UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

HELEN PITTS, KENNETH ROMAN, DENISE HODGES, and RICKII AINEY, on behalf of themselves and all others similarly situated,	**Civil Action No. 3:10-cv-00635-JJB-SCR**
Plaintiffs	**Judge James J. Brady**
v.	**Magistrate Judge Stephen C. Riedlinger**
BRUCE GREENSTEIN, in his official capacity as Secretary of the Louisiana Department of Health and Hospitals, and LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS,	**CLASS ACTION**
Defendants.	

DEFENDANTS' REPLY TO PLAINTIFFS' OPPOSITION
TO THE MOTION FOR SUMMARY JUDGMENT

Kimberly Humbles
La. Bar No. 24465
Kimberly.Humbles@la.gov
Michael J. Coleman
La. Bar No. 22756
Michael.Coleman@la.gov
Charles E. Daspit
La. Bar No. 4559
Charles.Daspit@la.gov
Neal R. Elliott
La. Bar No. 24084
Neal.Elliott@la.gov
Stephen R. Russo
La. Bar No. 23284
Stephen.Russo@la.gov
LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
P.O. Box 3836
Baton Rouge, LA 70821-3836
Telephone: 225-342-1128
Facsimile: 225-342-2232

Caroline M. Brown
cbrown@cov.com
D.C. Bar. No. 438342
Matthew Berns
mberns@cov.com
N.J. Bar No. 037232009
COVINGTON & BURLING LLP
1201 Pennsylvania Ave., N.W.
Washington, DC 20004-2401
Telephone: 202-662-6000
Facsimile: 202-662-6291

Counsel for Defendants

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I. Introduction

At issue in this case is whether Defendants, the Louisiana Department of Health and Hospitals and its Secretary (collectively, "the Department" or "DHH"), violated the Americans with Disabilities Act ("ADA") when they reduced from 42 to 32 hours per week the maximum amount of services available to participants in the Long Term Personal Care Services ("LT-PCS") program. Defendants contend that Plaintiffs—four individuals who currently receive services in excess of the new maximum—have failed to show that the 32-hour cap constitutes discrimination under the ADA, as it was construed in *Olmstead v. L.C.*, 527 U.S. 581 (1999), and, in any event, have demanded changes to the Department's programs that go beyond the "reasonable accommodation" required by law.

With respect to whether the 32-hour cap on LT-PCS is discriminatory, Defendants believe the following facts are material and dispositive:

A. There are other programs (with varying wait times and geographical availability) that, alone or in conjunction with LT-PCS, can provide additional assistance to someone with Plaintiffs' needs.

B. If Plaintiffs are in fact admitted to a nursing facility, they will have priority access to these other services.

In support of their alternative argument that Louisiana has a comprehensive, effectively working plan for placing qualified Medicaid beneficiaries in the community, Defendants believe the relevant inquiry is results: the State's overall record in allocating its limited budget to provide a range of institutional and community-based alternatives. To that end, Defendants submit that the following facts are relevant and dispositive:

C. Defendants' home and community-based services, including LT-PCS, serve an increasing number of individuals every year, while the population of nursing homes steadily declines.

D. Defendants have seen no increase in the number of LT-PCS recipients transitioning to nursing facilities since they adopted the 32-hour cap in September; this is consistent with the Department's prior experience when the maximum was reduced from 56 to 42 hours per week.

By contrast, Plaintiffs' position, as articulated in their Opposition and Statement of Disputed Facts, is that the ADA requires an exhaustive inquiry as to the number of hours of care each individual needs in order to receive adequate assistance in his or her home; predictions as to how many individuals will enter nursing homes under a service limitation; a value-inflected judgment as to whether the challenged service maximum is "necessary"; a comparison of expenditures in various service settings, including whether those services could be provided more efficiently; and an inquiry into the motivations of state policymakers in making determinations as to how best to allocate Medicaid resources.

In short, Defendants ask the Court to grant summary judgment based on the program they have and the outcomes that the current program has produced. Plaintiffs ask the Court to proceed to trial to make individual service determinations and to decide whether the State could afford to implement some alternative program that might better suit the needs of particular individuals. As set forth below, this is not a proper inquiry under the ADA, and the motion for summary judgment should be granted.

II. Statement of Facts

A. LT-PCS Is Not Defendants' Only HCBS Program.

As set forth in the background to Defendants' Motion to Dismiss (which has been converted to a motion for summary judgment), the State of Louisiana is committed to dedicating available resources to provide individuals with disabilities a full array of quality, long-term care services that will enable them to enjoy full lives of inclusion, productivity, and self-determination in the settings of their choice. In furtherance of that goal, the State currently has several programs that provide home-and community-based services ("HCBS") for individuals with disabilities, including the Adult Day Health Care ("ADHC") waiver, the Elderly and Disabled Adult ("EDA") waiver, the Program of All-Inclusive Care for the Elderly ("PACE"), and LT-PCS. Defs.' Statement of Undisputed Facts in Support of the Motion for Summary Judgment ¶4 ("SUF").

ADHC services are provided at licensed facilities that are operational at least five hours per day on a regularly scheduled basis or as specified in the recipient's plan of care. SUF ¶84. In addition to personal care services, ADHC facilities must provide transportation to and from the facility; counseling and education in the areas of health and nutrition; individualized exercise and recreation programs; nursing services; medical care management; and one hot meal and two snacks per day. SUF ¶¶85, 90. LT-PCS recipients can supplement their benefits with services offered through the ADHC waiver. SUF ¶33. There is currently a short wait of approximately 5 months, but there is no wait for someone who has recently had an overnight hospital stay. SUF ¶95.

The State also provides long-term care to individuals with adult-onset disabilities through the EDA waiver. In lieu of an hourly cap on services, the EDA program provides each participant with a needs-based "budget" of up to $40,046 per year. SUF ¶54-55. The enrollee

may allocate the budget toward a variety of services, which currently include support coordination, transition intensive support coordination, environmental accessibility adaptation, personal assistance services (a combination of personal care services and companion care), transition services, and ADHC services. *See* La. Admin. Code tit. 50, § 8301, 37 La. Reg. 18, 19-20 (Jan. 2011); SUF ¶57. This summer, the EDA waiver will be replaced with a new "Community Choice" waiver that will offer a more comprehensive package of services and will allow recipients greater flexibility to self-direct their care. SUF ¶¶105-108.

The EDA waiver has a capped number of slots and currently has a waiting list (called the "Request for Services Registry"). SUF ¶¶59-60. As slots open up, priority is given to individuals who have been abused or neglected, individuals with Lou Gehrig's disease, and individuals in nursing facilities. *See* La. Admin. Code tit. 50, § 8105(B), 37 La. Reg. 18, 19 (Jan. 2011). As of March 29, 2011, every individual on the EDA Registry who was in one of these priority groups had already received an offer. SUF ¶64.

Although individuals cannot receive LT-PCS and EDA services at the same time, they can continue to receive LT-PCS while they are on the waiting list for the EDA waiver. SUF ¶¶33, 72. Until October 2010, applicants who did not currently receive any HCBS were given priority over LT-PCS recipients. *See* La. Admin. Code tit. 50, § 8105(B), 35 La. Reg. 2447, 2447 (Nov. 2009). Now the two groups are treated the same, and both are offered EDA slots according to the date of application. *See* 36 La. Reg. 2217, 2218 (Oct. 2010) (amending *id.*).

While individuals who are not in one of the priority groups may wait longer than two years before being offered EDA services,[1] many individuals put their name on the EDA

[1] Before DHH revised the priority groups, the State was offering EDA slots to individuals who requested EDA services on or before April 15, 2008. SUF ¶70. LT-PCS recipients who had requested EDA services (continued…)

Registry at the time they apply to be assessed for LT-PCS. In fact, all of the named plaintiffs in the current action are on the EDA Registry, and so far, two Plaintiffs (Denise Hodges and Helen Pitts)[2] and the only unnamed class member identified by Plaintiffs (Cleo Lancaster) have already received EDA offers. SUF ¶73.

Finally, Defendants also have two PACE programs, serving the Baton Rouge and New Orleans areas. SUF ¶109. While both of these programs also have limited enrollment, both are currently accepting new enrollees. SUF ¶112. (None of the named plaintiffs live in these areas and meet the PACE eligibility criteria, but other members of the purported class might.)

B. Individuals in Nursing Facilities Have a Community Alternative.

As mentioned above, the EDA and ADHC waivers give priority to individuals in nursing facilities. Recently, DHH adopted a rule limiting priority offers to individuals who have been in a nursing facility for 90 consecutive days. *See* 36 La. Reg. at 2218 (amending La. Admin. Code tit. 50, § 8105(B)).[3] This was to address the situation where some individuals were only in need of nursing home care for a short period (for example, rehabilitation after a hospital stay) or were trying to avoid the waiting list by entering a nursing home for a brief stay and then

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before that date did not get an offer but remained on the Registry. SUF ¶71. The State has since begun giving offers to this group of LT-PCS recipients. The State most recently offered EDA slots to LT-PCS recipients who applied for the EDA waiver by November 30, 2007. SUF ¶72.

[2] Defendants wish to correct the statement in their Memorandum in Opposition to Class Certification (ECF No. 32), that "DHH records indicate that Ms. Pitts never sought an EDA waiver slot prior to the filing of this lawsuit." *Id.* at 4. This statement was based on Hugh Eley's declaration of October 21, 2010, in which he stated that "Ms. Pitts is not on the Registry for EDA services." (ECF No. 11-2, ¶21) Although Mr. Eley's declaration was correct at the time, after subsequent discussions with Plaintiffs' counsel, DHH determined that Ms. Pitts may have called regarding the EDA waiver in 2007 but was not placed on the Registry either because she had not subsequently returned the required paperwork or because of an error once her paperwork was received. As a result, Department personnel manually added Ms. Pitts to the EDA Registry with a request date of September 5, 2007.

[3] There was no length-of-stay requirement under the old rule. *See* La. Admin. Code tit. 50, § 8105(B)(2), 35 La. Reg. 2447, 2447 (Nov. 2009).

returning home to wait for their EDA offer. SUF ¶75. The agency determined that a "length of stay" requirement would close this loophole and reserve priority offers for nursing facility residents who truly needed EDA services in order to transition back into the community. DHH concluded that 90 days was an appropriate length of stay because that is the standard used by the federal government in the Money Follows the Person Program to determine who is at risk of being a long-term resident of a nursing facility. SUF ¶76; *see also* 42 U.S.C. § 1396a note, *as amended*, Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2403, 124 Stat. 119, 304-05 (Mar. 23, 2010).[4]

DHH adopted the new policy after several discussions with the HCBS Redesign Workgroup. SUF ¶77. The Workgroup included officials from DHH and several stakeholder advocacy groups—including the Advocacy Center —and was intended to solicit these groups' input on changes to the State's HCBS offerings. SUF ¶78. The consensus of the Workgroup was that DHH should revise its policy, SUF ¶79, and that a 90-day period was appropriate, SUF ¶80.

C. Defendants' home and community-based services, including LT-PCS, serve an increasing number of individuals every year, while the population of nursing homes steadily declines.

Over the last decade, Louisiana has taken significant steps to provide a greater array of long-term care service options for individuals with different needs. In SFY 2000, Louisiana served 34,727 individuals in private nursing facilities while providing HCBS to only 1,030 people. SUF ¶8. As of SFY 2010, the number of individuals receiving private nursing facility services dropped to 29,392—a decrease of over 15% in ten years. SUF ¶¶10, 14. [5] As a

[4] Additionally, DHH does not approve stays of over 90 days based solely on the need for rehabilitation-related services.

[5] While the State also operates two public nursing facilities serving approximately 250 individuals, those homes tend to serve very high needs patients who are hard to place in a private facility and whose needs (continued…)

result, while Louisiana remains among the States with the highest number of nursing home beds per capita, SUF ¶17, its nursing facilities now have nearly the lowest occupancy rate in the country. SUF ¶18. Meanwhile, the growth in the number of HCBS recipients far outpaced the drop in nursing facility recipients. The State's HCBS programs served 18,215 individuals in SFY 2010, an increase of 1668% since SFY 2000 and of 224% since SFY 2005. SUF ¶¶10, 13.

The growth in the State's HCBS population has been accompanied by a shift in expenditures toward HCBS. In SFY 2010, the State was devoting 29% of long-term care expenditures to HCBS. SUF ¶22. Between SFY 2005 and SFY 2010, expenditures on HCBS increased by 277.5% while expenditures on private nursing facilities grew by approximately 18%. SUF ¶25. According to Plaintiffs' expert witness, once expenditures are adjusted for inflation, nursing facilities have seen a decrease in per capita expenditures over the last decade. Pls.' Exh. 25, Declaration of H. Stephen Kaye, at ¶12 (ECF No. 38-3, page 407 of 455).

The lion's share of the growth in HCBS recipients and expenditures has been due to the LT-PCS program. Unlike the EDA and ADHC waiver programs, LT-PCS is a Medicaid state plan service, which means that the State cannot cap enrollment. LT-PCS is an optional Medicaid benefit, but once a State decides to offer the benefit, it must be made available to any Medicaid recipient that meets the criteria for enrollment.

The number of LT-PCS recipients has increased substantially every year since the program began: from 1,402 in SFY 2005 to more than 12,000 today, SUF ¶28, the LT-PCS

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likely could not be met in an HCBS option. Second Decl. of Hugh R. Eley, at ¶30. Therefore, they are not included in the data.

population has increased by nearly 800% in only five years. SUF ¶29. [6] Enrollment continues to increase by approximately 130 people every month. SUF ¶31.

Not surprisingly, the increase in recipients has been accompanied by a staggering increase in expenditures. Since SFY 2005, expenditures on LT-PCS have grown by over 600% to $237,616,920 in SFY 2010. SUF ¶35. LT-PCS was the fastest growing Medicaid service in three of the last five fiscal years, and only one line item in the State's entire Medicaid budget grew faster over the entire five-year period. SUF ¶26.[7] The program's future growth is expected to be significant as a result of the aging state population and the expansion of Medicaid eligibility under the Affordable Care Act. SUF ¶31.[8]

Faced with this growth, the policy of DHH is "to serve the greatest number of people that [it] can serve given the funding that is available." SUF ¶7. In keeping with that policy, DHH decided to reduce the cap on LT-PCS services from 42 hours per week to 32 hours per week. SUF ¶43. DHH has estimated that the 32-hour cap will allow it to avoid new expenditures of approximately $5 million annually in SFY 2011 and another $24 million annually in SFY 2012. SUF ¶36.

This is no way signals a retreat from the State's commitment to providing choice in long-term care services. The State has initiated new programs to help individuals move from

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[6] These statistics refer to the number of individuals who received LT-PCS but neither ADHC nor EDA. SUF ¶28. Currently, individuals can receive both LT-PCS and ADHC. SUF ¶33. Previously, EDA participants received personal care services through the LT-PCS program; now such services are paid for with the waiver budget. *See* SUF ¶32.

[7] The exception was the public psychiatric free standing unit, and those expenditures pale in comparison to LT-PCS. SUF ¶26.

[8] The EDA and ADHC waivers have also seen significant increases in recipients and expenditures since SFY 2000, although the capped nature of those programs means that the growth is more predictable and controlled than is the expansion of LT-PCS. *See* SUF ¶¶ 81, 92, 96.

nursing homes into the community. In 2007, Louisiana successfully applied for a federal grant under the Money Follows the Person ("MFP") program. SUF ¶99. Under the MFP program, States qualify for a higher percentage of federal matching dollars to help cover the costs of moving people out of nursing homes. SUF ¶100. Louisiana also uses MFP grant money to engage in outreach to nursing facility residents and to hire staff who can identify those residents who want to move into the community. SUF ¶100. The MFP program also provides recipients with transition-related services. These include assistance in finding a residence, paying a rental deposit, and identifying an HCBS provider. SUF ¶101. Once an individual transitions to the community, they can receive long term care through one or more of the State's several HCBS programs. SUF ¶102. The MFP program successfully helped 80 individuals transition out of nursing facilities between November 2009 and February 2011, and another 100 to 120 transitions were pending. SUF ¶103. Many others made the transition without the assistance of the MFP grant. SUF ¶104.

Part of Louisiana's strategy for serving a greater percentage of individuals with adult-onset disabilities in the community involves reducing the supply of institutional services. SUF ¶117. To that end, Louisiana has instituted a "Bed Buyback Program" that has led to the elimination of 461 nursing home beds from the market since July 2008 and to the permanent closure of 4 nursing facilities. SUF ¶¶118-119. Going forward, the State expects this program to lead to the elimination of 2 nursing facilities per year and an average of 115 to 144 beds per facility. SUF ¶120. For each facility closed under this program, the State expects to incur new costs for five years but then see savings of $378,706 per year thereafter. SUF ¶121. Additionally, the State established a Private Room Conversion Program in 2007. SUF ¶122. The program gives nursing facilities a financial incentive to convert semi-private Medicaid rooms into private

rooms and, in doing so, eliminate nursing home beds from the market. So far the program has led to the closure of 310 beds. SUF ¶123.

D. There Is No Evidence that the Imposition of the 32-Hour Maximum Will Lead to an Increase in Nursing Home Admissions.

The LT-PCS program has always had a limit on the number of hours of personal care any individual could receive in a given week. From its inception in 2005 until March 2009, the LT-PCS program provided up to 56 hours per week of Medicaid-funded personal care services. SUF ¶37. In March 2009, the cap was reduced to 42 hours per week. *See* 35 La. Reg. 401, 402 (Mar. 2009) (amending La. Admin. Code tit. 50, § 12915(A)).[9] Effective September 5, 2010, the cap became 32 hours per week. *See* 36 La. Reg. 1749, 1752 (Aug. 2010) (amending La. Admin. Code tit. 50, § 12915(A)). Both reductions in the service cap were accompanied by changes to the method for allocating hours among recipients so that the distribution would account for the new cap and better reflect recipients' relative acuity. *See* Opp'n at 18-19. DHH has closely monitored the effects of these changes to the LT-PCS program. SUF ¶46. In neither instance has the agency observed an uptick in the rate at which LT-PCS recipients transition into nursing facilities. SUF ¶47-52.

There were 941 LT-PCS participants who received more than 42 hours of services per week before the 42-hour cap took effect and received fewer than 42 hours afterwards. SUF

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[9] The State reduced the cap on LT-PCS hours to 42 in order to bring the EDA waiver into compliance with federal laws regarding waiver "cost effectiveness." Opp'n at 18. This service reduction was discussed with class counsel in the *Barthelemy* litigation, including lead counsel in the *Pitts* case. SUF ¶39. Class counsel agreed to the reduction, which was incorporated into the *Barthelemy* settlement agreement. SUF ¶40. Plaintiffs included the initial *Barthelemy* Settlement Agreement and the First Supplemental Settlement Agreement as Exhibits 14 and 15 in their summary judgment materials. (ECF No. 38-3, pages 297 and 334 of 455) Defendants are attaching the Second Supplemental Settlement Agreement, which Plaintiffs omitted, as Attachment E to the Second Declaration of Hugh R. Eley. Plaintiffs have asked the Court to take judicial notice of the *Barthelemy* pleadings. (Opp'n at 11 n.55)

¶42. Although nearly 1000 individuals had service reductions as a result of the 42-hour cap, the rate of transitions from LT-PCS to nursing homes did not increase after DHH cut the number of hours of paid care participants received. SUF ¶48. Rather, the percentage of LT-PCS recipients transitioning into nursing facilities steadily declined from 6% in October-December 2005 to 4% in January-March 2009 to 3% in July-September 2010. SUF ¶47. The State announced the 32-hour cap on August 20, 2010, and it took effect on September 5. *See* 36 La. Reg. at 1749, 1752. In September-December 2010, 512 individuals who previously received greater than 32 hours of LT-PCS had their services reduced under the new rule. SUF ¶49. The data show that 2% of the LT-PCS recipients who were enrolled in September transitioned into nursing facilities in October through December. SUF ¶50. That is the lowest rate of any quarter since the LT-PCS program began. SUF ¶46-50. The data for transitions from LT-PCS to nursing facilities in January through March are not yet available, but Defendants are continuing to monitor the rate of nursing home admissions for LT-PCS recipients. SUF ¶51-52.

III. Standard of Review

"The court shall grant summary judgment if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). "[T]he mere existence of *some* alleged factual dispute between the parties will not defeat an otherwise properly supported motion for summary judgment; the requirement is that there be no *genuine* issue of *material* fact." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48 (1986). The applicable substantive law determines which facts are material, and "[f]actual disputes that are irrelevant or unnecessary will not be counted." *Id.* at 248. An issue as to a material fact is genuine "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Id.*; *see also Firemen's Mut. Ins. Co. v. Aponaug Mfg.*

Co., 149 F.2d 359, 362 (5th Cir. 1945) ("A pretended issue, one that no substantial evidence can be offered to maintain, is not genuine.").

Because "[o]ne of the principal purposes of the summary judgment rule is to isolate and dispose of factually unsupported claims," Rule 56 does not require "that the moving party support its motion with affidavits or other similar materials *negating* the opponent's claim." *Celotex Corp. v. Catrett*, 477 U.S. 317, 323-24 (1986). "[T]he opposing party is not entitled to hold back his evidence until trial on the possibility that an issue of material fact might arise. . . ." *Sagers v. Yellow Freight Sys., Inc.*, 529 F.2d 721, 728 n.13 (5th Cir. 1976) (citation and internal quotation marks omitted). The fact that the nonmovant "vigorously dispute[s] the legal conclusions to be drawn from the facts presented" is "no bar to the grant of summary judgment." *Id.*

IV. The 32-Hour Cap Is Not Discrimination Under The ADA Because It Does Not Subject LT-PCS Recipients To "Unjustified Isolation."

Plaintiffs purport to rest their ADA claim on the interpretation of the statute adopted by the Supreme Court in *Olmstead v. L.C.*, 527 U.S. 581 (1999). At the same time, Plaintiffs observe of *Olmstead* that "[t]he instant action presents a very different situation." (Opp'n at 33) We agree. The heart of Plaintiffs' legal theory is that the ADA requires States to provide Medicaid recipients with enough personal care services to eliminate the risk that they will have to enter a nursing facility. No reading of *Olmstead* supports that theory.

A. The ADA Does Not Mandate that a State Provide Each LT-PCS Recipient with Services Sufficient to Eliminate the Risk of Institutional Care.

In *Olmstead*, the Supreme Court considered whether the ADA required a State to allow two women with developmental disabilities and mental illness to leave the state psychiatric unit and to receive treatment instead through the State's HCBS waiver program. *See* 527 U.S. at 593. There was no question in *Olmstead* of whether the waiver provided services sufficient to

eliminate the risk that the plaintiffs would again need institutional placement. Rather, the Court observed that the plaintiffs' needs could be met by a community-based waiver program that the State already supported, *id.*, and that the waiver had unfilled slots that could be offered to the plaintiffs, *id.* at 601 (noting that the State was using 700 of 2109 approved slots). Under these circumstances, the Court held that the plaintiffs' "continued confinement in a segregated environment," *id.* at 593, qualified as "unjustified isolation of individuals with disabilities" and was "properly regarded as discrimination based on disability," *id.* at 597.

The limits of *Olmstead* are clear from the facts of the case as well as from the Court's cautionary language. The *Olmstead* Court expressly declined to hold "that the ADA imposes on the States a standard of care for whatever medical services they render" or "that the ADA requires States to provide a certain level of benefits to individuals with disabilities." *Id.* at 603 n.14 (citation and internal quotation marks omitted). And the Court made clear that "[t]he State's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not boundless." *Id.* at 603.

These limitations on *Olmstead*'s reach are consistent with the Court's long-settled interpretation of the Rehabilitation Act.[10] In *Alexander v. Choate*, 469 U.S. 287 (1985), a unanimous Court established that a "State is not required to assure the handicapped 'adequate health care.'" *Id.* at 309. The plaintiffs in *Choate* brought a Rehabilitation Act challenge to Tennessee's reduction from 20 to 14 in the number of inpatient hospital days that the State would reimburse through its Medicaid program. *Id.* at 289. The Court upheld the service limitation, finding "unsound" the plaintiffs' suggestion that the policy was discriminatory because they

[10] Plaintiffs agree that the RA and the ADA should be treated as coterminous. (Opp'n to Defendants' Motion to Dismiss at 4 n.1 (ECF No. 17)). Our references to the ADA refer to both statutes unless the context forbids it.

required more than 14 days of inpatient care in order to have meaningful access to the service. *Id.* at 302-03. The claim that 14 days was inadequate to meet their needs "rest[ed] on the notion that the benefit provided through state Medicaid programs is the amorphous objective of 'adequate health care.' But Medicaid programs do not guarantee that each recipient will receive that level of health care precisely tailored to his or her particular needs. Instead, the benefit provided through Medicaid is a particular package of health care services, such as 14 days of inpatient coverage." *Id.* at 303.

So too here. The State offers a service that provides 32 hours per week of personal care. Like the plaintiffs in *Choate*, Plaintiffs here consider the service the State offers to be inadequate, and their proposed rule would establish a minimum level of services that the State must provide to individuals in the community (*i.e.*, the level necessary to prevent them from being "placed at risk of institutionalization"). (Opp'n at 31) In short, Plaintiffs ask this Court to find in the ADA exactly what the Supreme Court has twice declined to. *Cf. Buchanan v. Maine,* 469 F.3d 158, 174 (1st Cir. 2006) ("[T]he ADA does not itself mandate the provision of services . . . ."); *Cercpac v. Health & Hosps. Corp.*, 147 F.3d 165, 168 (2d Cir. 1998) ("[T]he disabilities statutes do not guarantee any particular level of medical care for disabled persons, nor assure maintenance of service previously provided.").

Plaintiffs rely (Opp'n at 30-32) on *Fisher v. Oklahoma Health Care Authority*, 335 F.3d 1175 (10th Cir. 2003), but *Fisher* is not as broad as Plaintiffs claim. In that case, the Tenth Circuit held that the plaintiffs had stated a claim under the ADA when they challenged a State's policy of providing unlimited prescriptions to nursing facility residents but no more than five prescriptions to individuals in the community. *See id.* at 1178-79. Thus, the community-based plaintiffs in *Fisher* asked for exactly the same services that they could receive in a nursing

facility. In this case, Plaintiffs' physicians have stated that their patients receive more one-on-one attention to activities of daily living in the community than they would in a nursing facility.[11] Thus while *Fisher* itself went beyond what *Olmstead* said the ADA requires, Plaintiffs ask this Court to go much further. *Cf. M.R. v. Dreyfus*, No. C10-2-52Z, 2011 WL 588511, at *13 (W.D. Wash. Feb. 9, 2011) (to be published) (distinguishing *Fisher* on this and other grounds). There is no limiting principle on the amount of services Plaintiffs would require the State to provide, other than that the State need not provide more than is adequate. *But see Choate*, 469 U.S. at 309 (holding a "State is not required to assure the handicapped 'adequate health care.'").

Nor is there any merit to Plaintiffs' effort to reformulate their *Olmstead*-based argument as an argument that the 32-hour cap on LT-PCS services "discriminates against LT-PCS recipients based on the severity of their disabilities." (Opp'n at 29-30) First, if Plaintiffs are right, any limit on services discriminates against individuals who require more. Yet as their own evidence shows, nearly every State caps either hours or costs in its HCBS programs. *See* Pls.' Exh. 26, Henry J. Kaiser Family Found., *Medicaid Home and Community-Based Programs: Data Update* (Feb. 2011), at 38 tbl.9 (ECF No. 38-3, page 450 of 455); *see also* Memorandum in Support of Defs.' Motion to Dismiss at 22 (ECF No. 11-1) (noting that 20 States do not have a

[11] Pls.' Exh. 8, Decl. of Gregory Ward, MD, at ¶14 (ECF No. 38-3, page 278 of 455) ("In a nursing facility, [Helen Pitts] will not receive the same one-on-one attention to her activities of daily living, which she presently receives."); Pls.' Exh. 9, Decl. of Keyna Whitney, MD, at ¶12 (ECF No. 38-3, page 281 of 455) ("In a nursing facility, [Kenneth Roman] will not receive the same one-on-one attention to his activities of daily living or his health care which he presently receives."); Pls.' Exh. 10, Letter from Alireza Minagar, MD, FAAN, at 2 (ECF No. 38-3, page 285 of 455) ("I do not believe Ms. Hodges can or will receive the same level of medical/health care and attention in a nursing facility that she receives in the community, and she will not receive the same one-on-one attention to her activities of daily living, which she presently receives and requires."); Pls.' Exh. 11, Decl. of Christopher Lege, MD, at ¶11 (ECF No. 38-3, page 288 of 455) ("In a nursing facility, [Rickii Ainey] will not receive the same level of one-on-one attention to her activities of daily living."). With limited exceptions, the minimum requirement in Louisiana is that nursing facilities provide 2.35 hours of direct care per resident per day. SUF ¶19.

personal care state plan service, and many that do provide less than 32 hours a week). Second, Plaintiffs' theory would render discriminatory any change in any Medicaid program if that change "disproportionately affects" recipients with different levels of acuity. The result would be paralysis for the entire Medicaid program. *Cf. M.R. v. Dreyfus*, 2011 WL 31553, at *8 n.8 (W.D. Wash. Jan. 5, 2011) ("[T]he variation in federally approved State limitations on the availability of personal care services is indicative of the discretion afforded to the States in crafting personal care programs."). Third, assuming the cases Plaintiffs cite stand for the proposition Plaintiffs say they do, they are all inconsistent with the narrower reading of the ADA adopted in *Olmstead*. Plaintiffs cite no post-*Olmstead* cases that support their argument. Fourth, the Complaint did not allege facts sufficient to give rise to this theory of Plaintiffs' case; to do so, the Complaint would have had to allege how the challenged rule incomparably affected LT-PCS recipients outside the asserted class. It didn't, and Plaintiffs should not be permitted to constructively amend the Complaint now. *Cf. Dussouy v. Gulf Coast Inv. Corp.*, 660 F.2d 594, 604 (5th Cir. 1981) (stating that a complaint need not "categorize correctly the legal theory giving rise to the claim" but must "allege[] facts upon which relief can be granted"). In short, both their main argument and their new one lack merit.

B. Other HCBS Programs in the State Are Open to LT-PCS Recipients Who Seek Additional Services.

Although *Olmstead* concluded that "unjustified isolation" in an institution constitutes discrimination under the ADA, Plaintiffs have not shown that they will be subjected to "unjustified isolation" and therefore have not shown that the 32-hour cap on LT-PCS is discriminatory. Louisiana provides personal care services through several HCBS programs in addition to LT-PCS, and these services are available to Plaintiffs, either immediately or

eventually. In these circumstances, the 32-hour cap on LT-PCS cannot fairly be said to cause "unjustified isolation" under *Olmstead*.

1. LT-PCS Recipients Can Supplement Their Services with ADHC Services.

As set forth above, LT-PCS recipients, including those who need more than 32 hours of personal care assistance per week, can supplement their LT-PCS with ADHC services. Plaintiffs did not mention the ADHC program in the Complaint and even now have little to say about it. They make basically two points: the wait for services is too long and there are not ADHC facilities in every area of the State. The first argument is meritless, and the second is inapplicable to at least three of the named plaintiffs.

LT-PCS recipients who apply for ADHC services currently wait about five months for their waiver offer.[12] Plaintiffs describe the five-month wait as "lengthy." (Opp'n at 15) The fact is that the LT-PCS service reductions are being implemented on a rolling basis, SUF ¶44, and LT-PCS recipients can apply for ADHC services at any time. SUF ¶33. If Plaintiffs had requested services rather than filing suit, they would already have received their offers.[13] Plaintiffs cannot reasonably claim that a wait of this length is unreasonable.

Plaintiffs also note (Opp'n at 16) that some members of the proposed class may not have an ADHC facility near their current residence. Each ADHC facility is required to provide recipients with transportation to and from the facility. SUF ¶85. Of the four named

[12] Individuals who have had an overnight hospital stay in the last 30 days and those who have been in a nursing facility for at least 90 consecutive days do not have a wait. SUF ¶95.

[13] As of March 22, 2011, the State was offering ADHC slots to LT-PCS recipients who applied for the ADHC waiver on October 22, 2010. SUF ¶94.

plaintiffs, three live within the transportation range of an ADHC facility that accepts Medicaid.[14] That *other* individuals do not live near an ADHC facility does not explain why *these* plaintiffs have decided not to take advantage of the services the State has to offer.

The fourth plaintiff, Kenneth Roman, lives 34 miles from an ADHC facility that accepts Medicaid, and Defendants have not determined whether a facility in his region would provide him with transportation to and from his home. SUF ¶89. Even if that transportation service is lacking, its unavailability is not discriminatory. The ADA's prohibition against unjustified isolation in institutions does not mean that States must provide HCBS wherever any qualified individual chooses to live, and Mr. Roman would have the services he needs if he relocated to a community where they are available or if he relied on other formal or informal supports to provide all or part of his transportation.

2. LT-PCS Recipients Can Request EDA Services, and Many Already Have.

As mentioned above, Louisiana also offers the EDA waiver, which provides a budget for services that Plaintiffs concede "would certainly be adequate" for them to avoid nursing facility placement. (Opp'n at 14) Two of the four named plaintiffs, and the only class member referenced in Plaintiffs' filings, have all already received EDA offers, with services to begin shortly.

The two plaintiffs who have not yet received EDA offers do not argue that they should be allowed to bypass the waiting list and enroll in the EDA program ahead of others, and *Olmstead* would foreclose such an argument. *See* 527 U.S. at 606 ("[A] court would have no

[14] Helen Pitts lives 2.6 miles away from the ADHC of Livingston Parish, SUF ¶86; Denise Hodges lives 7.7 miles away from Christus Schumpert ADHC, SUF ¶87; and Rickii Ainey lives 4.2 miles away from New Directions ADHC, SUF ¶88.

warrant effectively to order displacement of persons at the top of the community-based treatment waiting list by individuals lower down who commenced civil actions."). Instead, Plaintiffs make the more aggressive argument that the State is required to provide them with whatever services they need through the LT-PCS program, making it unnecessary for them to receive EDA services at all. That line of argument cannot be sustained in light of the substantial authority holding that waiting lists for waiver services are permissible. *See Olmstead*, 527 U.S. at 605-06; *see also Arc of. Wash. State, Inc. v. Braddock* , 427 F.3d 615, 621 (9th Cir. 2005); *Boyd v. Steckel*, 2:10-cv-688, 2010 WL 4683997 *passim* (M.D. Ala. Nov. 12, 2010); *Bryson v. Stephen*, 99-CV-558, 2006 WL 2805238 *passim* (D.N.H. Sept. 29, 2006).

3. LT-PCS Recipients Who Are in Fact Admitted to a Nursing Facility Will Receive Priority for EDA Services.

Assuming the 32-hour cap on LT-PCS does result in Plaintiffs seeking nursing facility services, they will be given priority for an EDA offer after 90 days. Plaintiffs' temporary stay in a nursing facility in the interim is not "unjustified isolation" under *Olmstead*.

It is undisputed that Plaintiffs would be placed in a high priority group for the EDA waiver if they entered a nursing facility for 90 consecutive days, SUF ¶62, and that, during this period, they would not be required to forfeit their residence in the community. SUF ¶66. Although they would "not be guaranteed adequate community services on the 91st day," (Opp'n at 30), it is undisputed that, as of March 29, 2011, no one on the EDA Registry who had resided in a nursing facility for 90 days was still waiting for a waiver offer. SUF ¶64. Once an offer is made, it generally takes another 60 to 90 days for EDA services to commence, although the individual would not be required to remain in the nursing facility if he or she wished to return home prior to the commencement of EDA services. SUF ¶¶65, 67. This latter period results from the person-centered planning that is part of the EDA waiver. The support coordinator is required

to meet with the individual and complete their evaluation, to determine the recipient's EDA budget, to help develop a comprehensive plan of care tailored to the individual's needs and preferences, and to find the recipient housing (if necessary). SUF ¶65.

Plaintiffs maintain that the State discriminates against them to the extent that they must "physically enter a nursing facility as a condition of receiving [services]." (Opp'n at 30) Plaintiffs are incorrect. Again Plaintiffs rely on the Tenth Circuit's *Fisher* decision. *Fisher* involved a challenge to a State's decision to provide nursing facility residents with unlimited prescriptions and HCBS recipients with no more than five. *See* 335 F.3d at 1178-79. There is no indication in the opinion that individuals who required more than five prescriptions would *ever* be able to get them outside a nursing home. Because it is undisputed that Plaintiffs in this case will enter a nursing facility only temporarily, if at all, *Fisher* is inapposite, as are most of the district court cases Plaintiffs cite without explanation.

Plaintiffs do cite one unpublished district court decision that does support their position. *Haddad v. Arnold*, No. 10-00414 (M.D. Fla. July 9, 2010) (ECF. No. 49); *see also Cruz v. Dudek*, No. 10-23048-CIV, 2010 WL 4284955, at *13 (S.D. Fla. Oct. 12, 2010) (following *Haddad*). The *Haddad* court addressed the issue presented here in only a single paragraph of an otherwise lengthy opinion, it did so without any citations to supporting authority, and it assumed without analysis that even a temporary stay in a nursing facility is discriminatory. *See Haddad*, *supra*, at 35-36.

Haddad was wrongly decided, and it is inconsistent with *Olmstead*. At issue in *Olmstead* was whether "continued confinement" in an institution was discriminatory. 527 U.S. at 593 (majority opinion); *see also id.* at 626 (Thomas, J., dissenting) (agreeing that the case involves "[c]ontinued institutional treatment"). The Court acknowledged that some individuals

who are qualified for HCBS "may need institutional care from time to time" when their needs exceed the level of care available in the community. *Id.* at 605 (plurality opinion).[15] Because the Court considered such temporary placements appropriate, they cannot also qualify as discriminatory "unjustified isolation," *id.* at 597.

The State's policy is to promptly offer EDA services to qualified individuals who prove unable to remain in the community with the services LT-PCS provides. This policy is not representative of the "isolat[ion] and segregat[ion]" that the ADA and *Olmstead* identified as discrimination, *Olmstead*, 527 U.S. at 588-89, 600 (quoting 42 U.S.C. § 12101(a)(2)), does not "perpetuate[] unwarranted assumptions that [Plaintiffs] are incapable or unworthy of participating in community life," *id.* at 600, and will not lead to the "continued confinement" of Plaintiffs or the class they purport to represent, *id.* at 593.

V. The ADA Does Not Require The State To Fundamentally Alter The Services It Provides To Individuals With Disabilities.

As discussed in Part IV, Plaintiffs have not shown the State's policies to be discriminatory. Accordingly, there is no need to consider whether the relief Plaintiffs seek would be a "reasonable modification" of the State's programs (which is required) or a "fundamental alteration" (which is not). *See Buchanan*, 469 F.3d at 176 n.12; *Rodriguez v. City of New York*, 197 F.3d 611, 619 n.6 (2d Cir. 1999) (declining to reach the reasonable-modification question).

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[15] Several lower court opinions indicate that *Olmstead* concerns only indefinite institutionalization. *See, e.g.*, *Frederick L. v. Dep't of Pub. Welfare (Frederick II)*, 422 F.3d 151, 158 (3d Cir. 2005) (concluding the State lacked an adequate plan to end the plaintiffs' "unnecessary and indefinite institutionalization"); *Frederick L. v. Dep't of Pub. Welfare*, 157 F. Supp. 2d 509, 541 (E.D. Pa. 2001) (concluding that institutionalized plaintiffs "are not left without recourse under *Olmstead* simply because the State has secured their indefinite placement on a waiting list"); *cf. Williams v. Wasserman*, 164 F. Supp. 2d 591, 597 (D. Md. 2001) (noting the plaintiffs sought a declaration that the State cannot "confine the plaintiffs in state psychiatric hospitals indefinitely").

However, even if the Court were to conclude that Plaintiffs may be able to prove "unjustified isolation" in violation of the ADA, Defendants are still entitled to summary judgment, because it is apparent that Plaintiffs' request for relief goes beyond a reasonable modification and would fundamentally alter the Medicaid services offered by the State. The "Supreme Court has instructed courts to be sympathetic to fundamental alteration defenses, and to give states 'leeway' in administering services for the disabled." *Braddock*, 427 F.3d at 618 (quoting *Olmstead*, 527 U.S. at 605); *see Boyd*, 2010 WL 4683997, at *10. Any rule that "would leave the State virtually defenseless" is "unacceptable." *Olmstead*, 527 U.S. at 603.

A. Plaintiffs Have Not Proposed a Reasonable Modification.

Plaintiffs bear the burden of proposing a reasonable modification, *Frederick L. v. Dep't of Pub. Welfare (Frederick I)*, 364 F.3d 487, 492 n.4 (3d Cir. 2004), which under *Olmstead* must take into account the resources available to the State and the needs of others with disabilities. *See* 527 U.S. at 607. [16] Plaintiffs have not consistently articulated the modification they seek and have not shown why it would not result in reduced services for others.

It is not clear whether Plaintiffs' requested modification would allow the State to continue applying its previous 42-hour cap on LT-PCS. Plaintiffs suggested in their initial opposition to Defendants' motion to dismiss that "[t]he reasonable accommodation proposed is to continue to assess each person with a disability individually and to authorize only the number of hours, up to 42 per week, that the person requires to avoid institutionalization." (Opp'n to Defendants' Motion to Dismiss at 19 (ECF No. 17)) But their more recent brief and their reply in the class certification pleadings appear to go much further: "the ADA requires Defendants to

[16] Defendants disagree with Plaintiffs that the burden shifts to Defendants to demonstrate that refusing a requested accommodation is "necessary for budgetary reasons," (Opp'n at 23) particularly when, unlike in *Olmstead*, the State is not raising an exclusively cost-based defense.

allow persons who need more than 32 hours of personal care services in order to avoid institutionalization to receive those services." (Opp'n at 27; Pls.' Reply to Defs.' Memorandum in Opp'n to Class Certification at 3 (ECF No. 33)) In any event, Plaintiffs fail to offer any principled reason why capping LT-PCS at 32 hours discriminates against individuals who need more than 32 hours while capping LT-PCS at 42 hours does not discriminate against individuals who need more.

At other points in their briefing, Plaintiffs describe their proposed modification a third way: "The modification that Plaintiffs propose is that they, and others in the class, be permitted to retain their hours of LT-PCS, which they have already been receiving, to the extent that the receipt of those hours of service is necessary to prevent their institutionalization." (Opp'n at 31) Presumably, this means that the State will never need to provide up to 42 hours of services to individuals currently receiving less. But this is not a passable description of the relief Plaintiffs seek, and Plaintiffs provide no justification for why individuals who have been receiving LT-PCS can continue to receive services in excess of 32 hours while the cap presumably could be applied to new enrollees. (In fact, Medicaid rules on comparability would generally prohibit such a distinction.)

Plaintiffs insist that they "are not seeking to enjoin reductions in the LT-PCS program to *all* recipients in the LT-PCS program—only those reductions to people who will be put at risk of unnecessary institutionalization by the reduction." (Opp'n at 27) This statement is meaningless. All LT-PCS recipients, by definition, must meet a nursing facility level of care and must satisfy additional factors showing that they have an immediate need for personal care assistance. *See* La. Admin. Code tit. 50, § 12905, 30 La. Reg. 2831, 2831-32 (Dec. 2004); Opp'n at 17 (quoting *id.*). All are "at risk" of nursing home admission.

Under *Olmstead*, Plaintiffs can succeed only if the relief they seek "can be reasonably accommodated, taking into account the resources available to the State and the needs of others with . . . disabilities." 527 U.S. at 587. Plaintiffs have not made the required showing that the hours of care they seek is a reasonable accommodation in light of "the resources available" and "the needs of others."

B. The State Maintains a Comprehensive and Effectively Working Plan to Move Individuals from Nursing Facilities to the Community.

The *Olmstead* Court explained that the "reasonable-modifications standard" has been met if the State maintains "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." 527 U.S. at 605-06. Louisiana's HCBS programs, taken as a whole, clearly satisfy these criteria. Even Plaintiffs' expert witness recognizes that:

> Louisiana has made substantial inroads in making LTC [long-term care] services more available in community settings and in reducing reliance on institutional services. Expanding HCBS, primarily through the creation and expansion of the state personal care plan (LT-PCS), appears to have been accompanied by a large reduction in the institutionalized population in the state, with declines exceeding both the national average and the other states in the South Central region.

Pls.' Exh. 25, Declaration of H. Stephen Kaye, at ¶16 (ECF No. 38-3, page 411 of 455).

1. Louisiana has achieved and continues to achieve great success in providing alternatives to institutionalization.

In confirming that a State has a "comprehensive, effectively working plan" that provides a defense under *Olmstead*, appellate courts have looked to whether the State's "commitment to deinstitutionalization" is "genuine, comprehensive, and reasonable." *Sanchez v. Johnson*, 416 F.3d 1051, 1067 (9th Cir. 2005). This test requires looking primarily at the State's

past efforts at de institutionalization "(*i.e.*, [whether] it has dem onstrated a comm itment to comply with the ADA and RA)." *Pa. Protection & Advocacy, Inc. v. Pa. Dep't of Pub. Welfare*, 402 F.3d 374, 381 (3d Cir. 2005). In som e cases, th e court also looks to whether the State remains committed to deinstitutionalization going forward. *See, e.g.*, *Sanchez*, 416 F.3d at 1067. *But see Braddock*, 427 F.3d at 621 (affirm ing summary judgment in favor of the S tate without such analysis).[17]

State Medicaid program s are constant ly evolving, and policym akers must sometimes respond to unforeseen circum stances. Courts therefore view the S tate's efforts at deinstitutionalization in their broader historical context. *See, e.g.*, *Braddock*, 427 F.3d at 621 (considering developments since 1983); *Sanchez*, 416 F.3d at 1067 (considering developm ents since 1991). Additionally, "[i]t is of central importance . . . that courts apply [*Olmstead*] . . . with appropriate deference to the program f unding decisions of state policym akers." *Olmstead*, 527 U.S. at 610 (Kennedy, J., concurring).

The decisions in *Braddock* and *Sanchez* are ins tructive. In both cases, plain tiffs who were currently institutionalized (or suing on behalf of institutionalized persons) brought suit under *Olmstead*, and the court of appeals af firmed the district court's entry of summ ary judgment in favor of the State based on its "co mprehensive, effectively working plan" for deinstitutionalization. In both ca ses, the state maintained a waiver p rogram but (ap parently) no state Medicaid plan service that could meet the plaintiffs' needs.

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[17] The Third C ircuit has said that the Sta te must meet only a "minimal burden" in demonstrating that its past progress will continue. *Pa. Protection & Advocacy*, 402 F.3d at 382. Nevertheless, the court has held in two different cases that a State has not met its burden and has required the State to make a very specific showing of its future plans. *See id.* at 383-85; *see also Frederick II*, 422 F.3d 151; *Frederick L. v. Dep't of Pub. Welfare*, 364 F.3d 487 (3d Cir. 2004). All of these cas es, however, involved a Stat e's efforts to reduce the p opulation of a single state-run instituti on. When, as in this case , a State's entire HCBS program is at issue, it is neither practical nor possible to require a comparable showing.

In *Braddock*, the court of appeals noted that the State's HCBS program was "substantial in size" at 10,000 people; that the State's waiver program was full, with slots being filled as they opened up; that the HCBS program had increased from 1,227 slots to 9,977 slots from 1983 to 1998; that the state budget for HCBS "more than doubled" from 1994 to 2001; that the budget for institutional programs "remained constant" from 1994 to 2001; and that the institutionalized population declined by 20% from 1994 to 2001. *See Braddock*, 427 F.3d at 621.[18]

In *Sanchez*, the court of appeals affirmed the entry of summary judgment based on evidence that the HCBS population increased by 55% between 1991 and 2001; that expenditures on HCBS increased by 196% between 1991 and 2001; that the State had reduced its institutionalized population by 20% between 1996 and 2000; that the State had applied for more waiver slots in the future; that the State had budgeted for the creation of new HCBS facilities; and that the State expected to close at least one institution within the next two years. *See Sanchez*, 416 F.3d at 1067.

With respect to almost every variable, Louisiana's programs are comparable to those at issue in these two cases. The State's HCBS population in SFY 2010 was 18,215. SUF ¶10. Both the EDA and ADHC waivers are full, and slots are offered, as they become available, first to individuals in nursing facilities and then to individuals already in the community. SUF ¶¶59-63, 91-95. The HCBS population increased by 1668% between SFY 2000 and SFY 2010 and by 224% between SFY 2005 and SFY 2010; meanwhile, the LT-PCS population alone increased by 777% between SFYs 2005 and 2010. SUF ¶29. The State's expenditures on HCBS

[18] The court also noted that the current HCBS-to-institutional population ratio was 10:1. *See Braddock*, 427 F.3d at 621. The court did not state how that ratio had changed in the past or how many of the institutionalized persons were qualified for community-based care.

grew by over 250% between SFYs 2005 and 2010, and its expenditures on LT-PCS grew by over 600%. SUF ¶35. These numbers indicate that payments to providers of HCBS generally and to LT-PCS providers in particular grew faster than payments to private providers of any other Medicaid service over the same period. *See* Second Decl. of Hugh R. Eley, att. C. Additionally, between SFYs 2000 and 2010, per capita expenditures on private nursing facilities decreased (once adjusted for inflation), Pls.' Exh. 25, Declaration of H. Stephen Kaye, at ¶12 (ECF No. 38-3, page 407 of 455), and expenditures on the State's two public institutions that provide skilled nursing services remained roughly the same (without any adjustment for inflation), Second Decl. of Hugh R. Eley, att C. Over the same period, the population of private nursing facilities in the State dropped by 15%. SUF ¶14.

Plaintiffs' own expert witness acknowledges that Louisiana has been successful relative to other States. Professor H. Stephen Kaye states that Louisiana's expenditures on HCBS "increased sharply" between 2004 and 2009 and that, "[b]y 2008, Louisiana's per-capita HCBS expenditure ($72) had exceeded that of the remainder of its region ($56), and by 2009 ($84), it was approaching the U.S. average ($91)." Pls.' Exh. 25, Declaration of H. Stephen Kaye, at ¶9 (ECF No. 38-3, page 404 of 455). This trend reflected comparable improvement in the proportion of long term care spending devoted to HCBS, with Louisiana besting the other South Central states in 2009 and approaching the national average. *See id.* at ¶10 (page 405).[19]

[19] On at least one point, Plaintiffs misrepresent their expert's evidence. Plaintiffs say Louisiana's HCBS spending has "declined sharply" since 2009 "so that it is now below both the national and the regional average." (Opp'n at 26) As Prof. Kaye's affidavit clearly explains, however, "for other states, data for 2010 and 2011 are not available, and the dotted lines [on his graphs] indicate linear projections based on expenditures for 2005-2009." Pls.' Exh. 25, Declaration of H. Stephen Kaye, at ¶8 (ECF No. 38-3, page 404 of 455). No record evidence shows how they responded to the financial crises all States have faced since 2008.

Louisiana is also working to ensure that these successes continue into the future. The State expects that the LT-PCS program will expand rapidly due to the aging population and changes to Medicaid eligibility rules. SUF ¶31. The State is also currently overseeing the expansion of the ADHC program into currently under-served areas: Nearly a dozen new facilities began accepting Medicaid since October,[20] and 22 facilities have applications pending. SUF ¶98. Louisiana also recently designed a "Community Choice" waiver that will replace the EDA waiver; the new program will offer recipients a more comprehensive menu of services and will allow them greater flexibility to self-direct their care. SUF ¶¶105-108. The PACE program, which started in 2008, continues to enroll new recipients in Baton Rouge and New Orleans and to provide services without a waiting list. SUF ¶¶112-113. The State is currently awaiting federal approval of a new ARC waiver that will create 200 new waiver slots, SUF ¶116, and recent changes to the EDA Registry made available approximately 75 slots that were previously going unused, SUF ¶¶114-115.[21] Meanwhile, the State has successfully applied for a grant under the federal Money Follows the Person program; it is now using these resources to identify individuals in nursing facilities who want to leave and then to help them transition to the community. SUF ¶¶99-100. And the State has recently initiated multiple programs designed to close nursing facilities and eliminate nursing facility beds. SUF ¶¶117-123.

In sum, the State operates a comprehensive, effectively working plan to provide alternatives to nursing facilities, and it remains committed to ensuring that its past successes

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[20] According to Plaintiffs, there were only 27 ADHC facilities that accepted Medicaid in October 2010. (Opp'n at 16) As of March, the number was 38. SUF ¶98.

[21] There were previously 150 slots in the EDA waiver set aside for individuals with ALS. *See* La. Admin. Code tit. 50, § 8105(C), 35 La. Reg. 2447, 2447 (Nov. 2009). DHH recently reduced the set-aside to 75 slots, making the 75 previously unfilled slots available for general use. SUF ¶115.

continue in the future. The "requested relief would require [the court] to disrupt this working plan and to restrict impermissibly the leeway that [the State] is permitted in its operation of . . . services under *Olmstead*." *Sanchez*, 416 F.3d at 1068. As one court observed:

> Although more can always be done, the reality is that states must make difficult decisions when allocating necessarily limited resources. Neither the ADA nor the RA require[s] states to raise, appropriate, and spend whatever amount is necessary to immediately afford all qualified disabled persons community-based services . . . .

Bryson v. Stephen, 2006 WL 2805238, at *5 (D.N.H. Sept. 29, 2006).

2. None of Plaintiffs' Three Counterarguments Has Merit.

Plaintiffs point to "three reasons" (Opp'n at 34) they believe that Louisiana lacks a "comprehensive, effectively working plan" of the kind described in *Olmstead*. In each case, Plaintiffs are wrong on the law.

1. Plaintiffs mainly argue (Opp'n at 33-36) that Louisiana has not published a document that lays out with sufficient specificity how the State plans to keep the individual plaintiffs from entering nursing homes. Plaintiffs note that the State has published two documents outlining action steps designed to facilitate community placements for individuals who would otherwise require institutional care—the *Plan for Immediate Action* (2005) and *Louisiana's Plan for Choice in Long-Term Care* (2007)—and since updated them several times. But Plaintiffs argue that these documents are not sufficiently "specific" to support the State's defense.

Plaintiffs' argument rests on two unsupported legal assumptions, neither of which is correct. Plaintiffs' first mistake is to assume that any particular document or documents must set forth the State's plan for providing community-based services. Plaintiffs' second mistake is to

assume that because Plaintiffs are currently in the community, the State can establish its defense only if it has developed a plan to keep the individual plaintiffs out of nursing facilities.

Plaintiffs argue that the *Plan for Immediate Action* and *Plan for Choice in Long-Term Care* "cannot serve as a defense to claims of unjustified institutionalization" (Opp'n at 36) because these documents are not sufficiently detailed, and Plaintiffs list several perceived deficiencies. The problem with this argument is that the State's defense can succeed without any written plan at all. The "plan" referenced in *Olmstead* comprises "the range of services that a state already provides." *Disability Advocates, Inc. v. Paterson*, 653 F. Supp. 2d 184, 268 (E.D.N.Y. 2009); *see also id.* at 269-70 (noting that the State has "no single document constituting an '*Olmstead* plan'" but continuing on to review "the steps Defendants have taken and plan to take to enable Adult Home residents to receive services in more integrated settings").

Plaintiffs read the Third Circuit's decision in *Frederick L. v. Department of Public Welfare (Frederick II)*, 422 F.3d 151 (3d Cir. 2005), to require the State to develop a written document setting forth "reasonably specific and measurable" benchmarks "for which [the state] may be held accountable." (Opp'n at 35). But that cannot be what the Third Circuit meant in *Frederick II* because in a prior appeal in the same case the court said, "The issue is not whether there is a piece of paper that reflects that there will be ongoing progress toward community placement." *Frederick I*, 364 F.3d at 500. And other circuits have rejected such burdensome oversight. *See, e.g.*, *Bruggeman ex rel Bruggeman v. Blagojevich*, 324 F.3d 906, 913 (7th Cir. 2003) ("The purpose of the ['integration mandate'] is not to constitute the federal courts the supervisors of the care and treatment of disabled persons.").

But *Frederick II* is beside the point for another reason, and that brings us to Plaintiffs' second mistake. At issue in *Frederick II* was whether the State had a comprehensive,

effectively working plan for deinstitutionalizing individuals presently isolated in institutions. *See Frederick II*, 422 F.3d at 153-54. Not only that, *Frederick II* involved whether the State was adequately working to discharge "long-term mental health patients" from a particular state-run hospital. *Id.* It was in that context that the Third Circuit developed the standards by which it would judge the State's plan for deinstitutionalization. The instant case does not involve deinstitutionalization of individuals presently in an institutional setting, and it does not involve a single state institution. It makes little sense to apply the criteria developed by the Third Circuit to a case like this one, where the plaintiffs are not currently institutionalized and where the case involves the comprehensiveness of the State's HCBS program as a whole.

Plaintiffs cite the unpublished decision in *Haddad v. Arnold*, No. 10-00414 (M.D. Fla. July 9, 2010) (ECF. No. 49), for the proposition that the State's plan must "address the effectiveness of the particular program available to the plaintiff," even when the plaintiff is currently living in the community. (Opp'n at 36) *Haddad* is an unclear opinion that may or may not stand for that proposition. The *Haddad* court does seem to assume that, when the plaintiff is currently in the community, the question is whether the State has "an efficient comprehensive plan to avoid institutionalization," slip op. at 35, and the court did appear particularly concerned with how long the plaintiff would need to wait to receive waiver services if the plaintiff were not in an institution, *see id.* at 34-35.

Haddad is both wrong and distinguishable. The result of *Haddad*, particularly when combined with *Frederick II*, is to make it more difficult for individuals who are presently confined in institutions to succeed on an *Olmstead* claim than it is for individuals who are already receiving HCBS. When the plaintiff is institutionalized, the State will need to show only that it has HCBS programs that will allow the plaintiff and others similarly situated to leave

institutions in a reasonable time frame. *See Olmstead*, 527 U.S. at 606; *Sanchez*, 416 F.3d at 1068 ("*Olmstead* does not require the immediate state-wide deinstitutionalization of all eligible … disabled persons"). Applied literally, *Haddad* would appear to give those in the community the greater right of avoiding institutionalization altogether. This cannot be correct. In any event, *Haddad* is different from this case. In *Haddad*, the State did not present *any* evidence that its institutionalized population had steadily declined. *Haddad*, slip op. at 35. In the case of Louisiana, the evidence is substantial and undisputed.

2. Although Plaintiffs also contend (Opp'n at 36-37) that the State's comprehensive plan is not "effectively working," their argument is probably better understood as a complaint that the waiting lists for the ADHC and EDA waivers do not move at a "reasonable pace," *Olmstead*, 527 U.S. at 606.

As discussed above, Plaintiffs would already have received an offer for a slot in the ADHC program if they had requested one when they filed their Complaint, and nothing prevented them from requesting an offer earlier.

Regarding the EDA waiver, Plaintiffs are wrong to focus on the length of the waiting list for individuals who live in the community. When the *Olmstead* Court said that a State's compliance with the ADA may turn on whether it has "a waiting list that moved at a reasonable pace," 527 U.S. at 606, it was obviously talking about a waiting list for individuals (like the *Olmstead* plaintiffs) who were waiting to leave an institution. *See id.* ("It is reasonable for the State to ask someone to wait until a community placement is available."). And Plaintiffs are not well positioned to challenge the relatively short length-of-stay requirement for individuals who are in nursing homes for two reasons. First, Plaintiffs claim is that the ADA requires the State to provide them with services to avoid institutionalization; the State's policies

on moving individuals out of institutions, though certainly part of the State's defense under *Olmstead*, are not being challenged in this action. Second, Plaintiffs are represented by an organization that agreed to the policy that made the wait for EDA services longer than it was previously. SUF ¶¶77-80.

As to whether the State's HCBS programs are "effectively working," the proper focus is on the State's demonstrated success in providing home- and community-based alternatives to institutions. *See, e.g.*, *Braddock*, 427 F.3d at 620 ("So long as states are genuinely and effectively in the process of deinstitutionalizing disabled persons 'with an even hand,' we will not interfere."). Louisiana's accomplishments over the last decade are remarkable, and it cannot fairly be said that the system is not "effectively working."

3. Finally, Plaintiffs argue (Opp'n at 37) that Defendants cannot rely on the *Plan for Immediate Action* and *Plan for Choice in Long-Term Care* because those documents did not contemplate the reduction in LT-PCS services to 32-hours per week or various recent budgetary adjustments. Again Plaintiffs misunderstand the State's defense, which is not pinned solely to these particular documents. In any event, the State can hardly be faulted for not foreseeing the explosion of LT-PCS costs or the recession that amplified the need to control those costs.

Moreover, Plaintiffs cite no authority for their argument that a State cannot reduce services without first declaring its intent to do so in a policy paper that (if States are held to Plaintiffs' standards) must describe the State's entire HCBS program down to the last detail. To the extent that courts have addressed the issue, they have concluded that once a State has a deinstitutionalization program in place, "*Olmstead* does not require . . . that a State's plan be always and in all cases successful." *Sanchez*, 416 F.3d at 1068; *cf. Frederick I*, 364 F.3d at 496

(suggesting that the responsible agency's "unsuccessful attempts at fund procurement through the Governor's budget" weighed in its favor).

More significant are the array of HCBS programs the State continues to make available and the State's demonstrated commitment to offering elderly and disabled adults alternatives to institutional care. As discussed above, over the last decade Louisiana has seen considerable accomplishments in expanding the HCBS options for its diverse population of elderly and disabled adults. The dramatic growth in the LT-PCS program and the financial difficulties of the last two-and-a-half years have presented some budgetary obstacles, but Defendants have managed to overcome them to serve a population that is increasing every single month.

C. The DOJ's "Most Integrated Setting" Regulation Does Not Create A Right To Home And Community-Based Services Beyond What *Olmstead* Requires.

Plaintiffs contend that the ADA requires States to provide an individual with disabilities whatever level of services is necessary for that individual to reside outside a nursing home. Although their more recent brief (ECF No. 38) lacks any substantial discussion of the statutory basis for this claim, their earlier brief made clear that their argument is based on what Plaintiffs call the "integration mandate." Opp'n to Defendants' Motion to Dismiss at 11-13, 15-18, 21 & nn.4-5, 8 (ECF No. 17). This "integration mandate" is a rule promulgated by the Department of Justice under Section 12134 of the ADA. *See* 28 C.F.R. § 35.130(d); *see also Olmstead*, 527 U.S. at 592 (labeling this the "integration regulation"). The rule provides: "A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d).

Nothing in the text of the ADA itself contains the requirement that States administer services in the most integrated setting appropriate. What the ADA does contain is a

prohibition of discrimination by reason of an individual's disability. In *Olmstead*, the Court held that the "[u]njustified isolation" of individuals with disabilities qualified as "discrimination" within the meaning of ADA. 527 U.S. at 597. The Court mentioned the integration regulation, *see id.* at 592-93, 596, 602, but it was not the basis for the decision.

Whatever the force of the integration regulation in cases not involving claims of "unjustified isolation," in a case such as this one, the regulation does not provide a basis for the Court to order relief not required by *Olmstead* itself, because a regulation cannot be the basis for a private cause of action to enforce requirements not set forth in the statute itself, at least in the absence of another statute expressly authorizing such an action. *See Alexander v. Sandoval*, 532 U.S. 275 (2001); *Lonberg v. City of Riverside*, 571 F.3d 846, 851-52 (9th Cir. 2009) (holding that private litigants cannot sue to enforce an ADA regulation that imposes obligations not found in the statute). Nor can the Department of Justice itself authorize private actions to enforce the integration regulation. *See Sandoval*, 532 U.S. at 291-93 ("[I]t is most certainly incorrect to say that language in a regulation can conjure up a private cause of action that has not been authorized by Congress.").

In this case, *Olmstead*, not the "integration regulation," governs the State's obligations under the ADA.[22]

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[22] The analysis under the Rehabilitation Act is parallel. Substantively, the statute provides in part: "No otherwise qualified individual with a disability . . . shall, solely by reason of her or his disability, . . . be subjected to discrimination under any program or activity receiving Federal financial assistance . . . ." 29 U.S.C. § 794(a). The same section directs the head of each agency to "promulgate such regulations as may be necessary to carry out," *id.*, the statute's substantive command. And another section confers a private right of action "to any person aggrieved by any act or failure to act by any recipient of Federal assistance or Federal provider of such assistance *under section 794 of this title*," *id.* § 794a(a)(2) (emphasis added), but says nothing of action or inaction under the regulations.

For this reason, Plaintiffs' argument that DHH has waived its sovereign immunity under the Rehabilitation Act by accepting federal funds must be rejected. The provision on which plaintiffs rely (continued…)

VI. The Matters That Plaintiffs Claim To Be In Dispute Are Not Material To The ADA Inquiry.

Plaintiffs argue (Opp'n 37-40) that there is a genuine dispute as to whether it would be "inequitable" to exempt them from the 32-hour cap on LT-PCS and contend that this question can be resolved only at a trial addressing a slew of factual questions about the needs of individuals with disabilities,[23] the services provided for them in Louisiana and elsewhere,[24] and how those services are funded.[25] Many of these questions are complicated or abstract, some are

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applies only to "suit in Federal court *for a violation of section 504 of the Rehabilitation Act of 1973* . . . or the provisions of any other *Federal statute* prohibiting discrimination." 42 U.S.C. § 2000d-7(a)(1) (emphasis added).

[23] Fact issues identified by plaintiffs include: How many hours of care people eligible for LT-PCS might actually need to live safely in the community (Opp'n at 19); How long it takes people with disabilities to perform ADLs (Opp'n at 19); Whether unmet need for home care" is "correlate[d]" with "increased risk of institutionalization" (Opp'n at 19); Whether the 32-hour cap on LT-PCS puts people at risk of needing nursing facility care (Opp'n at 28); How people who currently live in the community can manage to stay there with no more than 32 hours of LT-PCS (Opp'n at 34-35).

[24] Plaintiffs inquire: How Louisiana's eligibility criteria for LT-PCS compare with the criteria used in other States, including whether other States "require a nursing facility level of care," whether those States' nursing facility level of care is the same as Louisiana's, whether other States require all recipients to show "imminent risk of institutionalization," whether those States define that risk the same way Louisiana does (Opp'n at 21, 32); Whether other States use waiver or non-waiver services as their main program for personal care services (Opp'n at 22, 32); How waiting lists for waiver services in Louisiana compare with waiting lists in other States (Opp'n at 23); What is the number of waiver and non-waiver recipients in other States (Opp'n at 22); Whether other States providing fewer hours of services than Louisiana are in compliance with the ADA (Opp'n at 32).

[25] Issues raised by Plaintiffs include: How much Louisiana spends on waiver services compared to others States (Opp'n at 22, 32); Whether a reduction in LT-PCS services is "necessary for budgetary reasons" (Opp'n at 23); Whether past increases in the per diem reimbursement rate for nursing facilities was necessary to continue providing nursing facility services to those who need them (Opp'n at 23); Why expenditures on nursing facilities have increased over the last decade (Opp'n at 24); Why Louisiana has reduced its reimbursement rate for LT-PCS by 3.67% since SFY 2006 (Opp'n at 24); What is "the cost of providing services in excess of the 32-hour cap only to those individuals who face a risk of institutionalization as a result of the cap" (Opp'n at 24); How much would it cost for the plaintiff class to be placed in institutions (Opp'n at 38); Whether the State accurately calculated how much it would save from reducing the cap on LT-PCS (Opp'n at 37-38); How much less the State would have saved if it waived the 32-hour cap for individuals "at risk of institutionalization" (Opp'n at 38); What is "the budgetary effect of the 32-hour cap" and how this figure should be calculated (Opp'n at 24); Whether the 32-hour cap will increase "hospitalization or emergency room Medicaid expenditures" and, if so, by how much (Opp'n at 25); How do Louisiana's per capita expenditures on HCBS and nursing facilities compare (continued…)

inherently value-laden, and others may be unanswerable. But none is material to whether Louisiana has discriminated in its administration of its HCBS programs or whether the State has in place a comprehensive, effectively working plan for providing alternatives to nursing facilities.

The Court should not accept Plaintiffs' invitation to explore the intricacies of the State's Medicaid funding in order to determine whether limiting LT-PCS services is "equitable," and there is no need to consider all of the expenditure-related issues raised by Plaintiffs. Defendants' argument here is that the State already maintains a comprehensive and successful HCBS plan that provides thousands of individuals similarly situated to Plaintiffs with community care. Under *Olmstead*, that is sufficient. *See* 527 U.S. at 605-06; *cf. Pa. Protection & Advocacy*, 402 F.3d at 381-82 ("When an agency *has* implemented a sufficient compliance plan (i.e., when it has demonstrated a commitment to comply with the ADA and RA), we must be wary of judicial mandates that could thwart or undermine the agency's authority to carry out that plan as it sees fit.").

"Throughout *Olmstead*, the Justices' cautious reluctance to question State funding decisions is apparent," *Ligas v. Maram*, No. 05C4331, 2010 WL 1418583, at *2 n.5 (N.D. Ill. Apr. 7, 2010) (No. 05-4331), and the standardless and broad-ranging inquiry Plaintiffs ask the Court to undertake is simply not appropriate. "[T]he judiciary is not well-suited to superintend the internal budgetary decisions of [a state agency]," *Frederick I*, 364 F.3d at 498, and "[t]he purpose of the ['integration mandate'] is not to constitute the federal courts the supervisors of the care and treatment of disabled persons." *Bruggeman*, 324 F.3d at 913. Plenary review of a

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with those of other States (Opp'n at 25-26); How much it would cost to provide "services necessary to sustain [individuals who need more than 32 hours of LT-PCS] in the community" (Opp'n at 35).

State's expenditures on its entire Medicaid program for elderly and disabled adults is highly burdensome. Such an unmanageable inquiry is not warranted whenever an individual currently receiving services in the community is shown to be at risk of a temporary institutional placement, and Plaintiffs cite no authority for the relevance of the innumerable budgetary considerations they think have bearing on the State's defense. *Cf. Olmstead*, 527 U.S. at 610 (Kennedy, J., concurring) (noting that because of "the federalism costs inherent in referring state decisions regarding . . . the allocation of resources to the reviewing authority of the federal courts" "[i]t is of central importance . . . that courts apply [*Olmstead*] . . . with appropriate deference to the program funding decisions of state policymakers"). Appellate courts have not required this burdensome inquiry in cases where they have affirmed the entry of summary judgment based on a State's comprehensive, effectively working plan. *See, e.g.*, *Braddock*, 427 F.3d 615; *Sanchez*, 416 F.3d 1051.

VII. Plaintiffs Have Abandoned Their Remaining Claims.

Plaintiffs' "criteria and methods" ADA claim should be dismissed with prejudice as abandoned; their Third Claim for Relief should be dismissed without prejudice as unripe.

The Complaint included as an alternative basis for relief under the ADA allegations that "Defendants have utilized criteria and methods of administration that subject Plaintiffs to discrimination on the basis of disability, including unnecessary institutionalization, by (1) failing to assess properly the services and supports that would enable Plaintiffs to remain in the community and (2) denying Plaintiffs access to Medicaid-covered services that will meet their needs in the community . . . ." Compl. ¶107 (ADA claim); *see also id.* ¶110 (Rehabilitation Act claim). The Complaint also described the evolution from 2003 to the present of Defendants' methodology for allocating hours among LT-PCS recipients. *Id.* ¶¶31-34. Plaintiffs also discuss the allocation methodology in their opposition brief. (Opp'n at 18-19) At the same time,

Plaintiffs now maintain that they "are not challenging the change in allocation methodology in this case." (Opp'n at 19 n.105)

Because the Complaint clearly incorporated allegations that the State's allocation methodology discriminated in some fashion and because Plaintiffs have expressly abandoned that theory, their "criteria and methods" claims should be dismissed with prejudice. *See Michel v. Saint-Gobain Containers, Inc.*, Civ. A, 05-207, 2005 WL 3339568, at *2 (W.D. La. Dec. 8, 2005) (unpublished) (dismissing with prejudice claims abandoned by the plaintiff); *Woodland v. Nalco Chem. Co.*, Civ. A 01-3337, 2004 WL 253442, at *1 (E.D. La. Feb. 10, 2004) (unpublished) (same), *aff'd*, 114 Fed. App'x 150, 2004 WL 2722523 (5th Cir. Nov. 22, 2004).

Plaintiffs concede that all of their claims not founded on the ADA or the Rehabilitation Act "may be premature." Opp'n to Defendants' Motion to Dismiss at 22. This is in effect an acknowledgement that the claims are unripe and that the Court lacks jurisdiction to hear them. *See Roark & Hardee LP v. City of Austin*, 522 F.3d 533, 544 n.12 (5th Cir. 2008). The Court should therefore dismiss Plaintiffs' Third Claim for Relief under Rule 12(b)(1).

VIII. Conclusion

For the foregoing reasons, Defendants respectfully request that the Court enter judgment in their favor on Plaintiffs' First and Second Claims for Relief and dismiss Plaintiffs' Third Claim for Relief for lack of jurisdiction.

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Respectfully submitted,

/s/ Kimberly Humbles

Kimberly Humbles
La. Bar No. 24465
Kimberly.Humbles@la.gov
Michael J. Coleman
La. Bar No. 22756
Michael.Coleman@la.gov
Charles E. Daspit
La. Bar No. 4559
Charles.Daspit@la.gov
Neal R. Elliott
La. Bar No. 24084
Neal.Elliott@la.gov
Stephen R. Russo
La. Bar No. 23284
Stephen.Russo@la.gov
LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
P.O. Box 3836
Baton Rouge, LA 70821-3836
Telephone: 225-342-1128
Facsimile: 225-342-2232

Caroline M. Brown
cbrown@cov.com
D.C. Bar. No. 438342
Matthew Berns
mberns@cov.com
N.J. Bar No. 037232009
COVINGTON & BURLING LLP
1201 Pennsylvania Ave., N.W.
Washington, DC 20004-2401
Telephone: 202-662-6000
Facsimile: 202-662-6291
Counsel for Defendants

CERTIFICATE OF SERVICE

I certify on this 30th day of March, 2011, that a true and correct copy of the foregoing **Defendants' Memorandum in Opposition to Class Certification** was filed electronically using the CM/ECF system. Notice of this filing will be sent via operation of the Court's electronic filing system to the following:

Nell Hahn
nhahn@advocacyla.org
Stephen F. Gold
stevegoldada@cs.com
Bruce Vignery
bvignery@aarp.org
Kenneth Zeller
kzeller@aarp.org
Counsel for Plaintiffs

/s/ Matthew Berns
Matthew Berns