IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

WILLIAM R. HAMPE, by and through his mother / guardian Jill Hampe, **RICHARD L. WINFREY, III, ADAM CALE, OLIVIA WELTER,** by and through her parents / guardians John Welter and Tamara Welter, **PHILLIP BARON,** by and through his mother / guardian Barbara Baron, **JESSICA L. LYTLE,** by and through her mother / guardian Judith A. Lytle, **JACOB STRACKA,** by and through his parents / guardians, David Stracka and Nicole Stracka, and **CHARLES STOUT**, individually and on behalf of a class, Plaintiffs,	)	
vs.	)	No. 10-3121
JULIE HAMOS, in her official capacity as Director of the Illinois Department of Healthcare and Family Services, Defendant.	)	Judge: Ruben Castillo Magistrate: Arlander Keys

PLAINTIFFS' MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFFS MOTION FOR SUMMARY JUDGMENT PURSUANT TO LOCAL RULE 56.1(a)(2)

Now comes the Plaintiffs, by and through their attorneys, Robert H. Farley, Jr., Ltd., and Cahill & Associates, and pursuant to Local Rule 56.1(a)(2), files this Memorandum of Law in support of Plaintiffs Motion for Summary Judgment, as follows:

I. INTRODUCTION

The Plaintiff Class are medically fragile disabled persons who are enrolled or will be enrolled or were enrolled in the State of Illinois Medically Fragile, Technology Dependent Waiver Program ("MF/TD") and when they obtain the age of 21 years are subjected to reduced

Medicaid funding which reduces the level of medical care which they had been receiving prior to attaining 21 year of age. (Doc. 75; Plts. Stmt. 1)

The Defendant, the Illinois Department of Healthcare and Family Services ("HFS") determined that the Plaintiffs, Hampe, Winfrey, Cale, Welter, Baron, Stracka and Stout, (hereinafter referred to as the "7 Plaintiffs")[1] were all Medicaid eligible (Plts. Stmt. 30) and prior to the age of 21 years, due to their disability, required a hospital level of care (Plts. Stmt. 34, 36-38) and approved them for funding for community-based skilled nursing services. (Plts. Stmt. 33) The Plaintiffs received approximately 112 hours a week (16 hours per day) of nursing services plus 336 hours of nursing respite services per year from either a registered nurse (RN) or licensed practical nurse (LPN). (Plts. Stmt. 33) The Defendant determined that the cost of the community-based care skilled nursing services for the Plaintiffs was less than the cost of institutional (hospital) level of care for them. (Plts. Stmt. 48) The Defendant through their agent, the University of Illinois, Division of Specialized Care for Children ("DSCC") calculated that the in-home monthly care costs for the Plaintiffs was estimated to be in the range from $16,621 to $22,669 in contrast to the estimate institutional (hospital) monthly care costs in the range of from $42,971 to $50,884. (Plts. Stmt. 48)

Upon the Plaintiffs obtaining the age of 21 years, without any change in their medical conditions or disability, the Defendant's policy and practice is to reduce the level of Medicaid funding by approximately 50% and cap or limit their funding based on a nursing home level of

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[1] The 8th Plaintiff, Jessica Lytle, is not a class member due to the fact that she is not enrolled in the MF/TD waiver. However, Jessica received approval from the Defendant for in-home skilled nursing services prior to her 21st birthday and faced reduced funding upon obtaining the age of 21 years. (Plts. Stmt. 5)

care as opposed to a hospital level of care. (Plts. Stmt. 54-63) The level of care that the Plaintiffs need cannot be provided in a nursing home. (Plts. Stmt. 64-66)

The Seventh Circuit has previously framed the issue to be decided by this Court with respect to medically fragile persons seeking extension of services past 21 years of age. The Seventh Circuit stated:

> Although a State is not obliged to create entirely new services or to otherwise alter the substance of the care that it provides to Medicaid recipients in order to accommodate an individual's desire to be cared for at home, the integration mandate may well require the State to make reasonable modifications to the form of existing services in order to adapt them to community-integrated settings. *Radaszewski,* 383 F.3d at 611.
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> If the State would have to pay a private facility to care for Eric, for example, and the cost of that placement equaled or exceeded the cost of caring for him at home, **then it would be difficult to see how requiring the State to pay** for at-home care would amount to an unreasonable, fundamental alteration of its programs and services. (emphasis added) *Id.* at 614.

After *Radaszewski* was remanded to the District Court, three Federal District Courts found that the Defendant violated the ADA and RA by reducing funding for medically fragile plaintiffs who had been previously enrolled in the MF/TD waiver when they turned 21 years of age.[2] See *Radaszewski v. Maram*, 2008 U.S. Dist. LEXIS 24923, *37-41 (N.D. Ill. 2008) (J. Darrah); *Grooms v. Maram,* 563 F.Supp.2d 840 (N.D. Ill. 2008) (J. Pallmeyer); and *Sidell v. Maram,* 2009 U.S. Dist. LEXIS 131324 (C.D. Ill. 2009) (J. McDade).

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[2] Two other medically fragile plaintiffs have prevailed against the Defendant in Illinois. See: *Jones v. Maram,* 867 N.E.2d 563 (3rd Dist. 2007) (Illinois Appellate Court affirming lower court granting of preliminary injunction for plaintiff who aged out of MF/TD waiver program and was at-risk of institutionalization); *Fisher v. Maram,* 06 C 4405 (N.D. Ill.) (January 8, 2009 - Doc. 118) (J. Guzman) (enjoining Defendant from reducing services for plaintiff who aged out of MF/TD waiver program).

Due to the failure of the Defendant to change its policy and practice to reduce funding when a medically fragile person turns 21 years of age, after not prevailing in *Radaszewski, Grooms* and *Sidell,* this case was brought as a class action by the Plaintiffs in order to obtain relief for the class.[3]

The United States of America has filed a Statement of Interest in this case and asserts as follows:

> [T]his litigation implicates the proper interpretation and application of the integration mandate of title II of the Americans with Disabilities Act (cites omitted).
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> This litigation involves the defendant's systematic failure to modify its current policies and practices of providing insufficient home-based medical care for Medicaid-eligible adults to prevent institutionalization. Children and young adults in the State of Illinois who have exceptional medical needs are eligible to receive home-based Medicaid services to avoid institutionalization under the State's Medically Fragile/Technology Dependent ("MF/TD") waiver program. Under defendant's regulatory scheme, however, once these individuals reach the age of 21, they are ineligible for the MF/TD waiver. Because the adult waiver program to which a majority of people transition does not provide community-based services at the same level, these individuals may be forced to enter an institution in order to receive the medical services they need to survive. These institutional placements are often more costly to the State. (Doc. 26 at 1-2)
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> Defendant's policy of providing inadequate home and community-based services for the proposed class soley because they reach the age of 21 places them at risk of institutionalization and therefore violates the

[3] The State of Illinois through the Illinois Department of Human Services acknowledges the ongoing problem of the "cliff effect" which occurs to the Plaintiffs and the Class when they turn 21. When children in the MF/TD waiver turn 21 years of age and age out of the MF/TD waiver, their only current options for continued long term, Medicaid-funded care are Home Services Program (HSP) services or nursing facilities. Since HSP must stay within nursing home rates, its topmost level of reimbursement for care for both types of care is a bit less than half of what the children are receiving through MF/TD. This "cliff effect" has been an issue for some time. (Plts. Stmt. 52)

integration mandate of title II. (Id at 7)

Since the filing of this lawsuit, this Court has entered Agreed Orders for approximately 23 Plaintiffs and Class members to continue the same level of Medicaid and skilled nursing services past their 21st birthday pending the outcome of this case.[4]

The Defendant's reduction of Medicaid benefits to the Plaintiffs threatens to force the Plaintiffs into an institution to obtain the care he or she needs, which violates Title II of the ADA and Section 504 of the Rehabilitation Act.

II. STANDARD FOR SUMMARY JUDGMENT

Rule 56 of the Federal Rules of Civil Procedure provides that summary judgment is proper: "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." F.R.C.P. 56(c), *Anderson v. Liberty Lobby Inc.*, 477 U.S. 242, 250 (1986). In order for an issue to be a genuine issue of fact that may defeat a motion for summary judgment, there must be "sufficient evidence favoring the nonmoving party for a jury to return a verdict for that party." *Anderson,* 477 U.S. at 250. In addition, the nonmoving party may not "rest upon the mere allegations or denials of his pleading" but, instead, must "set forth specific facts." *Anderson,* 477 U.S. at 248.

III. AMERICANS WITH DISABILITIES ACT and REHABILITATION ACT

There are two federal statutes with implementing regulations that, read together, command that the Defendant be prevented from forcing the Plaintiffs into segregated institutions

[4] Doc. 11, 33, 49, 58, 73, 81, 83, 85, 87, 89, 95, 98, 104, 106, 108, 112, 114,.118, 146, 155, 166, 167, 169.

by arbitrarily reducing their community services.

Title II of the ADA prohibits public entities from discriminating against persons with disabilities:

> No qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity. 42 U.S.C. Sec. 12132.

A "qualified individual with a disability" is a person who "with or without reasonable modifications to rules, policies or practices" meets the "essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity." 42 U.S.C. Sec. 12131(2). Similarly, Section 504 of the Rehabilitation Act prohibits recipients of federal funds from discriminating based on disability. 29 U.S.C. Sec. 794(a).

The Attorney General of the United States has promulgated regulations to implement both these statutory prohibitions. Under 28 C.F.R. Sec. 35.130(d), a public entity must administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities. This regulation was based on the virtually identical regulation previously promulgated by the Attorney General to implement the Rehabilitation Act, 28 C.F.R. Sec. 41.51(d), known as the "integration mandate," requiring that recipients of federal funds administer their programs and activities in the "most integrated setting appropriate to the needs of qualified handicapped persons." *Radaszewski v. Maram,* 383 F.3d 599, 607 (7th Cir. 2004). The above-described provisions of the ADA and the Rehabilitation Act, and the integration mandate regulations promulgated under them, are construed and applied in the same manner. *Radaszewski v. Maram,* 383 F.3d at 607.

"[U]njustified institutional isolation" of a disabled individual receiving medical care from a state institution constitutes an actionable form of discrimination under Title II of the ADA. *Olmstead v. L.C. ex rel. Zimring,* 527 U.S. 581, 597-603. (1999) Institutional placement of individuals who can benefit from community-based settings perpetuate "unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life"; and institutional confinement "severely diminishes the everyday life activities of individuals, including family relations, social contacts . . . and cultural enrichment." *Id.* at 600-601. Thus a state may violate Title II if it refuses to provide an existing benefit to a disabled individual that would enable that person to live in a more community-integrated setting. *See Radaszewski,* 383 F.3d at 609; *Fisher v. Oklahoma Health Care Auth.,* 336 F.3d 1175, 1182-84 (10th Cir. 2003); *Townsend v. Quasim,* 328 F.3d 511, 516-520 (9th Cir. 2003).

A state is obligated to provide community-based treatment for disabled persons if: (1) the state's treatment professionals find that community-based treatment is appropriate; (2) the affected individuals do not oppose community-based treatment; and (3) placement in the community can reasonably be accommodated, taking into account the state's resources and the needs of others with similar disabilities. *See Olmstead,* 527 U.S. at 607; *Radaszewski,* 383 F.3d at 608.

Under the fundamental-alteration defense, the public entity may demonstrate that it should not be required to accommodate the disabled individual by providing the services in the community instead of an institution would affect a fundamental alternation of its programs and services. *See Olmstead,* 527 U.S. at 603-606; *Radaszewski,* 383 F.3d at 611, 614.

A. Plaintiffs Are Eligible For Illinois' Medicaid Program And Are "Qualified Individual[s] With A Disability"

All the Plaintiffs are recipients of Medical Assistance, commonly known as Medicaid. (Plts. Stmt. 30) The Plaintiffs are "qualified individual[s] with a disability" and "with or without reasonable modifications to rules, policies, or practices . . . meets the essential eligibility requirements of services or the participation in programs or activities provided by a public entity." 42 U.S.C. Sec. 12131(2). Prior to their 21st birthday, the Plaintiffs and Class met the eligibility requirements of services provided by the Defendant, a "public entity" for community-based services. (Plts. Stmt. 5, 30-33)

In *Radaszewski v. Maram,* 383 F.3d 599 (7th Cir. 2004), the Seventh Circuit found that a plaintiff who had been served in the MF/TD waiver program was a qualified individual with a disability. The Seventh Circuit stated:

> Eric thus appears to meet these "essential" requirements for at-home care. *See Townsend,* 328 F.3d at 516 (plaintiff was a "qualified individual with a disability "for purposes of Title II because he was eligible to receive services through State's Medicaid programs, he preferred to receive such services in a community-based setting, and community-based services were appropriate for his needs). *Radaszewski,* at 613.
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> Consequently, we discern no impediment concerning Eric's status as a "qualified individual with a disability" that would preclude the relief his mother seeks under Title II." *Id* at 614.

In addition, every District Court in the State of Illinois has found that a person previously enrolled in the MF/TD program has been found to be an "individual with a disability" without any difficulty. See *Grooms,* at 850-851 ("There is no dispute that Grooms meets all these criteria. . . .Accordingly, Grooms is a qualified individual with a disability); See *Radaszewski,* 2008 U.S. Dist. LEXIS at *38-39 ("Eric is a qualified individual with a disability under the ADA and the

RA. Eric and his parents do not oppose community-based treatment and specifically seek to allow Eric to remain at home and seek the same level of care he has been receiving for the last several years."); See *Sidell v. Maram,* 2009 U.S. Dist. LEXIS 131324 at *26 ("Gretchen is a qualified individual under the ADA and the RA, Gretchen is a qualified Medicaid recipient, Defendant is a public entity under the ADA and RA. Gretchen and Plaintiff do not oppose community treatment.")

B. Community-Based Treatment Is Appropriate For The Plaintiffs And They Do Not Oppose Community Placement.

Prior to the Plaintiffs' 21st birthday, the Defendant found that community-based treatment is appropriate as the Defendant approved funding for "In-home care plan . . . for nursing care." (Plts. Stmt. 25, 27, 33) The Plaintiffs do not oppose community placement. (Plts. Stmt. 25-29)

C. Placement In The Community Can Be Reasonably Accommodated As The Cost of Care In A Community Setting Is Less Than The Cost Of Care In An Institutional (Hospital) Setting.

Prior to the Plaintiffs 21st birthday, the Defendant determined that the cost of the community-based care skilled nursing services and other services for the Plaintiffs were less than the cost of institutional (hospital) level of care for them. (Plts. Stmt 48) The Plaintiffs medical needs did not change when they obtained the age of 21. (Plts. Stmt. 64)

(i) The Defendant Found That The Plaintiffs Required A Hospital Level of Care Prior To Age 21.

Prior to the Plaintiffs turning 21, the Defendant found that the Plaintiffs required a hospital level of care. (Plts. Stmt. 34) The Defendant's physician determined that the Plaintiffs need a hospital level of care. (Plts. Stmt. 35-37) The Defendant's physicians wrote that for the Plaintiffs, the "alternative care is long-term hospitalization." (Plts. Stmt. 38) Moreover, prior to

age 21, the Plaintiffs personal physicians stated that the Plaintiffs alternative to medical home care would be admission to a hospital. (Plts. Stmt. 39-46)

(ii) Plaintiffs Medical Condition and Needs Did Not Change Upon Turning 21 Years of Age - Plaintiffs Still Require A Hospital Level of Care.

Upon attaining the age of 21 years, the Plaintiffs medical conditions and needs did not change and they still require a hospital level of care.[5] (Plts. Stmt. 64) The level of care that the Plaintiffs need cannot be provided in a nursing home. (Plts. Stmt. 65)

(iii) Community-Based Care For The Plaintiffs Is Less Than Institutional (Hospital) Cost.

Providing in-home care for the Plaintiffs is less than the institutional (hospital) costs. (Plts. Stmt. 48) Prior to age 21, the Defendant approved community-based services for the Plaintiffs which is less than them receiving institutional costs. (Plts. Stmt. 33, 48) Providing skilled nursing care in their home and community is cheaper than the institutional equivalent. (Plts. Stmt. 33, 48-53)

IV. DEFENDANT'S POLICY AND PRACTICE OF REDUCING MEDICAID BENEFITS TO THE PLAINTIFFS AND CLASS WHEN THEY TURN 21

When children in the MF/TD waiver turn 21 years of age and age out of the MF/TD waiver, their only current options for continued long term, Medicaid-funded care are Home Services Program (HSP) services, nursing facilities or hospitals. Since HSP must stay within nursing home rates, its topmost level of reimbursement for care for both types of care is a bit less than half of what the children are receiving through MF/TD. This "cliff effect" has been an issue

[5] (See *Sidell v. Maram,* 2009 U.S. Dist. Lexis131324 at *28) ("While there may not be a hospital that would be available for Gretchen's care, the unavailability of an institution is irrelevant to the question of what level of care Gretchen requires.")

for some time.[6] (Plts. Stmt 54)

Children in the MF/TD waiver typically transition into the Persons With Disabilities (PWD) waiver at 21 years of age.[7] (Plts. Stmt. 105) The PWD Waiver is part of a larger program called the Home Services Program (HSP).[8] (Plts. Stmt 106) The PWD waiver limits medicaid benefits based on a nursing home level of care as opposed to a hospital level of care. (Plts. Stmt. 104) For example, in fiscal year 2010, the Service Cost Maximum ("SCM") for monthly benefits could not exceed the sum of $3,533. (Plt. Stmt. 112) For an individual who has complex medical needs and who cannot be served within the allowable SCM, that person may receive an Exceptional Care Rate ("ECR"). (Plt. Stmt. 113) The ECR rate is based on a nursing home rate (Id) despite the level of care needed by a particular individual.

The Exceptional Care Rate offered to the Plaintiffs were in the range of $5,133 to $11,484. The ECR is approximately fifty percent (50%) of the cost of the services which the Plaintiffs and Class received prior to them obtaining 21 years of age. (Plts. Stmt. 48, 54, 57-63, 115) Offering the Plaintiffs one-half the funding for services based only on the fact that they have obtained the age of 21 is a violation of both Title II of the ADA and the Rehabilitation Act.

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[6] Prior to age 21, the combination of EPSDT, waiver services, and other State plan services allow children with disabilities to remain in their own homes and communities and receive the support they needs. (Plts. Stmt. 83)

[7] A few young adults transition from the MFTD children's waiver into the adults with developmental disabilities waiver (DD), however, individuals that make that transfer do not require 24-hour nursing care. (Plts. Stmt. 105)

[8] The HSP offers services which include: personal assistants, homemaker, skilled professional nursing, certified nursing assistants, therapies, adult day care, emergency home response, respite, home-delivered meals, environmental modifications, and special medical equipment and supplies.

V. PLAINTIFFS AND CLASS CAN BE REASONABLY ACCOMMODATED - NO FUNDAMENTAL ALTERATION

Granting relief to the Plaintiffs and Class would not fundamentally alter the State's program or services as the costs of community-based services is less than the institutional (hospital) level of care. (Plts. Stmt. 48) The Seventh Circuit in *Radaszewski* at 611, determined that "the integration mandate may well require the State to make reasonable modifications to the form of existing services in order to adapt them to community-integrated settings."

The State has the ability to make reasonable modifications to the form of existing services in order to provide relief to the Plaintiffs while maximizing medicaid funding from the federal government. The Defendant could make a number of modifications as follows:

A. Defendant Could Amend the MF/TD Waiver To Provide Services Past The Age Of 21 Years.

The Defendant could amend the MF/TD Waiver to provide services past the age of 21 years. Such an amendment would not be a fundamental alteration. Currently, the Defendant has limited the MF/TD Waiver to medically fragile and technology dependent individuals under the age of 21 years. (Tab "29" HFS-000012) However, States can submit requests for approval to the Centers for Medicare and Medicaid Services ("CMS") to alter the terms of a particular waiver application at any time. *See* 42 C.F.R Sec. 441.355. Such requests are regularly granted by CMS. *See Knowles v. Horn,* 2010 WL 517591 (N.D. Tex., Feb. 10, 2010) (citing to *Grooms v. Maram,* 563 F.Supp.2d 840, 857 (N.D. Ill. 2008) ("[T]he federal government has not denied a single waiver application in the last ten years. Defendant here presents no basis to believe that the federal government would deny the State's application for an amendment in this case and the

court will concoct one.")[9]

The Defendant initiated review on 9 states that serve MF/TD children through HCBS waivers and 3 of the 9 states did not have transition issues from children to adult services as Iowa, Minnesota and Vermont serve adults under their MF/TD waivers. (Plts. Stmt 135) Likewise, Illinois could avoid transition issues and the "cliff effect" by amending the MF/TD waiver to serve the Plaintiffs and Class past the age of 21 years.

B. Defendant Could Amend PWD Waiver To Provide A Hospital Level Of Care.

The Defendant could amend the Persons With Disabilities waiver to provide both a nursing home level of care and a hospital level of care. In *Grooms,* at 856-857, the District Court stated:

> The waiver format requires the applying state to specify whether it seeks a waiver "in order to provide home and community-based services to individuals who, but for the provision of such services, would require" care in–among other alternatives–a nursing facility or a hospital. (Pl.'s 56.1 P 1; PWD Waiver Renewal at 3025.) It was the State of Illinois's choice to seek a waiver only for individuals who would require nursing-facility level care; the option to provide a waiver for individuals who would require hospital-level care demonstrates that the federal government would approve a waiver for individuals requiring a hospital level of care. Indeed, there is no indication that a need for care that exceeds what is available in a nursing facility

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[9] On May 20, 2010, the U.S. Department of Health and Human Services sent a letter to State Medicaid Directors reaffirming the federal commitment to the enforcement of the ADA with respect to Medicaid programs. The letter states that "[t]he HHS Office for Civil Rights is also collaborating with the Department of Justice to advance civil rights enforcement of the ADA and the U.S. Supreme Court's Olmstead decisions." (Plts. Stmt 132 at page 1) The letter further states that "CMS recognizes the importance role that Medicaid plays in State's efforts to ensure compliance with the ADA and *Olmstead.* (Plts. Stmt.132 at p.1-2) To that end, CMS is offering to provide to States, such as Illinois, "technical assistance . . . regarding the design and operations of their Medicaid programs" "to help them meet their obligations under the ADA." (Plts. Stmts 132 at p. 2-3)

> disqualifies an individual for the PWD waiver. *See* Opinion and Order, *Sidell v. Maram*, No. 05-1001, at 19-20. The parties agree that the State had discretion when designing the PWD waiver and is, even now, permitted to alter the waiver's terms by submitting an amendment to the federal government for approval. (Def.'s Am. Resp. To Pl.'s 56.1 P 3.) Through the amendment process, the State may add services to the waiver, delete services from the waiver, and/or change the selection of comparable institution for determining cost-neutrality. (*Id.* P 5.) This would not be the first time Illinois amended its waiver; the State has submitted several waivers to the federal government in recent years. (*Id.* P 4.) (footnote omitted)
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> As Judge Darrah explained in his decision on remand in the *Radaszewski* case, requiring the State to submit an amendment need not fundamentally alter the HSP or Medicaid waiver program. *Radaszewski*, 2008 U.S. Dist. LEXIS 24923, 2008 WL 2097382. In his Federal Rule of Civil Procedure 52 findings, Judge Darrah observed: "Illinois could act in cooperation with the federal government to achieve community-based integration which may otherwise be impeded by existing rules or requirements. Thus, there is no need to adapt existing institutional-based services to a community-based setting that would impose unreasonable burdens or fundamentally alter the nature of Illinois' services and programs." 2008 U.S. Dist. LEXIS 24923, [WL] at *15. He noted, further, that the federal government has not denied a single waiver application in the last ten years. 2008 U.S. Dist. LEXIS 24923, [WL] at *10. Defendant here presents no basis to believe the federal government would deny the State's application for an amendment in this case and the court will not concoct one. In fact, there are reasons to believe that the federal government would agree to amend the PWD waiver. Defendant does not dispute that the federal government encourages states to use waivers to attempt to achieve community integration. (Pl.'s 56.1 P 9.) Nor has Defendant established that such an amendment would impose significant costs on the State or the federal government. Accordingly, the requirement that HFS amend its waiver does not constitute a fundamental alteration in the PWD program.

Accordingly, Defendant can reasonably accommodate the Plaintiffs and Class by amending the Persons with Disabilities waiver to provide a hospital level of care.

C. Defendant Has Flexibility To Adjust Cap In The Home Services Program

The Defendant has the flexibility to adjust the cap in the Home Services Program.

HSP is an umbrella program which includes three waiver programs: the Persons with Disabilities Waiver (PWD), the HIV/AIDS waiver, and the Brain Injury Waiver. Nevertheless, the State has one set of regulations for the HSP. See, e.g., 89 Ill. Admin. Code Sec. 682.100. Nothing in the Illinois regulations governing the HSP actually limits the HSP to a nursing facility/home level. (See *Sidell v. Maram,* 2007 U.S. Dist. LEXIS 97649 at *4: "The limitation of the waiver document is not coextensive with the 'institutional care' restriction on which eligibility for the HSP is determined. 89 Ill.Admin. Cod 682.100" and *Sidell v. Maram,* 2007 U.S. Dist. LEXIS 97649 at *24: "there is nothing in the State's general eligibility criteria that articulates either a maximum level of disability or a bar against those who require a greater level of institutional care than what can be provided in a nursing home"). Accordingly, without a change to its rules, the state could accommodate the hospital-level-of-care relief plaintiff seeks.[10]

D. Reasonable Accommodations

The cost to allow the Plaintiffs and Class to continue receiving the same services in the community after age 21 as they did prior to age 21 is less than the cost of caring for them in the proper institutional setting.[11] As such, continuing the funding for these services after age 21 is a reasonable accommodation and would not impose an unreasonable burden on the Defendant or fundamentally alter its programs and services.

In *Radaszewski v. Maram,* 2008 U.S. Dist. LEXIS 24923, after the case was remanded from the U.S. Court of Appeals, the District Court found that the State of Illinois violated the

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[10] In *Radaszewski,* 2008 U.S. Dist. LEXIS 24923, *26, the District Court stated that Illinois law permits exceptional care rates up to a hospital rate.

[11] Plts. Stmt. 34-47, 48, 51-53

ADA and Rehabilitation Act when Eric Radaszewsli exited the MF/TD program and the State of Illinois reduced the level of funding which would not adequately fund skilled nursing care for Eric to remain in his home. The Court stated:

> Eric has severe, long-term disabilities. Eric is eligible to receive services through the Illinois Medicaid Program. Eric is at risk of being placed in an institutional setting, and Eric is qualified to receive services through HSP. Community-based treatment is an existing benefit under the Illinois Medicaid Program and is appropriate for Eric. *Radaszewski*, 2008 U.S. Dist. LEXIS 24923, *39.
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> The services that Eric requires and presently receives at home are, in substance, the services that would be required in a hospital. The unrebutted evidence clearly shows that the cost of caring for Eric in the proper institutional setting - - a hospital - - would be substantially greater than the cost of allowing Eric to remain in the community and receive the same proper treatment and health care. Allowing Eric to remain in the community can be readily accommodated, taking into Illinois resources and the needs of others with similar disabilities. Illinois can approve an HSP plan for Eric that exceeds the nursing home rate. If otherwise necessary, Illinois could also modify or alter the waiver from the federal government, which encourages the states to use home and community-based waivers to meet the community integration contemplated by *Olmstead.* Illinois could act in cooperation with the federal government to achieve community-based integration which may otherwise be impeded by existing rules or requirements. Thus, there is no need to adapt existing institutional-based services to a community-based setting that would impose unreasonable burdens or fundamentally alter the nature of Illinois' services and programs.
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> Illinois has not demonstrated that providing the requested accommodation to Eric would impose an unreasonable burden on the state or fundamentally alter the nature of its programs and services. The evidence offered by the state, . . . has not shown that Eric's healthcare needs cannot be reasonably accommodated by community placement considering the state's resources and the needs of others similarly situated. *Id.* at *39-41.

In *Grooms v. Maram,* 563 F.Supp.2d 840, 846, (N.D. Ill. 2008), the plaintiff, David Grooms was dependent upon a ventilator and relied on others for virtually all his care and he was funded under the MF/TD program and he received approximately $17,000 per month for home

base skill nursing funding. When he turned 21, the State would only approve an exceptional care rate of $8,517 per month. (Id at 847) For the same reasoning as in all the other cases litigated against the State of Illinois for persons exiting the MF/TD program, the Court found that "HFS could reasonably accommodate Grooms's request for home care" Id. at 856. The Court entered a Permanent Injunction Order against the State of Illinois and in favor of David Groom, so that the State is required to restore the level of approved skill nursing services which he had prior to his 21st birthday. (See *Grooms v. Maram,* No. 06-2211 (N.D. IL), at Doc. 196 - Permanent Injunction Order of June 13, 2008))

In *Sidall v. Maram,* 2009 U.S. Dist. LEXIS 131324 (C.D. Ill. 2009) the plaintiff, Gretchen Sidell was on a ventilator 24 hours a day. When Gretchen aged out of the MF/TD program, the State proposed to reduce her funding of $27,232 per month to $9,289 per month. (Id. at *15-16) The Court found that Gretchen required 24 hours per day skilled nursing care. (Id. at *21) The Court found that the cost of housing Gretchen in a hospital exceeds the cost of caring for her at home with skilled nurses. (Id. at *18) The Court held that the State's reduction of funding for skilled nursing for Gretchen violated the Americans with Disabilities Act and the Rehabilitation Act. (Id. at. *29)

In *Jones v. Maram,* 373 Ill.App.3d 184, 867 N.E.2d 563 (3rd Dist. 2007), the Illinois Appellate Court upheld the Circuit Court's entry of a preliminary injunction against the State of Illinois to prevent the State from reducing the funding for the plaintiff who had aged out of the MF/TD program. The plaintiff, Michael Jones "is completely ventilator dependent" and "requires skilled nursing services in order to survive." *Id.,* at 185-186. Under the MFTDC program, Michael received home nursing services at a cost of $17,000 per month and if he was to

be hospitalized, the cost of the care would be approximately $49,400 per month. The Court stated:

> . . .Michael's condition has not changed, only his age has changed. It seems likely the Department can accommodate the needs of Michael and others like him with reasonable modification to existing programs. The cost of caring for Michael at home would not exceed the cost of the comparable facility capable of meeting his needs, the intensive care unit of a hospital. *Id.*, at 197.

In summary, the Defendant can reasonably accommodate the Plaintiffs' and Class' need for continued skilled nursing care past their 21st birthday. As noted above, numerous Federal Courts have addressed this precise issue and have concluded that Illinois can reasonably accommodate the Plaintiffs' continued need for skilled nursing care past their 21st birthday.

V. CONCLUSION

Consistent with the Supreme Court's ruling in *Olmstead* and the Seventh Circuit's ruling in *Radaszewski* and the District Court rulings in *Radaszewski*, *Grooms* and *Sidell*, the Plaintiffs and Class are entitled to summary judgment against the Defendant on the their Americans with Disabilities Act (ADA) and Rehabilitation Act (RA) claims and an award of reasonable attorneys fees and costs.

Furthermore, after the finding of liability in favor of the Plaintiffs / Class and against the Defendant, this Court should direct the parties to meet and confer to attempt to develop a joint remedial plan consistent with this Court's ruling.[12]

Respectfully submitted,

/s/ Robert H. Farley, Jr.
One of the Attorneys for
the Plaintiffs & Class

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[12] *See: Memisolvski v. Maram,* 2004 U.S. Dist. LEXIS 16772, *166 (N.D. Ill) (J. Lefkow) (Medicaid class action lawsuit and after the court found the defendants' policies and practices violated the rights of the plaintiffs, the Court set a status date "to discuss further proceedings relating to an appropriate injunction to remedy the defendants' violations."); *Rosie D. v. Romney,* 410 F.Supp. 2d 18, 54 (D. Mass. 2006) (Medicaid class action lawsuit and after finding in favor of the plaintiffs on liability, "[t]he parties are ordered to meet within fourteen days to discuss the issues to be addressed in the remedy phase and to attempt to agree on a timetable for doing so."); *United States Department of Justice* Statement of Interest - Doc. 26 at page 13 - ("Plaintiffs' claims will require system-wide change in policies to ensure that defendant's Medicaid program allows individuals to live in the most integrated setting appropriate to their needs.")

Robert H. Farley, Jr.
Robert H. Farley, Jr., Ltd.
1155 S. Washington Street
Naperville, IL 60540
Phone: 630-369-0103
farleylaw@aol.com

Mary Denise Cahill
Cahill & Associates
1155 S. Washington Street
Naperville, IL 60540
Phone: 630-778-6500
mdcahill@sbcglobal.net

CERTIFICATE OF SERVICE

I, Robert H. Farley, Jr., Attorney for the Plaintiff, deposes and states that he caused the foregoing Plaintiffs' Memorandum of Law in Support of Plaintiffs Motion for Summary Judgment Pursuant to Local Rule 56.1(a)(2) to be served by electronically filing said document with the Clerk of the Court using the CM/ECF system, this 23rd day of August, 2012.

/s/ Robert H. Farley, Jr.