UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

EDWARD DAY, *et al.*,	)	
Plaintiffs,	)	
v.	)	Civil Action No. 10-cv-02250-ESH
DISTRICT OF COLUMBIA, *et al.*	)	
Defendants.	)	

DEFENDANTS' MOTION TO DISMISS, OR IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Pursuant to the Federal Rules of Civil Procedure 12(b)(6), Defendants the District of Columbia, Vincent Gray in his official capacity as Mayor of the District of Columbia, Wayne Turnage in his official capacity as Director of the District of Columbia Department of Health Care Finance, and Stephen Baron in his official capacity as Director of the District of Columbia Department of Mental Health, (collectively "Defendants" or the "District"), hereby move to dismiss Plaintiffs' claims against the District and the individually-named Plaintiffs. In the alternative, the District also moves for summary judgment on each of Plaintiffs' claims under the Federal Rules of Civil Procedure 56 and Local Civil Rule 7(h).

Plaintiffs allege in Count I of their First Amended Complaint ("Complaint") that the District has caused Plaintiffs and class members to be confined in nursing homes in order to obtain long-term services and, in doing so, has violated Title II of the Americans With Disabilities Act, 42 U.S.C §§ 12132 *et seq.* ("ADA"). In Count II, Plaintiffs claim that, for the same reason, the District has violated the Rehabilitation Act, 29 U.S.C. §§ 794 *et seq.*. These claims must be dismissed, or summary judgment granted in favor of the District, for the following reasons:

- First, Plaintiffs have failed to allege any relationship between themselves and the District that suggests the District's actions either resulted in or otherwise affects their residence in a nursing facility.

- Second, even assuming that there is a relationship between the District and Plaintiffs' continued residence in nursing facilities, Plaintiffs have not alleged that the District has determined community-based services are appropriate to meet their needs or that the cost of such care would be less than the cost of the care they receive in nursing facilities.

- Third, Plaintiffs' claims against the individually named defendants, in their official capacities only, are redundant of Plaintiffs' claims against the District.

- Fourth, despite Plaintiffs' attempts to suggest otherwise, the District has instituted several comprehensive and effective programs that facilitate community-based care and transitions from nursing facilities to community-based care.

A statement of points and authorities, a statement of material facts as to which there are no genuine issues, and proposed orders are attached hereto.

Dated: April 27, 2011

Respectfully submitted,

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MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS, OR IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

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PRELIMINARY STATEMENT

Plaintiffs appear to believe that they are entitled to unlimited Medicaid benefits and immediate placement in whatever program provides them the services that they wish to receive in the manner in which they receive them. This position simply is not supported by the Title II of the Americans With Disabilities Act, 42 U.S.C §§ 12132 *et seq.* ("ADA"), and the Rehabilitation Act, 29 U.S.C. §§ 794 *et seq.*

As a preliminary matter, Plaintiffs have failed to allege facts that are necessary for them to prevail on their claims against the District. First, and most surprisingly, Plaintiffs have failed to allege any relationship between their continued residence in nursing facilities and the actions of the District. Second, they have not alleged anything that suggests that, if the District was somehow involved in their placement or continued stay in nursing facilities, that the District has determined community-based services are appropriate to meet their needs or that the cost of such care would be less than the cost of the care they receive in nursing facilities. In addition, Plaintiffs' claims against the individually named defendants, in their official capacities only, are redundant of Plaintiffs' claims against the District and should be dismissed accordingly.

Of greater significance, Plaintiffs fail to understand that the District can, and has, met its obligation to provide its programs in the most integrated manner possible by developing and implementing comprehensive, effective, programs to facilitate care to disabled persons with disabilities in the least restrictive setting appropriate to meet their individual needs. Since 1999, the District has offered the Elderly and Physical Disabilities ("EPD") waiver program and Developmental Disabilities Home and Community Based Services waiver ("DD HCBS") waiver programs, through which any qualifying individual who requires the level of care provided in nursing facilities may instead receive community-based services funded through Medicaid. Through these programs, the District has continually supported home and community based

services for individuals with disability. For example, in Fiscal Year 2010, the District spent $495,887,575 in long-term care services in institutions and under waiver programs. Of that amount, $275,625,616 (55.6%) covered institutional services (intermediate care facilities and nursing homes); $220,261,959 (44.4%) covered home and community-based services under 1915(c) waiver programs for the elderly and physically disabled and persons with intellectual and development disabilities. (Exh. 1, ¶ 3.) Currently, approximately 3,278 individuals are enrolled in the EPD waiver program, which represents a 50% increase from the number of individuals enrolled in the program in 2007. (Exh. 2, ¶ 12.) Moreover, the EPD waiver has not even reached capacity; CMS has approved a cap at 3,940 individuals. (*Id.*, ¶ 10.)

In addition to these waiver programs, the District also has developed and implemented its Money Follows the Person ("MFP") program to provide additional funding and support to individuals transitioning from institutional settings to the community. Under this program, the District has successfully transitioned approximately seventy-seven (77) people from ICFs/MR to the DD HCBS waiver. The District has only recently obtained approval from the federal Center for Medicaid and Medicare Services ("CMS") to extent to extend its program to individuals who reside in nursing homes and who would qualify for the EPD waiver, however. (Exh. 3, ¶ 4.) Now that it has done so, DHCF is working diligently to fully implement this program and provide this additional assistance to individuals eligible for the EPD waiver. CMS also recently approved an additional expansion of the MFP program in March of this year, allowing DHCF to accept an additional three hundred twenty (320) qualified nursing home residents into the MFP program through 2016. (*Id.*, ¶ 27.)

Plaintiffs apparently are not satisfied with these programs, or the District's demonstrated willingness to facilitate community-based services for individuals with disabilities. They appear unwilling to work with the District to help them transition from nursing homes to community-

based services under these comprehensive programs that still have capacity to serve them. But the ADA, the Rehabilitation Act and the principles set forth by a plurality of the United States Supreme Court in *Olmstead, et al. v. L.C., et al,* 527 U.S. 581, 606-07 (1999) do not require that the District provide unlimited funding and dedicate unlimited resources to immediately effect the transition of every individual from a nursing facility who wishes to leave. Ultimately, Plaintiffs have failed to state a cause of action for which relief can be granted. Also, assuming, *arguendo*, that their allegations could survive this motion to dismiss, the District is entitled to summary judgment in its favor. Judgment therefore should be entered in favor of the District and Plaintiffs' First Amended Complaint should be dismissed in its entirety with prejudice.

ARGUMENT

I. LEGAL STANDARDS FOR MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT

Under the Federal Rules of Civil Procedure, the complaint must contain a "short and plain statement of the claim showing that the pleader is entitled to relief." Fed. R. Civ. P. 8(a)(2). This pleading standard "does not require 'detailed factual allegations,' but it demands more than an unadorned, the-defendant-unlawfully-harmed-me accusation." *Ashcroft v. Iqbal*, 129 S. Ct. 1937, 1949 (2009) (quoting *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 555 (2007)). "A pleading that offers 'labels and conclusions' or 'a formulaic recitation of the elements of a cause of action will not do.'" *Id.* (quoting *Twombly*, 550 U.S. at 555). "Nor does a complaint suffice if it tenders 'naked assertions' devoid of 'further factual enhancement.'" *Id.* (quoting *Twombly*, 550 U.S. at 557) (alteration marks omitted).

To survive a Rule 12(b)(6) motion to dismiss, a complaint "must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Id.* (quoting *Twombly*, 550 U.S. at 570). "A claim has facial plausibility when the plaintiff pleads

factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.* (citing *Twombly*, 550 U.S. at 556). This facial plausibility standard "asks for more than a sheer possibility that a defendant has acted unlawfully." *Id.* (citing *Twombly*, 550 U.S. at 556). " Where a complaint pleads facts that are merely consistent with a defendant's liability, it stops short of the line between possibility and plausibility of entitlement to relief." *Id.* (quoting *Twombly*, 550 U.S. at 557) (internal quotation marks omitted).

Although the allegations in the complaint must be taken as true, the Court is "not bound to accept as true a legal conclusion couched as a factual allegation." *Twombly*, 550 U.S. at 555 (internal quotation marks omitted); *see also Iqbal*, 129 S. Ct. at 1949 ("the tenet that a court must accept as true all of the allegations contained in a complaint is inapplicable to legal conclusions"). "[W]here the well-pleaded facts do not permit the court to infer more than the mere possibility of misconduct, the complaint has alleged – but it has not 'shown' – 'that the pleader is entitled to relief.'" *Iqbal*, 129 S. Ct. at 1950 (quoting Fed. R. Civ. P. 8(a)(2)) (alteration marks omitted). Under this standard, the instant complaint must be dismissed.

On the other hand, a "motion for summary judgment test[s] the legal sufficiency of a cause of action." *Smith v. Washington Metro. Area Transit Auth.*, 631 A.2d 387, 390 (D.C. 1993). Summary judgment is appropriate "where there is no genuine issue as to any material fact and the moving party is entitled to a judgment as a matter of law." *Briggs v. Washington Metro. Area Transit Auth.*, 481 F.3d 839, 843 (D.C. Cir. 2007) (ellipsis omitted) (quoting *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247 (1986)). It is "regarded not as disfavored procedural shortcut, but rather as an integral part" of the overall scheme of the rules of civil procedure, "which are designed to secure the just, speedy and inexpensive determination of every action." *Celotex Corp. v. Catrett*, 477 U.S. 317, 327 (1986) (internal quotation omitted).

The party moving for summary judgment bears the initial responsibility of informing the trial court of the basis for its motion and identifying those portions of the record that it believes demonstrate the absence of a genuine issue of material fact. *See Celotex Corp.*, 477 U.S. at 323; *see also Frito-Lay, Inc. v. Willoughby*, 863 F.2d 1029, 1032 (D.C. Cir. 1988). The moving party has no burden, however, of introducing evidence that negates the nonmovant's claim. *See Celotex Corp.*, 477 U.S. at 323; *Frito-Lay, Inc.*, at 1032. Instead, the moving party need only assert that there is a lack of necessary evidence to support the plaintiff's case. At that point, the burden shifts to the nonmoving party to show the existence of a genuine issue of material fact. *See Celotex Corp.*, 477 U.S. at 323. A trial court should enter summary judgment against a nonmoving party "who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which the party will bear the burden of proof at trial." *Celotex Corp.*, 477 U.S. at 322.

By either burden, and as set forth below, Plaintiffs' claims against the District cannot stand. As such, the District is entitled to dismissal with prejudice and/or judgment entered in its favor as a matter of law.

II. THE DISTRICT CANNOT BE HELD RESPONSIBLE FOR CHOICES MADE BY INDIVIDUALS WITH WHOM IT HAS NO RELATIONSHIP

Plaintiffs have filed this lawsuit on behalf of five named plaintiffs and as a putative class action that would include any disabled individual "receiving services in nursing facilities located in the District of Columbia or funded by the Defendants at any time during the pendency of this litigation." (Pls' Amend. Cmplt. at ¶ 96.) A fundamental principle of the American judicial system requires that there be some relationship between a defendant and the alleged harm suffered by the plaintiff before the defendant can be held responsible, however. *See, e.g.*, *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992) (requiring that there be "a causal connection between the

injury and the conduct complained of – the injury has to be fairly traceable to the challenged action of the defendant" as one of the three prongs required to establish constitutional standing). Accordingly, the District cannot be held responsible for an individual "receiving services in a nursing facility" if the District did not cause this placement or otherwise fund the individual's stay in a nursing facility. *See, e.g. Foley v. Bates*, 2007 WL 1831133, at *6 (NDCA March 30, 2007)(dismissing claims to allege any facts that demonstrate a connection between these defendants' purportedly wrongful acts and the plaintiff's alleged harm). Licensing nursing facilities within the District does not create the necessary relationship between the District and a third-party non-licensee, much less create an obligation to provide community-based care to these individuals. *See Gerneth v. Detroit*, 465 F.2d 784 (6th Cir. 1972).

Surprisingly, the named Plaintiffs have not alleged any facts that suggest a connection or a between the District and their placement, or continued stay, in nursing facilities. They do not, and cannot in good faith, claim that the District placed them in the nursing facility in which they reside; as discussed below, the only District agencies that approve or review the placement individuals in nursing facilities, the Department on Disability Services and the Department on Mental Health, were not involved in the placement of the named plaintiffs. Plaintiffs have not even alleged that the District funds their care in nursing facilities. Therefore, even taking all of Plaintiffs' allegations as true, the District's actions, or lack of action, have no effect on the named plaintiffs' continued stay in nursing facilities.

Plaintiffs also have failed to allege that the District has determined community-based services are appropriate for their needs. Instead, they alleged that each named Plaintiff "has been determined by health care professionals to be appropriate for community placement." (Pls' Amend. Cmplt., ¶¶ 31, 35,39, 42, 46.) If Plaintiffs expect the District to fund their community-based services, Plaintiffs are subject to the District's determination of whether or not such services are

appropriate to meet their needs. *Boyd v. Steckel*, 2010 U.S. Dist. LEXIS 120802 at *33 (MDAL Nov. 12, 2010). A bald assertion that some unidentified healthcare professional has determined that community-based services are appropriate to meet the medical and physical needs of the named plaintiffs is not enough. (*Id.*)

Moreover, the District is not required to fund community-based services for Medicaid recipients for whom the cost of such services would exceed the cost of care in a nursing facility. 42 U.S.C. § 1396n(c)(4(A). *See also*, *Sanchez v. Johnson*, 416 F.3d 1051,1054 (9th Cir. 2005). Yet none of the named Plaintiffs even suggest that the cost of the community-based services which they believe would allow them to live in the community would be less than the cost of their care in a nursing facility. For these reasons, the named Plaintiffs have failed to set forth specific facts that, if taken as true, could impose any liability on the District. Therefore, Plaintiffs' First Amended Complaint, both Counts I and II, must be dismissed in its entirety.

III. THE DISTRICT'S COMPREHENSIVE AND EXPANSIVE PROGRAMS REASONABLY FACILITATE THE ABILITY OF DISABLED INDIVIDUALS TO RECEIVE COMMUNITY-BASED SERVICES AND CARE

In addition to failing to state a cause of action for which relief can be granted, the ADA and the Rehabilitation Act do not provide the expansive and unlimited benefits to which Plaintiffs appear to believe they are entitled. [1] The gravamen of Plaintiffs' Complaint is that the District discriminates against people with disabilities by only funding long-term care in nursing facilities, rather than funding community-based services, thus effectively segregating people with disabilities from the community. (Pls' Amend. Cmplt. ¶ 111.) Plaintiffs appear to believe that

[1] Unlike the ADA, the Rehabilitation Act does not expressly recognize segregation of disabled individuals as discrimination and courts are divided on whether interpret the single sentence addressing discrimination attached to vocational rehabilitation legislation to encompass segregation. *Olmstead, et al. v. L.C., et al,* 527 U.S. 581, 600 fn 11 (1999). Nevertheless, courts have found that the Rehabilitation Act is "similar in substance" to the ADA and, therefore, "cases interpreting either are applicable and interchangeable." *The Am. Council of the Blind v. Paulson*, 525 F.3d 1256, 1262 fn 2 (D.C. Cir. 2008).

the law requires the District to appropriate unlimited funds and resources to guarantee community-based services to every disabled individual who wishes to receive them.[2] Despite their apparently interpretation of applicable law, the District is under no such extensive or unlimited obligation.

The principle set forth by the Supreme Court plurality in *Olmstead,* a case stemming from the state's continued institutionalization of mentally ill individuals long after their treatment professionals recommended their transfer to community-based care, requires only that the District have a:

> comprehensive, effectively working plan for placing qualified persons with . . . disabilities in less restrictive settings, and a waiting list that move[s] at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated.

Olmstead, 527 U.S. at 606-07. The District is not obligated to fund community-based services for every individual who otherwise would be entitled to funding for care in a nursing facility. *Boyd*, 2010 U.S. Dist. LEXIS 120802 at *45 (stating that "this Court is not convinced that the intended interaction between the statutes is such that States who choose to have Medicaid and who choose to use optional waiver programs must therefore provide such community-based services to all persons who could benefit from them even when the waiver programs are full"). Moreover, the ADA and the *Olmstead* plurality, "do[] not require the immediate, state-wide deinstitutionalization of all eligible developmentally disabled persons, nor that a State's plan be

[2] Plaintiffs may have based this action upon *Disability Advocates, Inc. v. Paterson,* 653 F.Supp.2d 184 (E.D.N.Y. 2009), a case brought on behalf of individuals with mental illness living in "adult homes." The Eastern District of New York granted the relief the plaintiff sought in that case because the state defendant did not have a plan in place to enable the plaintiff's constituents to receive community-based services. *Id.*, 269-78 (finding that general oversight of the mental health system, inspection of adult homes, and the addition of residents of adult homes to supported living beds, without any actual attempt to include such residents in the supported living program, did not constitute a transition plan). The situation before the *Disability Advocates* court is inapposite to the situation here. As explained in detail below, and as set forth in the affidavits accompanying this motion, the District ***has*** developed comprehensive, successful, plans to enable individuals to receive community-based services and to assist individuals transitioning from nursing facilities, and has expanded these plans to cover individuals such as the five named plaintiffs as soon as the federal program has approved it to do so.

always and in all cases successful." *Sanchez*, 416 F.3d at 1067 (upholding California's program as "genuine, comprehensive, and reasonable," as California had steadily increased the percentage of people receiving community-based services, reduced its institution population by 20%, and applied for increased waiver spots). Instead, a program available to all Medicaid recipients, based on spots available in the program, the recipients' medical needs, and the recipients' ability to secure needed services in the community, satisfies the principle set forth by the *Olmstead* plurality. *See, e.g., The Arc of Wash. State, Inc. v. Braddock*, 427 F.3d 615, 620-21 (9th Cir. 2005).

As a preliminary matter, the District does not concede that *Olmstead* applies to nursing facilities. As recognized by the District Court for the Middle District of Alabama, "the key in *Olmstead* is that the institutionalization must be unjustified and ***unnecessary.***" (*Boyd*, 2010 U.S. Dist. LEXIS 120802 at 29 (emphasis added). *Olmstead* dealt with two individuals who had have been deemed to no longer require institutional care. By definition, however, and as explained below, Medicaid recipients, or DDS or DMH consumers, who reside in nursing facilities require the level of care provided there. Accordingly, their residence in nursing facilities cannot be unjustified or unnecessary.

Nevertheless, even if the Court were to find that *Olmstead* applies to nursing facilities, Plaintiffs' unwillingness to work with the District to obtain spots in programs for which they may be eligible and that currently have capacity to facilitate their transition to community-based services does not suggest, much less establish, that the District has failed to meets its obligations under applicable law. The District has comprehensive and effective working plans that ensure it does not place individuals in nursing facilities unless it is necessary and appropriate to do so, as well programs that fund community-based services and specifically support the transition of disabled individuals from nursing facilities to community-based settings.

The District has embraced its obligation to provide community-based care. Three District agencies help determine whether placement in a nursing facility is appropriate or otherwise fund care for residents of nursing facilities. The Department on Disability Services, Developmental Disabilities Administration ("DDS" and "DDA," respectively) provides outreach and service coordination services, among other things, to individuals with intellectual disabilities. The Department of Mental Health provides comprehensive mental health services and supports to District residents in need of the public mental health system. As part of their operations, DDA and DMH may determine that placement in nursing facilities is appropriate if the individual requires the level of care available there.

Conversely, the Department of Health Care Finance ("DHCF"), the District agency that administers the Medicaid program within the District, does not place individuals in nursing facilities. Rather, DHCF funds care received by individuals eligible for its programs ("recipients" or "beneficiaries") by making direct payments to providers enrolled with the state Medicaid organization.[3] As a condition of receiving federal funds to pay for medical services received by qualified individuals, the District was required to submit a State Plan to be approved by the federal Centers for Medicaid and Medical Services ("CMS"). 42 USCS § 1396a. The District's State Plan is a comprehensive document that describes the nature and scope of DC Medicaid, including the manner in which DC Medicaid complies with the specific requirements of Title XIX of the Social Security Act. 42 USCS § 1396a(a); 42 C.F.R.§ 430.10 DHCF will pay for nursing

[3] State Medicaid organizations are required to "provide for making medical assistance available," 42 U.S.C. § 1396a(a)(10). The statute defines "medical assistance" as the "payment of part or all of the cost of the following care and services or the care and services themselves, or both," however. 42 U.S.C. § 1396d(a). Therefore, states are not required to directly provide medical services under the Medicaid Act, but to pay for the cost enumerated services provided to Medicaid beneficiaries. *See also, Ok. Chapter of the Am. Academy of Pediatrics v. Fogarty*, 472 F.3d 1208, 1215 (10th Cir. 2007).

home care if the vendor with whom DHCF contracts to make level of care determinations, currently Delmarva, decides the recipient requires the level of care provided in such a facility.

a. The District's Comprehensive, Effective, Programs That Facilitate Community-Based Services For Disabled Residents Are Available To Plaintiffs

Notwithstanding Plaintiffs' characterizations to the contrary, DHCF is fully committed to funding community-based services and facilitating the transition of individuals from nursing facilities. In furtherance of this goal, DHCF has been working with private and public partners and stakeholders such as University Legal Services to develop strategies to best transition individuals with disabilities from institutional settings to community-based services since 2007. (Exh. 3, ¶ 3.) DHCF has done significantly more than discuss best practices, however. DHCF operates several programs for which the named plaintiffs appear to be eligible that fund community-based services and, specifically, supports the transition of Medicaid recipients from nursing facilities to community-based services, including the EPD waiver program and the MFP program.

i. Elderly and Physically Disabled Waiver Program

The District has offered the EPD waiver program since 1999, using federal and local money to pay for home and community-based care to any qualified individuals aged sixty-five (65) and over and the physically disabled population aged eighteen (18) to sixty-four (64) who otherwise would require the level of care provided in a nursing home. (Exh. 3, ¶ 4.) *See also,* 42 USCS § 1396a (a)(10)(ii)(VI); 42 USC § 1396n(c); 42 C.F.R. § 441.301. Any individual who meets the eligibility requirements for the EPD waiver may participate, regardless of whether they reside in a nursing facility or whether they reside in the community when they apply for the program.[4] (*Id.*)

[4] Information about the EPD waiver is available on the DHCF and District of Columbia Office on Aging web-sites. (Exh. 3, ¶ 11) DHCF's Office of Chronic and Long-Term Care (CLTC) and the Office of the Ombudsman also send out information about the EPD Waiver program to callers requesting information. The Aging and Disabilities

Candidates for the EPD waiver program work with a case manager, a private, Medicaid-enrolled, provider selected by the candidate to create an individual service plan ("ISP") that is subject to DCHF approval and that must specify the community-based services to be furnished, their frequency, the type of provider who will furnish each specified service, and how backup and emergency services will be provided. (*Id.*, ¶¶ 6-7.) As part of this program, DHCF may pay for case management services, homemaker services, personal care aides, respite care, environmental adaptation and accessibility, personal emergency response services, assisted living services, and chore services. (*Id.*, ¶ 5; see also, Exh. 4 EPD 2007 Renewal, at 48-88.) DHCF is prohibited from paying for housing, meals, room and board, or 24-hour skilled care or supervision under the program. (Exh. 2, ¶ 8; Exh. 4, at 70, 167.)

DHCF could not implement its EPD waiver program before it received approval from CMS to do so, which it first received in 1999. (Exh. 2, ¶ 3.) CMS has twice approved the continuation of this program, most recently on March 29, 2007 and which remains valid for 5 years. (*Id.*) The cost of the EPD waiver program cannot exceed the cost of care absent a wavier program, nor can the cost of community-based services necessary to meet an individual's needs exceed the cost of services the individual would receive in a nursing facility. (*Id.*, ¶ 9.) Furthermore, the number of beneficiaries who can participate in each year in a waiver program is limited to the number approved by CMS. 42 C.F.R. § 441.303(f)(6). Currently, the EPD waiver is capped at 3,940 participants. (Exh. 2, ¶ 10.)

ii. Money Follows the Person Program

In addition to the EPD waiver, DHCF administers the Money Follows the Person ("MFP") program specifically designed to facilitate transitions from institutional settings to the community

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Resource Center in is the process of finalizing a brochure about the EPD Waiver program in conjunction with DHCF. (*Id.*)

and community-based services by helping such individuals identify and procure services necessary to allow them to live in the community. (Exh. 2, ¶ 4.). As with the EPD waiver program, the MFP program is limited to the number approved by CMS annually. (*Id.*, ¶ 6.) After initial referral of a nursing home resident for the MFP program, a candidate is referred to a Transition Coordinator, who then provides the candidate with a list of Medicaid enrolled case management providers from which the candidate selects the case manager with whom he or she would like to work. (*Id.*, ¶ 14.) MFP case managers work with an ISP team, usually comprised of the candidate, the case manager, the candidates' legal representative, and nursing facility staff familiar with the resident to create an ISP specifying the community-based services to be furnished, their frequency, the type of provider who will furnish each specified service, and how backup and emergency services will be provided. (*Id.*, ¶ 15.)

Unlike the EPD waiver program, however, only individuals currently residing in institutional settings, and therefore able to transition to community-based services, are eligible for this program. An MFP participant's transition to the community and first year of qualified community-based services are paid for at an enhanced Federal Match rate (89.65%. decreasing in 2011 to 85% under Federal regulation) under the MFP program, including a maximum $5,000 one-time transition service payment to purchase furniture, cooking utensils, and other items essential to living in the community, and to cover moving expenses. (*Id.*, ¶ 18.) After this initial year, MFP participants who continue to meet the eligibility requirements are transitioned from the MFP program to the EPD waiver program. (*Id.*, ¶ 5.)

CMS initially approved the District's MFP program in 2007. (*Id.*, ¶ 4.) The District could not begin the operational phase of the MFP program until CMS approved the Operational Protocol in June 2008, at which time CMS limited the District to running a pilot program limited solely to supporting the transfer of individuals with intellectual disabilities from Intermediate Care Facilities

for individuals with Mental Retardation ("ICFs/MR") under the DD HCBS.[5] (*Id.*) Furthermore, CMS did not approve DHCF's Operational Protocol for the MFP waiver program until October 2010, thereby preventing the District from beginning to expand this program to nursing homes residents eligible for the EPD waiver until the end of 2010. (*Id.*, ¶¶, 11-12; *see also*, Exh. 8, Oct. 22, 2010 Operational Protocol Amendment.)

Even though CMS had not yet approved the District's MFP Operational Protocol, University Legal Services provided DHCF a list of thirty (30) nursing home residents it claimed wished to transition to the MFP program in March 2010. (*Id.*, ¶ 23.) In anticipation of CMS approval of the MFP operational protocol, DHCF therefore launched an expanded MFP pilot project involving forty (40) nursing home residents in collaboration with the DC's Aging and Disability Resource Center, in August 2010. DHCF included any of the thirty (30) individuals identified by University Legal Services who still resided in nursing facilities at the time the pilot project was initiated, or sixteen (16) people. (*Id.*)

Furthermore, since CMS approved the expansion of the MFP pilot program to include individuals eligible for the EPD waiver, DHCF has been able to take other steps to implement the MFP program. For example, DHCF has hired two full-time Transition Coordinators focused on transitions from nursing facilities who, among their other duties, meet with nursing home administrators and staff to inform them about the EPD waiver program. (*Id.*, ¶ 26.) DCOA/ARDC also is in the process of hiring two (2) additional full-time MFP Transition Coordinators who will focus on transitions from nursing facilities. (*Id.*) Transition Coordinators

[5] Plaintiffs' counsel are well aware of the District's efforts in this area as University Legal Services ("ULS"), who represent Plaintiffs' in this lawsuit, was a member of the Money Follows the Program Advisory Committee and continued to receive updates from this program until this lawsuit was filed. Indeed, ULS has characterized itself as a co-author of the MFP proposal that was submitted to CMS and has taken credit for drafting portions of the MFP Operation Protocol. (Exh. 7, ULS newsletter from Summer 2008, at pp. 13-14, recognizing that DHCF could not implement the MFP program until CMS approved the Operational Protocol describing how the District's MFP program will work).

also assist with housing arrangements, work with the EPD waiver Case Manager selected by the participant to develop the participant's ISP, help coordinate the participant's initial move, and assess existing barriers that prevent an otherwise willing and eligible person for successfully transition to the community. (*Id.*) The District also established an Aging and Disability Resource Center Transition Team ("ARDC Transition Team") to begin the implementation of the MFP Operational Protocol. The ARDC Transition Team used a preference interview tool to identify residents of nursing facilities identified by ULS and nursing home administrators to determine eligibility for the MFP Demonstration. (*Id.*, ¶ 24.)

Through its Data Use Agreement with the District's Department of Health, DHCF and the MFP Project Team also requests and receives quarterly Minimum Data Set (MDS) information from The Delmarva Foundation. (*Id.*, ¶ 13.) Nursing facilities are required to collect certain information about their residents at least every three months by federal law. 42 C.F.R. 483.20(c) ("A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.") As part of what has been designated Section Q of this review, CMS requires nursing facilities to ask residents directly if they wish to speak to someone about the possibility of returning to the community and to refer any individual who answers affirmatively to the District. DHCF relies on this information and lists of possible candidates for the MDP program submitted by advocacy groups and nursing facilities, including individuals who have self-identified as being interested in transitioning to the community, to identify whether a nursing home resident is a potential candidate for the MFP program.

DHCF also has worked closely with the DC Health Care Association ("DCHCA"), the trade association for nursing homes, to inform administrators and staff about the MFP demonstration program. (Exh. 3, ¶ 13.) The Executive Director of the DCHCA is an active

member of the MFP Stakeholder Advisory Commission and has worked with members of the MFP Project Team to disseminate information to administrators and staff via email and in person at DCHCA meetings. (*Id.*) The MFP Outreach Specialist housed in the DC Office on Aging/Aging and Disability Resource Center also contacted each nursing home in the District by telephone in June 2010 to reintroduce the MFP Demonstration and conducted one-on-one follow-up visits with interested administrators and social work/nursing staff to provide preliminary information in anticipation of the official submission and approval of the MFP Operational Protocol expanding the MFP program to people eligible for the EPD waiver. (*Id.*) The Outreach Specialist has begun a list of nursing home residents' names who are candidates for MFP either based on nursing homes administrators' and/or staff recommendations or self-referral. (*Id.*) Moreover, the Outreach Specialist will continue to provide information to nursing home residents, administrators and staff through meetings of the DCHCA, and nursing home resident councils, as well as one-on-one meetings with residents who express an interest in transitioning to the community. (*Id.*)

b. The District Will Only Approve Placement Of Individuals In Nursing Facilities If Necessary And Appropriate

As referenced above, DMH and DDA, may determine that placement in a nursing facility is appropriate for individuals from the populations that they serve. Significantly, however, both DMH and DDA require stringent reviews of any proposed placement in a nursing facility to ensure that placement in a nursing home is both medically necessary and the least restrictive, most appropriate, location to meet the needs of this individual.

Under federal regulations which require an independent evaluation of all referrals to nursing facilities for individuals with mental illness and mental retardation, DMH conducts Pre-admission Screening and Resident Reviews ("PASRR") for any individual indentified by his or

her provider as having a mental health diagnosis and for whom the provider has reason to believe placement in a nursing facility will be appropriate. (Exh. 5, ¶ 3.) The referring clinician conducts the Level 1 Screening to determine whether an individual being referred to a nursing facility has a primary or secondary diagnosis of mental illness. (*Id.*, ¶ 4.) If so, DMH conducts a Level II Screening, which requires an independent psychiatric evaluation of the individual and a determination as to whether the level of care provided by a nursing facility is required. (*Id.*)

DMH does not operate, or provide services in, nursing facilities. Therefore, if placement in a nursing facility is deemed appropriate and the individual is admitted into a nursing facility, the facility assumes all responsibility for that individual's physical and mental health care.[6] Nevertheless, nursing facilities are required to notify DMH and request a PASSR review if a patient with a primary or secondary mental health diagnosis has undergone significant change in his or her physical or mental conditions.[7] (*Id.*, ¶ 5.) DMH reminded the nineteen (19) nursing facilities within the District of Columbia, which provide direct care to their residents, of their continuing obligation to notify DMH of any significant changes in the physical or mental condition of a nursing facilities resident on October 8, 2010 and again on January 12, 2011. (*Id.*, ¶ 6.) In addition, Dr. Elspeth Ritchie, the Chief Clinical Officer with DMH who is responsible for managing the PASRR determinations for current and potential nursing facility residents, has personally reached out to nursing facilities to remind them of their obligations to request PASARR reviews. To date, she has visited seven (7) nursing facilities to discuss the PASRR program and provide technical assistance and has two (2) additional visits scheduled. (*Id.*, ¶ 6.)

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[6] The District has been unable to find any legal support for Plaintiffs' apparent assertion that the District is responsible for ensuring continuity of care by facilitating continued access to the same providers from whom residents of nursing facilities were receiving care in the community.

[7] Vietress Bacon is the only named plaintiff in this lawsuit who has alleged a primary or secondary diagnosis of mental illness. DMH has conducted a PASARR review of Ms. Bacon and determined that her physical disabilities required the level of care provided in a nursing facility. Ms. Bacon therefore is working with DHCF, as part of the MFP pilot program, to transition from the nursing facility in which she currently resides to the community.

DDA, which oversees and coordinates care for 2,094 individuals with developmental disabilities, and none of whom are the named plaintiffs, also requires a thorough review of an individual's needs before placing him or her in a nursing facility. (Exh. 6, ¶¶ 3-5, 15.) When determining which services are necessary for an individual it serves, DDA assumes that all individuals can live in the most inclusive setting possible, and an individual's ISP must address any deviation from this assumption and must be reviewed by DDA's Human Rights Advisory Committee ("HRAC"). (*Id.*, ¶¶ 6-7.) Before DDA approves placement in a nursing facility, the individual, his or her family or guardian and advocate, if any, the current service provider and medical staff, and the HRAC must be involved in that decision. (*Id.*, ¶ 9.) Moreover, the ISP must document why a community setting is not appropriate, a determination that must be corroborate by a medical provider not currently directly involved in the individual's ongoing care. (*Id.*) The ISP also must include a description of the specific supports and services required due to the individual's diagnosis and medical status, and specify a planning process to address the individual's needs and potential barriers to the individual's transition back to a community-based setting. (*Id.*)

Finally, after an individual has been placed in a nursing facility, his or her advocate or DDA service coordinator must appear monthly before the HRAC to justify the individual's continued residence in a nursing facility. (*Id.*, ¶ 11.) If the HRAC believes placement in a nursing facility no longer is appropriate for an individual, it recommends that DDA aggressively pursue an alternative, less restrictive, setting that can appropriately meet the individual's needs. (*Id.*, ¶ 12.) DDA's Provider Resource Management Unit and Service Planning and Coordination Division will work to identify the appropriate residential setting and/or other relevant support and service providers and, once these providers are secured, the individual is transitioned to the community-based residential setting. (*Id.*, ¶ 13.)

c. The District Has, and Continues to, Successfully Implement Its Comprehensive Programs that Support and Facilitate Community-Based Services

Plaintiffs' insinuation that the District has done nothing to support home and community-based services for its disabled residents is belied by reality. As required by the ADA and the core principle of *Olmstead*, the District has comprehensive programs, policies, and procedures in place that effectively ensure that individuals with disabilities are receiving care in the most integrated setting appropriate to care for their physical, medical, and mental health needs. As evidenced by the number of individuals currently served in the waiver programs, the amount of money spent on community-based services, and the District's diligent efforts to increase available funding, the District's efforts overall have been successful.

Candidates for the MFP program are not given a spot in the program and transitioned to the community until all necessary community-based services are identified and approved, and housing appropriate to meet his or her needs is procured. (Exh. 3, ¶ 20.) Candidates for the MFP program with whom DHCF is currently working, and who would be eligible for the EPD waiver, have encountered several barriers to transition to the community, and thus barriers to being placed in the MFP program. For example, certain candidates lack housing in the community in which they can receive community-based services; they require public housing assistance. (*Id.*, ¶ 21.) DHCF does not pay for housing.[8] MFP candidates eligible for the EPD Waiver may apply to the District of Columbia Housing Authority ("DCHA") for a spot in the Housing Choice Voucher program and the

[8] The District is not aware, and has not been able to locate, any statue or legal decision that would obligate it to provide or subsidize housing for any and all individuals otherwise medically eligible for Medicaid. As explained in footnote one, *supra*, DHCF's legal duty is to fund qualifying care for beneficiaries. DHCF's mandate does not change or expand because its beneficiaries lack housing in which to receive community-based services. Nor is the District required to providing housing or extra financial support because of a possible lack of accessible housing stock on the market. As long as the District is administering the programs it offers evenly across the disabled population, it has satisfied the requirements of the ADA. The District is not required to attempt to remedy a lack of resources for individuals with disabilities through new or additional government-run programs. The ADA "seeks to assure even handed treatment and the opportunity for handicapped individuals to participate in and benefit from [government] programs, [it] does not guarantee the handicapped equal results." *Liberty Resources* at 566 (discussing *Alexander v. Choate,* 469 U.S. 287, 301 (1985)and the Supreme Court's application of the Rehabilitation Act)

Moderate Rehabilitation program, but these programs are available to any qualified individual regardless of disability.[9] (*Id.*, ¶ 17.) Transition Coordinators work with MFP and EPD candidates to secure housing, including by assisting them in filing out the appropriate housing vouchers forms. (*Id.*, ¶ 26.) In 2011, DHCF was able to secure ten (10) additional housing choice vouchers specifically for non-elderly Medicaid recipients. (*Id.*, ¶ 18.) Nevertheless, there is a limited supply of Housing Choice Vouchers set aside specifically for MFP participants (currently under 100 for all MFP transitions through the end of the Demonstration) and a diminished use of other federal housing subsidy programs. (*Id.*, ¶ 21.) Some candidates also have credit histories that prevent property managers from approving leasing applications; others lack family members or friends willing to provide support in the community in preparation for, during, and post-transition. (*Id.*)

Furthermore, some candidates cannot secure the services necessary to meet their physical and medical needs in the community. Some require a level of care that cannot be provided by the District's current Home and Community-Based Service (HCBS) system. In addition, some necessary services are not provided in the HCBS waiver package (adult day services, 24-hour care), and in certain situations the current pool of HCBS waiver providers do not have the capacity to provide these services based on the number of qualified staff and a provider's ability, readiness, and willingness to accept liability for level care needed). (*Id.*)

Despite the complexities inherent in fully implementing a program as necessarily intricate as the MFP program and a lack of housing appropriate to meet the needs of the disabled population available on the market, the District has demonstrated that its efforts with individuals eligible for the DD HCBS waiver have been successful. In Fiscal Year 2010, the District spent $495,887,575 in long-term care services in institutions and under waiver programs in Fiscal Year 2010. Still, $220,261,959 of the money spent covered home and community-based services

[9] Individuals aged sixty-two (62) and older also may be eligible for housing subsidies available to residents of seniors-only housing. (*Id.*, ¶ 15.)

under 1915(c) waiver programs for the elderly and physically disabled and persons with intellectual and development disabilities. (Exh. 1, ¶ 3.)

Moreover, as of April 2011, approximately 3,278 individuals are enrolled in the EPD waiver program. (Exh. 2, ¶ 15.) Further, since October 2008, the District has transitioned approximately seventy-seven (77) people from ICFs/MR to the DD HCBS waiver – these individuals are now receiving community-based services. (*Id.*, ¶ 4.) CMS also approved an additional expansion of the MFP program, allowing DHCF to accept an additional three hundred twenty (320) qualified nursing home residents into the MFP program through 2016. (*Id.*, ¶ 27.)

The District reasonably expects to have the same success with the MFP program as it pertains to individuals eligible for the EPD waiver program as it has had with individuals transitioning from institutional settings to the DD HCBS waiver. DHCF is working with 26 candidates for the MFP program, including all MPF pilot participants who remain interested in receiving community-based services. (Exh. 3, ¶ 25.) For example, DHCF is not currently working with plaintiff Edward Day, as he indicated to the ARDC Transition Coordinator who met with him to discuss a possible transition to community-based services that he was not interested in leaving the nursing facility where he resides.

Transition Coordinators have met with all residents in the pilot to align both housing and health services and Housing Choice Voucher applications have been submitted to the DC Housing Authority for all pilot participants. (*Id.*) Participants have also been connected to EPD HCBS Waiver case management agencies to conduct initial EPD Waiver assessments. The first nursing home resident transitioned on April 13, 2011, and all pilot participants should be transitioned by September 2011 barring any unanticipated barriers, many of which were listed above. (*Id.*) DHCF also anticipates transitioning eighty (80) nursing home residents to the community under the MFP program each year from 2011 through 2016. (*Id.,* ¶ 28.)

The efforts of DMH and DDS also have successfully increased the number of individuals within the populations served by these agencies receiving community-based services. For example, as a result of DDA's rigorous human rights policy, very few individuals served by DDA are placed in nursing facilities. As of December 31, 2008, eight (8) individuals served by DDA resided in nursing facilities; as of December 31, 2009, six (6) individuals served by DDA resided in nursing facilities; and as of December 31, 2010, five (5) individuals served by DDA resided in nursing facilities. (Exh. 6, ¶ 13.)

Plaintiffs may wish that the District could provide unlimited funding and support to allow for the immediate de-institutionalization for all individuals for whom community-based services could be appropriate. But Plaintiffs' desires do not create legal obligations under which the District must operate. The District has the comprehensive and effective programs to transition individuals from nursing facilities to community-based services as required by the *Olmstead* plurality, and is working with plaintiffs to do just that. Plaintiffs cannot prevail under the theory of liability they have put forth in their First Amended Complaint, and judgment accordingly should be entered in favor of this District.

IV. MAYOR VINCENT GRAY, WAYNE TURNAGE AND STEPHEN BARON SHOULD BE DISMISSED AS PARTY DEFENDANTS

In addition to the reasons above why Plaintiffs' claims should be dismissed in their entirety, Plaintiffs cannot maintain a suit against the individually-named defendants who have been sued in their official capacities only. A suit against a municipal official in his or her official capacity is a suit against the municipality that employs that official. *Kentucky v. Graham*, 473 U.S. 159, 165-66 (1985) (recognizing that official capacity suits "generally represent only another way of pleading an action against an entity of which an officer is an agent") (internal citations omitted). Accordingly, "[b]ecause it is duplicative to name both a governmental entity

and the entity's employees in their official capacity, claims against individuals named in their official capacity have been routinely dismissed as redundant and an inefficient use of judicial resources." *Barnes v. District of Columbia*, 2005 U.S. Dist. LEXIS 10435, at *9 (D.D.C. May 24, 2005) (internal quotation marks omitted) (quoting *Cooke-Seals v. District of Columbia*, 973 F. Supp. 184, 187 (D.D.C. 1997)).

Here, the plaintiffs have sued defendants Vincent Gray, Wayne Turnage and Stephen Baron solely in their official capacities as the Mayor of the District of Columbia, the Director of the District of Columbia Department of Health Care Finance and Director of the District of Columbia Department of Mental Health, respectively. The suits against them are duplicative and redundant of the plaintiffs' claims against the District; thus, all claims against defendants Gray, Turnage, and Baron should be dismissed, these individuals should be dismissed from this lawsuit, and the caption amended accordingly.

V. D.C. OFFICIAL CODE § 2-1431.048(A) DOES NOT CONFER A PRIVATE RIGHT OF ACTION

Plaintiffs also appear to complain about Mayor Vincent Gray's purported failure to finalize, through the Office of Disability Rights, an "*Olmstead* Plan" as required by D.C. OFFICIAL CODE § 2-1431.048(A). (First Amend. Complaint, ¶ 20.) While all charges should be dismissed against Mayor Gray for the reasons discussed above, to the extent Plaintiffs would pursue a claim under D.C. OFFICIAL CODE § 2-1431.048(A), this provision does not establish a private right of action.

Plaintiffs have no cause of action under a statutory provision unless the legislative body enacting the provision intended to confer individual rights upon a class to which the plaintiffs belong. *Gonzaga Univ. v. Doe*, 536 U.S. 273, 285-86 (2002) (finding no cause of action "where the text and structure of a statute provide no indication that Congress intends to create new

individual rights"). To determine whether a private right of action exists, courts must consider whether plaintiffs are "of the class for whose especial benefit the statute was enacted" and whether there is "any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one." *Cal. v. Sierra Club*, 451 U.S. 287, 293 (1981) (finding that neither the language of the statute in question or its legislative history suggested that the legislature intended to create a private right of action). Pursuant to D.C. OFFICIAL CODE § 2-1431.048(A), the District of Columbia Office of Disability Rights is instructed, "[n]o later than one year after the establishment of the Office, and by January 1 of each year thereafter, submit to the Mayor and Council an Olmstead Compliance Plan." Nothing in this provision authorizes Plaintiffs to sue for relief. As is clear from the plain language, it does grant rights to any class of persons and does not contain the elements required for an implied right of action under the law. Indeed, this provision refers only to a report to be submitted annually to the Mayor and the D.C. Council. Because the statute does not contain any language indicating, or even implying, that enforceable rights are created in private citizens or other third parties, the District is entitled to a dismissal of this implied claim.

CONCLUSION

Because Plaintiffs have failed to allege any relationship between their continued residence in nursing facilities and the actions of the District, that the District has concluded that community-based services are appropriate to meet their needs, or that the cost of such care would be less than the cost of the care they receive in nursing facilities, Plaintiffs have failed to allege facts necessary to prove their claims against the District. Furthermore, because Plaintiffs have sued the individually-named defendants in their official capacities only, these claims are redundant. In addition, any implied claim under D.C. OFFICIAL CODE § 2-1431.048(A) cannot stand, as this provision does not confer a private cause of action. For these reasons, Plaintiffs' First Amended

Complaint should be dismissed in its entirety, or the claims against the individually-named defendants and any implied claim under D.C. OFFICIAL CODE § 2-1431.048(A) should be dismissed.

Moreover, because the District has several comprehensive, effective, programs to facilitate community-based services for disabled individuals, it is entitled to judgment in its favor. Plaintiffs simply are not entitled to the unlimited government-funded services or to demand different procedures because they are unwilling to work with the District to obtain spots in the District's existing programs. For these reasons, judgment therefore should be entered in favor of the District and Plaintiffs' First Amended Complaint should be dismissed in its entirety.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

EDWARD DAY, *et al.*,	)	
Plaintiffs,	)	
v.	)	Civil Action No. 10-cv-02250-ESH
DISTRICT OF COLUMBIA, *et al.*	)	
Defendants.	)	

STATEMENT OF MATERIAL FACTS
AS TO WHICH THERE IS NO GENUINE ISSUE

1. The District has offered the Elderly and Physical Disabilities ("EPD") waiver program since 1999, when it first received approval from the Center for Medicaid and Medicare Services ("CMS") to do so. (Exh. 2, ¶¶ 3-4.)
2. Through the EPD waiver program, the District uses federal and local money to pay for home and community-based care to any qualified individuals aged sixty-five (65) and over and the physically disabled population aged eighteen (18) to sixty-four (64) who otherwise would require the level of care provided in a nursing home. (*Id.*, ¶ 4.)
3. Any individual who meets the eligibility requirements for the EPD waiver may participate, regardless of whether they reside in a nursing facility or whether they reside in the community when they apply for the program. (*Id.*, ¶ 4.)
4. DHCF may pay for case management services, homemaker services, personal care aides, respite care, environmental adaptation and accessibility, personal emergency response services, assisted living services, and chore services. (*Id.*, ¶ 5; see also, Exh. 4 EPD 2007

Renewal, at 48-88.) Housing, meals, room and board, or 24-hour skilled care or supervision are not eligible expenses under the EPD waiver program. (Exh. 2, ¶ 8.)

5. Candidates for the EPD waiver program work with a case manager, a private, Medicaid-enrolled, provider selected by the candidate to create an individual service plan ("ISP") that is subject to DCHF approval and that must specify the community-based services to be furnished, their frequency, the type of provider who will furnish each specified service, and how backup and emergency services will be provided. (*Id.*, ¶¶ 6-7.)

6. The EPD waiver program must be cost-neutral; the cost of the program in its entirety cannot exceed the cost of care absent a wavier program, nor can the cost of community-based services necessary to meet an individual's needs exceed the cost of services the individual would receive in a nursing facility. (*Id.*, ¶ 9.) In addition, the number of beneficiaries who can participate in each year in a waiver program is limited to the number approved by CMS. (*Id.*, ¶ 10.) CMS has approved a cap at 3,940 individuals. (*Id.*, ¶ 10.) Approximately 3,278 individuals are enrolled in the EPD waiver program. (*Id.*, ¶ 12.)

7. Information about the EPD waiver is available on the DHCF and District of Columbia Office on Aging websites. (*Id.*, ¶ 14) DHCF's Office of Chronic and Long-Term Care (CLTC) and the Office of the Ombudsman also send out information about the EPD Waiver program to callers requesting information. The Aging and Disabilities Resource Center in is the process of finalizing a brochure about the EPD Waiver program in conjunction with DHCF. (*Id.*, ¶ 14.)

8. In Fiscal Year 2010, the District spent $495,887,575 in long-term care services in institutions and under waiver programs. Of that amount, $275,625,616 (55.6%) covered institutional services (intermediate care facilities and nursing homes); $220,261,959 (44.4%) covered home and community-based services under 1915(c) waiver programs

for the elderly and physically disabled and persons with intellectual and development disabilities. (Exh. 1, ¶ 3.)

9. DHCF also operates the Money Follows the Person ("MFP") program, providing additional funding and support to individuals transitioning from institutional settings to the community. (Exh. 3, ¶ 4.).

10. An MFP participant's transition to the community and first year of qualified community-based services are paid for at an enhanced Federal Match rate (89.65%. decreasing in 2011 to 85% under Federal regulation) under the MFP program, including a maximum $5,000 one-time transition service payment to purchase furniture, cooking utensils, and other items essential to living in the community, and to cover moving expenses. (*Id.*, ¶ 18.) After this initial year, MFP participants who continue to meet the eligibility requirements are transitioned from the MFP program to the EPD waiver program. (*Id.*, ¶ 5.)

11. As with the EPD waiver program, a candidate for the MFP program is referred to a Transition Coordinator, who then provides the candidate with a list of Medicaid enrolled case management providers from which the candidate selects the case manager with whom he or she would like to work. (*Id.*, ¶ 14.) Case Managers work with an ISP team to create an ISP specifying the community-based services to be furnished, their frequency, the type of provider who will furnish each specified service, and how backup and emergency services will be provided. (*Id.*, ¶ 15.)

12. CMS initially approved the District's MFP program in 2007, but did not approve the Operational Protocol until June 2008. (*Id.*, ¶ 4.) At that time, CMS limited the District to running a pilot program limited solely to supporting the transfer of individuals with intellectual disabilities from Intermediate Care Facilities for individuals with Mental Retardation ("ICFs/MR") under the DD HCBS. (*Id.*) CMS did not approve DHCF's

Operational Protocol for the MFP waiver program until October 2010, thereby preventing the District from beginning to expand this program to nursing homes residents eligible for the EPD waiver until the end of 2010. (*Id.*, ¶¶, 11-12.)

13. The MFP program is limited to the number annually approved by CMS annually. (*Id.*, ¶ 6.) CMS recently approved an additional expansion of the MFP program in March of this year, allowing DHCF to accept an additional three hundred twenty (320) qualified nursing home residents into the MFP program through 2016. (*Id.*, ¶ 27.)

14. Under the MFP program, the District has successfully transitioned approximately seventy-seven (77) people from ICFs/MR to the DD HCBS waiver.

15. Since the MFP Operational Protocol was approved, DHCF has hired two full-time Transition Coordinators focused on transitions from nursing facilities who, among their other duties, meet with nursing home administrators and staff to inform them about the EPD waiver program. (*Id.*, ¶ 26.) DCOA/ARDC also is in the process of hiring two (2) additional full-time MFP Transition Coordinators who will focus on transitions from nursing facilities. (*Id.*) Transition Coordinators also assist with housing arrangements, work with the EPD waiver Case Manager selected by the participant to develop the participant's ISP, help coordinate the participant's initial move, and assess existing barriers that prevent an otherwise willing and eligible person for successfully transition to the community. (*Id.*)

16. The District established an Aging and Disability Resource Center Transition Team ("ARDC Transition Team") to begin the implementation of the MFP Operational Protocol. The ARDC Transition Team has used a preference interview tool to identify residents of nursing facilities identified by ULS and nursing home administrators to determine eligibility for the MFP Demonstration. (*Id.*, ¶ 24.)

17. DHCF and the MFP Project Team requests and receives quarterly Minimum Data Set (MDS) information from The Delmarva Foundation, comprised of information nursing facilities are required to collect about their residents at least every three months. (*Id.*, ¶ 13.) This information includes whether residents wish to speak to someone about the possibility of returning to the community and to refer any individual who answers affirmatively to the District.

18. DHCF also has worked closely with the DC Health Care Association ("DCHCA"), the trade association for nursing homes, to inform administrators and staff about the MFP demonstration program. (*Id.*) The Executive Director of the DCHCA is an active member of the MFP Stakeholder Advisory Commission and has worked with members of the MFP Project Team to disseminate information to administrators and staff via email and in person at DCHCA meetings. (*Id.*)

19. The MFP Outreach Specialist housed in the DC Office on Aging/Aging and Disability Resource Center also is in contact with each nursing home in the District regarding the MFP Demonstration and has conducted one-on-one follow-up visits with interested administrators and social work/nursing staff to provide preliminary. (*Id.*) The Outreach Specialist has begun a list of nursing home residents' names who are candidates for MFP either based on nursing homes administrators' and/or staff recommendations or self-referral. (*Id.*)

20. University Legal Services ("ULS") was a member of the Money Follows the Program Advisory Committee and continued to receive updates from this program until this lawsuit was filed in December 2010. In March 2010, they provided DHCF a list of thirty (30) nursing home residents it claimed wished to transition to the MFP program. (*Id.*, ¶ 23.) DHCF subsequently launched an expanded MFP pilot project involving forty (40)

nursing home residents in collaboration with the DC's Aging and Disability Resource Center, in August 2010, including any of the thirty (30) individuals identified by University Legal Services who still resided in nursing facilities at the time the pilot project was initiated, or sixteen (16) people. (*Id.*)

21. DHCF is working with 26 candidates for the MFP program, including all MPF pilot participants who remain interested in receiving community-based services. (*Id.*, ¶ 25.) Transition Coordinators have met with all residents in the pilot to align both housing and health services and Housing Choice Voucher applications have been submitted to the DC Housing Authority for all pilot participants. (*Id.*) Participants have also been connected to EPD HCBS Waiver case management agencies to conduct initial EPD Waiver assessments.

22. Candidates for the MFP program are not given a spot in the program and transitioned to the community until all necessary community-based services are identified and approved, and housing appropriate to meet his or her needs is procured. (*Id.*, ¶ 20.)

23. Some candidates for the MFP program with whom DHCF is working lack housing in the community in which they can receive community- based services; they require public housing assistance. (*Id.*, ¶ 21.) MFP candidates eligible for the EPD Waiver may apply to the District of Columbia Housing Authority ("DCHA") for a spot in the Housing Choice Voucher program and the Moderate Rehabilitation program, which are available to any qualified individual regardless of disability. (*Id.*, ¶ 17.) Individuals aged sixty-two (62) and older also may be eligible for housing subsidies available to residents of seniors-only housing. (*Id.*, ¶ 15.) Transition Coordinators work with MFP and EPD candidates to secure housing, including by assisting them in filing out the appropriate housing voucher forms. (*Id.*, ¶ 26.) In 2011, DHCF was able to secure ten (10) additional housing choice

vouchers specifically for non-elderly Medicaid recipients. (*Id.*, ¶ 18.) There also is a limited supply of Housing Choice Vouchers set aside specifically for MFP participants (currently under 100 for all MFP transitions through the end of the Demonstration) and a diminished use of other federal housing subsidy programs, however. (*Id.*, ¶ 21.)

24. Some candidates for the MFP program also have credit histories that prevent property managers from approving leasing applications; and others lack family members or friends willing to provide support in the community in preparation for, during, and post-transition. (*Id.*)

25. Some candidates for the MFP program cannot secure the services necessary to meet their physical and medical needs in the community because they require a level of care that cannot be provided by the District's current Home and Community-Based Service (HCBS) system, because certain necessary services are not provided in the HCBS waiver package (adult day services, 24-hour care),and/or the current pool of HCBS waiver providers do not have the capacity to provide these services based on the number of qualified staff and a provider's ability, readiness, and willingness to accept liability for level care needed). (*Id.*)

26. The first nursing home resident eligible for the EPF waiver transitioned to the community under the MFP program on April 13, 2011, and all pilot participants should be transitioned by September 2011 barring any unanticipated barriers, many of which were listed above. (*Id.*)

27. DHCF anticipates transitioning eighty (80) nursing home residents to the community under the MFP program each year from 2011 through 2016. (*Id.,* ¶ 28.)

28. The Department of Mental Health ("DMH") conducts Pre-admission Screening and Resident Reviews ("PASRR") for any individual indentified by his or her provider as having a mental health diagnosis and for whom the provider has reason to believe

placement in a nursing facility will be appropriate. (Exh. 5, ¶ 3.) The referring clinician conducts the Level 1 Screening to determine whether an individual being referred to a nursing facility has a primary or secondary diagnosis of mental illness. (*Id.*, ¶ 4.) If so, DMH conducts a Level II Screening, which requires an independent psychiatric evaluation of the individual and a determination as to whether the level of care provided by a nursing facility is required. (*Id.*)

29. DMH does not operate, or provide services in, nursing facilities.

30. Nursing facilities are required to notify DMH and request a PASSR review if a patient with a primary or secondary mental health diagnosis has undergone significant change in his or her physical or mental conditions. (*Id.*, ¶ 5.)

31. DMH reminded the nineteen (19) nursing facilities within the District of Columbia, which provide direct care to their residents, of their continuing obligation to notify DMH of any significant changes in the physical or mental condition of a nursing facilities resident on October 8, 2010 and again on January 12, 2011. (*Id.*, ¶ 6.)

32. Dr. Elspeth Ritchie, the Chief Clinical Officer with DMH who is responsible for managing the PASRR determinations for current and potential nursing facility residents, has personally reached out to nursing facilities to remind them of their obligations to request PASARR reviews. She has visited seven (7) nursing facilities to discuss the PASRR program and provide technical assistance and has two (2) additional visits scheduled. (*Id.*, ¶ 6.)

33. The Department on Disability Services, Developmental Disabilities Administration ("DDA") oversees and coordinates care for 2,094 individuals with developmental disabilities, and none of whom are the named plaintiffs. (Exh. 6, ¶¶ 5, 15.)

34. DDA assumes that all individuals can live in the most inclusive setting possible, and an individual's ISP must address any deviation from this assumption and must be reviewed by DDA's Human Rights Advisory Committee ("HRAC"). (*Id.*, ¶¶ 6-7.) Before DDA approves placement in a nursing facility, the individual, his or her family or guardian and advocate, if any, the current service provider and medical staff, and the HRAC must be involved in that decision. (*Id.*, ¶ 9.) The individual's ISP must document why a community setting is not appropriate, a determination that must be corroborate by a medical provider not currently directly involved in the individual's ongoing care. (*Id.*) The ISP also must include a description of the specific supports and services required due to the individual's diagnosis and medical status, and specify a planning process to address the individual's needs and potential barriers to the individual's transition back to a community-based setting. (*Id.*)

35. The advocate for any individual whose placement in a nursing facility has been approved by DDA must appear monthly before the HRAC to justify the individual's continued residence in a nursing facility. (*Id.*, ¶ 11.) If the HRAC believes placement in a nursing facility no longer is appropriate for an individual, it recommends that DDA aggressively pursue an alternative, less restrictive, setting that can appropriately meet the individual's needs. (*Id.*, ¶ 12.)

36. As of December 31, 2008, eight (8) individuals served by DDA resided in nursing facilities; as of December 31, 2009, six (6) individuals served by DDA resided in nursing facilities; and as of December 31, 2010, five (5) individuals served by DDA resided in nursing facilities. (*Id.*, ¶ 13.)

Dated: April 27, 2011

Respectfully submitted,

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

EDWARD DAY, *et al.*,	)	
Plaintiffs,	)	
v.	)	Civil Action No. 10-cv-02250-ESH
DISTRICT OF COLUMBIA, *et al.*	)	
Defendants.	)	

PROPOSED ORDER

Upon consideration of Defendants' motion to dismiss or, in the alternative, for summary judgment, any opposition thereto, and the entire record in this matter, it is hereby

ORDERED that Defendants' motion is GRANTED, and it is further

ORDERED that Counts One and Two of Plaintiffs' Complaint are DISMISSED WITH PREJUDICE.

SO ORDERED.

Dated: _____ _____
Hon. Ellen S. Huvelle
Judge, United States District Court

CERTIFICATE OF SERVICE

I hereby certify that on April 27, 2011, a true copy of the foregoing Defendants' Motion to Dismiss or, in the Alternative, for Summary Judgment, Memorandum of Points and Authorities in Support of Defendant's Motion for Summary Judgment, Statement of Material Facts As To Which There Is No Genuine Issue, and Proposed Orders were served by filing with the Court's electronic filing system, thereby electronically serving all counsel of record.

/s/ Melissa L. Baker
Melissa L. Baker
Assistant Attorney General