UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF IOWA
CENTRAL DIVISION

MELINDA FISHER, et al., Plaintiffs, v. KIM REYNOLDS, et al., Defendants.	Case No. 4:17-cv-00208-RGE-CFB **PLAINTIFF'S REPLY IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION**

COME NOW Plaintiffs and hereby files this Reply in Support of the Motion for Preliminary Injunction.

Defendants' brief confirms that a preliminary injunction is warranted. As stated in the Medicaid Act, the purpose of Medicaid is to provide "medical assistance [to] . . . meet the costs of necessary medical services, and [to furnish such assistance and] services to help . . . such individuals attain or retain the capability for independence and self-care[.]" 42 U.S.C. § 1396-1. The profit margins of the MCOs, who entered risk-based contracts, is not legally relevant to the Defendants' obligation to ensure that eligible individuals receive the services to which they are entitled under Medicaid, the ADA, and Section 504, including through appropriate supervision and enforcement of policy when those individuals are enrolled in an MCO.

Likelihood of Success on the Merits

Defendants misconstrue what the law requires when operating waivers within "cost neutral parameters." Cost neutrality under a Medicaid waiver means the average per participant expenditures for the waiver and non-waiver Medicaid services must be no more costly than the average per person costs of furnishing institutional care, not that all waiver participants "need to be served at the same level as other Medicaid members on the waiver" or that exceptions to policy

requests are for extraordinary services in excess of what is entitled. (42 U.S.C. 1396n(c)(2)(D); Resistance Brief p. 5, 17). Even if Defendants had elected to limit individual waiver services to institutional cost limits, which they did not, Plaintiffs' costs at their previously approved exceptions to policy service levels are under the costs of institutionalization. (Docket 16-1, p. 34; Attachment C, p. 43). The argument that Plaintiffs requests exceed their entitlement is without merit as the exceptions to policy process is set forth in the approved waiver as part of the array of Medicaid services available to waiver participants. (Docket 16-1, p. 34). The Defendants' approved waiver application sets forth how the state is supposed to operate the wavier. The state must keep the waiver policies, practices, procedures and operations in sync with the approved waiver. 42 C.F.R. § 441 Subpart G; *Myers v. S.C. Dept. of Health & Human Servs*., 795 S.E.2d 301, 308 (S.C. Ct. App. 2016) (finding the approved waiver carries the force and effect of law).

In its approved waivers, Defendants specifically set the entitlement to an exceptions process as part of the array of services available under the waiver. "If there is a need that goes beyond the budget amount and/or the waiver service limit, the participant has ***the right*** to request an exception to policy." (Attachment C, pg. 200-201) (emphasis added).[1] There is no fundamental alteration defense when Defendants' own waiver sets forth this process to meet the needs of the waiver participants. Plaintiffs' services are not "extraordinary or greater support" than others, they are simply part of the population served by the waiver. Any services that are provided in an exception to policy are still Medicaid services and thus services to which courts have held plaintiffs have a legitimate claim of entitlement. *Schweiker v. Gray Panthers*, 453 U.S. 34, 36-37 (1981) ("An individual is entitled to Medicaid if he fulfills the criteria established by the State in which

[1] The Brain Injury 1915(c) approved waiver includes additional information in this section: "MCOs do not have a limit on the cost of services they can pay for under HCBS. The MCOs are required to balance to an aggregate average for services including self-direction; therefore, they have the flexibility to pay for services beyond the current rate caps that are allowed under the fee for service program." BI waiver at pg. 185.

he lives.") (*Murphy by Murphy v. Minnesota Dep't of Human Servs*, No. 16-2623, 2017 WL 2198133 at 17-18 (D. Minn. May 18, 2017)(stating entitlement when already enrolled in a waiver).

Due process requires that the discretion of Defendants in reviewing exceptions for these services cannot be arbitrary. The criteria used in making decisions must be ascertainable and known. *Michael T. v. Bowling*, 2016 WL 4870284 at *11 (S.D. W.Va. 2016). The MCOs have not granted and continue to deny exceptions to policy, often without notice, without any ascertainable standards in violation of Medicaid and the Constitution. (Doocy Decl. ¶ 13, Kuhl Decl. 15¶, Fisher Decl. ¶ 36, Wargo Decl. ¶ 17). The policy cited by Defendants is broad and does not provide sufficient specificity to allow enrollees to determine why they were denied, the criteria they would have to meet to be granted an exception, and allow them to adequately prepare for a hearing. *Memphis Light, Gas & Water Div. v. Craft*, 436 U.S. 1, 14 (1978); 42 C.F.R. § 438.404.

Approval of a waiver by CMS does not in any way address the State's independent obligation under the American's with Disabilities Act and the *Olmstead* decision. *Steimel v. Wernert*, 823 F.3d 902, 916 ("If the state's own waiver criteria could prevent enforcement of the integration mandate, the mandate would be meaningless."). The Defendants argument regarding fiscal restraint and having to manage services in this way is without merit as states are expected to manage waiver spending not by cutting services "or undermining the waiver purpose or quality by exceptional restrictions", but by controlling the number of individuals who may enroll in a waiver. 42 C.F.R. § 441.303(f)(6); Olmstead Letter No. 4, page 7.[2] Defendants cannot limit an eligible individual's covered waiver service simply because the spending for such service is more than the amount anticipated in the budget. Olmstead Letter No. 4, page 6. The Plaintiffs had their needs assessed and their service plans of care outlined, which Defendants routinely determined was

[2] CMS, SMDL 01-006, Olmstead Letter No. 4 (Jan. 10, 2001), https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd011001a.pdf.

necessary and granted services through the exceptions process prior to managed care. The Plaintiffs do not require fewer services now than they did prior to April 2016 and the costs of the plaintiffs' assessed needs still do not exceed the cost of intuitional placement.

Fundamental Alteration

Defendants cannot argue that state budget and costs issues establish a fundamental alteration defense to Olmstead claims. See *Pashby v. Delia*, 709 F.3d 307, 323 (4th Cir. 2013). The cases cited by Defendants in *Bryson* and *Arc of Washington* are inapplicable and pertain to limits on waiver slots or waiver wait lists. This class action and request for injunction is not about expanding the number of individuals who may enroll in a waiver. As the court in *Pashby* ruled, "although budgetary concerns are relevant to the fundamental alteration calculus, financial constraints alone cannot sustain a fundamental alteration defense." *Id.* at 324. The Defendants' other fundamental alteration defense regarding a functioning *Olmstead* plan is not supported by any evidence to show the state has such a plan as the mere existence of a plan is insufficient. *Day v. D.C.*, 894 F.Supp.2d 1, 28 (D.D.C. 2012).

Defendant DHS is the single state agency wholly responsible for the implementation and management of the state's Medicaid program and is not simply a "contract manager." To imply that the State is hands off to oversight and enforcement of the contract is a gross misunderstanding of their responsibilities under Medicaid law and under *Olmstead*. Simply having language in a contract is insufficient when Defendants do not enforce implementation of these contract provisions. *J.K. ex rel. R.K. v. Dillenberg*, 836 F.Supp. 694, 699 (D.Ariz. 1993).

Balance of Harms

Defendants argue that an injunction will force the State to direct funds away from other state agency programs or even other Medicaid individuals. Other courts have heard this same

argument and held that the harm to plaintiffs' health outweighs any burden on a state's budget. *See Pashby v. Delia*, 709 F.3d 307, 329 (2013) (citing *Cal. Phamacists Ass'n v. Maxwell*, 596 F.3d 1098, 1115 (9th Cir. 2010) (upholding district court's decision to grant an injunction explaining that California's financial problems did not outweigh the plaintiffs' health concerns even when the states' financial situation threatened to cause the end of other Medicaid services.).

Defendants argue that increased reliance upon natural supports is not a harm to the plaintiffs. Defendants fail to recognize that "increased reliance on natural supports" cannot be compelled and violates the law. 42 C.F.R. §§ 441.301(c)(2)(v), 441.725(b)(5). The Plaintiffs health and welfare are at serious risk of harm by Defendants lack of implementation of the laws and provisions in the waiver simply for budgetary convenience. Defendant also minimizes the impact of fewer services, but "'[u]njustified isolation…is properly regarded as discrimination based on disability' beyond the limited scope of institutionalization." *Guggenberger v. Minnesota*, 198 F.Supp.3d 973, 1026 (D. Minn. 2016) (quoting *Olmstead*, 527 U.S. at 597). The balance of harms weighs heavily in favor of the Plaintiffs here.

There is no exhaustion of remedies requirement as alleged by Defendants. *See Patsy v. Florida Board of Regents*, 457 U.S. 496, 516 (1982) (no duty to exhaust in 1983 cases). Plaintiffs have adequately described the cycle of appeals and futility of ALJ rulings in its brief in support for preliminary injunction.

WHEREFORE, Plaintiffs request their motion for preliminary injunction be granted.

Respectfully submitted,
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