changes the entire structure of the Medicaid Act. But as noted above, § 12132 does not go nearly as far as the "integration mandate." Lacking this regulatory provision, no court would find that a state providing nursing facility services to individuals with disabilities through its Medicaid program, as the Medicaid Act *requires* states to do, constitutes discrimination. Of course, no regulation can amend a statute.

Even if it were found that the ADA, or more specifically, the "integration mandate" in the ADA regulations, does in fact amend the Medicaid Act by implication, there is no basis in law or logic to support Plaintiff's position as to the nature of that amendment. The Plaintiff wants the ADA's prohibition of discrimination to change, or remove a word or two here and there in the Medicaid Act, leaving the overall structure and the HCBS waiver programs intact. The Plaintiff, however, fails to provide a rational basis for why the TBI/SCI Waiver program itself comports with the ADA, as the TBI/SCI Waiver program is a service that **blatantly discriminates on the basis of disability**. The TBI/SCI Waiver program is **only** available to persons with a traumatic brain injury or a spinal cord injury. It is not available to persons with any other sort of disability, nor is it available to individuals who have no disabilities at all.

In fact, **all** HCBS waiver programs discriminate in the class of persons they serve. The Medicaid Act permits and contemplates such discrimination. 42 U.S.C. § 1396n(c)(1), (2), (3), (4), and (7). Regulations of the Centers for Medicare and Medicaid Services (CMS) implementing the Medicaid Act **require** discrimination on the basis of diagnosis (or disability) in the provision of HCBS services. CMS requires that if a State "furnishes home

and community-based services… under a waiver granted under this subpart, the waiver request must…[b]e limited to one of the following target groups or any **subgroup** thereof that the State may define: (i) Aged or **disabled**, or both. (ii) Mentally retarded or **developmentally disabled**, or both. (iii) Mentally ill." 42 C.F.R. § 441.301(b)(6) (emphasis added).

The HCBS waiver programs discriminate based on disability in order to provide persons with disabilities services that would not otherwise be available to them. But they still **discriminate on the basis of disability**. As a result, there are persons with disabilities who are excluded from or denied benefits of HCBS waiver programs that are targeted to persons with other disabilities. If the ADA's prohibition of discrimination "by reason of…disability" amends the Medicaid Act, then surely the HCBS waiver programs would not survive.

A grant of the relief requested in the Complaint will essentially require a finding that the ADA amends the Medicaid Act by prohibiting a certain kind of discrimination (i.e., institutionalization of persons with disabilities) while permitting another kind of discrimination (i.e., creating an HCBS waiver program exclusively for persons with a spinal cord injury). But this makes no sense. If the ADA trumps Medicaid, it must do so in a comprehensive and coherent way. If the ADA indeed prohibits Florida from denying PCA in the community, then it must necessarily also prohibit Florida from offering an inherently discriminatory program like the TBI/SCI Waiver program. Because the ADA neither abrogates nor amends the Medicaid Act, the Plaintiff's Complaint fails to state a cause of

action upon which relief can be granted and should be dismissed pursuant to Rule 12(b)(6), Fed. R. Civ. P.

VI. Plaintiff's Claim Fails to State a Claim Upon Which Relief Can Be Granted Because It Would Result in an Impermissible Fundamental Alteration to the Florida Medicaid Program in Violation of the ADA

The regulations implementing Title II of the ADA provide that a "public entity shall 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). Here, any interpretation that allows the ADA (or its regulations) to trump the Medicaid Act would involve a fundamental alteration of the Medicaid Program. If, contrary to the Medicaid Act, this Court uses the ADA to convert PCA into a mandatory service, it will create federal entitlement to PCA in all 2.7 million Medicaid recipients in Florida. If, contrary to the Medicaid Act, this Court uses the ADA to make waiver services mandatory and removes states' ability to cap the waivers, it will destroy the states' reasonably delegated responsibility to ensure the adequacy of its provider networks and to create other safeguards prior to providing community-based services. As far as Defendants are aware, no other court has required a state Medicaid program to expand a waiver based on the ADA or Rehab Act. Finally, if this Court strikes down waivers entirely, it will fundamentally alter Medicaid.

Even if the Court were to interpret the ADA to uphold the HCBS waiver programs but prohibit institutionalization of certain disabled individuals, such would still constitute a fundamental alteration of the Florida Medicaid Program, because Florida would be required

by the Medicaid Act to provide assurances to CMS that it will provide "necessary safeguards" for a greatly increased number of recipients and "financial accountability for funds expended" for a greatly increased amount of services. 42 U.S.C. § 1396n(c)(2)(A).

In addition, as demonstrated in the Affidavit of Kristen Russell dated April 29, 2010, and attached to this Response as Exhibit D, if the State of Florida were forced to place Ms. Haddad on the TBI/SCI Waiver program, they would be forced to reduce services that others on the TBI/SCI Waiver program are currently receiving. As those individuals on the TBI/SCI Waiver program are entitled to the services they are receiving, this would surely constitute a fundamental alteration. Such a modification is not reasonable.

The case law Plaintiff cites in her Motion for Preliminary Injunction regarding reasonable modifications is instructive here. In Alexander v. Choate, 469 U.S. 287 (U.S. 1985), the U.S. Supreme Court made clear that while state Medicaid programs may not discriminate against the disabled, neither are such programs bound to provide specialized services to the disabled that are not available to other Medicaid recipients, "as long as care and services are provided in „the best interests of the recipients.'" Alexander v. Choate, 469 U.S. 287, 303 (U.S. 1985) (Citing 42 U. S. C. § 1396a(a)(19)). The Rehab Act, the Court held, does not require states to alter the "definition of the benefit being offered simply to meet the reality that the handicapped have greater medical needs." Id., at 304.

1. Florida's Comprehensive, Effectively Working Plan

Plaintiff's requested relief would also constitute a fundamental alteration in that it would disrupt Florida's "comprehensive, effectively working plan" to provide HCBS to those qualified individuals who desire such services. See Olmstead, at 606 ("If, for example,

[a] State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with…disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met"). In Arc of Wash. State Inc. v. Braddock, 427 F.3d 615 (9th Cir. Wash. 2005), the Ninth Circuit held that Washington was not required by the ADA to expand its waiver program because Washington's HCBS program "(1) [was] sizeable, with a cap that ha[d] increased substantially over the past two decades; (2) [was] full; (3) [was] available to all Medicaid-eligible disabled persons as slots become available, based only on their [health needs] and position on the waiting list; (4) ha[d] already significantly reduced the size of the state's institutionalized population." Arc of Wash. State Inc., at 622.

Florida has a "comprehensive, effectively working plan" to provide HCBS to those qualified individuals who desire such services. As shown in the Affidavit of Elizabeth Y. Kidder, dated June 2, 2010, the Florida Medicaid Program administers 14 HCBS waiver programs. These programs began in the 1980s, and have consistently expanded since that time. Florida added new HCBS waiver programs in 1982, 1985, 1989, 1991, 1995, 1998, 1999, 2004, 2006, and 2008. As shown in the Affidavit of S. Michele Hudson, dated June 2, 2010, the following HCBS waivers all expanded over the past four years: the Adult Cystic Fibrosis Waiver, the Alzheimer's Disease Waiver, the Developmental Disabilities Waiver (Tier 1), the Family Dysautonomia Waiver, the Family Supported Living Waiver, the Nursing Home Diversion Waiver, and the TBI/SCI Waiver. The Florida Medicaid Program now serves more nursing home-eligible persons outside of nursing homes than in them in any

given month. See Affidavit of S. Michele Hudson, dated June 2, 2010. The TBI/SCI Waiver program in particular has grown. Implemented in 1999, the TBI/SCI Waiver program expanded from an average monthly caseload of 245 persons (Fiscal Year 2005-06) to 309 persons (FY 2008-09). Id. In addition, TBI/SCI Waiver program expenditures have increased from $5,874,815 (FY 2005-06) to $10,066,381 (FY 2008-2009). Id.

A look at three waivers in particular over the past four years illustrates the growth of Florida's HCBS waiver programs. Between Fiscal Year 2005-06 and Fiscal Year 2008-09, the total average monthly caseload of the Family Supported Living Waiver (Tier 44 of the Developmental Disabilities Waiver), the Nursing Home Diversion Waiver, and the TBI/SCI Waiver program increased by more than 224%. During this time, the total expenditures for these three waivers increased by more than 219%.

As shown in the April 29, 2010, Affidavit of Kristen Russell (attached to this Motion as Exhibit A), the TBI/SCI Waiver program is full, with no funded slots available. In addition, the TBI/SCI Waiver program is available to all Medicaid eligible individuals with a traumatic brain injury or spinal cord injury based only on their health needs and position on the waiting list. What is more, the vast majority of the SSI population in the Florida Medicaid Program are currently in the community and not in institutions. In Fiscal Year 2008-09, the Florida Medicaid Program had an average monthly caseload of about 311,000 SSI persons. Id. Of those, only about 45,000, or 14%, were residing in nursing facilities in any given month. Id.

Because Florida has a "comprehensive, effectively working plan" to provide HCBS to qualified individuals who desire such services, interference with that plan would constitute an impermissible fundamental alteration.

2. Costs

Plaintiff alleges that the requested relief constitutes a "reasonable modification" because the provision of services would be less expensive in the community than in a nursing facility. See e.g., Motion for Preliminary Injunction, p. 20-21. However, the cost analysis is not so simple. As the Affidavit of Kristen Russell, dated June 2, 2010, demonstrates, less than 10% of the individuals on the waiting list for the TBI/SCI Waiver program currently reside in a nursing facility, yet they all seek to be placed in the TBI/SCI Waiver program. Defendants realize **no** cost savings by placing such individual in the TBI/SCI Waiver program unless the individual would have entered a nursing facility but for the waiver program.

Because the relief requested under the ADA would fundamentally alter the Florida Medicaid Program, it is not required by the ADA and Plaintiff has failed to state a claim upon which relief can be granted. This Court should dismiss the Complaint pursuant to Rule 12(b)(6), Fed. R. Civ. P.

CONCLUSION

For the reasons stated above, this Court should dismiss Plaintiff's Complaint pursuant to Rules 12(b)(1) and (6), Fed. R. Civ. P.

Respectfully submitted this 8th day of June, 2010.

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been served by the Notice of Electronic Filing, and was electronically filed with the Clerk of the Court via the CM/ECF system, which generates a notice of the filing to the following: Stephen F. Gold, 1709 Benjamin Franklin Parkway, Second Floor, Philadelphia, PA 19103, and Jay M. Howanitz, SPOHRER & DODD, P.L., 701 West Adams Street, Suite 2, Jacksonville, Florida 32204 this 8th day of June, 2010.

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