UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

MICHAEL T., a person with diminished capacity, *et al*.,	)	
Plaintiffs,	)	
	)	**CASE NO.** 2:15-cv-09655
KAREN BOWLING, in her official capacity as Secretary of the WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES,	)	
Defendant.	)	

MEMORANDUM OF LAW IN SUPPORT OF DEFENDANT'S MOTION TO DISMISS PLAINTIFFS' COMPLAINT

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September 14, 2015

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INTRODUCTION

The State of West Virginia is committed to providing individuals with intellectual disabilities a broad array of services to avoid unnecessary institutionalization. The State's Medicaid program spends hundreds of millions of dollars annually to accomplish this goal and, as a result, individuals with intellectual disabilities in West Virginia overwhelmingly receive services in their homes and communities and not in institutions. Indeed, none of the Plaintiffs in this case are institutionalized, and all are receiving extensive services so that they can safely remain in their homes and communities. The West Virginia Department of Health and Human Resources ("DHHR") allocates funding for services for individuals with intellectual and/or developmental disabilities living in the community through a system that considers each member's unique functionality, circumstances, and needs. This system fairly and objectively allocates funds to support services to thousands of individuals, and it is fully consistent with federal Medicaid law, the Due Process Clause, the Americans with Disabilities Act (ADA), the Rehabilitation Act, and the Supreme Court's *Olmstead* decision. The Complaint should therefore be dismissed under Rule 12(b)(6) of the Federal Rules of Civil Procedure.

BACKGROUND

A. West Virginia's Medicaid Program and Services to Individuals with Intellectual Disabilities

Medicaid is a cooperative federal-state program that provides health care to low-income families and individuals. The program is administered by the States and overseen by the federal Centers for Medicare & Medicaid Services (CMS). Social Security Act ("SSA") § 1901, 42 U.S.C. § 1396 *et seq*. DHHR's Bureau for Medical Services' ("BMS") is the state agency responsible for administering the Medicaid program in West Virginia. West Virginia's Medicaid program is approximately $3.35 billion in size, with the federal government contributing around

73% of the funding and the remaining 27% coming from the State. This represents one of the single largest items in the state budget. Most of West Virginia's Medicaid spending is directed to services to the aged and individuals with disabilities. *See* Kaiser Family Foundation ("KFF"), Medicaid Spending, http://kff.org/state-category/medicaid-chip/medicaid-spending/ (last visited Sept. 8, 2015). With respect to individuals with intellectual and developmental disabilities, West Virginia provides the following array of services:

1. ICF/IID Services. Institutions for individuals with intellectual disabilities are known as intermediate care facility services for individuals with intellectual disabilities, or ICFs/IID. West Virginia, like all other States, has chosen to cover ICF/IID services in its Medicaid state plan; unlike most other States, however, West Virginia has capped the number of individuals who can receive services in an ICF/IID. The cap has been set at 509 for a number of years. *See* Compl. ¶ 203. There have been no large state-run developmental centers in West Virginia for almost twenty years. Today, the ICF/IIDs in the State are all small (eight or fewer residents) and privately-run. While necessary for some individuals who cannot be safely cared for at home, an ICF/IID is the least common service setting. Approximately 5.5% of the State's long-term care expenditures go to ICF/IIDs, below the national average (9.9%). *See* KFF, Medicaid Spending.

2. Section 1915(c) Services. Section 1915(c) of the Social Security Act permits the Secretary of HHS to waive certain Medicaid rules to permit States to provide "home- and community-based services" ("HCBS") to individuals who, but for the provision of HCBS, would require the level of care provided in a hospital, a nursing facility, or an ICF/IID. SSA § 1915(c), 42 U.S.C. § 1396n(c). Under a 1915(c) waiver, the State must specify the number of individuals it serves, the characteristics of the population it is serving, and the specific services it will provide. To secure approval for a waiver from CMS, a State must establish that the program will be "cost

effective," *i.e.*, on average, it will be no more expensive to serve an individual in the waiver than it would be to provide care in an institution. § 1915(c)(2)(D). In order to ensure compliance with this and other requirements, a Section 1915(c) waiver must be renewed every five years.

West Virginia has three Section 1915(c) waiver programs: the Traumatic Brain Injury Waiver; the Aged & Disabled Waiver; and the Intellectual/Developmental Disabilities ("I/DD") Waiver. These waivers are developed, implemented, and managed through BMS's Office of Home and Community-Based Services ("OHCBS"). BMS, *HCBS Information About New Rule*, http://www.dhhr.wv.gov/bms3/hcbs/HCBSSTP/Pages/default.aspx (last visited Sept. 6, 2015).

The I/DD Waiver provides HCBS for individuals with intellectual and developmental disabilities who would be eligible to receive care in an ICF/IID. Waiver services include: day habilitation, participant-centered support, respite, service coordination, supported employment, crisis services, dietary therapy, electronic monitoring, environmental accessibility adaptations, occupational therapy, physical therapy, positive behavioral support, skilled nursing services, speech therapy, therapeutic consultant, and transportation. *See* Mental Retardation/Developmental Disability Waiver, Application for a 1915(c) HCBS Waiver (eff. July 1, 2011) ("I/DD Waiver Application").[1] BMS contracts with an administrative services organization, APS Healthcare Inc. (APS), to help administer the I/DD Waiver, and the waiver services are provided to members through provider agencies. Compl. ¶¶ 221-24.

In 2009, DHHR agreed, in a settlement in another case, to "make annual budget requests [to the legislature] to at least maintain current appropriations" and to add 300 new slots over sev-

[1] The I/DD Waiver Application is available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers_faceted.html. The I/DD Waiver was scheduled to expire on June 30, 2015, but CMS has temporarily extended it through September 2015 while the State's renewal application is pending.

eral years. In addition, DHHR agreed to evaluate whether additional slots are needed and "can be supported based on the cost efficiencies from the [I/DD] Waiver." *Benjamin H. v. Walker*, No. 99-cv-0338 (S.D. W. Va. April 8, 2009). Since 2010, the number of waiver slots has grown from 4,334 to 4,634. *See* I/DD Waiver Application. If BMS is able to achieve cost efficiencies in the I/DD Waiver by adhering more closely to member budgets, it may be able to add even more slots to the waiver, to the benefit of the hundreds of individuals on the waiting list.

Since state fiscal year (SFY) 2006, annual expenditures for I/DD Waiver members have increased by almost $200 million. DHHR, *Changes Made to the I/DD Waiver Application* (May 5, 2015), http://www.dhhr.wv.gov/News/2015/Pages/Changes-Made-to-the-Intellectual-Developmental-Disabilities-Waiver-Application.aspx. Currently, West Virginia spends between approximately $10,000 and $232,000 annually per member for waiver services (not including acute care). The average per member cost is $85,000. Compl. ¶ 212. The West Virginia legislature appropriates a specific amount of funding for the I/DD Waiver. For the last three years, expenditures for the waiver have exceeded the amount appropriated:

Table 1

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
Waiver expenditures (state share)	$274M ($80M)	$281M ($88M)	$337M ($92M)	$366M ($102M)	$385M ($110M)
State appropriation for waiver	$80M	$88M	$85M	$89M	$89M
Waiver budget deficit	$0	$0	$7M	$13M	$21M
Members	4,334	4,484	4,534	4,534	4,534

See Compl., Ex. 5; I/DD Waiver Application.

3. State Plan Services. Because enrollment in the I/DD Waiver is capped, there are over 1,000 West Virginians currently on the waiting list to receive waiver services. DHHR, *Changes Made to the I/DD Waiver Application*. Because of the size of the list, the wait for services is approximately three years long. While individuals on the waiting list do not have access to the

broad array of services available under the waiver, West Virginia provides Medicaid state plan services for which there is no wait. When an individual is determined eligible for the I/DD Waiver and placed on the waiting list, the State sends him or her a letter outlining these other services. Template Letter from T. Hardy, BMS, re: Approval for the WV I/DD Waiver Program (undated) (attached as Ex. 1). For example, all children enrolled in Medicaid – including children eligible through the Children with Disabilities Community Service Program – are entitled to "early and periodic screening, diagnostic and treatment" ("EPSDT") services, which includes all medically necessary physical/occupational/speech therapy, physician services, and durable medical equipment. In addition, for all Medicaid enrollees, West Virginia has opted to cover case management, personal care services in the home, and private duty nursing. *See id*. For individuals with co-occurring mental health condition(s) and mild mental retardation, West Virginia offers Assertive Community Treatment, through which eligible individuals receive a coordinated package of services to live successfully in the community. *Id*.

4. State Grant Programs. West Virginia also offers benefits through 100%-state-funded, non-Medicaid programs. The I/DD Wait List Support Grant provides certain individuals on the wait list with supported employment, day habilitation, respite, behavioral support, and environmental adaptations. The Unmet Needs Grant provides eligible individuals with adaptive equipment, occupational/physical therapy, as well as dental, vision, and hearing services.[2]

[2] *See* Bureau for Behavioral Health and Health Facilities ("BHHF"), Specialized Funds Policy, *I/DD Wait List Support Grant* (eff. July 1, 2013), http://www.dhhr.wv.gov/bhhf/Sections/programs/ProgramsPartnerships/IDD/Documents/Wait%20list%20support%20grant%20policy%20FY%202014.pdf; BHHF, Specialized Funds Policy, *Unmet Needs Fund* (eff. July 1, 2013), http://www.dhhr.wv.gov/bhhf/Sections/programs/ProgramsPartnerships/IDD/Documents/Unmet%20Needs%20Policy%20FY%202015.pdf.

B. The Service Authorization Process for the I/DD Waiver

This case turns on the service authorization process for I/DD Waiver members. Service authorization begins with APS's annual calculation of the member's budget, which is a baseline dollar amount for the purchase of waiver services. APS's budget process has been in place since 2008 and is described in the CMS-approved I/DD Waiver document, I/DD Waiver Application, App'x A. The first step in the budget process is an in-depth functional assessment in which APS collects data specific to the individual and his or her relationships and environments. *See* Compl. ¶ 225; W. Va. Medicaid Provider Manual § 513.4.[3] APS uses standard assessment tools (the Inventory for Client and Agency Planning and the Adaptive Behavior Assessment System) commonly used in other States to analyze the functionality of individuals receiving long-term supports and services.

APS has conducted a multi-variable statistical analysis, based on data specific to West Virginia's I/DD Waiver, that is applied to APS's functional assessment to produce a presumptive budget designed to cover the cost of services comparable to those used in the past by I/DD Waiver members with similar assessment results. *See* I/DD Waiver Application, App'x A; Compl. ¶ 232-34. This is an objective, equitable means of allocating funds to individuals with different diagnoses, situations, and needs. Members' budgets range from approximately $10,000 to $232,000, depending on their functionality. If a member disagrees with APS's assessment, he or she can request a modification. W. Va. Medicaid Provider Manual § 513.5.3. Based on this request, APS may adjust the assessment findings or budget amount. *Id*. The most recent annual budgets calculated for the Plaintiffs range from $174,000 (Michael T.) to $65,900 (Eric D.). Compl. ¶¶ 47, 72, 101, 136, 164.

[3] The manual can be found at http://www.dhhr.wv.gov/bms3/Pages/ProviderManuals.aspx.

Once the budget is developed, it is sent to the member, his or her guardian, and the provider agency. *See* Compl., Ex. 1. The provider agency uses an interdisciplinary team, which includes the member and/or his or her legal representative, to develop an Individualized Program Plan ("IPP") that details: the member's care needs, how much of each waiver service the member will purchase, and the schedule for receiving those services. *See id*. ¶¶ 226-28. In developing the IPP, the interdisciplinary team "make[s] every effort to" remain within the budget. § 513.5.3.

Once the IPP is complete, the provider agency requests approval of the service levels in the IPP. APS reviews the IPP to ensure it complies with BMS policies and addresses the member's health and safety. *See* I/DD Waiver Application, App'x A. If the IPP is within the budget (as is generally the case) and otherwise complies with BMS policies, APS approves it. If the interdisciplinary team, the provider agency, and/or the member believes services in excess of the budget are necessary for the member, they submit IPP service levels that exceed the budget and seek "second level negotiation" of the service request from BMS. *Id*.; *see also* Compl., Ex. 6. If BMS determines that additional services are necessary to keep the member safely in the community, it approves the requested service levels in excess of the budget. *See* § 513.5.3; I/DD Waiver Application, App'x A. If BMS determines that additional services are not necessary, it denies the request and the member is sent a denial letter with appeal rights. *See* Compl., Exh. 2. The denial notice explains, among other things, that the member has 90 days to appeal, but "for services to continue at the previously-approved level through the hearing/appeals process" the request for a hearing must be received within 13 days. *See id*. If a member appeals the denial of services in excess of the budget, a State Hearing Officer determines whether additional services should be authorized. *See id*. Some State Hearing Officers have concluded that they cannot overturn BMS decisions not to authorize services in excess of the member's budget, because that

is a policy decision. Once services begin pursuant to the IPP, APS continues to monitor the member's health and safety, including by monitoring and reviewing incident reports.

Prior to 2014, APS routinely approved requests for services in excess of the member's budget, even though it was only supposed to make changes based on a change to the underlying assessment. *See* Compl. ¶ 240. As Table 1 shows, by SFY 2014, the I/DD Waiver budget deficit had grown to approximately $21 million, which represented a 20% increase over what the state had budgeted for the program. This caused BMS staff to closely scrutinize I/DD Waiver expenditures, and APS's practice of approving services in excess of the budget was discovered. When BMS learned of this practice at the end of 2014, it instructed APS that all requests for services in excess of the member's budget must go through the second level negotiation. *See* Compl. ¶ 246; Compl., Ex. 6. Of the over 2,500 members who have had budgets calculated and IPPs completed in 2015, BMS has approved 359 members' requests for services in excess of their budget through the second level negotiation, because it has determined that those services are necessary to keep the member safely in the community.

Budgets and service levels are reviewed and redetermined annually. If there is a change in the member's needs in the interim, the member's interdisciplinary team holds a "Critical Juncture" meeting to consider updating the IPP, including the service levels therein. W. Va. Medicaid Provider Manual § 513.8.2.4. "A Critical Juncture may be the result of a change in the member's medical/physical status, behavioral status or availability of natural supports." *Id*.

ARGUMENT

The Plaintiffs' Complaint attacks West Virginia's system for allocating funds for I/DD Waiver members. To begin with, this action is premature – three of the Plaintiffs have not completed the process through which their service levels are finalized and therefore their claims are not ripe for review. As for the merits, West Virginia uses a fair, equitable, and objective system

for allocating funds to support thousands of I/DD Waiver members with different disabilities, circumstances, and needs. This system is fully consistent with the Medicaid Act, the Due Process Clause, the ADA, and the Rehabilitation Act, and the Complaint should be dismissed.

I. The Claims of Michael T., Eric. D, and Jeremy C. Should Be Dismissed As Not Ripe for Judicial Review.

Plaintiffs seek injunctive and declaratory relief, which are discretionary remedies that "courts traditionally have been reluctant to apply . . . to administrative determinations unless these arise in the context of a controversy 'ripe' for judicial resolution." *Abbott Labs v. Gardner*, 387 U.S. 136, 148 (1967). "A case is fit for judicial decision when the issues are purely legal and when the action in controversy is final and not dependent on future uncertainties." *Miller v. Brown*, 462 F.3d 312, 319 (4th Cir. 2006). To evaluate whether a case is ripe, courts must assess both "the fitness of the issues for judicial decision" as well as "the hardship to the parties of withholding court consideration." *Abbott Labs*, 387 U.S. at 149.

This dispute is not ripe with respect to Michael T., Eric. D, and Jeremy C., and therefore this Court lacks jurisdiction to review their claims. First, these claims are not ripe because a final agency decision regarding I/DD Waiver benefits has not yet been issued in these Plaintiffs' cases. *Tammy W. v. Hardy*, 681 F. Supp. 2d 732, 736 (S.D. W. Va. 2010) (dismissing action where a child had received notice that benefits would be terminated, but had not yet completed the administrative review process). I/DD Waiver members dissatisfied with their service levels may pursue second level negotiation from BMS and, ultimately, a Medicaid Fair Hearing appeal. Compl. ¶¶ 267-70; *see also* Compl., Ex. 2. Plaintiff Michael T. has not yet completed even a second level negotiation, let alone filed an appeal. *See* Compl. ¶ 53. Plaintiffs Eric D. and Jeremy C. were denied additional services through second level negotiation, but the Complaint does

not allege that they have received a final decision from the Medicaid Hearing Officer on appeal. *See* Compl. ¶¶ 78, 141-144.

Moreover, delaying judicial review until there is final agency action would not result in hardship to these Plaintiffs. All three Plaintiffs had the option to continue to receive I/DD Waiver benefits pending administrative determination of their benefit levels. While he seeks additional services, Michael T. "continue[s] to receive the amount of waiver benefits he needed and had previously received." Compl. ¶¶ 49, 55. The Complaint states that Eric D. and Jeremy C. are not receiving their previously-authorized services while their appeals are pending. Compl. ¶¶ 78, 142. However, both Eric D. and Jeremy C. had the opportunity to receive services "at the previously-approved level throughout the hearing/appeals process" by requesting a hearing within 13 days of receipt of BMS's second level negotiation decision. *See* Compl. Ex. 2, p. 2, 3. Presumably, Eric D. and Jeremy C.'s representatives chose not to pursue the appeal within 13 days. Further, if their appeals result in a determination that Eric D. and Jeremy C. are eligible for the requested services, services will begin again on the date of that determination. § 513.4.1.

As this Court has previously explained, "judicial intervention at this stage would interfere with [the State's] authority to determine [Plaintiffs'] eligibility for benefits." *Tammy*, 681 F. Supp. 2d at 737. While Medicaid is funded with both federal and state dollars, States are responsible for administering the Medicaid program. "Basic notions of federalism and comity counsel that the state system should first make a final determination" regarding Plaintiff's I/DD Waiver benefits "before this federal court intervenes." *Id*. Dismissing the claims of Michael T., Eric D., and Jeremy C. will allow the State to make final I/DD Waiver benefit decisions and "help preserve the states' important role in administering the program." *Id*.

II. Counts I and II Should Be Dismissed Because Plaintiffs Received Notice and Appeal Rights.

A. West Virginia Complies with the Medicaid Act.

Plaintiffs assert that the State reduced or terminated waiver benefits "in violation of the Medicaid Act by failing to provide proper notice, or to grant the opportunity for fair hearing as required by" Section 1902(a)(3) of the SSA. Compl. ¶ 286.

The State fully complies with the notice and appeal requirements under the Medicaid Act and federal Medicaid regulations, and the Complaint does not allege any facts to the contrary. The State provides written notice of Medicaid Fair Hearing rights and conducts such hearings for any "applicant who requests it because his claim for services was denied." 42 C.F.R. § 431.220(a)(1); *see generally* 42 C.F.R Part 431, Subpart E. Waiver members may request a second level negotiation of their service levels if they are unsatisfied with their individualized budget. Compl. ¶ 270. If this request is denied, BMS sends a written notice stating the reason for the denial and informs the recipient of his or her "right to appeal the decision through a Medicaid Fair Hearing" within 90 days. Compl. Ex. 2. Four Plaintiffs have requested fair hearings to challenge their services levels. *See* Compl. ¶¶ 78, 106, 141-144, 168-70. The fifth Plaintiff has requested a second level negotiation from BMS and may request a fair hearing later if unsatisfied with BMS's decision. *See* Compl. ¶ 53. The Plaintiffs also acknowledge that "[o]ther recipients have been granted fair hearings, and given opportunity to present evidence showing receipt of authorized waiver benefits in greater amounts in prior years, and a continuing need for that level of waiver benefits." Compl. ¶ 274. Thus, Plaintiffs have not been denied notice or opportunity for a Medicaid Fair Hearing and Count II should be dismissed.

B. West Virginia Complies with the Due Process Clause.

The Plaintiffs assert that DHHR violated the Due Process Clause of the U.S. Constitution by reducing Plaintiffs' waiver services "without adequate prior notice or timely, meaningful hearing and a reasoned decision based on the governing law." Compl. ¶ 283.

The Complaint does not allege facts supporting this claim. To the contrary, as explained in the previous section, *see supra* Section II.A, the Complaint details how DHHR provided the Plaintiffs, and other I/DD Waiver members, with "timely and adequate notice" of the reasons for the reduction and an opportunity to challenge the State's action, *see McCartney v. Cansler*, 608 F. Supp. 2d 694, 699 (E.D.N.C. 2009) (quoting *Goldberg v. Kelly*, 397 U.S. 254, 262 (1970)). There is no question that DHHR "inform[ed] recipients that they can request a hearing and that the government will reinstate their benefits during the pendency of that hearing." *See Pashby v. Delia*, 709 F.3d 307, 328 (4th Cir. 2013). The Plaintiffs complain about DHHR's use of "a secret algorithm" and an "unpublished policy" to determine a budget. First, although some technical aspects of APS's analysis are proprietary, the key features of the system for calculating budgets are not secret. *See* I/DD Waiver Application, App'x A; *supra* Background Section. Second, DHHR did not act under an "unpublished policy." BMS's written policy authorizes it to deny I/DD Waiver services that exceed a member's budget. *See, e.g.*, §§ 513.2.2. 513.9.1.1. For some time, some members benefited from APS's authorization of services in excess of their budgets, but APS's practice was not pursuant to a state policy and it was unknown to BMS.

The Complaint also advances the theory that the reduction of waiver services is a Due Process violation "unless and until DHHR first establishes that a change has occurred in the recipient's medical or financial circumstances which justifies the reduction or termination." Compl. ¶ 279. This is not the law. Otherwise, States could never change Medicaid service levels or phase out optional Medicaid services. *Cf. Atkins v. Parker*, 472 U.S. 115, 129 (1985)

("The procedural component of the Due Process Clause does not impose a constitutional limitation on the power of Congress to make substantive changes in the law of entitlement to public benefits." (internal quotation marks omitted)). In support of this theory, Plaintiffs cite *Hardy v. B.H.*, 719 S.E.2d 804 (W. Va. 2011). But *Hardy* involves the burden of proof when DHHR is claiming that a beneficiary's circumstances have changed, and is not relevant here.

III. Counts III and IV Should be Dismissed Because Plaintiffs' Allegations Do Not Constitute Discrimination in Violation of the ADA or the Rehabilitation Act.

Counts III and IV allege that the I/DD Waiver service levels discriminated against Plaintiffs on the basis of their disability, in violation of Title II of the ADA and the Rehabilitation Act. The Complaint fails to state a claim of discrimination under either statute.[4]

The ADA and the Rehabilitation Act prohibit certain discrimination on the basis of disability. Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. Department of Justice (DOJ) regulations promulgated to enforce the ADA state that "[a] public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d). This regulation is often referred to as the "integration mandate."

In *Olmstead v. L.C.*, the Supreme Court considered "whether the [ADA's] proscription of discrimination may require placement of persons with mental disabilities in community settings rather than in institutions." 527 U.S. 581, 587 (1999). The two plaintiffs in *Olmstead*, who had

[4] Because Title II of the ADA and Section 504 of the Rehabilitation Act "impose the same integration requirements," *Pashby*, 709 F.3d at 321, this brief focuses on the Plaintiffs' ADA claim, but every argument raised with respect to the ADA claim should be read as applying with equal force to the Rehabilitation Act claim.

co-occurring developmental disabilities and mental health disorders, had continued to live in an institution for years after their treatment teams had determined community placement was appropriate because the State had not accepted them into its Medicaid HCBS waiver, even though the waiver was only one-third filled to capacity. *Id*. at 593-594, 601. The Court held that "unjustified" institutionalization of persons with disabilities can be discrimination, explaining:

> [P]ersons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice.

Id. at 601.

The *Olmstead* Court concluded that keeping these plaintiffs in an institutional setting constituted "unjustified isolation," and therefore discrimination under the ADA, if "[1] the State's treatment professionals determine that [home- or community-based] placement is appropriate, [2] the affected persons do not oppose such treatment, and [3] the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities." *Id*. at 598, 607. The Court then remanded for further proceedings relating to the third element of the plaintiffs' claims. The Court explained that the lower courts had not provided the State enough "leeway" to show that it could not reasonably accommodate the plaintiffs' request for non-institutional care, given the State's obligations "[t]o maintain a range of facilities and to administer services with an even hand." *Id*. at 605.

A. *Olmstead* Does Not Establish A Minimum Level of Home- and Community-Based Services.

The Plaintiffs allege that DHHR's adherence to members' APS budgets has resulted or will result in cuts to services that increase the Plaintiffs' risk of institutionalization, and that this violates the ADA as interpreted by *Olmstead*. Compl. ¶¶ 288-98.

The Plaintiffs' reading of *Olmstead* is wrong. The ADA is a discrimination statute and not a health care statute. Neither *Olmstead* nor the ADA require States "to provide a certain level of benefits to individuals with disabilities." *Olmstead*, 527 U.S. at 603 n.14; *see also M.R. v. Dreyfus*, 697 F.3d 706, 714 (9th Cir. 2011) (Bea. J., dissent from denial of rehearing *en banc*); *Buchanan v. Maine*, 469 F.3d 158, 174 (1st Cir. 2006); *cf. Alexander v. Choate*, 469 U.S. 287, 303 (1985). Instead, *Olmstead* means "only that States must adhere to the ADA's nondiscrimination requirement with regard to the services they in fact provide." 527 U.S. at 603 n.14. Accordingly, to properly allege an *Olmstead* violation, Plaintiffs must allege sufficient facts to show that the State is "discriminating against community-based recipients by favoring institutionalized recipients with more or better services, programs or activities." *M.R.*, 697 F.3d at 713-14 (dissent from denial of rehearing *en banc*). For example, a State policy that provides personal care services to institutional residents but not to community-based residents may be discriminatory under the ADA. *See id*. But, as the Second Circuit has observed, "*Olmstead* does not . . . stand for the proposition that states must provide disabled individuals with the opportunity to remain out of institutions" in all circumstances. *Rodriguez v. City of New York*, 197 F.3d 611, 619 (2d Cir. 1999). "What *Olmstead* did not hold—indeed what it specifically stated it was not holding—was that any sort of a level of services must be provided to prevent institutionalization, else the recipient would suffer discrimination." *M.R.*, 697 F.3d at 709 (Bea, J., dissenting).

Plaintiffs have not alleged facts that suggest West Virginia discriminates against community residents in favor of institutionalized individuals. The Complaint does not allege that the State provides services to institutional residents that it does not provide to community-based residents, or that eligibility standards for services are more lenient for individuals in institutions than for individuals in the community. Indeed, the State's HCBS expenditures far exceed its in-

stitutional expenditures. In 2014, West Virginia's Medicaid program spent over four times as much money on the I/DD Waiver than it did on ICF/IID services – approximately $385 million on the waiver versus $70 million on ICF/IID services . *See* Compl. ¶212, Exh. 5. And ICF/IID enrollment has not increased in recent years, but has remained steady at approximately 509 beds, due in part to the moratorium on ICF/IID beds imposed in West Virginia in 1989. *See* Compl. ¶203. Nor do Plaintiffs allege, as was the case in *Olmstead*, that they have been denied access to specific services in the community that they could access in an institution.

In *Pashby v*. *Delia*, the Fourth Circuit held that "individuals who must enter institutions to obtain Medicaid services for which they qualify may be able to raise successful Title II and Rehabilitation Act claims because they face a risk of institutionalization." 709 F.3d at 322. This does not mean that an *Olmstead* claim arises whenever an individual's services do not suffice to allow her to reside in the community. If that was *Pashby*'s holding, States would be required to provide optional Medicaid HCBS at levels that guarantee community placement without "risk" of institutionalization, regardless of how disabled an individual may be or how costly those services may be, as long a treatment professional believes that home- or community-based placement is desirable. This is not and cannot be the law. Rather, *Pashby* must be read in light of the state policy that was challenged in that case, which treated individuals in the community less favorably than those in institutions: to access personal care in the community, an individual had to require assistance with at least two of five activities of daily living ("ADL"), whereas an institutionalized individual qualified for personal care by requiring assistance or limited supervision with one of seven ADLs. *Id*. at 314. Accordingly, *Pashby* stands for the proposition that serious risk of institutionalization gives rise to an ADA claim when that risk is caused by policies that discriminate between access to services in an institution and access to services in the community.

In contrast to the state policy in *Pashby*, in this case, the Plaintiffs do not allege discriminatory treatment between themselves (as members in the I/DD Waiver) and institutionalized Medicaid enrollees. The Complaint does not claim that it is easier to access any Medicaid service in an institution than it is in the community. As a result, Plaintiffs have not alleged facts sufficient to support a claim of discrimination under the ADA or the Rehabilitation Act, and counts III and IV should be dismissed.

B. Plaintiffs Do Not Allege Facts Sufficient to Show that I/DD Waiver Policies Create a Serious Risk of Institutionalization.

Even if simply showing a "serious risk of institutionalization" caused by a benefit reduction could sustain a claim of discrimination under the ADA, Plaintiffs do not allege facts sufficient to make that showing *See Pashby*, 709 F.3d at 322 (quoting DOJ, *Statement of the DOJ on the Integration Mandate of Title II of the ADA and Olmstead v. L.C.* (June 22, 2011)). A "serious risk of institutionalization" means that Plaintiffs must show that the risk is actual and severe. *See V.L. v. Wagner*, 669 F. Supp. 2d 1106, 1119 (N.D. Cal. 2009); *G. v. Hawaii*, 676 F. Supp. 2d 1046, 1057 (D. Haw. 2009).

Plaintiffs allege that their budgets have or may be decreased, but they have not alleged facts to show that those decreases (or potential decreases) create a serious risk of institutionalization. The Complaint describes each named Plaintiffs' recent service budget, and any decreases that have occurred or might occur in the future, followed by the assertion that the Plaintiff "is at a serious risk of being institutionalized" as a result of the State's actions. Compl. ¶¶ 57, 79, 87, 119, 149. This type of "wholly conclusory statement" is insufficient to support a claim of discrimination; a complaint "requires more than labels and conclusions." *See Bell Atl. Corp. v. Twombly,* 550 U.S. 544, 555, 561 (2007). It is quite possible that services can be maintained (or even increased) within a decreased budget. For example, a member can substitute less expensive

services for more expensive services, share services with another member (for those individuals living in congregate settings), or make greater use of natural supports such as family members.

Rather than focus on potential risks to the individual member, the Complaint largely relies on increased strain and pressure on family caregivers. DHHR recognizes the difficulties any family caring for a loved one faces, but the goal of the I/DD waiver, as with DHHR's other waivers, is to supplement and not supplant family support, and the budgets are calculated accordingly. Even if the allegations of increased strain on family caregivers are accepted as true, that does not mean that Plaintiffs are at increased risk of institutionalization. In some cases the paid caregiver is a family member, which means that there is no change in the care, other than the amount that the State is able to pay. The Complaint explains that Tara R. moved out of her family home when her budget was decreased, but she is not in an institution. She continues to reside in the community in an Individualized Support Setting ("ISS") apartment. Tara R. is an example of how West Virginia's comprehensive system of care provides individuals with multiple pathways to remain in the community.

In sum, the Complaint does not allege facts sufficient to conclude that Plaintiffs face a serious risk of institutionalization "above the speculative level," and therefore the ADA and Rehabilitation Act claims should be dismissed. *See Twombly*, 550 U.S. at 555.

C. Plaintiffs Do Not Allege They Can be Reasonably Accommodated.

The Plaintiffs' Complaint incorrectly assumes that *Olmstead* provides each Plaintiff an individual right to avoid institutionalization. Under the ADA, a public entity is only required to modify a program to avoid discrimination if such a modification is "reasonable." *See* 28 C.F.R. § 35.130(b)(7). A public entity is not required to make any change that would "fundamentally alter" a program. *See id*. A "fundamental alteration" of a program occurs when, "in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the re-

sponsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities." *Olmstead*, 527 U.S. at 605. At the outset, plaintiffs "bear[] the burden of articulating a reasonable accommodation" to address the alleged discrimination. *Frederick L. Dep't of Pub. Welfare of the Commonwealth of Penn.*, 364 F.3d 487, 492 n.4 (3d Cir. 2004).

In this case, the Plaintiffs' have not alleged a reasonable modification to the I/DD Waiver. The Plaintiffs' Complaint does not expressly identify a reasonable modification, nor do the Plaintiffs' request relief that constitutes a reasonably modification. To the contrary, the breadth of the relief requested by the Plaintiffs is striking. Plaintiffs ask this Court to order the State to abandon its CMS-approved system for allocating funding in the I/DD Waiver, shift control of the funding process from the executive branch to the legislative branch, and await a "legislatively-established" "formula" that does not yield lower service levels for any member without "proof of a change in the individual recipient's circumstances reducing her or his actual needs." This would result in effectively a new and different program; it is not the type of limited program modification that is "reasonable" under the ADA. *Cf., e.g.*, *Pashby*, 307 F.3d at 323-24 (preventing the State from implementing stricter eligibility requirements for personal care services is a reasonable modification); *M.R.*, 697 F.3d at 736-37 (preserving pre-existing service levels by preventing implementation of an average 10% across-the-board cut in personal care is a reasonable modification).

In *Olmstead*, a plurality of the Court concluded that a plaintiff cannot compel a program change if the State already has "a comprehensive, effectively working plan for placing qualified persons . . . in less restrictive settings, and a waiting list that move[s] at a reasonable pace not controlled by the State endeavors to keep its institutions fully populated." 527 U.S. at 605-06.

"In such circumstances, a court would have no warrant effectively to order displacement of persons at the top of the community-based treatment waiting list by individuals lower down who commenced civil actions." *Id*. at 606.

West Virginia has a "comprehensive, effectively working plan" for helping individuals with physical and developmental disabilities remain in the community. The West Virginia Medicaid program spends hundreds of millions of dollar annually to help disabled residents remain in the community. Other than the system for allocating funding in the I/DD Waiver, the Complaint does not take issue with any feature of the State's comprehensive HCBS program. Nor does the Complaint allege that the waiting list for the I/DD Waiver fails to move a "reasonable pace" or is "controlled by the State endeavors to keep its institutions fully populated." The fact that the I/DD Waiver does not offer enrollees unlimited services does not mean the State does not have a "comprehensive, effectively working" plan to avoid institutionalization. Plaintiffs' request for increased services would result in increased costs, which would presumably be paid for by serving fewer individuals in the I/DD Waiver. This is the type of "displacement" of another group of disabled individuals that the *Olmstead* Court warned against.

Because the Plaintiffs have not articulated a reasonable modification that can be made to the I/DD waiver, their ADA and Rehabilitation Act claims should be dismissed.

CONCLUSION

For the foregoing reasons, the Plaintiffs' Complaint should be dismissed.

CERTIFICATE OF SERVICE

I, Caroline M. Brown, hereby certify that I caused a true and correct copy of Defendant's Memorandum of Law in Support of the Motion to Dismiss to the following via ECF notification:

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