IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

ERIC STEWARD, *et al*., *Plaintiffs*	§ § §	
v.	§	Case No. 5:10-CV-1025-OG
RICK PERRY, Governor of the State of Texas, THOMAS SUEHS, Executive Commissioner of the Texas Health and Human Services Commission, CHRIS TRAYLOR, Commissioner of the Texas Department of Aging and Disability Services, *Defendants*	§ § § § § § § §	

DEFENDANTS' MOTION TO DISMISS PLAINTIFFS' COMPLAINT

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TO THE HONORABLE JUDGE ORLANDO L. GARCIA:

Defendants, **RICK PERRY**, in his official capacity as Governor of The State of Texas ("Governor"), **THOMAS SUEHS**, in his official capacity as Executive Commissioner of the Texas Health and Human Services Commission ("HHSC"), and **CHRIS TRAYLOR**, in his official capacity as Commissioner of the Texas Department of Aging and Disability Services ("DADS") (collectively, "Defendants"), hereby move this Court to dismiss Plaintiffs' claims pursuant to Rules 12(b)(1) and 12(b)(6), for the reasons stated herein.

INTRODUCTION

In this lawsuit, Plaintiffs seek to expand the Medicaid Act and the Texas Medicaid program to require Texas to provide community-based services to all current and potential nursing facility residents who have developmental disabilities. This would require Texas to fundamentally alter its Medicaid program and expand its optional Medicaid waiver program beyond what federal law requires. While Defendants strive to provide all Medicaid recipients with the assistance to which they are entitled under Texas's Medicaid program, they nevertheless must ask this Court to dismiss Plaintiffs' claims, as a matter of law, for the reasons stated herein.

I. Plaintiffs' Claims

Plaintiffs are six individual named plaintiffs who say they are adult persons with mental retardation or other related conditions (hereinafter referred to as "developmental disabilities").[1] Plaintiffs are suing on behalf of themselves and a purported class, claiming to have been inappropriately and unnecessarily segregated in nursing facilities ("NFs") because of Defendants' purported failure to provide services to which Plaintiffs claim entitlement, and to

[1] In their Complaint, Plaintiffs refer to "mental retardation or other related conditions" as "developmental disabilities." Defendants normally use the term "intellectual disability" to refer to mental retardation, and "developmental disability" to refer to "related conditions." However, for purposes of this motion, Defendants will use the term "developmental disability" to refer to both mental retardation and related conditions.

provide services in a community-based residential placement. *See, e.g.*, Dkt. #1 ("Complaint") ¶¶ 1-5. Specifically, Plaintiffs complain that Defendants have failed to: timely and appropriately conduct pre-admission screening and assessments before NF placement; provide all needed specialized services; assess the appropriateness of alternative, less restrictive settings; and advise of and provide a choice of community-based services and supports. *See, e.g.*, Complaint ¶¶ 5, 214, 226, 229, 231, 232, 236-38. Plaintiffs assert that in so doing, Defendants have violated their rights under the Americans with Disabilities Act, 42 U.S.C. § 12132 *et seq*. ("ADA"), Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 ("§ 504" or "Rehab. Act"), several sections of Title XIX of the Social Security Act, 42 U.S.C. § 1396a, *et seq*. ("Medicaid Act"), and the 1987 Nursing Home Reform Amendments to the Medicaid Act, 42 U.S.C. § 1396r, *et seq*. ("NHRA"). Plaintiffs bring their claims under 42 U.S.C. § 1983 ("Section 1983").

As relief, Plaintiffs seek expansive, far-reaching declaratory and injunctive relief touching virtually every aspect of Texas's Medicaid program for PASRR-eligible persons with developmental disabilities.[2] *See* Complaint pp. 54-56.

II. The Defendants and Their Role in the Texas Medicaid Program

The Texas Medicaid Program is a state- and federally funded program that provides health benefits to nearly 3.4 million low-income, elderly, and disabled Texans.[3] Thomas Suehs, as the Executive Commissioner of HHSC, and Chris Traylor, as the Commissioner of DADS, are the state officials who head the two state agencies charged with administering those parts of the Texas Medicaid Program targeted by this lawsuit, namely, the provision of Medicaid services to

[2] "PASRR" (formerly known as "PASARR") means "Pre-Admission Screening and Resident Review," as set out in the NHRA, 42 U.S.C. § 1396r(e)(7).

[3] Texas Medicaid Enrollment by Month, July 2010, available at: http://www.hhsc.state.tx.us/research/MedicaidEnrollment/meByMonthCompletedCount.html (last visited March 7, 2011).

Medicaid-eligible persons meeting the medical necessity requirement for admission to a nursing facility who also have developmental disabilities.

HHSC is the state agency with primary responsibility for ensuring the delivery of health and human services in Texas in a manner that: (1) uses an integrated system to determine client eligibility; (2) maximizes the use of federal, state, and local funds; and (3) emphasizes coordination, flexibility, and decision-making at the local level. TEX. GOV'T CODE § 531.002. In that role, HHSC provides oversight and strategic direction to the state agencies that make up the health and human services system in Texas. TEX. GOV'T CODE § 531.001(4); *see generally,* TEX. GOV'T CODE § 531.001 *et seq*. HHSC is governed by an executive commissioner, now Thomas Suehs, who is appointed by the governor with the advice and consent of the senate. *Id*. § 531.005(a); *see* Complaint ¶¶ 22, 23. HHSC's executive commissioner adopts rules and policies for the operation and provision of health and human services by the health and human services agencies, and manages and directs the operations of each health and human services agency. TEX. GOV'T CODE §531.0055(e) and (e)(2); *see* Complaint ¶ 23.

Specifically, HHSC "supervise[s] the administration and operation of the Medicaid program," TEX. GOV'T CODE § 531.0055(b)(1), and is the single state agency designated to administer federal medical assistance funds.[4] TEX. GOV'T CODE § 531.021(a). Accordingly, HHSC plans and directs the Medicaid program in each agency that operates a portion of the Medicaid program, including DADS. *Id*. § 531.021(b)(1). HHSC also receives and distributes federal Medicaid funds to the health and human services agencies which administer the Texas Medicaid program. TEX. HUM. RES. CODE § 32.031. As specifically related to this lawsuit,

[4] The Medicaid Act and its implementing regulations require the states to designate a "single State agency … to administer or supervise the administration of the [state Medicaid] plan." 42 C.F.R. § 431.10(b)(1); *see* 42 U.S.C. § 1396a(5). In Texas, HHSC is that agency.

HHSC is responsible for the administration of the PASRR program in Texas. HHSC is a "public entity" for purposes of Title II of the ADA. 42 U.S.C.A. § 12131(1)(A) and (B) (2011).

DADS is the state agency responsible for administering human services programs for the aging and disabled, including: (1) administering and coordinating programs to provide community-based care and support services to promote independent living for populations that would otherwise be institutionalized; (2) providing institutional care services, including services through convalescent and nursing homes and related institutions; (3) providing and coordinating programs and services for persons with disabilities, including programs for the treatment, rehabilitation, or benefit of persons with developmental disabilities or mental retardation; and (4) performing all licensing and enforcement activities and functions related to nursing homes and related institutions. TEX. HUM. RES. CODE § 161.071 (1)-(3), (6); *see* Complaint ¶ 24. The DADS Commissioner, now Chris Traylor, is appointed by the Executive Commissioner of HHSC, with the approval of the Governor, and serves at the pleasure of the Executive Commissioner. TEX. GOV'T CODE § 531.0056; TEX. HUM. RES. CODE § 161.051(a), (b); Complaint ¶ 22, 23, 24. DADS is a "public entity" for purposes of Title II of the ADA. 42 U.S.C.A. § 12131(1)(A) and (B).

The Governor of Texas is the chief executive officer of the State. TEX. CONST. art IV, § 1; *see* Complaint ¶ 22. However, Texas law does not imbue the Governor with any direct responsibilities for development, administration, or funding of the state's Medicaid program. Specifically, the Governor is not "responsible for directing, supervising, and controlling" the Texas Medicaid program, as Plaintiffs allege. Complaint ¶ 22. To the contrary, as discussed above, the Texas Legislature has specifically designated HHSC as the state agency to "supervise the administration and operation of the Medicaid program," TEX. GOV'T CODE § 531.0055(b)(1),

and as the single state agency designated to administer federal medical assistance funds, TEX. GOV'T CODE § 531.021(a). Nor is the Governor "responsible for … seeking funds from the legislature to implement … programs and deliver … services." Complaint ¶ 22. While it is true that the Governor is required to submit a biennial budget to the Legislature, TEX. GOV'T CODE § 401.0445, and that he is permitted to submit a proposed general appropriations bill to the Legislature, TEX. GOV'T CODE § 316.009, the Governor has no authority to appropriate state funds for the Texas Medicaid program. Instead, only members of the Legislature are authorized to file a general appropriations bill, and only the Legislature can appropriate state funds. TEX. GOV'T CODE § 316.021. Finally, the Governor's authority to appoint the Executive Commissioner of HHSC, subject to the advice and consent of the Senate, TEX. GOV'T CODE § 531.005, and to approve the appointment of the Commissioner of DADS, TEX. GOV'T CODE § 531.0056), does not give him the authority to administer or operate Texas's Medicaid program, which by law is administered and operated by HHSC and other health and human services agencies, including DADS.[5]

III. Overview of the Medicaid Act and Medicaid Waivers

Congress created the Medicaid program in 1965 by adding Title XIX to the Social Security Act, 42 U.S.C. § 1396, *et seq*. The program authorizes federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons. In order to participate in the Medicaid program, a State must have a plan for medical assistance that meets certain statutorily defined requirements, 42 U.S.C. § 1396a(a), and that is approved by the Secretary of Health and Human Services ("Secretary"), 42 U.S.C. § 1396a(b). A state plan

[5] By contrast, the Governor does have authority to: appoint state and district offices, TEX. CONST., art. IV, § 12; direct homeland security in Texas and develop a statewide homeland security strategy, TEX. GOV'T CODE § 421.002; declare a state of disaster and meet the dangers to the state and people presented by disasters, TEX. GOV'T CODE § 418.001, *et seq*.

defines the categories of individuals eligible for benefits, § 1396a(a)(10), and the specific kinds of medical services that are covered, 42 U.S.C. § 1396d(a). States participating in the Medicaid program are required to provide coverage to certain groups, and are given the option to extend coverage to various other groups. The line between mandatory and optional coverage is primarily drawn in § 1396a(a) – mandatory coverage is specified in § 1396a(a)(10)(A)(i), and the state options are set forth in subsection (ii). *Skandalis v. Rowe*, 14 F.3d 173 (2d Cir. 1994). States participating in the program must provide coverage to the required groups of the "categorically needy"[6] and, at the state's option, may also cover one or more optional "categorically needy" groups. 42 U.S.C. § 1396a(a)(10)(A)(ii). A state, at its option, may also cover the "medically needy."[7] *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 650-51 (2003); *Atkins v. Rivera*, 477 U.S. 154, 154 (1986). These categories are determined based on financial eligibility standards. 42 U.S.C. § 1396a(a)(10)(A). Federal law, however, does not require participating states to provide all services and devices covered by the statute. Rather, Congress has set a basic minimum standard for any state Medicaid program which requires it to provide financial assistance only for certain specified medical treatment. *Id.*

In 1981, Congress amended the Medicaid Act by adding 42 U.S.C. § 1396n(c) to allow the Secretary of Health and Human Services, through the Health Care Finance Administration (now the Center for Medicare & Medicaid Services ("CMS")), to waive certain statutory Medicaid requirements, and to allow participating states, upon the state's application, to use federal and state funds to provide home- and community-based services as alternatives to placing

[6] The required "categorically needy" groups include individuals eligible for cash benefits under the Temporary Assistance for Needy Families (TANF) program; the aged, blind, or disabled individuals who qualify for supplemental security income (SSI) benefits; and other low-income groups such as pregnant women and children entitled to poverty-related coverage. 42 U.S.C. § 1396a(a)(10)(A)(i); *see Pharm. Research & Mfrs. of America v. Walsh*, 538 U.S. 644, 651 (2003).

[7] The "medically needy" are individuals who meet the nonfinancial eligibility requirements for inclusion in one of the groups covered under Medicaid, but whose income or resources exceed the financial eligibility requirements for categorically needy eligibility. § 1396a(a)(10)(C); *see Walsh*, 538 U.S. at 650-51.

Medicaid-eligible individuals in hospitals, nursing facilities or intermediate care facilities for individuals with mental retardation ("ICFs-MR") under the State Plan. 42 U.S.C. § 1396n(c); 42 C.F.R. §440.180; 42 C.F.R. §441.301(b)(1)(iii). As its name suggests, a waiver relieves states from complying with certain federal requirements that ordinarily must be complied with in order to receive federal Medicaid funding under the State Plan.[8] The statute specifically provides that the requirements of statewideness, comparability of services, and single standard for income and resource eligibility, may be waived. 42 U.S.C. § 1396n(c)(3); 42 C.F.R. §430.25(d)(2).

Unlike ICF-MR or nursing facility services, which must be made available to all individuals who are categorically eligible for Medicaid services in conformance with the Medicaid Act, there is no statutory entitlement to waiver services. In other words, not all people who are eligible for these "waiver" services are entitled to receive them. A participating state has wide latitude to define the types of services that it will offer under the waiver, to limit the geographical areas where waiver services are offered and the target groups to whom the services are offered, and to make waiver services available in an amount, duration and scope that differs from the amount, duration and scope of services provided to other Medicaid recipients. 42 U.S.C. §§ 1396n(c)(3), 1396n(c)(4), 1396n(c)(9), 1396n(c)(10); 42 C.F.R. §§ 441.301(b)(3) & (6), 430.25(h)(3)(ii), 440.180, 441.303(f)(6), 441.305(a). Finally, the Medicaid Act and applicable regulations expressly require states to place a limit on the number of persons who may

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[8] The Medicaid regulations describe the purpose of a Medicaid waiver program as follows:

> Waivers are intended to provide the flexibility needed to enable States to try new or different approaches to the efficient and cost-effective delivery of health care services, or to adapt their programs to the special needs of particular areas or groups of recipients. Waivers allow exceptions to State plan requirements and permit a State to implement innovative programs or activities on a time-limited basis, and subject to specific safeguards for the protection of recipients and the program.

42 C.F.R. §430.25(b). To qualify for a waiver, a state must demonstrate that rendering home and community-based services to qualified individuals would not result in overall expenditures in excess of those that would be incurred if those individuals received services in the traditional institutional program. 42 U.S.C. § 1396n(c)(2).

receive waiver services. 42 U.S.C. § 1396n(c)(9) & (10); 42 C.F.R. §§ 441.303(f)(6), 441.305(a). Moreover, an approved cap is binding on the state.[9]

Accordingly, as permitted by 42 U.S.C. § 1396n(c), the State of Texas, through its Medicaid program, has obtained approval from CMS to offer home and community-based services to a specified number of individuals who require the level of care provided in ICFs-MR. As Plaintiffs acknowledge, the Home and Community-Based Services ("HCS") waiver is one such program. Complaint ¶ 57. The HCS waiver program has a limited number of slots,[10] and there is an interest list of approximately 45,756 persons, as of August 31, 2010, who are waiting for HCS waiver services to become available. *Id*. Defendants are prohibited from increasing the number of waiver slots unless they request amendment to their waiver applications and receive necessary approval from CMS. Nothing in federal Medicaid law or regulation requires a state to increase the number of persons served in its waiver programs.

ARGUMENT AND AUTHORITY

I. This Court Lacks Jurisdiction Over Plaintiffs' Claims

A. Plaintiffs Lack Standing to Bring This Action.

1. Elements of Standing.

A federal court lacks subject-matter jurisdiction over a matter when the plaintiff lacks standing to bring suit. *See Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992). To establish his or her own standing to sue, a plaintiff must make a three-pronged showing of:

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[9] Specifically, the regulations provide that a state seeking a waiver:

> must indicate the number of unduplicated beneficiaries to which it intends to provide waiver services in each year of its program. This number will constitute a limit on the size of the waiver program unless the State requests and the Secretary approves a greater number of waiver participants in a waiver amendment.

42 C.F.R. § 441.303(f)(6)(emphasis added); *see* 42 C.F.R. § 441.305(a). In fact, the statute expressly contemplates that waiver programs may be limited to as few as 200 individuals. 42 U.S.C. § 1396n(c)(10).

[10] The number of HCS waiver slots approved by CMS for the state fiscal year ending August 31, 2010 is 19,695. *See* http://www.dads.state.tx.us/providers/HCS/HCSwaiveramendment2.pdf.

(1) an "injury-in fact" that is concrete and particularized, and actual or imminent, not conjectural or hypothetical; (2) a causal connection between the injury and the conduct complained of that is fairly traceable to the challenged action of the defendant; and (3) redressability—it must be likely, not merely speculative, that the injury will be redressed by a favorable decision. *Id*. at 560-61. "This triad of injury in fact, causation, and redressability constitutes the core of Article III's case-or-controversy requirement, and the party invoking federal jurisdiction bears the burden of establishing its existence." *Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 103-04 (1998). Failure to establish any one element deprives the federal courts of jurisdiction to hear the suit. *Id.* at 103. Standing is a threshold jurisdictional issue that the Court must evaluate before addressing the merits of Plaintiffs' action.[11] *See Friends of the Earth, Inc. v. Laidlaw Env't. Servs. (TOC)*, 528 U.S. 167, 180 (2000).

2. Plaintiffs Have No Case or Controversy with Governor Perry.

In Texas, the portions of the Medicaid Act at issue in this lawsuit are administered by DADS and HHSC. The Governor has no direct control over the running of the Texas Medicaid Program; that function is clearly assigned to HHSC and its health services agencies, including DADS. Therefore, Plaintiffs have no case or controversy with Governor Perry.

a. Governor Perry did not, and could not, cause Plaintiffs' injuries, if any.

Even assuming, for purposes of a standing analysis here, that Plaintiffs have suffered some injury-in-fact, no injury has been, or could be, caused by the Governor. As discussed above, it is HHSC and DADS that implement the particular aspects of Texas's Medicaid

[11] Furthermore, Plaintiffs must establish their own standing before addressing class certification because "[s]tanding is an inherent prerequisite to the class certification inquiry." *Bertulli v. Indep. Ass'n of Cont. Pilots*, 242 F.3d 290, 294 (5th Cir. 2001); *see also Rivera v. Wyeth-Ayerst Lab*., 283 F.3d 315, 319 (5th Cir. 2002) ("Even though the certification inquiry is more straightforward, we must decide standing first, because it determines the court's fundamental power to hear the suit."). If a plaintiff fails to establish standing to pursue claims for the named plaintiff's personal injuries, the class claim based on those injuries will also fail. *Daughtery v. I-Flow, Inc*., No. 3:09-CV-2120-P, 2010 WL 2034835, at *2 (N.D. Tex. April 29, 2010).

program for persons with developmental disabilities at issue in this lawsuit. The Governor does not. Specifically, the Governor's role does not encompass the particular actions or failures to act about which Plaintiffs complain. For example, neither the Governor nor his office is charged with: conducting pre-admission screening and assessments, providing specialized services, or providing community-based services and supports. *See, e.g.*, Complaint ¶¶ 5, 226, 229, 231, 232, 236, 237, 238. Article III jurisdiction is simply lacking where Plaintiffs sue a state official who is without power to take the complained-of action, and whose actions have not caused, or could not cause, any injury to them. *See Okpalobi v. Foster*, 244 F.3d 405, 426 (5th Cir. 2001) (plaintiffs failed to satisfy Article III standing with respect to the Governor, who had no authority to enforce the allegedly-unconstitutional state statute).

b. Plaintiffs' injuries, if any, are not redressable through Governor Perry.

In *Okpalobi v. Foster*, the plaintiffs tried to enjoin enforcement of a Louisiana statute that made abortion providers liable in tort for any damages caused by abortion procedures, and named Louisiana's governor and attorney general as defendants in the lawsuit. In an *en banc* opinion, the Fifth Circuit held that an injunction against the governor and the attorney general would be "utterly meaningless" because "[t]he governor and the attorney general have no power to redress the asserted injuries … Because these defendants have no powers to redress the injuries alleged, the plaintiffs have no case or controversy with these defendants that will permit them to maintain this action in federal court." *Id*. at 427.

The same is true of Plaintiffs' claims against Governor Perry in this lawsuit. Because the Governor does not administer any of the federal-state programs complained-of in Plaintiffs' complaint, and therefore has no authority to redress Plaintiffs' purported injuries, Plaintiffs also fail to satisfy the redressability prerequisite for Article III standing.

3. Plaintiffs lack standing to assert claims under 42 U.S.C. §§ 1396n(c)(2)(B) and (C).

Plaintiffs lack standing to assert a challenge to Defendants' compliance with the "freedom of choice" provision of the Medicaid Act, 42 U.S.C. § 1396n(c)(2)(C), because they do not allege an injury-in-fact from Defendants' alleged failure to comply with that provision. Section 1396n(c)(2)(C) provides that the Secretary of Health and Human Services shall not grant a waiver under the Medicaid Act unless the state seeking the waiver provides assurances that "individuals who are determined to be likely to require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded are informed of the feasible alternatives, if available under the waiver, at the choice of such individuals, to the provision of inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded." 42 U.S.C. § 1396n(c)(2)(C). Plaintiffs lack standing to assert this claim because—with one exception (Benny Holmes)—Plaintiffs have not pled that they have even *applied for* one of Texas's several waiver programs. Complaint ¶¶ 136-176, 199-209. The Fifth Circuit has clearly held that in order to have standing to raise a § 1396n(c)(2)(C) claim, an individual must have applied for waiver services. *Grant ex rel. Family Eldercare v. Gilbert*, 324 F.3d 383, 388 (5th Cir. 2003). As do the Plaintiffs here, the plaintiff in *Grant* asserted that, during his admittance to nursing facility care some years before, the state failed to provide him sufficient information regarding alternative residential placements, thereby allegedly violating his rights under both NHRA and § 1396n(c)(2)(C). Regarding the latter claim, the Fifth Circuit held that Grant's failure to allege that he had applied for waiver services then or at any time before the pendency of the appeal deprived him of standing. The same applies to all of the Plaintiffs here (other than Benny Holmes).

On the other hand, Benny Holmes lacks standing under § 1396n(c)(2)(B) and (C) because he admits that he has twice been placed in the HCS waiver program and currently has an HCS placement. Complaint ¶¶ 177-198, especially ¶ 195. Therefore, as a matter of law, he has suffered no injury-in-fact for purposes of the § 1396n(c)(2) claim.

B. Sovereign Immunity Bars Plaintiffs' Claims Against Governor Perry.

The Eleventh Amendment bars suits by private citizens against a state in federal court, irrespective of the nature of the relief requested, including suits against state officials in their official capacities. *Pennhurst State Sch. & Hosp. v. Halderman*, 465 U.S. 89, 102 (1984); *Edelman v. Jordan*, 415 U.S. 651, 663-69 (1974); *McCarthy ex rel. Travis v. Hawkins*, 381 F.3d 407, 412 (5th Cir.2004). Under the narrow *Ex parte Young* exception to this rule, "a federal court, consistent with the Eleventh Amendment, may enjoin state officials to conform their future conduct to the requirements of federal law." *Pennhurst*, 465 U.S. at 102-103; *Quern v. Jordan*, 440 U.S. 332, 337 (1979). However, in order to overcome the Eleventh Amendment bar, the defendant state official must have "'some connection with the enforcement of the act' in question or be 'specially charged with the duty to enforce the statute.'" *Okpalobi*, 244 F.3d at 414-15 (quoting *Ex parte Young*). For example, a governor's general duty to "take care that the laws are faithfully executed" is an insufficient connection under *Young* "to dissolve the Eleventh Amendment bar." *Id*. at 416-17 (quotation marks and citation omitted). Accordingly, since Governor Perry has no connection to the administration of the Medicaid Act, including the delivery of Medicaid assistance or services in nursing facilities or in a community setting, Plaintiffs' suit against him is barred by sovereign immunity.

II. Plaintiffs Have Failed to State a Claim Upon Which Relief May Be Granted.

A. Standard for Dismissal Under Rule 12(b)(6)

Dismissal is proper pursuant to Federal Rule of Civil Procedure 12(b)(6) when a party's complaint fails to state a claim upon which relief can be granted. When considering a motion to dismiss under Rule 12(b)(6), the Court accepts all well-pleaded facts as true, viewing them in the light most favorable to the plaintiff. *Martin K. Eby Constr. Co. v. Dallas Area Rapid Transit,* 369 F.3d 464, 467 (5th Cir. 2004). To survive a Rule 12(b)(6) motion, the plaintiff must plead "enough facts to state a claim to relief that is plausible on its face." *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 127 S.Ct. 1955, 1974 (2007). Although a court accepts all well-pleaded facts as true, "the tenet that a court must accept as true all of the allegations contained in a complaint is inapplicable to legal conclusions." *Ashcroft v. Iqbal*, __ U.S. __, 129 S.Ct. 1937, 1949 (2009).

B. Plaintiffs' Claims Arising Before December 20, 2008 Are Time Barred.

Plaintiffs' claims based on Defendants' alleged conduct at the time of Plaintiffs' admission to a nursing facility are time barred to the extent those claims are based on events occurring before December 20, 2008.

This lawsuit was filed on December 20, 2010. Applying the two-year statute of limitations applicable here,[12] Plaintiffs' claims that accrued prior to December 20, 2008 are time-barred. The time at which the claim accrues is a matter of federal law. *Rodriguez v. Holmes*,

[12] Because there is no federal statute of limitations for Section 1983 claims, the state statute of limitations from the most analogous state law claim applies, which is the Texas two-year statute of limitations for personal injury claims. *See Wallace v. Kato*, 549 U.S. 384, 387 (2007) (holding that statute of limitations for Section 1983 claims "is that which the State provides for personal-injury torts."); *Stanley v. Foster*, 464 F.3d 565, 568 (5th Cir. 2006) (two-year statute of limitations applies to Section 1983 actions in Texas); TEX. CIV. PRAC. & REM. CODE § 16.003(a). Furthermore, the underlying federal statutes do not specify a statute of limitations, and as a result, Texas' two-year statute of limitations for personal injury claims applies to cases filed in Texas federal courts. *See Holmes v. Texas A&M Univ.*, 145 F.3d 681, 683-84 (5th Cir. 1998); *Hickey v. Irving Indep. Sch. Dist.*, 976 F.2d 980, 982 (5th Cir. 1992).

963 F.2d 799, 803 (5th Cir. 1992). Under the Fifth Circuit's "discovery rule," a Section 1983 claim accrues when the plaintiff knows or has reason to know of the injury on which his suit is based. *Rubin v. O'Koren*, 621 F.2d 114, 116 (5th Cir. 1980) (citations omitted). Thus, the limitations period begins to run when the plaintiff is or should be aware of the "critical facts that he has been hurt and who has inflicted the injury." *Lavellee v. Listi*, 611 F.2d 1129, 1130 (5th Cir. 1980) (quotation marks omitted).

Plaintiffs assert a number of claims relating to Defendants' alleged conduct at the time of Plaintiffs' admission to nursing facility care. These claims include: (1) Defendants applying allegedly discriminatory eligibility requirements to screen out developmentally disabled individuals from community-based care in violation of Title II of the ADA, Complaint ¶¶ 213-14; (2) Defendants failing to provide notice of opportunities of community-based services in violation of Title XIX of the Social Security Act, *id.* ¶ 227; and (3) Defendants failing to appropriately screen and assess and place individuals admitted to nursing facilities under the PASRR program in violation of the NHRA, *id.* ¶¶ 230-32.[13] Presumably, Plaintiffs' desire for community placement and specialized services existed at the time they were admitted. Accordingly, the Plaintiffs were well aware of the basis of their claims when they were admitted, and any alleged failures by the Defendants were not concealed in any way. Accordingly, each of Plaintiffs' claims related to Defendants' alleged actions at the time that Plaintiffs were admitted to nursing facilities accrued at the time of admission.

Here, all but one of the Plaintiffs was placed in nursing facilities prior to December 20, 2008. Complaint ¶¶ 137, 146, 155, 164, 200. Thus, each of these Plaintiffs' claims regarding

[13] For purposes of this motion, Defendants do not challenge the timeliness of Plaintiffs' claims that their continued placement in nursing facilities violates the integration mandate of the ADA and the Rehabilitation Act, and that they are being currently denied community-based placement and specialized services in violation of the ADA and the Medicaid Act. Complaint ¶¶ 210-12, 215-26, 228-29.

Defendants' actions or omissions at the time of admission into the nursing facility is time-barred. *See Joseph S. v. Hogan*, 561 F. Supp. 2d 280, 312-17 (E.D.N.Y. 2008) (dismissing time-barred NHRA claims based on failure to conduct PASSR evaluations at time of admission). The *Joseph S.* case is instructive. In that case, the plaintiffs alleged that defendants violated the NHRA by failing to conduct the requisite PASRR evaluations and determinations. *Id.* at 315. The court held that those claims accrued at the time of admission to the nursing facility and that the "plaintiffs were not otherwise prevented from pursuing their NHRA claims that independent evaluations were not completed or that they were 'rubber-stamp' evaluations." *Id.* at 316. Furthermore, the court held, "[t]he organizational plaintiffs were or should have been aware at the time of any violations that defendants were not complying with the NHRA." *Id.* Therefore, the court dismissed plaintiffs' NHRA claims based on conduct prior to the limitations period. *Id.* at 317.

This Court should reach the same decision here. Specifically, the Court should dismiss Plaintiffs' claims that are premised on Defendants' alleged conduct at the time of admission to nursing facilities to the extent those claims are based on events occurring before December 20, 2008.

C. Plaintiffs Have Failed To State a Claim Against Governor Perry.

For the same reasons set out above under the "standing" arguments, *see supra* Part I.A.2, Plaintiffs have failed to state a cognizable claim against Governor Perry upon which relief can be granted. Even assuming Plaintiffs' claims of injury and deprivation to be true, they have not asserted claims establishing any action on the part of Governor Perry that caused, or could cause, their alleged deprivation, and the relief they seek cannot be effectuated through the Governor. Accordingly, Plaintiffs' claims against Governor Perry should be dismissed under Rule 12(b)(6) as well as under Rule 12(b)(1).

Furthermore, as a matter of law, Governor Perry is not a "public entity" within the meaning of Title II of the ADA. That statute provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities *of a public entity*, or be subjected to discrimination *by any such entity*." 42 U.S.C.A. § 12132 (emphasis added). To establish a claim under this statute, a plaintiff must show that: (1) he is a qualified individual within the meaning of the ADA; (2) he is being excluded from participating in, or being denied benefits of services, programs, or activities *for which the public entity is responsible*, or is otherwise being *discriminated against by the public entity*; and (3) that such exclusion, denial of benefits, or discrimination is because of his disability. *Melton v. Dallas Area Rapid Transit*, 391 F.3d 669, 669 (5th Cir. 2004). The ADA defines a "public entity" as any state or local government, or any department, agency, special purpose district, or other instrumentality of a state's government. 42 U.S.C.A. §§ 12131(1)(A) & (B) (2011). In *Nelson v. Schwarzenegger*, No. C 09-04937 JW (PR), 2010 WL 890028 (N.D. Cal. Mar. 8, 2010), the court considered whether the governor of California was a public entity under this definition. The plaintiff claimed that the governor violated the ADA by not providing adequate wheelchair accommodations in state prisons. The district court held that the governor was not a proper plaintiff in this case because he was not a "public entity" for purposes of the ADA. *Id*. at *2. Likewise, in Texas, the Governor does not qualify as a "public entity." Plaintiffs acknowledge as much in paragraph 211 of their Complaint, where they identify Defendants Suehs and Traylor as "public entities," but not the Governor. Complaint ¶ 211.[14] Moreover, even were the Governor to be considered a "public entity" for some purpose under the ADA, Plaintiffs' allegations show they are not being

[14] Plaintiffs wrongly generalize that "[t]he Defendants are all public entities subject to Title II of the ADA." Complaint ¶ 8.

excluded from participating in, or being denied benefits of services, programs, or activities *for which the Office of the Governor is responsible*, nor are they otherwise being *discriminated against by the Office of the Governor*.

Similarly, Governor Perry is not a proper defendant under the Rehabilitation Act because the Act applies to recipients of federal funds and the Governor neither receives nor distributes the Medicaid funds at issue in this lawsuit. Section 504 of the Rehab. Act, which is designed to eliminate discrimination on the basis of handicap in any program or activity receiving federal financial assistance, 29 U.S.C. § 794(a),[15] applies to "recipients" of such financial assistance, including "the entity of…State or local government that distributes such assistance and each such department or agency (and each other State or local government entity) to which the assistance is extended…." 29 U.S.C. § 794(b)(1)(B); 28 C.F.R. § 41.3(d) (defining "recipient");[16] *see also* 28 CFR § 41.51 (b)(1) (applying the prohibitions against discrimination on the basis of handicap to a "recipient" providing an aid, benefit, or service). Specifically, the Act applies to each recipient of federal financial assistance from the Department of Health and Human Services (*e.g.*, Medicaid funds) and to the program or activity that receives such assistance. 45 C.F.R. §§ 84.1, 84.2. None of this implicates the Governor of Texas, who neither receives Medicaid funds, nor distributes those funds. That responsibility falls to HHSC.

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[15] Section 5 of the Rehab. Act provides:

> No otherwise qualified individual with a disability in the United States, as defined in section 705(20) of this title, shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination *under any program or activity receiving Federal financial assistance*….

29 U.S.C. § 794(a) (emphasis added). *See also* 28 C.F.R. § 41.51(a) ("No qualified handicapped person, shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity that receives or benefits from federal financial assistance.").

[16] "Recipient" means any State or its political subdivision, any instrumentality of a State or its political subdivision, any public or private agency, institution, organization, or other entity, or any person to which Federal financial assistance is extended directly or through another recipient, including any successor, assignee, or transferee of a recipient, but excluding the ultimate beneficiary of the assistance. 28 C.F.R. § 41.3(d).

D. Plaintiffs Have No Right of Action Under Section 1983 To Redress Alleged Violations of the Medicaid Act.

Plaintiffs allege that Texas's Medicaid program departs from the criteria for federal reimbursement specified in the Medicaid Act. *See* Complaint at 50–54. But the Medicaid statute does not create a private right of action, and Plaintiffs cannot rely on 42 U.S.C. § 1983 because the statutory provisions of the Medicaid Act fail to establish an "unambiguously conferred right." *See Gonzaga Univ. v. Doe*, 536 U.S. 273, 823 (2002). Plaintiffs thus fail to state a claim on which relief can be granted.

1. Plaintiffs have no "rights" under the Medicaid Act.

Plaintiffs glibly assume that Section 1983 provides a cause of action for their Medicaid Act claims. But Section 1983 applies only when state officials violate a plaintiff's federal *rights*; it does not provide a remedy for a mere violation of federal law. *See Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 106 (1989) ("Section 1983 speaks in terms of 'rights, privileges, or immunities,' not violations of federal law."). And nothing short of an "unambiguously conferred right" can support a cause of action under Section 1983. *See Gonzaga*, 536 U.S. at 823.

The Medicaid statutes that Plaintiffs invoke do not confer *any* federal "rights" on the Plaintiffs, let alone an "unambiguously conferred" right. The Medicaid statutes impose legal obligations *only* on the Secretary of Health and Human Services, who may reimburse a State for its Medicaid expenses only if he concludes that the State's Medicaid program satisfies the criteria enumerated in federal statutes. 42 U.S.C. § 1396c explains how this Spending Clause legislation works:

> If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds–

> (1) that the plan has been so changed that it no longer complies with the provisions of section 1396a of this title; or
>
> (2) that in the administration of the plan there is a failure to comply substantially with any such provision;
>
> the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

42 U.S.C. § 1396c. Two features of this statutory scheme have particular relevance for this litigation. First, the statute *permits* States to establish Medicaid programs that will not qualify for federal funds. Even after accepting federal funds, 42 U.S.C. § 1396c recognizes the State's continuing prerogative to alter its Medicaid program. Any State that administers a program that deviates from the criteria for federal funding will run the risk that the Secretary will turn off the funding spigot, but this remains a lawful option for the State under the statute. Plaintiffs cannot possibly have a federally protected "right" to state Medicaid services when the statutes do nothing more than supply criteria for federal reimbursement.

Second, the statute withdraws funding only after *the Secretary* has determined that a State's Medicaid program fails to satisfy the criteria in the federal Medicaid statutes. The Secretary—not the federal courts—determines whether a State's Medicaid program is worthy of federal funds. The Secretary's decision is of course subject to judicial review under the arbitrary-and-capricious test. *See Walsh*, 538 U.S. at 675 (Scalia, J., concurring). But allowing Plaintiffs to pursue a Section 1983 action would empower the federal courts to conduct a *de novo* review of the State's Medicaid program, undermining the Administrative Procedure Act's efforts to protect the decision making autonomy of federal administrative officials.

We recognize that the Supreme Court has permitted at least one provision of the federal Medicaid Act to be enforced under Section 1983. *See Wilder v. Va. Hosp. Assoc.*, 496 U.S. 498 (1990) (allowing hospitals to sue under Section 1983 to enforce the "Boren Amendment," which requires participating States' Medicaid programs to reimburse providers at "reasonable and adequate" rates), *superseded by statute as discussed in Evergreen Presbyterian Ministries Inc. v. Hood*, 235 F.3d 908, 919 n.12 (5th Cir. 2000) (recognizing Congressional repeal of Boren Amendment to preclude private right of action). But *Gonzaga* limited *Wilder*'s holding to provisions in the Medicaid Act that "explicitly confer[] specific *monetary* entitlements upon the plaintiffs." 536 U.S. at 280 (emphasis added). It also noted that "[o]ur more recent decisions . . . have rejected attempts to infer enforceable rights from Spending Clause statutes." *Id.* at 281. And *Gonzaga* quoted with approval the following passage from *Pennhurst State Sch. & Hosp. v. Halderman*:

> In legislation enacted pursuant to the spending power, the typical remedy for state noncompliance with federally imposed conditions in *not a private cause of action for noncompliance but rather action by the Federal Government to terminate funds to the State*.

536 U.S. at 280 (emphasis added). After *Gonzaga*, *Wilder* cannot stand for the proposition that *any* provision of the Medicaid statute can be enforced via Section 1983. If anything, *Gonzaga* indicates that *Wilder* and *Wright v. Roanoke Redevelopment and Housing Authority*, 479 U.S. 418 (1987), represent narrow exceptions to a general principle that excludes spending legislation from judicial enforcement. *See Gonzaga*, 536 U.S. at 280 ("Since *Pennhurst*, only twice have we found spending legislation to give rise to enforceable rights.").

The Fifth Circuit has also recognized that *Gonzaga* limits the ability of Medicaid recipients to bring Section 1983 claims. In *Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697 (5th Cir. 2007), the court refused to allow Medicaid recipients to sue under Section 1983 to

enforce the "equal access" provisions of the Medicaid statute—even though an earlier-decided case had allowed such a claim to proceed. Wrote the Court:

> We may no longer, as we did in *Evergreen* [*Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908 (5th Cir. 2000)], resolve the ambiguities of *Blessing*, *Wilder*, and the Equal Access provision in favor of finding a Congressional intent to authorize Medicaid recipients to bring Equal Access provision suits under § 1983. We are forced by *Gonzaga* to abjure the notion that anything short of an unambiguously conferred private individual 'right,' rather than the broader or vaguer 'benefits' or 'interests,' may be enforced under § 1983.

To the extent that other Fifth Circuit decisions allow Medicaid recipients to sue to enforce provisions other than those that secure specific *monetary* entitlements to the party bringing suit, those rulings either pre-date *Gonzaga* or else rely on the now-overruled *Evergreen* decision. *See, e.g., S.D. v. Hood*, 391 F.3d 581, 605 (5th Cir. 2004) (relying on *Evergreen* to permit a Section 1983 lawsuit to enforce provisions in the Medicaid Act); *id*. at 604 (relying on pre-*Gonzaga* case law from other circuits); *Frazar v. Gilbert*, 300 F.3d 530 (5th Cir. 2002) (relying on *Evergreen*), *rev'd on other grounds*, *Frew v. Hawkins*, 540 U.S. 431 (2004).

If this Court concludes that either *S.D.* or some other decision of the Fifth Circuit compels it to permit Plaintiffs to seek judicial enforcement of some of their Medicaid Act claims, then we ask this Court to limit those rulings to the specific provisions of the Medicaid Act found to be judicially enforceable, and we wish to preserve for appeal our contentions that those decisions should be overruled. *See Blessing v. Freestone*, 520 U.S. 329, 349 (Scalia J., concurring, joined by Kennedy, J.) (questioning the notion that "§ 1983 *ever* authorizes the beneficiaries of a federal-state funding and spending agreement . . . to bring suit"). The Supreme Court's ruling in *Gonzaga* signals a shift away from the Court's earlier rulings allowing plaintiffs use of Section 1983 to enforce conditions in federal spending legislation.

Indeed, the Plaintiffs' Medicaid Act claims have not even alleged that the Defendants have violated federal law, let alone invaded their federally protected "rights." The Medicaid statutes allow Texas officials to cease complying with the statutory criteria for federal reimbursement at any moment. If this happens, the Secretary must decide whether to cut off federal funds. But no State, and no state official, violates federal law by administering a Medicaid program that fails to qualify for federal reimbursement. Nor do they violate federal law by provoking the Secretary to withhold federal funds. It is impossible for state officials to "violate" the Medicaid Act. Only the Secretary can violate the Act—by approving federal reimbursement for a state program that fails to satisfy the criteria listed in 42 U.S.C. § 1396a.

2. The *Wilder/Blessing* test.

Even applying the Supreme Court's pre-*Gonzaga* analysis to the Medicaid Act sections at issue here, there is no right of enforcement conferred upon Plaintiffs either by the Medicaid Act or Section 1983. *Blessing* applied a three-part test to determine whether legislation creates a private right of action under Section 1983: (1) Congress must have intended the provision in question to benefit the plaintiff, (2) the plaintiff must demonstrate that the right allegedly protected by the statutes is not so "vague and amorphous" that its enforcement would strain judicial competence, and (3) the statute must unambiguously impose a binding obligation on the States. *Blessing*, 520 U.S. at 340-41; *see S.D.*, 391 F.3d at 603. Basically, "the provision giving rise to the asserted right must be couched in mandatory rather than precatory terms." *Blessing*, 520 U.S. at 340-41. The burden rests on the plaintiff to show that the statute created an enforceable right. *Id*. In *Gonzaga,* the Supreme Court clarified that nothing short of an "unambiguously conferred *right*" can support a cause of action under Section 1983. 536 U.S. at

283.[17] Finally, even if a plaintiff demonstrates that a federal statute creates an individual right, there is only a rebuttable presumption that the right is enforceable under Section 1983, and dismissal is nevertheless proper if Congress "specifically foreclosed a remedy under § 1983." *Blessing*, 520 U.S. at 341. "Congress may do so expressly, by forbidding recourse to § 1983 in the statute itself, or impliedly, by creating a comprehensive enforcement scheme that is incompatible with individual enforcement under § 1983." *Id.*[18]

3. The NHRA creates no rights enforceable by Plaintiffs under Section 1983.

a. Summary of Plaintiffs' NHRA Claims.

In their Nursing Home Reform Act claims under 42 U.S.C. § 1983, Plaintiffs allege that Texas violates the NHRA and its implementing regulations, 42 C.F.R. § 483.100 *et seq.*, in several ways related to Texas's PASRR process[19] and its administration of specialized services.[20] Plaintiffs' claimed rights relating to specialized services include rights to: (1) a program that assesses whether a person needs specialized services and what those services should include, *id.* at ¶¶ 77, 236; (2) unlimited specialized services to all persons with developmental disabilities in nursing facilities, *id.* at ¶¶ 78, 79, 236; (3) the currently available, but limited specialized services, to persons with developmental disabilities in nursing facilities, *id.* at ¶¶ 87, 237; and (4) a program of specialized services that meets the federal active treatment standard required in an intermediate care facility, *id.* at ¶¶ 27(b), 72, 96, 238, 235. Plaintiffs' claimed rights relating to screening, assessment, and placement include rights to: (1) a screening program that timely and

[17] The Court noted that some courts had misinterpreted the first *Blessing* factor as permitting a Section 1983 action whenever the plaintiff fell within the general "zone of interests" protected by the statute at issue. It does not. *Id.* at 283.
[18] A "comprehensive remedial scheme is "a scheme that itself provid[es] for private actions and le[aves] no room for additional private remedies under Section 1983." *Wilder*, 496 U.S. at 522-23; *see also Middlesex County Sewerage Authority v. Nat. Sea Clammers Assoc.*, 453 U.S. 1, 14-15 (1981).
[19] *See* Complaint ¶¶ 53, 55, 74-76, 96, 231, 232.
[20] *See* Complaint ¶¶ 27(b), 72, 77-79, 87, 96, 235-38.

appropriately determines if nursing facility applicants have developmental disabilities, *id*. at ¶¶ 74, 96, 231; (2) a screening program that, prior to admission to a nursing facility**,** accurately determines if persons with developmental disabilities can be appropriately served in a less restrictive community setting, *id*. at ¶¶ 75, 231; (3) a screening program that appropriately screens all nursing facility applicants for developmental disabilities, and a right to those so identified being assessed to determine whether individuals who need nursing facility services can be served in another specialized facility, including ICFs-MR, for persons with developmental disabilities, *id*. at ¶¶ 76, 232; and (4) a program allowing persons residing in nursing facilities with developmental disabilities to transition into integrated community settings by providing residential assistance services and habilitation services, *id*. at ¶¶ 53, 55. Plaintiffs attempt to assert their claims under various provisions within three subparts of the NHRA—42 U.S.C. § 1396r(b), (e), and (f). Complaint ¶¶ 231, 232, 236, and 238.

However, neither the statutory provisions within the three subparts of the NHRA nor any of the NHRA's implementing regulations under which Plaintiffs bring their claims provides any express private right of action. *See generally* 42 U.S.C. § 1396r(b), (e), (f); 42 C.F.R. 483.112(b), .114(b)(2), .116(b)(2), .118, .120(a)(2) and (b), .128, .132(a), and .440. Therefore, in order for Plaintiffs to bring their NHRA claims under Section 1983, this Court must find that the NHRA confers a federal right to Plaintiffs. *See Gonzaga*, 536 U.S. at 274.[21] Applying the Fifth Circuit's four-factor test used in determining whether Congress intended a statute to confer a right, while remaining mindful of *Gonzaga*'s strong limitations on finding privately enforceable

[21] Moreover, while Plaintiffs also allege Defendants violate various implementing regulations of the Medicaid Act, these regulations cannot invoke a private right of action where the statute itself does not. "Language in a regulation may invoke a private right of action that Congress through statutory text created, but it may not create a right that Congress has not.... [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." *Alexander v. Sandoval*, 532 U.S. 275, 291 (2001). Therefore, the proper inquiry is whether the NHRA creates a privately enforceable right, not whether its implementing regulations do. *Casas v. American Airlines Inc.*, 304 F.3d 517, 520 (5th Cir. 2002).

rights under federal Spending Clause statutes, shows that Plaintiffs' cited provisions of the NHRA do not confer any enforceable rights. Here, just like the statute in *Gonzaga*, the NHRA lacks the necessary "unambiguous intent."

b. NHRA provisions are not intended to benefit Plaintiffs.

First, the context of the cited provisions, coupled with the lack of rights/benefits-granting language, evidences an intent to establish institutional policy and practice, not to benefit the Plaintiffs. *See Banks v. Dallas Housing Authority*, 271 F.3d 605, 609-10 (5th Cir. 2001) (conditions imposed for receipt of federal funds are focused on the regulated agency and not intended to benefit the Plaintiffs); *Alexander v. Sandoval*, 532 U.S. 289 (2001) (discussing that "statutes that focus on the person regulated rather than the individuals protected create 'no implication of an intention to confer rights on a particular class of persons.'") (citing *California v. Sierra Club*, 451 U.S. 287, 294 (1981)). The NHRA is entitled "Requirements for nursing facilities." 42 U.S.C. § 1396r. The subparts of this statute set forth the necessary requirements a nursing facility must meet in providing services and activities for residents in order to maintain funding and certification, 42 U.S.C. § 1396r(b)-(d), the provisions that a State must include in its state plan for administering federal funds to nursing facilities, 42 U.S.C. 1396r(e), and the parameters of the Secretary's oversight authority and the Secretary and State's enforcement mechanisms to ensure nursing facilities' compliance with the NHRA, 42 U.S.C.§ 1369r(f)-(h). "The [NHRA] does not have an 'unmistakable focus' on the rights of individual nursing home residents, but instead focuses on requirements that the nursing homes must meet in order to become and remain eligible for funding." *Duncan v. Johnson-Mathers Health Care, Inc.*, Civ. A. No. 5:09-CV-00417-KKC, 2010 WL 3000718, at *7-8 (E.D. Ky. July 28, 2010) (*citing Sandoval*, 532 U.S. at 289). Both the text and structure of the NHRA show that the focus of this

statute is the "nursing homes—not the nursing home residents." *Id*. at *8; *see* 42 U.S.C. § 1369r(b), (c), and (d) (focusing on what the nursing facility must do in return for federal funds); (e) (directing states to establish an appeals process for individuals adversely affected by determinations made as part of their pre-admission screening or resident review; (g) (the "survey and certification" process for nursing facilities provides for both the Secretary and the State to investigate and monitor nursing facilities for compliance with subparts (b), (c), and (d) of the NHRA); (h) (providing for an "enforcement" mechanism authorizing action by the State or the Secretary to deny a nursing facility payments, assess civil penalties, and appoint temporary management to improve or close a facility). For these reasons, Plaintiffs' cited provisions of the NHRA do not evidence Congressional intent to benefit Plaintiffs. Instead, the intent is to establish institutional policy and practice.

c. The NHRA imposes no binding obligations on Defendants.

While Plaintiffs' cited NHRA sections do contain unambiguous binding obligations on the parties/entities to whom they are directed, not all of the cited sections are unambiguous obligations on the State. For example, Section 1396r(b)(3)(F)(i)-(ii), to which Plaintiffs cite as the basis for their claimed rights related to screening, assessment, and placement and to specialized services, is directed to nursing facilities and sets out which new residents such a facility can admit.[22] Complaint at ¶¶ 230, 236; *see* 42 U.S.C. § 1369r(b)(3)(F). This section actually puts an unambiguous binding obligation on the *nursing facilities* to not admit residents before certain determinations are made by the state mental retardation or developmental disability authority. 42 U.S.C. § 1396r(b)(3)(F). This is not the same as an unambiguous

[22] Plaintiffs allege that Defendants violated 42 U.S.C. § 1396r(b)(3)(F)(i), which dictates to nursing facilities which new residents with *mental illness* can be admitted to a nursing facility. Defendants construe each citation in the NHRA section of Plaintiffs' Complaint referencing § 1396r(b)(3)(F)(i) to be intended to reference § 1396r(b)(3)(F)(ii) which is the section that dictates to nursing facilities which new residents with *mental retardation* can be admitted to a nursing facility.

binding obligation on the State to make such determinations. Further, precluding States from delegating the making of the specified determinations to nursing facilities also falls short of an unambiguous binding obligation to provide the rights Plaintiffs claim. *Id*.

Section 1396r(e), which deals with "State requirements relating to nursing facility requirements," specifies that "[a]s a condition of approval of [a State's] plan . . . a State must provide" certain enumerated specifications in its state plan for the Secretary's review. 42 U.S.C. § 1369r(e)(7) (requiring state plan to include requirements for preadmission screening and resident review). This Section does not put an unambiguous obligation upon the State to ensure Plaintiffs' claimed rights related to screening, assessment, and placement and specialized services. Instead, the statute's text puts an unambiguous obligation on the State to provide certain specifications in its state plan. Specifically, it dictates that "[a]s a condition of approval of [a State's] plan . . . a State must provide" certain enumerated specifications related to preadmission screening and resident reviews in its state plan for the Secretary's review. *See* 42 U.S.C. § 1396r(e)(7). This subpart of the NHRA obligates the state to *develop* a plan. *Id*. The plan is then subject to the Secretary's approval. *Id*. In this way, Section 1396r(e) does not unambiguously place on Defendants the obligations alleged by the Plaintiffs.

Section 1396r(f) sets forth the "[r]esponsibilities *of the Secretary* relating to nursing facility requirements." 42 U.S.C. § 1396r(f) (emphasis added). Subsection (f)(8) directs *the Secretary* to develop minimum criteria for states to use in making PASRR determinations and in permitting persons adversely affected to appeal such determinations, and further directs *the Secretary* to "monitor" states through case reviews for their compliance with NHRA. 42 U.S.C. § 1396r(f)(8). Section 1396r(f)(8) (related to specialized services) actually puts an unambiguous obligation on the *Secretary* to review states for compliance and to establish minimum criteria for

states to use in (a) making determinations related to preadmission screening and resident reviews; and (b) in permitting individuals adversely affected to appeal such determinations. *See* 42 U.S.C. § 1396r(f)(8); *see* Complaint at ¶ 236. This provision does not unambiguously impose a binding obligation on the State because this statutory requirement is solely directed to the Secretary.

d. NHRA's remedial scheme precludes individual remedies.

Fourth, the NHRA contains sufficiently comprehensive remedial devices related to preadmission screening, resident reviews, and specialized services evidencing an intent to preclude remedies for individuals under Section 1983. The statutory text's comprehensive remedial devices contemplate different enforcement mechanisms by different parties. Some NHRA provisions are directed at actions by individuals. For example, Section 1396r(e)(7)(F) requires that each state "as a condition of approval of its plan . . . must have in effect an appeals process for individuals adversely affected by" preadmission screening and resident reviews. 42 U.S.C. § 1396r(e)(7)(F); *see also* 42 C.F.R. § 483.204 (requiring states to provide an appeal process to nursing facility residents adversely affected by preadmission screening and resident reviews).[23] Other NHRA comprehensive remedial devices are directed to enforcement actions against nursing facilities brought by either the Secretary and/or Texas.[24] Moreover, the NHRA

[23] In Texas, the appeals process for preadmission screening and resident reviews is set out in the Texas Health and Human Services Commission's fair hearing rules. *See* 1 TAC §§ 357.3(a) (fair hearing rules govern Medicaid-funded services), (b)(1)(D) (clients of Medicaid funded services are entitled to appeal adverse determinations regarding preadmission screening and resident reviews), (b)(2)(B) (the client has within 90 days of the later of the date on the notice of agency action, or effective date of agency action to appeal a determination); 357.5(c)(3)(D) (fair hearing officer issues a final order), 357.703 (a)-(c) (providing that client may file a motion for rehearing of fair hearing officer's final order and then seek judicial review of that final determination); *see also see also* TEX. GOV'T CODE ANN. § 531.019 (sets out administrative remedies and right to judicial review for a party who is aggrieved by a final order of a fair hearing officer).

[24] *See* 42 U.S.C. § 1396r(h)(1)-(2) (setting forth specified enforcement actions for a state to remedy a nursing facility's deficiencies), (3) (setting forth the Secretary's authority and specified enforcement actions to remedy a nursing facility's deficiencies), (4) (setting forth that nursing facilities must be found in "substantial compliance" before a denial of payment finding shall be terminated), (5) (setting forth grounds for a state or the Secretary to

specifically provides that the remedial devices available to the State or the Secretary are not limited to the enumerated devices. *Id*. at § 1369r(h)(8). The NHRA also states that the remedies provided under subsection (h) are "in addition to those otherwise available under State or Federal law and shall not be construed as limiting such other remedies." *Id*. While federal and state statutory remedies are not foreclosed to the State and the Secretary, the NHRA only notes that individuals may pursue their common law claims against nursing facilities. 42 U.S.C. § 1369r(h)(8). These different NHRA provisions, directed at different parties and for different purposes, together, evidence Congress's intent to preclude remedies for individuals under Section 1983.

For all of these reasons, the NHRA confers no federal right to Plaintiffs and their claims should be dismissed under Rule 12(b)(6). A number of courts that have considered whether the NHRA confers an enforceable private right have reached the same conclusion—there is no such right.[25] This issue has not been determined in the Fifth Circuit.

4. Sections 1396a(a)(8) and 1396a(a)(10(B) create no rights enforceable under Section 1983.

Section 1396a(a) of the Medicaid Act sets out the requirements for a State Plan for states seeking Medicaid funds. Certainly, the text of § 1396a(a) does not explicitly and unambiguously grant a private right. *Gonzaga*, 536 U.S. at 282, 283. Rather, the requirements for the contents of the State Plan simply establish criteria the State may choose to satisfy in order to participate in the cost-sharing program. They provide the outline by which the Secretary fulfills his duty under

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immediately terminate a nursing facility's participation), (6) (setting forth special rules where a state and the Secretary do not agree on a nursing facility's compliance status).

[25] *See Sparr v. Berks County*, No. CIV. A. 02-2576, 2002 WL 1608243 (E.D. Pa. July 18, 2002) (post-*Gonzaga* decision finding no private right of action under Section 1396r); *Duncan v. Johnson-Mathers Health Care, Inc.*, Civ. A. No. 5:09-CV-00417-KKC (E.D. Ky. July 28, 2010) (post-*Gonzaga* decision finding no privately enforceable right under Section 1396r); *Prince v. Dicker*, 29 Fed. Appx. 52 (2nd Cir. 2002) (finding no privately enforceable right under Section 1396r); *Baum v. Northern Dutchess Hosp.*, --- F.Supp.2d ---, 2011 WL 240196 (N.D.N.Y. January 24, 2011) (post-*Gonzaga* decision finding no privately enforceable right under Section 1396r).

the Act to approve the States' participation. Thus, the requirements of a State Plan create no rights for a Medicaid beneficiary, and all of Plaintiffs' claims under these sections should be dismissed. See Complaint ¶¶ 225-229.

The Fifth Circuit has not ruled on the question whether Sections 1396a(a)(8) or 1396a(a)(10(B) create privately-enforceable rights. Its ruling in *S.D. v. Hood*—that Section 1396a(a)(10)(A) creates a right to enforce the provision of early and periodic screening, diagnostic, and treatment services (EPSDT") for eligible individuals under the age of twenty-one—is not controlling here because *S.D.* was decided in reliance pre-*Gonzaga* case law from other circuits and the *Evergreen* decision, which was later repudiated in *Equal Access*, 509 F.3d at 704. To the extent this Court would rely on *S.D.*, Defendants wish to preserve for appeal their contention that *S.D.* must be overturned in light of *Gonzaga*.

5. No provision of the Medicaid Act confers a right to force provision of waiver services under Sections 1396a(a)(8), 1396a (a)(10), or 1396n(c)(2).

Even were Sections 1396a(a)(8), 1396a (a)(10), or 1396n(c)(2) to confer enforceable rights to Plaintiffs with regard to the provision of specialized services in nursing facilities, they confer no such rights in connection with the provision of community-based waiver services.

a. There is no § 1396a(a)(8) entitlement to reasonable promptness in delivery of waiver services where the waiver cap is met.

It is settled that the Medicaid Act provides no right to enforce Section 1396a(a)(8) with regard to Plaintiffs' claim that Texas is limiting its waiver programs that provide community-based services and supports for persons with developmental disabilities, and therefore those waiver services and supports are not being provided with reasonable promptness. *See* Complaint ¶ 226. In a 2003 decision in a case brought in the Western District of Texas, Austin Division, in which the plaintiffs claimed—as do the Plaintiffs here—that Texas violated their rights under §

1396a(a)(8) for failing to deliver waiver services in Texas's HCS (and CLASS) waiver programs with "reasonable promptness" in light of the wait list for such services, the court ruled that Congress did not intend to create in 42 U.S.C. § 1396a(a)(8) an individual right enforceable under § 1983 for individuals who apply for Medicaid waiver services after the waiver ceiling has been met or surpassed. *McCarthy, ex rel. Travis v. Hawkins*, Cause No. A-03-CA-231-SS, United States District Court for the Western District of Texas, Austin Div., Dkt. #11, pp. 14–16 (unpublished), attached hereto as Exh. 1. The court correctly recognized that "the cap on the number of waiver recipients functions as 'a constraint on eligibility,' and '[i]ndividuals who apply after the cap has been reached are not eligible.'" *Id*. at p. 15 (quoting *Boulet v. Celucci*, 107 F.Supp.2d 61, 76-80 (D.Mass. 2000)). The court found that the plaintiffs therefore failed to satisfy the first prong of *Blessing*, in that they were not among the class of individuals Congress intended to benefit; therefore, they had no entitlement to reasonable promptness in the delivery of waiver services, and could not enforce Section 1396a(a)(8). *Id*. The same reasoning applies here.

Moreover, courts that considered the effect of a waiver cap on the enforceability of the Medicaid Act have consistently taken the approach that once the waiver cap is reached, individuals seeking waiver services are not eligible for such services, and therefore have asserted no right enforceable under the Act. *See, e.g.*, *Boulet*, 107 F.Supp.2d at 76-80 ("As a practical matter, the statute can best be read to mandate that, once a state chooses to implement a waiver program and chooses the eligibility requirements, a cap is simply another eligibility requirement for that program . . . . Individuals who apply after the cap has been reached are not eligible, or alternatively, the waiver services are not "feasible" for them until the cap has risen to include them.); *see Bryson v. Shumway*, 308 F.3d 79, 88 (1st Cir. 2002) ("[t]hose patients who are on the

waiting list and for whom slots are available are, we think, 'eligible' under the statute such that they are entitled to reasonable promptness"). The Fifth Circuit has not ruled to the contrary.

b. There is no § 1396a(a)(10) comparability requirement for delivery of waiver services.

Section 1396a(a)(10)(B) states that services provided under the State Plan be comparable in amount, duration and scope for all groups covered under the plan. However, this requirement applies only to services provided under the State Plan, and does not apply to waiver programs such as HCS. 42 U.S.C. § 1396a. In fact, the requirements set out in § 1396a(a)(10) are expressly waived under the provisions of the Act relating to waiver programs, which are found in 42 U.S.C. § 1396n(c). 42 U.S.C. § 1396n(c)(3). Therefore, even assuming, *arguendo*, that Congress intended the provisions of § 1396a(a)(10) to benefit recipients of Medicaid services provided under the State Plan, it is clear that Congress did not intend § 1396a(a)(10) to apply to recipients or applicants for services under a waiver program. Therefore, Plaintiffs cannot satisfy the first element of the *Blessing* test—that the statute be intended to benefit Plaintiffs. Furthermore, Plaintiffs fail the third element of the *Blessing* test because they cannot show that § 1396a(a)(10) "unambiguously imposes a binding obligation" on Texas with regard to administration of the Medicaid waiver programs. *Blessing*, 520 U.S. at 340-41.

c. Sections 1396n(c)(2)(B) and (C) create no rights enforceable under § 1983.

Sections 1396n(c)(2)(B) and (C) of the Medicaid Act provide that the Secretary shall not grant a waiver under the Medicaid Act unless the State seeking the waiver provides the Secretary with certain assurances. Under *Gonzaga*, the assurances provisions of § 1396n(c)(2), including the "freedom of choice" provision of § 1396n(c)(2)(C), create no privately enforceable rights for waiver applicants. Certainly, the text of § 1396n(c)(2) is not phrased "in terms of the persons

benefitted." *Gonzaga*, 536 U.S. at 283. Rather, § 1396n(c) and the implementing regulations set forth the guidelines by which the Secretary determines whether to grant or deny a state's request for waiver. § 1396n(c)(2)(B), (C); 42 CFR §441.302. The result of a failure to comply with § 1396n(c)(2)(B) and (C) is that a state's request for a waiver may be denied, or a waiver already granted may be terminated. § 1396n(c)(2)(B), (C); 42 CFR §441.302.

Nor does § 1396n(c) explicitly and unambiguously grant a private right to the "particular class of persons" that Plaintiffs purport to represent. *Id*., 536 U.S. at 282, 283. The literal text of § 1396n(c) unquestionably focuses on the duties of the Secretary and of the states—"the person regulated"—rather than "the individuals protected," and thus demonstrates no intent to confer rights on the beneficiaries of the Act. *Id*. at 2277 (citing *Sandoval*, 532 U.S. 289). For example, Section 1396n(c)(2)(C) requires only that states seeking a Medicaid waiver assure the Secretary of Health and Human Services that eligible individuals will be informed of the "feasible alternatives" to ICFs-MR " if available under the waiver." 42 U.S.C. § 1396n(c)(2)(C). Based on the plain language of the statute, no requirement is imposed if there are no waiver services available at the time. Thus, when one of Texas's waiver programs, such as HCS, has reached its enrollment limit, the services under the program are not "available" and do not constitute a "feasible" alternative. Therefore, they need not be offered or provided. Section § 1396n(c)(2)(C) thus imposes no "binding obligation" on Texas when there are no openings for the waiver services, and Plaintiffs cannot satisfy the third prong of the *Blessing* test.

The district court in *McCarthy* (discussed above) agreed with this view, ruling that 42 U.S.C. § 1396n(c)(2)(C) did not create an individual right enforceable under Section 1983 for individuals who apply for Medicaid waiver services after the waiver ceiling has been met or surpassed. *McCarthy,* Cause No. A-03-CA-231-SS, Dkt. #11, pp. 12-14; *see* Exh. 1. Similarly,

another district court has ruled that "the freedom of choice provisions do not contain the unambiguous rights-creating language of *Gonzaga*, and consequently, there is no private right of action based on these provisions." *M.A.C. v. Betit*, 284 F.Supp.2d 1298, 1307 (D. Utah 2003). So should the Court rule here.

E. Even if the Medicaid Act Creates Rights Enforceable by Plaintiffs, Plaintiffs Have Failed to State a Cognizable Claim.

In the alternative, should this Court find that the Medicaid Act creates rights enforceable by Plaintiffs under Section 1983, Plaintiffs have failed to state a cognizable claim under the NHRA provisions, 42 U.S.C. § 1396a(a)(8) (the "reasonable promptness" provision); § 1396n(c)(2)(B) and (C) (the "freedom of choice" provision); and § 1396a(a)(10)(B)(i) and (ii) (the "comparability" provision). These claims should be dismissed.

1. Plaintiffs state no cognizable NHRA claim.

This Court should dismiss Plaintiffs' claim that Defendants do not provide specialized services in a manner that meets the federal active treatment standard required in an ICF-MR as measured by 42 C.F.R. § 483.440(a)-(f). *See* Complaint at ¶¶ 27(b), 72, 96, 235, 238. While Defendants do not dispute that the implementing regulations of the NHRA require specialized services to provide active treatment, active treatment in a nursing facility is measured by 42 C.F.R. § 483.440(a)(1) and not the other subparts of this regulation. Accordingly, this Court should dismiss Plaintiffs' NHRA claim related to specialized services, to the extent this claim attempts to require that Defendants' delivery of specialized services to nursing facility residents be measured by ***all*** of the same standards applicable to determining what constitutes active treatment in an ICF-MR, for failure to state a claim for which relief can be granted.

Specialized services are defined differently for different categories of residents. *See* 42 C.F.R. § 483.120(a). For nursing home residents with mental retardation, specialized services

means "the services specified by the State which, combined with services provided by the [nursing facility] or other service providers, result in treatment which meets the requirements of § 483.440(a)(1)." *Id*. at § 483.120 (a)(2). As such, this regulation related to nursing facilities imports a certain and limited portion of the regulations that are related to ICFs-MR. In this way, Section 483.440(a)(1), and no other subpart of Section 483.440, constitutes the yardstick by which the provision of specialized services in a nursing facility can be measured. Section 483.440(a)(1) provides that

> Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health service, and related services described in this subpart, that is directed toward--
>
> (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and
>
> (ii) The prevention or deceleration of regression or loss of current optimal functional status.

42 C.F.R. § 483.440(a)(1) (2010). Importantly, the nursing facility regulation at issue does not import the entirety of the provisions used to measure delivery of specialized services to residents in ICFs-MR. *Compare* 42 C.F.R. § 483.120(a) (only importing one subpart of the ICF-MR regulation) *with* 42 C.F.R. § 483.440 (containing several subparts that relate to specialized services in an ICF-MR).

Moreover, the United States Court of Appeals for the First Circuit's decision regarding specialized services in nursing facilities as compared to active treatment in ICFs-MR—the only circuit to have considered whether active treatment is required in NFs—is instructive. In *Rolland v. Romney*, the appellate court affirmed the district court's ruling that the defendant state had to comply with the active treatment standard, set out at 42 C.F.R. § 483.440(a)(1), applicable to ICF-MRs in its providing specialized services to mentally retarded NF residents. 318 F.3d 42,

57 (1st Cir. 2003), affirming *Rolland v. Cellucci*, 198 F.Supp.2d 25, 46 (D. Mass. 2002) (district court cited only 42 C.F.R. § 483.440(a)(1) and not subparts (b)-(f) in setting forth standard to be met in NF). However, the appellate court clarified that the regulations do not "impose on states, when serving mentally retarded nursing home residents, the considerable onus of complying with *every* obligation placed on them in their broader role in *ICF-MR*s." *Id*. (emphasis added).

Accordingly, to the extent Plaintiffs attempt to assert a claim for violation of the NHRA based on Defendants' alleged failure to provide specialized services constituting active treatment as measured by 42 C.F.R. § 483.440(a)-(f), Plaintiffs fail to state a claim for which relief can be granted because, in the NF setting, Defendants are not required to comply with all of the provisions of Plaintiffs' cited regulations. Instead, Defendants must only provide specialized services, as measured by Section 483.440(a)(1).

2. Plaintiffs state no cognizable § 1396a(a)(8) claim.

Plaintiffs claim that Defendants' limits on community-based services and supports—including residential, habilitation and other specialized services provided in the community through the state's waiver programs—violate § 1396a(a)(8) of the Medicaid Act. Complaint at ¶ 226. The "reasonable promptness" provision of the Medicaid Act requires that state Medicaid plans "provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals."

Prior to the 2010 amendments made by the Patient Protection and Affordable Care Act ("PRACA"),[26] "medical assistance," as defined in the Act, meant "payment of part or all of the cost" of certain specified services. 42 U.S.C. § 1396d(a). Under this definition, the Fifth Circuit

[26] Pub. L. No. 111-148, 124 Stat. 119 (March 23, 2010), as amended by Health Care and Education Reconciliation Act of 2010, Pub.L. No. 111-152, 124 Stat. 1029 (March 30, 2010) (collectively ("PPACA").

had ruled that "medical assistance" refers to payment, not to the actual delivery of medical services, and therefore plaintiff beneficiaries who claimed failure to deliver services promptly failed to state an actionable claim. *Equal Access for El Paso, Inc. v. Hawkins*, 562 F.3d 724, 727-29 (5th Cir. 2009).[27] The 2010 amendments changed the definition of "medical assistance" to include "payment of part or all of the cost of … care and services *or the care and services themselves, or both*." 42 U.S.C. § 1396d(a) (2010) (amending 42 U.S.C. § 1396d(a) (2008)) (emphasis added). No courts have yet specifically addressed the effect of the 2010 amendments on the issue of whether Section 1396a(a)(8) confers enforceable rights on Medicaid recipients.

However, a federal district court in Florida has ruled that the 2010 amendments to the Medicaid Act are invalid. *See Florida et al. v. U.S. Dept. of Health and Human Services*, --- F. Supp. 2d ---, 2011 WL 285683. The district court nullified these amendments because they were enacted as part of a non-severable statute that included an unconstitutional provision requiring Americans to purchase health insurance. This includes any of the 2010 amendments that affect sections of the Medicaid Act under which Plaintiffs bring their claims in this lawsuit—namely, §§ 1396a(8) and (10), § 1396n, and § 1396r (and its subparts), as well as provisions implicated by those claims, such as § 1396d (definitions).

The Florida court's ruling is not binding in this litigation because Plaintiffs were not parties to those proceedings. The State of Texas, however, is a party to the Florida litigation and agrees with the district court's reasoning. Fortunately, this Court need not reach these constitutional questions if it concludes that the plaintiffs' Medicaid Act claims are not judicially enforceable. But if this Court concludes that Plaintiffs have asserted a valid cause of action for their Medicaid Act claims, then Defendants assert in defense that the amended provisions of the

[27] The Fifth Circuit's ruling in *Equal Access* was consistent with rulings on § 1396a(a)(8) in the Sixth, Seventh, and Tenth Circuits. *Id*. at 728.

Medicaid Act under which Plaintiffs assert their claims via 42 U.S.C. § 1983 in this lawsuit are invalid as non-severable from the unconstitutional individual-mandate provisions in PRACA.

3. Plaintiffs state no cognizable § 1396n(c)(2)(B) or (C) claim.

Even assuming that Plaintiffs have a right to sue under Section 1983 to enforce § 1396n(c)(2)(B) and (C), Plaintiffs' claims under these sections are not cognizable and should be dismissed in their entirety under Rule 12(b)(6).

First, there is no doubt that the Court must dismiss the claims based on Defendants' purported failure to take actions that are not even required under these sections of the Medicaid Act. Thus, the dismissal must include Plaintiffs' claims that Defendants violated § 1396n(c)(2)(B) and (C) when they allegedly failed to provide persons with developmental disabilities residing in nursing facilities with—

- equal opportunities to apply for and access medically necessary community-based services;
- an assessment of their eligibility for such services; and
- a meaningful choice between "institutional" and community-based services.

Complaint ¶ 227. The plain wording of Sections 1396n(c)(2)(B) and (C) quite simply contain no such requirements.[28]

[28] Sections 1396n(c)(2)(A) and (B) of the Medicaid Act prohibit the Secretary of Health and Human Services from granting a waiver unless the state provides assurances that—

> (B) the State will provide, with respect to individuals who—
> (i) are entitled to medical assistance for inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded under the State plan,
> (ii) may require such services, and
> (iii) may be eligible for such home or community-based care under such waiver,
> *for an evaluation of the need for inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded*;
> (C) such individuals who are determined to be likely to require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded *are informed of the feasible alternatives, if available under the waiver*, at the choice of such individuals, to the provision of inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded….

42 U.S.C. § 1396n(c)(2) (emphasis added).

Second, subpart B prohibits the Secretary of HHS from granting the state a Medicaid waiver unless the state assures the Secretary that persons who are entitled to in-patient hospital services, NF services, and services in an ICF-MR, who may require such services, and who may be eligible for home or community-based care under the waiver program, be given an evaluation of the need *for in-patient hospital services, NF services, or services in an* ICF-MR. It does *not* require an assessment of eligibility for waiver services, as Plaintiffs assert. Complaint ¶227, *see also* ¶¶ 143, 161, 174.

Subpart C is an informational requirement. *See Bertrand ex rel. Bertrand v. Maram*, 495 F.3d 452, 459 (7th Cir. 2007) (subsection C "does not make any particular option 'available' to anyone. It just requires the provision of information about options that are available."); *Grant*, 324 F.3d at 388. Literally, it requires only that states assure the Secretary that persons determined to be likely to require the level of care provided in a hospital, NF, or ICF-MR "are informed of the feasible alternatives" to such hospital, NF, or ICF-MR services, "*if available under the waiver*." 42 U.S.C. § 1396n(c)(2)(C); see also, 42 C.F.R. § 441.302. It does not require "equal opportunities to apply for and access medically necessary community-based services," or "a meaningful choice between 'institutional' and community-based services." *See Bertand, supra*. The individual Plaintiffs have alleged that they failed to be informed of feasible alternatives to NF or ICFs-MR available to them under a Texas waiver. *See, e.g.*, Complaint ¶¶ 143, 161, 174 (complaining of no assessment for community placement). To the contrary, they admit that the HCS waiver—which they prefer because it includes a residential component—has a wait list of approximately 45,756. Complaint ¶ 57. It is well established that when waiver caps have already been met (as here with the HCS waiver), such waiver services are no longer "feasible" or "available." *See, e.g., Makin v. Hawaii*, 114 F.Supp.2d 1017, 1027-28 (D. Haw.

1999). Therefore, Plaintiffs have failed to state a § 1396n(c)(2)(B) or (C) claim for which relief may be granted.

4. Plaintiffs state no cognizable claim under 42 U.S.C. §§ 1396a(a)(10)(B)(i) and (ii).

Plaintiffs assert that § 1396a(a)(10)(B) requires that persons with developmental disabilities residing in nursing facilities be provided the same services as those residing in ICFs-MR. Complaint ¶ 229. Plaintiffs' claim fails to state a cognizable claim for two reasons: first, the Act contains no such requirement, and Plaintiffs' interpretation would lead to absurd results not contemplated by the Act; and second, Plaintiffs do not allege facts showing they are being deprived of ICF-MR services.

The purpose of the comparability provision of § 1396a(a)(10)(B) is "to ensure that recipients who qualify as categorically needy under one form of federal assistance should receive the same 'amount, duration, or scope' of assistance as those who qualify under another federal assistance program." *Greenstein by Horowitz v. Bane*, 833 F.Supp 1054, 1073 (S.D. N.Y. 1993) (referring to legislative history of the Act). Section 1396a(a)(10)(B) guarantees that if a state elects to provide Medicaid to the medically needy, it must also provide it to the categorically needy and that it may not provide more assistance to the former group than to the latter. *See id*. at 39. Moreover, states may not provide benefits to some categorically needy individuals but not to others. 42 U.S.C. § 1396a(a)(10)(B)(i); *Rodriguez v. City of New York*, 197 F.3d 611, 615 (2d Cir. 1999) (citing *Schweiker v. Hogan*, 457 U.S. 569, 573 n. 6 (1982) (stating that Section 1396a(a)(10)(B) ensures "that the medical assistance afforded to an individual who qualified under any categorical assistance program could not be different from that afforded to an individual who qualified under any other program")). "In other words, the amount, duration, and scope of medical assistance provided to an individual who qualified to receive assistance for the

aged could not be different from the amount, duration, and scope of benefits provided to an individual who qualified to receive assistance for the blind." *Schweiker, id*. Thus, the comparison is between and among *financial eligibility categories*. That is, the amount, duration, and scope of available services cannot differ among Medicaid recipients based on how they became eligible for Medicaid. Certainly, nothing in Section 1396a(a)(10)(B) requires that *all* of the specific services defined in Section 1396d(a) must be provided to every developmentally disabled person receiving services in a nursing facility.[29]

Again, Section 1396a(a)(10)(A), by reference to Section 1396d(a), establishes the minimum care and services required for categorically needy recipients.[30] The services required for the categorically needy are also set out in the regulations at 42 C.F.R. § 440.210.[31] In both the statute and the regulations, nursing facility services and ICF-MR services are listed as completely separate services. *Compare*, 42 U.S.C. § 1396d(a)(4) and 42 C.F.R. § 440.40 (nursing facility services) *with* 42 U.S.C. § 1396d(a)(15) and 42 C.F.R. § 440.150 (ICF-MR services). Furthermore, NF services are required, but ICF-MR services are optional. *See* 42 U.S.C. § 1396a(a)(10)(A); *see* 42 C.F.R. § 440.225 (governing optional services). The requirements for nursing facilities are completely separate from the requirements for ICFs-MR.

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[29] Nor is there any such requirement in the implementing regulation, 42 C.F. R. §440.240, which provides:

> Except as limited in § 440.250-
> (a) The plan must provide that the services available to any categorically needy recipient under the plan are not less in amount, duration, and scope than those services available to a medically needy recipient; and
> (b) The plan must provide that the services available to any individual in the following groups are equal in amount, duration, and scope for all recipients within the group:
> (1) The categorically needy.
> (2) A covered medically needy group.

42 C.F.R. § 440.240.

[30] Section 1396a(a)(10)(A) requires state plans to provide for "making medical assistance available, including at least the care and services listed" in § 1396d(a)(1)-(5), (17), (21), and (28).

[31] 42 C.F.R. § 440.210 states that a state plan must specify that, at a minimum, categorically needy recipients are furnished the services defined in 42 C.F.R. §§ 440.10 - .50, .70, and, if authorized to practice under state law, §§ 440.165 and .166. With the exception of home health services, these are the same services referenced in 42 U.S.C. § 1396a(10)(B) as the minimum required services for participating states. .

Compare, 42 C.F.R. § 483.1–483.138 (requirements for nursing facilities, including PASRR) *with* 42 C.F.R. § 483.400–483.480. In fact, ICFs-MR are specifically excluded from the definition of NFs. 42 C.F.R. § 483.5. Significantly, neither specialized services nor active treatment are listed or discussed as independent services in Part 440 of the C.F.R. Plaintiffs' claim, then, has no basis in law, and must be dismissed.

Moreover, Plaintiffs' novel view would produce an absurd result. It would mean that every Medicaid recipient in any program and in any type of facility must be provided the same care and services as every other recipient. Were that what Congress or the Secretary intended, then there would be no need for the various specifically- and carefully-defined programs and services. In particular, there would be no need for the specific PASRR requirements for nursing facilities set out in 42 C.F.R. §§ 483.100–.483.138. Finally, Plaintiffs make no claim that they are being denied ICF-MR services in the same amount, duration, or scope as other Medicaid recipients receiving ICF-MR services. They have failed to state a claim under § 1396a(a)(10)(B) for which relief can be granted, and their claims should be dismissed.

CONCLUSION

For the foregoing reasons, Plaintiffs' claims as against Governor Perry should be dismissed in their entirety on the basis of standing, sovereign immunity, and failure to state a claim. Furthermore, all of Plaintiffs' claims under the Medicaid Act and the NHRA should be dismissed on numerous grounds, including standing, limitations, no private right of action, and failure to state a claim. Finally, Plaintiffs' claim under Title II of the ADA regarding eligibility criteria is time-barred and should be dismissed. Defendants, therefore, respectfully request that this Court grant this motion, dismiss these claims, and grant such further relief as is just and proper.

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