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' PARTIAL MOTION TO DISMISS
PLAINTIFFS' AMENDED 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"), move this Court pursuant to Rules 12(b)(1) and 12(b)(6) to dismiss Governor Perry and all of Plaintiffs' Medicaid Act claims, for the reasons stated herein.

INTRODUCTION

Plaintiffs filed their original Complaint on December 20, 2010. Dkt. # 1. On March 8, 2011, Defendants filed a motion to dismiss. Dkt. ## 30, 32. Plaintiffs responded on April 18, Dkt. # 40, and Defendants replied on June 1, 2011. Dkt. # 51. On October 4, 2011, Plaintiffs were granted leave to file an Amended and Supplemental Complaint" ("Amended Complaint" or "Am. Complt."). Dkt. # 63. Notwithstanding the newly-asserted allegations, however, Plaintiffs have failed to cure the deficiencies in their original Complaint. Governor Perry and all of Plaintiffs' Medicaid Act claims should be dismissed entirely.

I. Plaintiffs' Claims

Plaintiffs are six individual named plaintiffs ("Individual Plaintiffs") who claim they are adult persons with mental retardation or other related conditions (hereinafter referred to as "developmental disabilities"),[1] and two organizational plaintiffs ("Organizational Plaintiffs"). Plaintiffs are suing on behalf of themselves and a purported class,[2] claiming to have been inappropriately and unnecessarily segregated in nursing facilities ("NFs") because of

[1] In their Amended 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.

[2] The Organizational Plaintiffs also sue on behalf of their members. Am. Complt. ¶¶ 18, 21.

Defendants' purported failure to provide certain services, and to provide services in a community-based residential placement. Am. Complt. ¶¶ 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 timely provide a choice of community-based services and supports. Am. Complt. ¶¶ 5, 234, 246, 249, 251, 252, 256-58. 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"), and several sections of Title XIX of the Social Security Act, 42 U.S.C. § 1396a, *et seq*. ("Medicaid Act"), including 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.[3] Am. Complt. pp. 58–60.

II. The Defendants and Their Roles 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.[4] 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 responsible for administering those parts of the Texas Medicaid Program targeted by this lawsuit, namely, the provision of Medicaid services to

[3] "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).
[4] Texas Medicaid Enrollment by Month, July 2010, available at: http://www.hhsc.state.tx.us/research/MedicaidEnrollment/meByMonthCompletedCount.html.

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* Am. Complt. ¶¶ 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* Am. Complt. ¶ 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.[5] 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, HHSC is responsible for the administration of the PASRR program in Texas.

[5] The Medicaid Act and its implementing regulations allow States to receive Medicaid funding only it they 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.

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* Am. Complt. ¶ 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); *see* Am. Complt. ¶ 22, 23, 24.

The Governor of Texas is the chief executive officer of the State. TEX. CONST. art IV, § 1; *see* Am. Complt. ¶ 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. Am. Complt. ¶ 22. To the contrary, 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." Am. Complt. ¶ 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.[6]

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 qualify for federal reimbursement under Medicaid, 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" defines the categories of individuals eligible for benefits, 42 U.S.C. § 1396a(a)(10), and the specific kinds of medical services that are covered, 42 U.S.C. § 1396d(a). States cannot qualify for federal Medicaid funds unless they provide coverage to

[6] 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*.

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 1396a(a)(10)(A)(ii). *Skandalis v. Rowe*, 14 F.3d 173 (2d Cir. 1994). States receive federal Medicaid funds only if they provide coverage to the required groups of the "categorically needy"[7] 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).[8] These categories are determined based on financial eligibility standards. 42 U.S.C. § 1396a(a)(10)(A). Federal law, however, does not condition federal reimbursement on a State's decision to provide all services and devices covered by the statute. Rather, Congress has set a basic minimum standard for any state Medicaid program; a state need only provide financial assistance for certain specified medical treatment to receive Medicaid funds. *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 Centers for Medicare & Medicaid Services ("CMS")), to waive certain statutory criteria for Medicaid reimbursement, 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 funding

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[7] 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).

[8] A state, at its option, may also cover the "medically needy." *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 650–51 (2003); *Atkins v. Rivera*, 477 U.S. 154, 154 (1986). 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 id.* at 650-51. Texas has a program for the "medically needy," but that program does not include the aged, blind, or disabled. *See* http://www.hhsc.state.tx.us/medicaid/StatePlanDocs/BasicStatePlanAttachments.pdf, p. 79 (State Plan).

care for 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; § 441.301(b)(1)(iii). As its name suggests, a waiver relieves states from complying with certain federal reimbursement criteria that ordinarily must be met to receive federal Medicaid funding under the State Plan.[9] The statute specifically provides that the criteria 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. In fact, the Medicaid Act and applicable regulations expressly require participating states to limit the number of persons who may 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.[10] 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

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[9] 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).

[10] 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); *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).

or regulation requires a participating state to increase the number of persons served in its waiver programs. Additionally, 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), (4), (9), 1396n(c)(10); 42 C.F.R. §§ 430.25(h)(3)(ii), 440.180, 441.301(b)(3), (6), 441.303(f)(6), 440.250(j), (k), (l), 441.305(a).

As permitted by 42 U.S.C. § 1396n(c), HHSC 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. Am. Complt. ¶ 57. The HCS waiver program has a limited number of slots,[11] and, as Plaintiffs' acknowledge, 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. Am. Complt. ¶ 57.

Texas also offers a statewide community-based alternative for persons age 21 and over requiring a nursing facility level of care. Such care is provided through the Community Based Alternatives ("CBA") waiver,[12] and the managed-care equivalent to CBA, the "STAR+PLUS"

[11] The number of unduplicated individuals approved by CMS for the HCS waiver for the state fiscal year ending August 31, 2011 is 22,756. *See* http://www.dads.state.tx.us/providers/HCS/HCSwaiveramendment2.pdf (CMS approval letter); *see also* http://www.cms.gov/MedicaidStWaivProgDemoPGI/MWDL/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=ascending&itemID=CMS1216924&intNumPerPage=10 (CMS website containing the original approved HSC waiver (2008) and three subsequent amendments. The current amendment (6/1/2010) is TX 0110.R05.03).

[12] *See* http://cfoweb.dads.state.tx.us/ReferenceGuide/guides/FY11ReferenceGuide.pdf p. 32 (CBA is alternative to NF); *see* http://www.dads.state.tx.us/providers/CBA/CBAWaiver.pdf (CBA waiver application) pp. 3 (showing waiver as alternative to care in a NF as described in 42 C.F.R. § 440.40 and 42 C.F.R. § 440.155), 4 (describing waiver as alternative to NF care).

waiver.[13] No Plaintiff has pleaded facts showing she has even attempted to apply for a CBA or STAR+PLUS waiver slot, or any other waiver other than HCS. Am. Complt. ¶¶ 147, 157, 167, 185, 194, 223, 224.

SUMMARY OF ARGUMENT

The Individual Plaintiffs lack standing to assert claims under 42 U.S.C. § 1396n(c)(2)(B) because they have asserted no injury in connection with that section's requirement to evaluate whether they require the level of care provided in a nursing facility. They also lack standing under § 1396n(c)(2)(C) because that section's informational requirement arises at the time the individual is actually being offered a waiver slot, and there are no "feasible alternatives" under the waiver when, as Plaintiffs here admit, the waiver is full. Thus, they have suffered no § 1396n(c)(2)(C) injury, either.

For these same reasons, the Organizational Plaintiffs lack standing to assert § 1396n(c)(2)(B) or (C) claims on behalf of their members. The Organizational Plaintiffs also lack standing to assert claims on their own behalf because they have failed to plead facts showing any injury whatsoever to the organizations *per se*.

This Court should dismiss Governor Perry under Rule 12(b)(1) for lack of standing because Plaintiffs pled no facts showing that the Governor caused Plaintiffs' injuries or that he could redress those injuries. Similarly, the Governor of Texas is entitled to Eleventh Amendment immunity because the Governor lacks the requisite "connection" to the Texas Medicaid Program. Alternatively, Plaintiffs' claims against the Governor should be dismissed under Rule 12(b)(6) for failure to state a viable claim, since the Governor did not cause any deprivation of Plaintiffs' rights and cannot provide the relief Plaintiffs seek.

[13] STAR+PLUS is available in only certain defined service areas. *See* 1 TEX. ADMIN. CODE § 353.601 – 603 (showing STAR+PLUS as alternative to NF care).

All of Plaintiffs' Medicaid Act claims should be dismissed under Rule 12(b)(6) for the following reasons. ***First***, Section 1983 is not available to enforce a federal law where there is no violation of that law, and Defendants cannot violate the Medicaid Act because the Medicaid Act, as spending legislation, does not require state officials to do anything. ***Second***, even under a traditional section-by-section analysis, Plaintiffs' Medicaid Act claims also fail because these statutes create no individual "rights" that can be vindicated under Section 1983. ***Third***, even if this Court finds that the Medicaid Act provisions at issue confer federal rights enforceable through Section 1983, this Court should still dismiss these claims because Plaintiffs' allegations fail to state viable Medicaid Act claims. Specifically, Plaintiffs have failed to state a claim under the NHRA and 42 U.S.C. § 1396a(a)(8) ("Reasonable Promptness") to the extent they seek redress for an alleged failure to provide specialized services other than to the limited extent required by 42 C.F.R. § 483.120(a)(2) and 42 C.F.R. § 483.440(a)(1). Next, Plaintiffs' § 1396a(a)(8) claim regarding "community placement" fails to state a viable claim because a state may properly limit a waiver program's size and scope, and "reasonable promptness" does not apply to community placement when, as here, the community-based waiver they seek is full. Plaintiffs' claims under 42 U.S.C. § 1396a(a)(10)(B) ("Comparability") should be dismissed because the Medicaid Act outlines distinct programs and services, and does not require that all services provided to categorically needy recipients in an ICF-MR must also be provided in the same amount, duration, and scope to categorically needy recipients in a NF; moreover, Plaintiffs seek to impose a duty under § 1396a(a)(10)(B) to provide specialized services, active treatment, or other services to individuals in a NF that exceed the requirements of the NHRA. Lastly, Plaintiffs fail to state a claim under 42 U.S.C. §§ 1396n(c)(2)(B) and (C) ("Freedom of Choice") because the statutory text contains none of the requirements that Plaintiffs create from whole

cloth and then claim Defendants fail to satisfy. Instead, these statutory provisions afford a right of information only for waiver applicants at the time the individual is actually being assessed for and offered a waiver placement, and Plaintiffs acknowledge that the HCS waiver is full and there is no slot available for them at this time. In short, Plaintiffs have failed to plead any actionable Medicaid Act claim.

ARGUMENT AND AUTHORITY

I. This Court Lacks Jurisdiction Over Claims for Which Plaintiffs Lack Standing.

A. 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: (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.[14] *See Friends of the Earth, Inc. v. Laidlaw Env't. Servs. (TOC)*, 528 U.S. 167, 180 (2000).

[14] 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,

B. Plaintiffs Lack Standing for 42 U.S.C. §§ 1396n(c)(2)(B) and (C) Claims.

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)(B) or (C), because they do not allege an injury-in-fact from Defendants' alleged failure to comply with those provisions.

Section 1396n(c)(2)(B) requires a state to give assurances that certain persons will be given an evaluation of the need for in-patient hospital services, NF services, or services in an ICF-MR. 42 U.S.C. § 1396n(c)(2)(B). According to CMS, such an evaluation is for the purpose of determining whether the individual may be eligible for a particular waiver program because "[o]nly individuals who are determined to require an institutional level of care specified for the waiver may be enrolled in the waiver." CMS Instructions, Technical Guide and Review Criteria ("CMS Technical Guide"), Version 3.5, p. 99.[15] Specifically, for persons such as Plaintiffs, entering a NF, a nursing home assessment tool (known as the "MDS 3.0") is used to determine whether the individual meets the medical necessity standard for a NF.[16] Here, no Plaintiff has claimed that s/he does not require a level of care provided by a nursing facility, or that s/he was not administered an MDS 3.0. Instead, Plaintiffs assert that their medical needs could and should be met elsewhere than in a nursing facility. Accordingly, Plaintiffs have no standing to bring a

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).

[15] *See* http://www.dads.state.tx.us/providers/waiver_instructions/index.html.

[16] The MDS ("Minimum Data Set") 3.0 is a "standardized collection of demographic and clinical information that describes a person's overall condition. All licensed nursing facilities in Texas are required to submit MDS assessments for all residents admitted into their facility." *See* http://www.dads.state.tx.us/providers/MDS/index.cfm. The MDS 3.0 was the result of a CMS-initiated a national project developed by a joint RAND/Harvard team. *See* http://www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp (RAND MDS 3.0 Final Study Report and Appendices 2008, MDS Final Report, p. ix).

claim under § 1396n(c)(2)(B) because they have asserted no injury in connection with that section's requirement to evaluate whether they need the level of care provided in a nursing facility.

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 . . . nursing facility . . . are informed of the feasible alternatives, *if available under the waiver*, at the choice of such individuals, to the provision of . . . nursing facility services . . . ." 42 U.S.C. § 1396n(c)(2)(C) (emphasis added). According to CMS—which provides the criteria for evaluating states' waiver applications—the informational requirement for which the state must give § 1396n(c)(2)(C) assurances arises at the time the individual is actually being offered a waiver slot and being assessed for the waiver program. CMS Technical Guide, p. 106.[17] Specifically, CMS requires that the "individual's choice must be documented during entrance into the waiver program." *Id*. The "feasible alternatives" under the waiver mean the services within a waiver program that could meet the needs of the individual, and are determined during consideration for entrance into the waiver program. *Id*. Accordingly, CMS's State Medicaid Manual reflects that—"Feasible alternatives may only be determined after the assessment of an individual's care needs and an evaluation of level of care."[18]

In this case, neither Eric Steward nor Andrea Padron even alleges a failure to inform them of the "feasible alternatives" under the waiver. *See id*. ¶¶ 139–48, 161–72. In addition,

[17] *See also* http://www.cms.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021927&intNumPerPage=10 (State Medicaid Manual), Ch. 4, p. 4–456, § 4442.7. The State Medicaid Manual "makes available to all State Medicaid agencies, in a form suitable for ready reference, informational and procedural material needed by the States to administer the Medicaid program. It is an official medium by which the Health Care Financing Administration (HCFA) (now CMS) issues mandatory, advisory, and optional Medicaid policies and procedures to the Medicaid State agencies." *Id*. Ch. 1 (Forward).

[18] *See id*. (State Medicaid Manual), pp. 4-456.

two Plaintiffs—Andrea Padron and Benny Holmes[19]—have been offered HCS waiver slots and therefore, as a matter of law, they have suffered no injury-in-fact for purposes of the § 1396n(c)(2) claim. Am. Complt. ¶¶ 166, 194, 209. Finally, of the five plaintiffs not currently participating in the HCS waiver, all of them acknowledge that the waiver is full and there is no spot for them at this time. *See id*., ¶¶ 147, 157, 167, 185, 224. In other words, although they are on the HCS interest list, there is currently no "feasible alternative" available to them under the waiver. Accordingly, the obligation to inform them of the waiver alternatives is not triggered, but even if it were, they can have suffered no injury from any failure to inform them of alternatives "available under the waiver" because there are none.

C. Organizational Plaintiffs Lack Standing.

Organizational Plaintiffs Arc of Texas and Coalition of Texans with Disabilities, Inc. have asserted claims on behalf of both themselves and their members. Am. Compl. ¶¶ 18, 21. However, they do not have standing to assert all of their claims in both capacities.

"An organization has standing to sue on its own behalf if it meets the same standing test that applies to individuals." *Assoc. of Cmty. Orgs. For Reform Now v. Fowler*, 178 F.3d 350, 356 (5th Cir. 1999) (citing *Havens Realty Corp. v. Coleman*, 455 U.S. 363, 378-79 (1982)). Accordingly, an organization must show that it has suffered a direct injury-in-fact that is fairly traceable to the actions of the defendant, and that the injury will likely be redressed by a favorable judgment. *Id*.; *see Lujan*, 560 U.S. at 560-61.

Both Organizational Plaintiffs assert they are comprised of numerous individual members with developmental disabilities. Am. Complt. ¶¶ 16, 19. Yet while the Amended Complaint asserts claims stemming from injuries that allegedly affect such individual members, it wholly

[19] Benny Holmes admits that he has twice been placed in the HCS waiver program and currently has an HCS placement. Am. Complt. ¶¶ 194 (nine years in 3-bedroom home provided in HCS), 208-09 (current HCS placement is in 4-bedroom residential home).

fails to allege any injury directly suffered by the Organizational Plaintiffs. *See id*. ¶¶ 53–54, 56–57, 59, 74–80, 83–85, 87–88, 90, 96, 100–103, 115, 127, 137–38, 230, 232, 234, 236, 242–43, 246–47, 249, 251–52, 256–58. For example, the Organizational Plaintiffs' assertions that they operate to ensure that "persons with developmental disabilities receive the services to which they are entitled" and that "people with disabilities may live, learn, work, play and fully participate in their community of choice" fail to describe any injury whatsoever. *See* Am. Complt. ¶¶ 17, 20. Moreover, allegations of a mere setback to an organization's social interests—had the Organizational Plaintiffs pled such facts, which they did not—are insufficient to establish the organization's standing on its own behalf. *Assoc. of Cmty. Orgs. For Reform Now*, 178 F.3d at 357-58 (quoting *Havens Realty*, 455 U.S. at 379). Thus, having failed to show an injury-in-fact of their own, the Organizational Plaintiffs lack standing to assert claims on their own behalf, and all claims brought by the Organizational Plaintiffs on their own behalf should be dismissed.[20]

Alternatively, for an organization to maintain associational standing on behalf of its members, the organization must satisfy a three-pronged standing test:

> [A]n association has standing to bring suit on behalf of its members when: (a) its members would otherwise have standing to sue in their own right; (b) the interests it seeks to protect are germane to the organization's purpose; and (c) neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit.

Hunt v. Wash. State Apple Adver. Comm'n, 432 U.S. 333, 343 (1977). In the instant case, the Organizational Plaintiffs' members have no standing in their own rights with regard to certain of their claims. Specifically, Plaintiffs' Amended Complaint fails to show that the Organizational Plaintiffs' members have standing to assert claims under the so-called "freedom of choice" provisions of the Medicaid Act, 42 U.S.C. §§ 1396n(c)(2)(B) or (C), just as it fails to establish such standing with regard to the Individual Plaintiffs. Plaintiffs' Amended Complaint fails to

[20] This would include the ADA and Rehabilitation Act claims as well as the Medicaid Act claims.

allege that any member of the Organizational Plaintiffs does not require a level of care provided by a nursing facility and/or was not administered an MDS 3.0, and fails to allege that a waiver spot is a "feasible alternative" currently available to any member of the Organizational Plaintiffs or that any member has failed to receive the assurances guaranteed under § 1396n(c)(2)(C) upon actually being offered a waiver slot. Accordingly, under the same line of reasoning applied to the Individual Plaintiffs' claims, the Organizational Plaintiffs have failed to show that their members have suffered any injury-in-fact with regard to sections 1396n(c)(2)(B) and (C).[21] Therefore, the Organizational Plaintiffs lack standing to maintain such claims on their members' behalf, and such claims should also be dismissed.

II. The Governor Is Not A Proper Party.

A. Plaintiffs Lack Standing to Sue the Governor.

To establish standing against the Governor for any of the claims asserted in this case, Plaintiffs must allege how the Governor "has caused, will cause, or could possibly cause any injury to them." *Okpalobi v. Foster*, 244 F.3d 405, 426 (5th Cir. 2001) (*en banc*). In addition, if the Governor does not have the power "to redress the injuries alleged, [Plaintiffs] have no case or controversy with [the Governor] that will permit them to maintain this action in federal court." *See id.* at 427. Here, Plaintiffs have established neither.

1. The Governor did not, and could not, cause Plaintiffs any injury.

Even assuming for purposes of this standing analysis that Plaintiffs have suffered some injury-in-fact, no injury has been, or could be, caused by the Governor. As discussed above, the portions of the Medicaid Act at issue in this lawsuit are administered by DADS and HHSC. *See*

[21] Furthermore, as noted below with regard to the Individual Plaintiffs, Governor Perry does not possess the authority either to have caused the injuries alleged by the Organizational Plaintiffs' members, or to redress any such injuries. *See infra* pp. 16–20. Thus, under the same reasoning applied to the Individual Plaintiffs' claims against Governor Perry, the Organizational Plaintiffs' members have no case or controversy with Governor Perry, and therefore, the Organizational Plaintiffs lack standing to assert such claims on their members' behalf.

supra, pp. 3−4. 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.

Rather, the powers of the Governor with respect to HHSC and DADS are limited to appointing the HHSC Executive Commissioner and approving the DADS commissioner. *See* Am. Complt. ¶ 22.[22] Plaintiffs do not allege that any of the Governor's acts in connection with those powers have caused Plaintiffs' injuries. Nor do Plaintiffs allege that the Governor caused them injury by exercising his more general executive powers, such as holding budget hearings, compiling a proposed biennial appropriations budget, or using his line-item veto authority.[23] Indeed, Plaintiffs make no allegation that the Governor has any direct control over how the State administers Medicaid "services, programs and activities," such that he would have any responsibility for satisfying the integration mandate of the ADA or the Rehabilitation Act. *See* Am. Complt. ¶¶ 231, 240. Similarly, Plaintiffs make no allegation that the Governor has any involvement in developing policies and procedures to ensure that the various statutory and regulatory requirements of the Medicaid Act and the NHRA are satisfied. For example, neither the Governor nor his office is alleged to be responsible for: conducting pre-admission screening and assessments, providing specialized services, or providing community-based services and supports. *See, e.g.*, Am. Complt. ¶¶ 5, 246, 249, 251, 252, 256–58. In short, Plaintiffs do not allege that the Governor has done anything (or failed to do anything) that is within his constitutional power to do that has caused the injuries that Plaintiffs allege.

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

[22] *See also* TEX. GOV'T CODE §§ 531.005, 531.0056.
[23] *See* TEX. GOV'T CODE § 401.041, 401.043, 401.0045, TEX. CONST. art. IV, § 14.

cause, any injury to them. *See Okpalobi*, 244 F.3d at 426 (plaintiffs failed to satisfy Article III standing with respect to the Governor, who had no authority to enforce the allegedly-unconstitutional state statute).

2. Plaintiffs' injuries, if any, are not redressable through the Governor.

In addition, the Governor cannot grant Plaintiffs any of the relief they seek regarding the provision of community-based Medicaid services, supports and programs. *See* Am. Complt. ¶¶ 54-56. As described above, the Governor's powers with regard to management and oversight of HHSC and DADS are extremely limited. Plaintiffs are not requesting injunctive relief requiring the Governor to appoint an HHSC Executive Commissioner, approve an agency director for DADS, compile the biennial appropriations budget, or use the line-item veto. Indeed, the Governor does not adopt policies or procedures regarding the provision of Medicaid services, nor does he have any direct control over such services.[24] Consequently, the relief Plaintiffs seek cannot be obtained by enjoining the Governor. *See Okpalobi*, 244 F.3d at 427 ("a state official cannot be enjoined to act in any way that is beyond his authority to act in the first place.").

[24] Plaintiffs' complaint refers to two executive orders that the Governor issued in 1999 and 2002 regarding community-based services for people with disabilities. Am. Complt. ¶¶ 48-49. Under Article IV section 10 of the Texas Constitution, the Governor has power to give direction in all branches of the executive department in the form of executive orders. But the Governor's power to enforce those orders is limited and is based primarily on his constitutional appointment power. Concomitant with his authority to appoint, the Governor has the power to refuse to reappoint the person as agency head. However, unlike the federal President, he has no power to force the removal of the agency head prior to the termination of the agency head's appointed term, nor does he have absolute power to force an appointed agency head to carry out his orders. *See* Ron Beal, *Power of the Governor: Did the Court Unconstitutionally Tell the Governor to Shut Up?*, 62 BAYLOR L. REV. 72, 81-88 (2010). Undoubtedly, the Governor has the power to issue executive orders and may exert his influence to see that they are carried out, but he has no constitutional or statutory (that is, no judicially-enforceable) duty to do either. The limitations on his ability to enforce executive orders preclude the Governor from providing the relief that Plaintiffs seek in this case. The Governor can refuse to reappoint the HHSC Executive Commissioner or refuse to approve the reappointment of the Commissioner of DADS in the event an executive order is not followed. But Plaintiffs are not seeking an injunction requiring the Governor to refuse to reappoint the HHSC Executive Commissioner or the DADS Commissioner due to failure to follow executive orders. Rather, they are seeking an injunction requiring actions that only HHSC and DADS (or, in the case of appropriations, the Legislature) can perform. Am. Complt. ¶¶ 54-56.

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.

Without causation or redressability, all Plaintiffs have left is their conclusory assertion that the Governor "is responsible for ensuring that the State submits a State Medicaid Plan which conforms to federal law, and that Texas's Medicaid program is administered consistent with that Plan, relevant federal statutes, and federal regulations." Am. Complt. ¶ 136. As an initial matter, this allegation is incorrect as a matter of law, since federal law mandates that a single state agency (not the governor) be responsible for "exercis[ing] administrative discretion in the administration or supervision of the [Medicaid state] plan" and for "issu[ing] policies, rules, and regulations on program matters." 42 C.F.R. § 431.10(e)(1)(ii); *see also* 42 U.S.C. § 1396a(a)(5) (establishing single agency mandate for Medicaid).

Moreover, such allegations of generalized executive enforcement powers are insufficient to establish standing over a governor or other state officer. *See Women's Emergency Network v.*

Bush, 323 F.3d 937, 949 (11th Cir. 2003) ("Where the enforcement of a statute is the responsibility of parties other than the governor … the governor's general executive power is insufficient to confer jurisdiction.") (affirming dismissal of governor); *1st Westo Corp. v. School Dist. of Philadelphia*, 6 F.3d 108, 113 (3d Cir. 1993) (dismissing claims against Secretary of Education and Attorney General; "General authority to enforce the laws of the state is not sufficient to make government officials the proper parties to litigation challenging the law."); *see also Okpalobi*, 244 F.3d at 416 (plurality op.) ("it is not merely the general duty to see that the laws of the state are implemented that substantiates the required 'connection,' but the particular duty to enforce the statute in question and a demonstrated willingness to exercise that duty.").

In short, Plaintiffs have failed to establish Article III standing for their claims against the Governor.

B. The Governor is Immune From Suit Under the Eleventh Amendment.

Plaintiffs' claims against the Governor fail for the additional reason that he is immune from suit. 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, as the Supreme Court made clear in *Ex parte Young*, a state officer named in suit seeking injunctive relief "must have some connection with the enforcement of the act" for sovereign immunity to be waived. 209 U.S. 123, 153 (1908); *see*

also Fitts v. McGhee, 172 U.S. 516, 530 (1899) ("neither of the state officers named held any special relation to the particular statute alleged to be unconstitutional.").

The precise contours of this requirement have been subject to some debate, including whether a "special charge" of enforcement must be found in the statute. *See Okpalobi*, 244 F.3d at 416-21 (plurality op.).[25] However, what is clear is that to establish the connection required by *Ex parte Young*, there must be more than a general duty upon the state officer to enforce the laws of the state in order to dissolve the Eleventh Amendment bar. *See Women's Emergency Network*, 323 F.3d at 949 ("A governor's 'general executive power' is not a basis for jurisdiction in most instances."); *Waste Mgmt. Holdings, Inc. v. Gilmore*, 252 F.3d 316, 331 (4th Cir. 2001) (dismissing governor); *Confederated Tribes & Bands of the Yakama Indian Nation v. Locke*, 176 F.3d 467, 469-70 (9th Cir. 1999) (dismissing governor); *Children's Healthcare Is A Legal Duty, Inc. v. Deters*, 92 F.3d 1412, 1416-18 (6th Cir. 1996) (dismissing attorney general); *Okpalobi*, 244 F.3d at 419 (plurality opinion); *Day v. Sebelius*, 376 F.Supp.2d 1022, 1031 (D. Kan. 2005) (dismissing governor).

Here, the Governor 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. Rather, the Governor appoints the HHSC Executive Commissioner, approves the DADS commissioner, and submits a biennial budget. *See* Am. Complt. ¶ 22. Those separate state agencies (and their commissioners, for purposes of *Ex parte Young*) are responsible for the direction and oversight of the Texas Medicaid Program and ensuring that program complies with federal law. *See* Am. Complt. ¶¶ 23-24. Furthermore, the Legislature (not the Governor)

[25] The sovereign immunity holding in *Okpalobi* failed to garner sufficient votes to be a majority opinion not because the majority disagreed with its holding, but rather because two judges who joined in the holding on standing determined that the immunity issue need not have been addressed since the standing issue was determinative in any event. *See Okpalobi*, 244 F.3d at 429 (Higginbotham, J., concurring, joined by King, J.).

appropriates funds, and the Governor enjoys legislative immunity for his actions in connection with the budgeting process and the use of line-item veto powers. *See Bagley v. Blagojevich,* 646 F.3d 378, 394-95 (7th Cir. 2011), *cert. denied,* 2011 WL 4534022 (Oct. 3, 2011) (applying legislative immunity to claims against governor related to line-item veto); *Abbey v. Rowland*, 359 F.Supp.2d 94, 100 (D. Conn. 2005) (applying legislative immunity to claims against governor related to budget process).[26]

In short, the Governor of Texas lacks the requisite connection to the provision of Medicaid services to individuals with developmental disabilities to be a proper party under *Ex parte Young*, and therefore, is protected by sovereign immunity from Plaintiffs' claims.

C. Plaintiffs Have Failed to State a Claim Against the Governor.

For the same reasons set out above under the "standing" arguments, *see supra* at pp. 16−20, Plaintiffs have failed to state a cognizable claim against the Governor 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 the Governor that caused, or could cause, their alleged deprivation, and the relief they seek cannot be effectuated through the Governor. Accordingly, Plaintiffs' claims against the Governor should be dismissed under Rule 12(b)(6), as well as under Rule 12(b)(1).

Similarly, the Governor 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 Rehabilitation Act, which is designed to eliminate discrimination on the basis of handicap in any program or activity

[26] This is true even for claims seeking prospective injunctive relief. *See State Employees Bargaining Agent Coalition v. Rowland*, 494 F.3d 71, 88 (2d Cir. 2007) (applying legislative immunity to claims for injunctive relief against state officials sued in their official capacity); *Scott v. Taylor*, 405 F.3d 1251, 1257 (11th Cir. 2005) (same).

receiving federal financial assistance, 29 U.S.C. § 794(a),[27] 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");[28] *see also* 28 C.F.R. § 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. TEX. GOV'T CODE § 531.021(b)(1); TEX. HUM. RES. CODE § 32.031.

III. 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

[27] 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.").

[28] "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).

"enough facts to state a claim to relief that is plausible on its face." *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 570 (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*, 556 U.S. 662, 129 S.Ct. 1937, 1949 (2009).

B. 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* Am. Complt. pp. 53–57. 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 with respect to all of their Medicaid Act claims.

1. Plaintiffs have no "rights" under any section of 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 (noting that in *Suter v. Artist M.*, 503 U.S. 347 (1992) and *Blessing v. Freestone*, 520 U.S. 329 (1997), the Court rejected attempts to infer enforceable rights from Spending Clause statutes analyzed in those suits). And *Gonzaga* quoted with approval the following passage from *Pennhurst*:

> 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.

Equal Access, 509 F.3d at 704. 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*, 520 U.S. at 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.

Moreover, the claims Plaintiffs bring under the Medicaid Act fail to state a claim that the Defendants have violated federal law, let alone invaded their federally protected "rights." State officials cannot violate the Medicaid statutes cited by Plaintiffs because they impose no affirmative obligation on States that accept federal reimbursement money to preserve their Medicaid programs in any particular manner. More specifically, 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 the State's 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.

Further, it is uncertain whether the Medicaid statutes Plaintiffs rely upon are even good law. Amendments to the Medicaid Act, including the statutes 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)—were enacted in 2010 as part of the Patient Protection and Affordable Care Act (PPACA).[29] In January 2011, a federal district court in Florida struck down the entirety of the PPACA, including the 2010

[29] *See* 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").

amendments to the Medicaid Act. *See Florida et al. v. U.S. Dept. of Health and Human Services*, 780 F. Supp. 2d 1256 (N.D. Fla.), *clarified by Florida ex rel. Bondi v. U.S. Dept. of Health and Human Services*, 780 F.Supp.2d 1307, *aff'd in part, rev'd in part*, 648 F.3d 1235 (11th Cir.), *pet. cert. filed* (2011). The court did so after holding that the "individual mandate" provision in the PPACA, which requires all individuals to purchase health insurance, was unconstitutional and could not be severed from the rest of the act. *Id.* Although the Eleventh Circuit later reversed the district court on the issue of severability, *see* 648 F.3d at 1328, that issue is now pending before the U.S. Supreme Court via the petition for writ of certiori filed by the state plaintiffs, which include Texas. *See Florida, et al., v. Department of Health and Human Services, et al.*, No. 11-400 (U.S. pet. filed Sept. 27, 2011). Accordingly, it remains to be seen whether the amended statutes relied on by Plaintiff will be struck down.

Fortunately, this Court need not concern itself with whether constitutional questions the amended statutes relied on by plaitniffs are unconstitutional 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 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 PPACA.

2. The Wilder/Blessing test.

Even applying the Supreme Court's three-pronged 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. In *Blessing v. Freestone*, the Supreme Court applied a three-part test to determine whether legislation creates a federal *right* redressable 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. 520 U.S. at 340–41; *see also Wilder*, 496 U.S. at 509–10; *S.D.*, 391 F.3d at 602. Basically, "the provision giving rise to the asserted right must be couched in mandatory rather than precatory terms." *Blessing*, 520 U.S. at 341. 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.[30] 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*.[31]

Plaintiffs assert claims under various provisions of the Medicaid Act and accompanying regulations. Am. Complt. ¶¶ 245–58. Unquestionably, neither these statutory provisions nor any of the Act's implementing regulations provides any express private right of action for these Plaintiffs to enforce the Act.[32] Therefore, if this Court considers Plaintiffs' Medicaid Act claims

[30] 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.

[31] 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).

[32] Medicaid Act 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

at all, it must find that each section of the Act under which Plaintiffs claim unambiguously confers a federal right enforceable by these Plaintiffs. *See Gonzaga*, 536 U.S. at 274. Certainly, the Medicaid Act does not unambiguously confer rights on associational plaintiffs to assert claims *on their own behalf*. For this reason alone, the Organizational Plaintiffs' Medicaid Act claims brought on behalf of themselves should be dismissed.

3. The NHRA creates no rights enforceable by Plaintiffs.

a. Summary of Plaintiffs' NHRA claims.

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[33] and its administration of specialized services.[34] Plaintiffs attempt to assert their claims under various provisions within three subparts of the NHRA—42 U.S.C. §§ 1396r(b), (e), and (f)[35]—none of which provides any express private right of action. Am. Complt. ¶¶ 251, 252, 256, 258. Applying the three-factor test used in determining whether Congress intended a statute to confer a right, while remaining mindful of *Gonzaga*'s strong limitation on finding privately enforceable

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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 a particular statory provision creates a privately enforceable right, not whether its implementing regulations do. *Casas v. American Airlines Inc.*, 304 F.3d 517, 520 (5th Cir. 2002).

[33] *See* Am. Complt. ¶¶ 53, 55, 74-76, 96, 251-252. Plaintiffs' claimed rights relating to screening, assessment, and placement include rights to: (1) a screening program that timely and appropriately determines if nursing facility applicants have developmental disabilities, *id*. ¶¶ 74, 96, 251; (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*. ¶¶ 75, 251; (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*. ¶¶ 76, 252; 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*. ¶¶ 53, 55.

[34] *See* Am. Complt. ¶¶ 27(b), 72, 77-79, 87, 96,255-58. 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*. ¶¶ 77, 256; (2) unlimited specialized services to all persons with developmental disabilities in nursing facilities, *id*. ¶¶ 78, 79, 256; (3) the currently available, but limited specialized services, to persons with developmental disabilities in nursing facilities, *id*. ¶¶ 87, 257; and (4) a program of specialized services that meets the federal active treatment standard required in an intermediate care facility, *id*. ¶¶ 27(b), 72, 96, 258, 255.

[35] Specifically, Plaintiffs assert claims under 42 U.S,C. §§ 1396r(b)(3)(F), 1396r(e)(7)(A) and (B), and 1396r(f)(8). Am. Complt. ¶¶ 250–58. Plaintiffs also cite the following regulations: 42 C.F.R. §§ 483.112(b), .114(b)(2), .116(b)(2), .118, .120(a)(2) and (b), .128, .132(a), and .440. Am. Complt. ¶¶ 250–58.

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

b. NHRA provisions are not intended to benefit Plaintiffs.

The context of the cited NHRA provisions, coupled with the absence of rights/benefits-granting language, evidences intent to establish institutional policy and practice, not to benefit the Plaintiffs. The NHRA is entitled "Requirements for nursing facilities." 42 U.S.C. § 1396r. Subparts (b)–(d) set forth requirements a nursing facility must meet in providing services and activities for NF residents in order to maintain funding and certification. 42 U.S.C. § 1396r(b)–(d). Subpart (e) sets out the provisions a State must include in its state plan in order to secure the Secretary's approval of the plan for administering federal funds to nursing facilities. 42 U.S.C. 1396r(e). Subpart (f) outlines the Secretary's duties and responsibilities for developing and enforcing requirements for provision of care in nursing facilities. 42 U.S.C.§ 1369r(f). Subpart (g), containing 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). 42 U.S.C. § 1369r(g). Subpart (h) provides for an "enforcement" mechanism authorizing action by the State or the Secretary to deny nursing facility payments, assess civil penalties, and appoint temporary management to improve or close a facility. 42 U.S.C. § 1369r(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 *Alexander v. Sandoval*, 532 U.S. 275, 289 (2001). 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. "[S]tatutes 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.'" *Sandoval*, 532 U.S. at 289.[36] For these reasons, Plaintiffs' cited provisions of the NHRA do not evidence Congressional intent to benefit Plaintiffs.

c. The NHRA imposes no binding obligations on Defendants.

While Plaintiffs' cited NHRA sections do contain requirements for the parties/entities to whom they are directed, not all of the cited sections contain requirements directed to the states. For example, § 1396r(b)(3)(F)—to which Plaintiffs cite as the basis for their claimed rights related to specialized services and to screening, assessment, and placement—is directed to nursing facilities and sets out which new residents such a facility can admit.[37] Am. Complt. ¶¶ 250, 251, 256. This section puts an unambiguous binding obligation on the *nursing facility*—not on the *State*—not to admit residents before certain determinations are made by the state mental retardation or developmental disability authority. 42 U.S.C. § 1396r(b)(3)(F).

Similarly, § 1396r(e), which deals with "State requirements relating to nursing facility requirements," does not put an unambiguous obligation upon the State to ensure Plaintiffs' claimed rights related to specialized services or screening, assessment, and placement. *See* Am.

[36] Fifth Circuit precedent establishes that when a statute imposes conditions on a regulated entity for its receipt of federal funds, those conditions are focused on the regulated entity and do not evidence congressional intent to confer rights on individuals. *See Anderson v. Jackson*, 556 F.3d 351, (5th Cir. 2009) (applying *Gonzaga* to find that the United States Housing Act, 42 U.S.C. § 1437p, does not unambiguously confer a federal right); *Banks v. Dallas Housing Authority*, 271 F.3d 605, 609-10 (5th Cir. 2001) (conditions imposed for receipt of federal funds under the United States Housing Act, 42 U.S.C. § 1437f(e), are focused on the regulated agency and were not intended to benefit the plaintiff residents); *see also Grammer v. John J. Kane Reg'l Ctrs-Glen Hazel.*, 570 F.3d 520, 532 (3rd Cir. 2009) (Stafford, J., dissenting) (noting that the NHRA is Spending Clause legislation, and concluding that the NHRA does not evidence any intent of Congress to confer federal right on nursing home residents).

[37] 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 NF. Am. Complt. ¶¶ 250, 251. Because Plaintiffs make no claims in this lawsuit on behalf of persons with mental illness, Defendants construe each citation 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 NF.

Complt. ¶¶ 250, 251, 252, 253, 256, 258 (referencing 42 U.S.C. § 1396r(e)(7)(A), (B), (C)). Instead, the statute's text dictates that "[a]s a condition of approval of [a State's] plan . . . a State must provide" for certain enumerated requirements related to preadmission screening and resident reviews in its state plan. *See* 42 U.S.C. § 1396r(e). Thus, § 1396r(e) contains requirements for obtaining the Secretary's approval for a state plan; it 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)—cited by Plaintiffs as one of the NHRA provisions Defendants allegedly violate by limiting specialized services—specifically directs *the Secretary* to develop minimum criteria for states to use in making determinations related to preadmission screening and resident reviews, and in permitting individuals adversely affected to appeal such determinations. *See* 42 U.S.C. § 1396r(f)(8); *see also* Am. Complt. ¶ 256. It further directs *the Secretary* to "monitor" states through case reviews for their compliance with NHRA. 42 U.S.C. § 1396r(f)(8)(B). 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 judicial remedies against the State.

The NHRA's comprehensive remedial scheme related to preadmission screening, resident reviews, and specialized services—which contemplates actions taken by recipients, States, and the Secretary— evidences clear intent to preclude remedies for individuals under Section 1983. For example, the remedy for failure to conduct a PASRR review under § 1396r(b)(3)(F) is that no payment may be made with respect to NF services furnished without a PASRR determination. 42 U.S.C. § 1396r(e)(7)(D). The statute could have, but did not, confer upon Medicaid

recipients the right to judicially enforce § 1396r(b)(3)(F) directly. Instead, the only remedy provided for "individuals adversely affected by" a PASRR reviews described under §§ 1396r(e)((7)(A) or (B) (which references § 1396r(b)(3)(F)) is an appeals process which a State must develop "as a condition of approval of its plan." 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).[38] The "enforcement" subpart of the NHRA, 42 U.S.C. § 1396r(h), provides for enforcement actions against nursing facilities brought by the Secretary, the States, or both, including both specifically-enumerated remedies and remedies otherwise available against nursing facilities under state or federal law. 42 U.S.C. § 1396r(h)(8).[39] The NHRA also states that the remedies provided under subsection (h)—all of which are directed against nursing facilities—are "in addition to those otherwise available under State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law." 42 U.S.C. § 1396r (h)(8). Thus, apart from the ability to appeal the results of a PASRR review, the only remedies contemplated for individuals under the NHRA are those otherwise available to the individual as against a nursing facility. The remedies specified in the NHRA, directed at different parties and

[38] 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 the 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) (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* TEX. GOV'T CODE ANN. § 531.019 (setting out administrative remedies and right to judicial review for a party who is aggrieved by a final order of a fair hearing officer).

[39] *See* 42 U.S.C. § 1396r(h)(1)–(2) (specifying state enforcement actions for remedying a NF's deficiencies), (3) (outlining the Secretary's authority and specified enforcement actions for remedying a NF's deficiencies), (4) (the Secretary or the state must find a NF in "substantial compliance" before a finding to deny payment may be terminated), (5) (grounds for a state or the Secretary to immediately terminate a NF's participation), and (6) (special rules to apply when a state and the Secretary do not agree on a NF's compliance status).

for different purposes, together, evidence Congress's intent to preclude judicial remedies for individuals under Section 1983.

For all of these reasons, the NHRA confers no federal right on Plaintiffs, and their NHRA claims should be dismissed. 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.[40] 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.

Plaintiffs claim that Defendants' limits on specialized services and community-based services violate the "reasonable promptness" provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(8), and that Defendants violate the "comparability" requirement of § 1396a(a)(10)(B) by failing to provide the same level of "active treatment" in NFs as is provided in ICFs-MR. Am. Complt. ¶¶ 245–46, 248–49. The Fifth Circuit has not ruled on the question whether §§ 1396a(a)(8) or 1396a(a)(10)(B) create privately-enforceable rights.[41] 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 on 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

[40] *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 against a nursing facility); *Duncan v. Johnson-Mathers Health Care, Inc.*, Civ. A. No. 5:09-CV-00417-KKC, 2010 WL 3000718 (E.D. Ky. July 28, 2010) (post-*Gonzaga* decision finding no privately enforceable right against a nursing home under Section 1396r); *Prince v. Dicker*, 29 Fed. Appx. 52 (2nd Cir. 2002) (finding no privately enforceable right under Section 1396r against a private nursing home); *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 because the NHRA does not articulate a clear and unambiguous intent to confer individual federal rights on nursing home residents).

[41] In *Blancahrd v. Forrest*, 71 F.3d 1163 (5th Cir. 1996), the Fifth Circuit analyzed a Section 1396a(10)(B) claim against Louisiana, but did not address whether that section of the Act provides a private right of action.

appeal their contention that *S.D*. must be overturned in light of *Gonzaga*. But even were sections 1396a(a)(8) and 1396a(a)(10)(B) to be determined to create rights enforceable rights by 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, such as the HCS waiver, through which all Plaintiffs purport to seek services. Am. Complt. ¶¶ 139–229.

Moreover, § 1396a(a)(8) confers no right to reasonable promptness in the delivery of community-based waiver services where, as here, the desired waiver is full. It is settled that the Medicaid Act provides no right to enforce § 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* Am. Complt. ¶ 246. 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 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., pp. 14–16 ("slip op."), attached hereto as Exh. 1. The *McCarthy* 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)).[42]

[42] *See also M.A.C. v. Betit*, 284 F.Supp.2d 1298, 1308 (D. Utah 2003) (plaintiffs had no private right of action to enforce § 1396a(a)(8) because they were not "eligible individuals" under that provision where waiver slots were not

The court found that the plaintiffs 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 § 1396a(a)(8). *McCarthy*, slip op. at 15; *see also M.A.C.*, 284 F.Supp.2d at 1308 ("… because [section 1396a(a)(8) does not contain] the unambiguous rights-creating language required by *Gonzaga,* this court finds that Plaintiffs do not have a private right of action to enforce the Medicaid Act"). The same reasoning applies here, and the Fifth Circuit has not ruled to the contrary.

5. Sections 1396n(c)(2)(B) and (C), relating to state waiver applications, confer no private rights enforceable under Section 1983.

Plaintiffs claim that Defendants violate 42 U.S.C. §§ 1396n(c)(2)(B) and (C) by failing to provide NF residents with DD with notice and opportunity to access community-based services, an assessment of their eligibility for such services, and a meaningful choice between institutional and community-based services. Am. Complt. ¶ 247. Sections 1396n(c)(2)(B) and (C) 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 *Blessing* and *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

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available); *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.); *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") (emphasis added).

Secretary determines whether to grant or deny a state's request for waiver. §§ 1396n(c)(2)(B), (C); 42 C.F.R. § 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). 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.

Furthermore, the assurance required under § 1396n(c)(2)(B) (referencing an evaluation of the need for NF level of services), arising as it does in the context of the requirements for approval of a state's waiver application, and taking into account the high costs of care of persons with medical needs requiring a NF level of care, may be considered as much a focus on general cost-saving measures as a focus on the individual. That is, a state applying for a NF waiver must assure the Secretary that only persons confirmed to require a NF level of care will be eligible for a home or community-based NF waiver. Thus, this section creates no right of enforcement for Plaintiffs. *See Frazar*, 300 F.3d at 545 (state's failure to meet a systemwide performance standard does not give rise to individual rights actionable under § 1983).

Section 1396n(c)(2)(C) requires only that states seeking a Medicaid waiver assure the Secretary 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 very least, section 1396n(c)(2)(C) imposes no "binding obligation" on Texas when—as Plaintiffs here

admit—there are no openings for the HCS waiver services. Consequently, Plaintiffs cannot satisfy the third prong of the *Blessing* test. The district court in *McCarthy* 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. *See* McCarthy, slip op. at 12-14. 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. The Fifth Circuit has not ruled on the private enforceability of sections 1396n(c)(2)(B) or (C).

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

Should this Court find that the Medicaid Act creates rights enforceable by Plaintiffs under Section 1983, Plaintiffs' Medicaid Act claims should nevertheless be dismissed for failure to state a legally cognizable claim.

1. Plaintiffs state no cognizable NHRA claim.

a. Plaintiffs state no § 1396r(b)(3)(F) or § 1396r(e) claim.

Plaintiffs' claims for violations of screening, assessment, placement, and specialized services requirements are brought under 42 U.S.C. §§ 1396r(b)(3)(F) and 1396r(e)(7)(A), (B)(ii), and (C). Am. Complt. ¶¶ 250–53, 256, 258. However, as discussed above, § 1396r(b)(3)(F) imposes a requirement on nursing facilities, not on the states. Accordingly, Plaintiffs' claims, which are directed against the defendant state governmental entities, fail under Rule 12(b)(6). Further, sections 1396r(b)(3)(F) and 1396r(e)(A), (B), and (C) simply do not contain the

requirements Plaintiffs attribute to them. *See* Am. Complt. ¶¶ 250–53, 256, 258. Therefore, Plaintiffs' related allegations of Defendants' failures under these sections state no viable claim.

b. Plaintiffs state no violation of the "active treatment" regulations.

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* Am. Complt. ¶¶ 27(b), 72, 96, 255–58. 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 § 483.440.

Specialized services are defined differently for different categories of residents. *See* 42 C.F.R. § 483.120(a). For NF 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)."[43] 42 C.F.R. § 483.120 (a)(2). Accordingly, § 483.440(a)(1), and no other subpart of § 483.440, constitutes the yardstick by which the provision of specialized services in a nursing facility can be measured.

The First Circuit Court of Appeals—the only circuit court to have considered whether active treatment is required in NFs—agrees. In *Rolland v. Romney*, the appellate court affirmed the district court's ruling that the defendant state had only to comply with the active treatment

[43] 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).

standard set out at 42 C.F.R. § 483.440(a)(1) in providing specialized services to mentally retarded NF residents. 318 F.3d 42, 57 (1st Cir. 2003).[44] In so doing, 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, Plaintiffs 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), fails to state a claim for which relief can be granted and should be dismissed.

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

Plaintiffs' twofold Section 1396a(a)(8) claim is that Defendants' limits on community-based services and supports, as well as Defendants' limits on specialized services, violate the "reasonable promptness" provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(8). Am. Complt. ¶¶ 245–46. The "reasonable promptness" provision 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." 42 U.S.C. § 1396a(a)(8).

a. Plaintiffs have failed to state a cognizable § 1396a(a)(8) "specialized services" claim for alleged delay in providing services not required under the NHRA.

The "specialized services" prong of Plaintiffs' "reasonable promptness" claim is that Defendants "limit … medically necessary specialized services, result[ing] in extended delays and the outright denial of medically necessary care." Am. Complt. ¶ 246. To the extent Plaintiffs assert delay or denial of specialized services that are not required to be provided as part of NF

[44] The appeals court affirmed *Rolland v. Cellucci*, 198 F.Supp.2d 25, 46 (D. Mass. 2002) (citing only 42 C.F.R. § 483.440(a)(1) and not subparts (b)–(f) in setting forth standard to be met in NF).

care, they fail to state a cognizable claim under § 1396a(a)(8). Thus, Plaintiffs' § 1396a(a)(8) claims relating to anything but the failure to provide the specialized services required by 42 C.F.R. § 483.120(a)(2) and 42 C.F.R. § 483.440(a)(1) must be dismissed for failure to state a claim. See discussion *supra* at pp. 41−42.

b. Plaintiffs have failed to state a cognizable § 1396a(a)(8) "community placement" claim where, as here, the waiver is full and Plaintiffs have not been determined to be eligible.

The "community placement" prong of Plaintiffs' "reasonable promptness" claim is that Defendants "limit the provision of medically necessary community-based services and supports, … result[ing] in extended delays and the outright denial of medically necessary care." Am. Complt. ¶ 246. This claim fails for several reasons.

First, Plaintiffs' claim that Defendants' limit on the provision of community-based waiver programs (as compared to state plan entitlement programs) results in delays and denials of care, this claim is untenable because the very nature of a Medicaid waiver program is that the state may limit its scope and size. *See* 42 U.S.C. § 1396n; 42 C.F.R. § 441.301(b)(3); *Skandalis v. Rowe*, 14 F.3d 173, 181 (2nd Cir. 1994); *Beckwith v. Kizer*, 912 F.2d 1139, 1143-44 (9th Cir. 1990).[45] "Congress intended for states to have maximum flexibility in operating their waiver programs," *Skandalis*, 14 F.3d at 180 (quoting the Department of Health and Human Services at 50 Fed. Reg. 10,013, 10,021 (Mar. 13, 1985)), and States are permitted to make seemingly harsh distinctions when offering waiver services, even if those distinctions appear to result in disparate treatment, *id*. at 181. Section 1396n(c) does not expressly guarantee waiver slots or the availability of a waiver at all to any group of individuals, *id.* ("Certainly no broad or categorical

[45] Under the Act, states are specifically allowed to set their own eligibility requirements for waiver services. *See* 42 U.S.C. § 1396n(c); *Skandalis*, 14 F.3d at 181; *Beckwith*, 912 F.2d at 1143-44. States have the option to provide waiver services to "any group or groups of individuals" who qualify for medical assistance under 42 U.S.C. § 1396d(a). 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(VI), 1396n(c); *Skandalis*, 14 F.3d at 179-81.

entitlement can be deemed secured under a program that allows a state to impose a limit of as few as 200 people on the total number of participants."), and the "reasonable promptness" section of the Medicaid Act is not a tool for forcing a state to expand its waiver program. *See Arc of Wash. State Inc. v. Braddock*, 427 F.3d 615, 619 (9th Cir. 2005). Specifically, Texas is permitted under federal law to place a limitation on the number of waiver slots that are available and to set additional eligibility requirements.[46] 42 U.S.C. § 1396n(c)(10); 42 C.F.R. § 441.301(b)(3) (permits states to define groups or subgroups who can receive waiver services); 42 C.F.R. § 441.303(b); *see also Skandalis*, 14 F.3d at 181-82; *Beckwith*, 912 F.2d at 1143-44. Consequently, Plaintiffs' argument that the State violates § 1396a(a)(8) when it creates waivers with specific eligibility criteria that may not include Plaintiffs, or that waiver services are delayed because of the limited number of waiver slots available, fails to state a cognizable § 1396a(a)(8) claim.

Second, § 1396a(a)(8)'s "reasonable promptness" provision applies only to "*eligible* individuals." 42 U.S.C. § 1396a(a)(8) (emphasis added). Courts have 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.'" *McCarthy*, slip op. at 15 (quoting *Boulet v. Celucci*, 107 F.Supp.2d 61, 76–80 (D.Mass. 2000)). In fact, the overwhelming body of case law addressing the "reasonable promptness" provision has held that where a waiver is full, there can be no § 1396a(a)(8) claim.[47] Only those individuals who are eligible for waiver services have a § 1396a(a)(8) claim, and one is not eligible for waiver services until all

[46] Each Medicaid waiver has its own eligibility criteria. *See* 42 CFR § 441.301(b)(3) (waiver request must describe groups to be served); 40 TEX. ADMIN. CODE §§ 9.155 (eligibility requirements for HCS), 45.201 (eligibility requirements for CLASS), and 48.6003 (eligibility requirements for CBA).

[47] The cap is essentially an additional eligibility requirement to fully qualify for waiver services because it establishes an additional subclassification and thus limits the number of individuals who are eligible for waiver services. *Boulet*, 107 F.Supp. 2d at 77; *Susan J. v. Riley*, 254 F.R.D. 439, 454 (M.D. Ala. 2008). The cap on the number of individuals who may receive a waiver slot is also considered a constraint on eligibility for waiver services. *Boulet*, 107 F. Supp. 2d at 76-77.

requirements for the waiver program are met and an open spot in a waiver program is available. *Id.*; *see also Lewis v. N.M. Dept. of Health*, 275 F. Supp. 2d 1319, 1340 (D.N.M. 2003); *McCarthy*, slip op. at 15–16. "Plaintiffs who are not either actually in a Waiver slot or entitled to one have no legal basis to support their claim for the provision of assistance with reasonable promptness." *Susan J. v. Riley*, 616 F.Supp.2d 1219, 1241 (M.D. Ala. 2009). No court has held that reasonable promptness applies to waiver slots when, as with the HSC waiver, the waiver is full.[48]

In this case, Benny Holmes is receiving HCS waiver services, and the other five individual plaintiffs are only on the interest list for the HCS waiver and they admit that there is no waiver slot available for them. Am. Complt. ¶¶ 147, 157, 167, 185, 209, 224. Accordingly, these Plaintiffs have failed to state an actionable claim under § 1396a(a)(8).

c. Plaintiffs have no § 1396a(a)(8) claim under the pre-2010 definition of "medical assistance."

As noted above, currently pending before the U.S. Supreme Court is a challenge to the Patient Protection and Affordable Care Act (PPACA) that may result in the 2010 amendments to the Medicaid statutes at issue here being invalidated in full. *See supra* pp. 28–29. Whether or not these amendments remain effective impacts greatly the viability of the Plaintiffs' claim under § 1396a(a)(8). More specifically, prior to the 2010 amendments,[49] "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 pre-2010 definition, the Fifth Circuit ruled that "medical

[48] A claim under section 1396a(a)(8) has only been recognized in a waiver context with individuals on waiting lists when there are remaining waiver slots that are unfilled. *See Bryson v. Shumway*, 308 F.3d 79, 88-89 (1st Cir. 2002); *Boudreau ex rel. Boudreau v. Ryan*, No. 00-C-5392, 2001 WL 840583, at *10 (N.D. Ill. May 2, 2001), *vacated in part on other grounds sub nom. Bruggerman ex rel. Bruggerman*, 324 F.3d 906 (7th Cir. 2003).

[49] 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.

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*., 562 F.3d 724, 727-29 (5th Cir. 2009).[50] Here, Plaintiffs have claimed only a failure to promptly deliver services; they have not claimed failure to provide financial assistance with reasonable promptness. Am. Complt. ¶¶ 245–46. Accordingly, should the Supreme Court declare the entirety of the PPACA invalid, thereby invalidating the 2010 amendments, Plaintiffs' § 1396a(a)(8) claims must be dismissed in accordance with the pre-2010 law.

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),[51] Plaintiffs' claims under these sections are not cognizable and should be dismissed in their entirety under Rule 12(b)(6). Specifically, Plaintiffs assert that Defendants have violated these provisions of the Medicaid Act by failing to provide residents of nursing facilities with—(1) notice of and equal opportunities to apply for and access medically necessary community-based services; (2) an assessment of their eligibility for such services; and

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[50] 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.

[51] Sections 1396n(c)(2)(B) and (C) 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).

(3) meaningful choice between institutional and community-based services. Am. Complt. ¶ 247. But the focus of § 1396n(c)(2) is much narrower than Plaintiffs' claim, and the plain wording of §§ 1396n(c)(2)(B) and (C) contain none of these requirements.

To begin with, section 1396n(c) falls within the portion of the Act that sets out the requirements for applying for and obtaining approval for home and community-based waivers. In particular, subsection 1396n(c)(2) "prescribes what states must include in their waiver applications to receive approval by the Secretary of Health and Human Services." *McCarthy*, slip op. at 13.

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. Am. Complt. ¶247.

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. Specifically, it says that the Secretary may not grant a waiver—that is, the particular waiver for which the state is applying—unless the state assures that individuals who are determined to be likely to require the level of care provided in a nursing facility "are informed of the *feasible alternatives* to such services, *if available under the waiver*." 42 U.S.C. § 1396n(c)(2)(C) (emphasis added); *see also* 42 C.F.R. § 441.302. In this context, "*the waiver*" means the specific waiver program for which the state is submitting an application seeking

approval from the Secretary.[52] Contrary to Plaintiffs' embellished interpretation, 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*. Moreover, Plaintiffs here admit that the HCS waiver—the only waiver they say they have applied for—has a wait list of approximately 45,756. Am. Complt. ¶ 57. It is well established that when waiver caps have already been met, waiver services are no longer "feasible" or "available" for purposes of § 1396n(c)(2)(C). *See, e.g., Makin v. Hawaii*, 114 F.Supp.2d 1017, 1027–28 (D. Haw. 1999).

Finally, only three of the individual Plaintiffs have alleged that they were not informed of feasible alternatives to NF or ICFs-MR available to them under a Texas waiver. *See, e.g.*, Am. Complt. ¶¶ 158, 186, 199, 226. Plaintiffs Steward and Padron make no such allegation, and therefore, have stated no § 1396n(c)(2)(B) claim. *Id*. §§ 139–48, 160–72.

For all of these reasons, Plaintiffs' have failed to state a § 1396n(c)(2) claim.

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. Am. Complt. ¶¶ 229–30. Plaintiffs' claim fails to state a cognizable claim for four reasons: first, the Act contains no such requirement, and Plaintiffs' interpretation would lead to absurd results not contemplated by the Act; second, Plaintiffs do not allege facts showing they are being deprived of ICF-MR services or that they are receiving NF services in an amount, duration or scope less than other NF residents; third, even if Plaintiffs have otherwise stated a

[52] In the case of a person "determined to be likely to require the level of care provided in a…nursing facility," the referenced "waiver" would be the state's waiver program providing a community-based alternative to services and care in a NF.

§ 1396a(a)(10)(B) claim, there is no cognizable claim for failure to provide specialized services that are not required to be provided to NF residents; and fourth, Texas has no program for the "medically needy" that covers disabled persons,[53] and Plaintiffs do not compare themselves to the "medically needy," so § 1396a(10)(B)(ii) simply does not apply to the facts as plead in this case.

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). 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)("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."). 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. Nothing in § 1396a(a)(10)(B) requires that *all* of the specific services defined in § 1396d(a) must be provided to every developmentally disabled person receiving services in a nursing facility.[54]

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[53] *See* http://www.hhsc.state.tx.us/medicaid/StatePlanDocs/BasicStatePlanAttachments.pdf, p. 79.

[54] 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

Section 1396a(a)(10)(A), by reference to § 1396d(a), establishes the minimum care and services required for categorically needy recipients.[55] The services required for the categorically needy are also set out in the regulations at 42 C.F.R. § 440.210.[56] 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); 42 C.F.R. § 440.225 (governing optional services). The requirements for nursing facilities are completely separate from the requirements for ICFs-MR.[57] *Compare*, 42 C.F.R. § 483.1–483.138 (requirements for nursing facilities, including PASRR) *with* 42 C.F.R. § 483.400–.480. In fact, ICFs-MR are specifically excluded from the definition of NFs. 42 C.F.R. § 483.5. Plaintiffs' claim that care provided through one program's services (ICF-MR services) must necessarily be provided through another program's services (NF services), then, has no basis in law.

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,

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> (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.

[55] 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).

[56] 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; ICFs-MR are not required.

[57] Significantly, neither specialized services nor active treatment is listed or discussed as an independent service. *See* 42 C.F.R. Part 440, § 440.1, *et seq*. Therefore, these services need only be provided to the extent outlined in the requirements for other defined programs, *e.g.*, in NFs or ICFs-MR.

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–.138.

Plaintiffs also fail to state an actionable claim because they 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 (or that they are being denied NF services in the same amount, duration, or scope as other Medicaid recipients receiving NF services). And, for the same reasons discussed above at pages 41−42, Plaintiffs' § 1396a(a)(10)(B) claims relating to the alleged failure to provide the specialized services required by 42 C.F.R. § 483.120(a)(2) and 42 C.F.R. § 483.440(a)–(f) must be dismissed for failure to state a cognizable claim.

Plaintiffs state no claim under § 1396a(a)(10)(B)(ii)—which requires that the assistance provided to the "medically needy" cannot not be greater in amount, duration, or scope than the assistance provided to the "categorically needy"[58]—fails for two reasons. First, Plaintiffs—who describe themselves as "categorically eligible" individuals, based on their disability and income—do not complain that they have received medical assistance different in amount, duration, or scope than "medically needy" individuals. *See* Am. Complt. ¶¶ 248, 249. Furthermore, Texas has no program for the "medically needy" with which Plaintiffs can compare the provision of medical assistance.

Finally, as discussed in relation to § 1396a (a)(8), see *supra* pp. 45−46, should the Supreme Court declare the entirety of the PPACA invalid, thereby invalidating the 2010 amendment to the definition of "medical assistance," Plaintiffs' § 1396a(a)(10)(B) claims must be dismissed because they have not claimed that they have been denied *financial assistance* in violation of § 1396a(a)(10)(B).

[58] 42 U.S.C. § 1396a(a)(10)(B)(ii); *Schweiker*, 457 U.S. at 573 n. 6.

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, no private right of action, and failure to state a claim. 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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