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15 UNITED STATES DISTRICT COURT  
16 DISTRICT OF ARIZONA

17 PEG BALL, CREE JAMES, a minor )  
18 person by and through her )  
grandfather and guardian, BENNIE )  
19 JAMES, JEANNE SPINKA, VENNETTA )  
GRAHAM, COLLIN PHELAN, a minor )  
20 person by and through his mother )  
KIM BOWMAN, JUDETH HINTON, and )  
21 VIRGINIA HASKELL, as individuals )  
and as representatives of a class )  
22 of persons similarly situated, )  
Plaintiffs, )  
23 v. )  
24 PHYLLIS BIEDESS, Director of the )  
Arizona Health Care Cost )  
25 Containment System, THE ARIZONA )  
HEALTH CARE COST CONTAINMENT )  
26 SYSTEM ADMINISTRATION, and the )  
STATE OF ARIZONA, )  
27 Defendants. )

No. CIV 00 - 67 TUC ACM  
**MEMORANDUM OF POINTS AND  
AUTHORITIES IN SUPPORT  
OF PLAINTIFFS' MOTION  
FOR SUMMARY JUDGMENT**

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INTRODUCTION

This lawsuit challenges policies of the Arizona Health Care Cost Containment System (AHCCCS) that deprive the elderly and disabled of desperately needed home care services. The plaintiffs are a class of persons in Arizona who have been or will be eligible for home care services because their disabilities put them at risk of institutionalization, but who do not receive the full amount of such services prescribed in their care plans.

AHCCCS is part of the joint federal and state Medicaid program. In choosing to participate in Medicaid, AHCCCS has agreed to comply with standards established in the federal Medicaid statute and regulations. Several of these standards are violated by the inadequacy of AHCCCS' Home and Community Based Services (HCBS), which are part of the Arizona Long Term Care System (ALTCs). Defendants' failure to provide adequate amounts of home care worker services also violates the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973. Finally, defendants' failure to give denial notices and appeal rights when they do not provide home care services violates constitutional and statutory protections.

I. FACTS

A. PLAINTIFFS' LACK OF SERVICES

The plaintiffs in this case are aged and disabled individuals who have been determined eligible for HCBS services under care plans developed for them by their AHCCCS program contractors. Each of the named plaintiffs has gone without her needed home care

1 services for substantial periods of time. When AHCCCS failed to  
2 send the promised home care workers, it gave plaintiffs no written  
3 notices that would advise them of the availability of appeals or  
4 other remedies. Complete descriptions of plaintiffs' situations  
5 are set out in their declarations, filed in the Appendix hereto.

6 Peg Ball, who has quadriplegia and sleep apnea, had an HCBS  
7 care plan that called for her to receive 50 hours of attendant care  
8 per week. However, she actually received only 20 to 31 hours of  
9 care, and she got no care on weekends. There were constant changes  
10 and resignations of staff. She managed to survive through the  
11 unpaid services of her companion, but had to go into a nursing home  
12 in 1997 when her companion could not care for her. Plaintiff Ball  
13 moved to Michigan after this case was filed because Michigan's  
14 Medicaid program provides the home care services she needs, but she  
15 would return to Arizona if the HCBS program were reformed.

16 Plaintiff Cree James is an 9 year old child with  
17 periventricular leukomalacia, mental retardation and developmental  
18 delay. Her care plan called for 60 hours of home care monthly as  
19 well as respite care. Her grandparents have been forced to care  
20 for her without assistance for long periods of time due to the  
21 failure of the Division of Developmental Disabilities (DDD) to fill  
22 and maintain her care plan.

23 Jeanne Spinka has quadriplegia with limited use of her hands  
24 as a result of Infantile Progressive Spinal Muscular Dystrophy, and  
25 needs total care. Her HCBS plan prescribed 40 hours of attendant  
26 care per week, but because she was actually receiving only 25

1 hours, her 82 year old mother attempted to help, at risk to her own  
2 frail health.

3 Vennetta Graham is a 66 year old woman who has permanent head  
4 and back injuries from an accident, including some left side  
5 paralysis. She has undergone 9 brain surgeries to try to correct a  
6 leak of brain fluid, which in turn have caused her to have grand  
7 mal seizures and to lose one eye. She also has a history of stroke  
8 and allergies, and walks with a cane and seeing eye dog. She cares  
9 for her 43 year old son Gregory, who has a mental disability,  
10 various physical problems, and cannot speak. Both Ms. Graham and  
11 Gregory were enrolled in the HCBS program on or about October,  
12 1998. Their HCBS care plan included 4 hours of home care services  
13 per week, but the workers quit constantly, leaving gaps in their  
14 services. When Ms. Graham complained about theft by one of the  
15 workers, her case manager said that she would get no more workers.  
16 Although the case manager apologized later, Ms. Graham in fact  
17 received very little home care service after she complained.

18 Collin Phelan is a 4 year old boy with quadriplegia, a seizure  
19 disorder and psycho-motor delays due to a brain injury at birth.  
20 He lives at home with his mother, Kimberly Bowman, and requires  
21 total care with all activities of daily living. Collin's HCBS  
22 benefits are administered by the Division of Developmental  
23 Disabilities (DDD) of the Department of Economic Security (DES).  
24 He was authorized for 720 hours per year of respite care and 740  
25 hours per year of personal attendant/habilitation care. However,  
26 with no explanation, DDD simply failed to provide any of these

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1 services. As a result, Collin's mother had great difficulty  
2 performing and keeping the job she needs.

3 Judeth Hinton is a 42 year old woman who has systemic lupus, a  
4 seizure disorder, muscular dystrophy and a third-degree heart block  
5 for which she has a pacemaker. She had a brain stem stroke in 1996  
6 which left her with a respiratory disorder and a speech impediment.

7 She uses a wheelchair, and needs help with all activities of daily  
8 living. Ms. Hinton's care plan included 35 hours per week of  
9 attendant care services. However, her ALTCS case manager at Pima  
10 Health System told her it had no attendants available and she would  
11 have to go into a nursing home unless she had a friend or family  
12 member who would work as her attendant. Eventually Pima Health  
13 System arranged for part of her care plan to be filled, but even  
14 these partial services were not provided reliably. On 10 occasions  
15 she spent the night in her wheelchair because her evening attendant  
16 did not come. Because Ms. Hinton did not have sufficient  
17 assistance with toileting, she was hospitalized in December, 1999  
18 after a seizure, and lost the ability to self-toilet. A friend  
19 then agreed to work as her attendant, but when she fell ill, the  
20 ALTCS provider did not send a substitute and Ms. Hinton was left  
21 alone in bed all day.

22 Both Grace Collier and Virginia Haskell were in their late  
23 70s, were homebound and used wheelchairs due to serious  
24 disabilities. Although Ms. Collier resided in Tucson, and Ms.  
25 Haskell resides in Scottsdale, they have both experienced  
26 situations in which HCBS home care workers upon whom they depend

1 for assistance with their basic activities of daily living simply  
2 failed to show up. In Ms. Collier's case, the unreliable services  
3 were provided directly by Pima Health System, the county agency  
4 that contracts with AHCCCS. In Ms. Haskell's case, dependable  
5 services were provided by a private agency until its contract with  
6 Maricopa County was terminated; however, when the county began to  
7 provide HCBS services directly, Ms. Haskell's care became as  
8 unreliable as that provided to Ms. Collier by Pima County. Mrs.  
9 Collier has passed away since this lawsuit was filed.

10 The named plaintiffs' difficulties getting promised services  
11 are echoed in the problems experienced by class members whose  
12 declarations are also filed in the Appendix. Many of these HCBS  
13 beneficiaries were told by home care workers who quit that salaries  
14 and working conditions under the HCBS program are so poor that they  
15 could not continue to work for the program. Many beneficiaries  
16 report that if they complain about the lack of home care services,  
17 they are told by their case managers that they can get services if  
18 they go into a nursing home. Beneficiaries who report thefts or  
19 unreliability of their workers are labeled "difficult" by their  
20 case managers and receive fewer worker assignments.

21 Plaintiffs have no remedies for the failure of AHCCCS to  
22 provide them with the home care services to which they are  
23 entitled. AHCCCS gives no notice of adverse action when it fails  
24 to fill their care plans because it does not consider this to be a  
25 denial of services. Some HCBS recipients have managed to file  
26 grievances with their health plans, and in response more services

1 were provided to them for a short period of time.

2 B. DESCRIPTION OF THE ALTCS HCBS PROGRAM

3 1. Overview

4 Defendant AHCCCS Administration provides HCBS services under  
5 the ALTCS program. HCBS services may be provided in the ALTCS  
6 member's home or in an alternative residential setting, such as an  
7 adult foster care home. ALTCS provides not only HCBS services, but  
8 also acute medical care services, institutional services (such as  
9 care in nursing facilities), behavioral health services, and case  
10 management services. ALTCS is funded by federal, state, and county  
11 monies.

12 To be eligible for ALTCS services, a person must be: (1)  
13 elderly, physically disabled, or developmentally disabled; and (2)  
14 financially eligible. As of September 1, 2000, the ALTCS program  
15 was serving 29,700 members; more than 18,000 of those members were  
16 receiving HCBS services.

17 ALTCS services are delivered by: (1) seven program  
18 contractors that deliver services in different counties of the  
19 State to the elderly and physically disabled; (2) the Arizona  
20 Department of Economic Security (DES), a program contractor that  
21 delivers services throughout the State to the developmentally  
22 disabled; and (3) six Native American tribes that deliver HCBS  
23 services to Native American ALTCS members who reside on  
24 reservations. Approximately 97% of ALTCS members receive their  
25 ALTCS services through a program contractor, while 3% receive such  
26 services through a Native American tribe.

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1 Program contractors are paid by defendant AHCCCS on a  
2 capitated basis. A capitation rate is the amount of money  
3 defendant AHCCCS pays per month for each member served by a  
4 particular program contractor. Different capitation rates are paid  
5 to each program contractor. For the year beginning October 1,  
6 2000, weighted average statewide capitation rates were as follows:  
7 \$2,344 per member per month for the elderly and physically  
8 disabled, and \$2,397 for the developmentally disabled.

9 In turn, program contractors contract with service providers  
10 to provide ALTCS services, including HCBS services. Service  
11 providers submit their bills to program contractors, not to  
12 defendant AHCCCS.

13 While program contractors are paid on a capitated basis,  
14 Native American tribes are paid on a fee-for-service basis.  
15 Providers of ALTCS services to members residing on reservations  
16 submit bills directly to defendant AHCCCS. Only about 3% of ALTCS  
17 members are covered under the fee-for-service program.

18 If the ALTCS member is eligible for HCBS services, a case  
19 manager (employed by the program contractor or Native American  
20 tribe) specifies in a case management plan the particular HCBS  
21 services to be received. Ariz. Admin. Code ' R9-28-510(B)(3).<sup>1</sup>

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22 <sup>1</sup> To determine whether the ALTCS member is eligible for HCBS  
23 services, the member's case manager must complete a Acost  
24 effectiveness study@ (CES). The CES compares the cost of HCBS  
25 services with the cost of institutional care. An ALTCS member may  
26 receive medically necessary HCBS services if: (1) the cost of HCBS  
27 services does not exceed 100% of the net cost of institutional  
28 care; or (2) the cost of HCBS services exceeds 100% of the cost of  
institutional care, but is expected to be below 100% within the

1 The plan also includes the amount and frequency of each such HCBS  
2 service. Id. All HCBS services in the member's plan have been  
3 determined by the program contractor to be medically necessary.  
4 Ariz. Admin. Code ' R9-28-201(1). The gravamen of this lawsuit is  
5 that HCBS services specified in case management plans are  
6 frequently not delivered, even though these services are medically  
7 necessary.

8 2. Systemic Problems Exist In The Home Care Worker Component Of  
9 ALTCS

10 a) There Is A Chronic Shortage Of HCBS Home Care Workers

11 The problems obtaining HCBS home care workers experienced by  
12 class members are well-documented in numerous sources. Supra, 1-6.  
13 Both of the major ALTCS program contractors have long waiting lists  
14 for home care services. Plaintiffs' Statement of Material Facts  
15 (Statement of Facts), ¶ 66. A Community Based Report prepared for  
16 ALTCS by a statewide workgroup stated that there appeared to be a  
17 shortage of home care workers. Id., ¶ 69. The ALTCS Clinical  
18 Quality Manager also testified that she believes there is a  
19 shortage of attendant care workers. Id., ¶ 68. A study by the  
20 Arizona Ass'n of Providers For People With Disabilities found that  
21 next six months. However, if the cost of HCBS services exceeds 80%  
22 of the cost of institutional care, case managers must submit  
23 written justification to their supervisors for including HCBS  
services in a case management plan. Ariz. Admin. Code ' R9-28-  
510(B)(10).

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1 annual turnover rates in personnel range from 42 to 175%  
2 throughout urban and rural Arizona. Id., ¶ 75. Executive  
3 Directors of agencies that assist disabled individuals to live  
4 independently state that lack of HCBS services forces beneficiaries  
5 to live in nursing homes. Id., ¶ 76.

6 b) AHCCCS Does Not Provide Adequate Funding And Wage  
7 Levels For HCBS Workers

8 Many sources trace this shortage in HCBS home care workers to  
9 inadequate levels of compensation. The ALTCS Manager admitted  
10 that it is common for HCBS providers to complain that they are paid  
11 less than providers in the private market. Statement of Facts, ¶  
12 77. The ALTCS Clinical Quality Manager admitted that HCBS rates  
13 might be too low to provide quality care and communicated this to  
14 the ALTCS Manager. Id., ¶ 79. The Director of DDD told ALTCS in a  
15 number of meetings that deficiencies in respite care, attendant  
16 care and personal care workers result from inadequate ALTCS  
17 payments. Id., ¶ 80. A DDD rate study found that low reimbursement  
18 failed to cover the actual costs of services and resulted in high  
19 staff turnover. Id., ¶ 81. A large DDD provider agency testified  
20 that the low rates greatly limit the amount of attendant care  
21 services they can supply, and that as of June, 2001 there were  
22 several hundred beneficiaries going without services as a result.  
23 Id., ¶ 82.

24 Pima County is the ALTCS program contractor in the second  
25 largest county in Arizona. It hires attendant care workers  
26 directly rather than using provider agencies. Pima Health System

1 (PHS) classifies its attendant care workers as temporary, part time  
2 employees and they receive no job benefits. Id., ¶ 83. PHS does  
3 not pay attendant care workers for their travel time as they go  
4 from one patient's home to another during the day. Id., ¶ 84.  
5 Although ALTCS increased the portion of its capitation rates for FY  
6 2001 attributed to attendant care workers by 10% after this lawsuit  
7 was filed, PHS did not increase its hourly wage for attendant care  
8 workers in FY 2001. Id., ¶¶ 85, 86.

9 ALTCS program contractors are allowed to keep the profit that  
10 they make by not spending all of their capitation payments on  
11 services. Statement of Facts, ¶¶ 116, 119. Both Maricopa and Pima  
12 Counties made profits of 5 to 7% on their ALTCS contracts in 1999  
13 and 2000. Id., ¶ 117. Pima Health System was allowed to transfer  
14 more than 5 million dollars from its ALTCS program to other county  
15 programs in 2001. Id., ¶ 118.

16 c) Compensation For Workers From HCBS Is Inferior To  
17 Compensation From Other Payment Sources

18 ALTCS rates for home care have traditionally fallen below  
19 rates paid by Medicare and other insurers. As a result, many home  
20 health agencies will not contract with ALTCS to provide workers, so  
21 that ALTCS beneficiaries lack access to adequate in-home services.  
22 Statement of Facts, ¶¶ 87, 88, 91, 92. A home care worker  
23 receives \$1 an hour higher wages for her Medicare work than for her  
24 ALTCS work. Id., ¶ 80. A private guardian/conservator is able to  
25 provide adequate home care services when his ward/beneficiaries  
26 have Medicare or private insurance. Id., ¶ 80. Several large

1 providers of home care services in Arizona have stopped supplying  
2 workers for ALTCS in one or more categories of home care, although  
3 they continue to provide workers in these categories to other  
4 payers. In addition, because of the lower ALTCS rates providers  
5 are not able to find enough workers to meet HCBS needs in those  
6 remaining job categories for which they still contract with ALTCS.  
7 Id., ¶¶ 83-84.

8 d) ALTCS Fails To Effectively Monitor Its Program  
9 Contractors

10 The AHCCCS managed care system creates an incentive to  
11 underserve beneficiaries. ALTCS program contractors make more  
12 profit if they provide fewer services to the members. Deposition  
13 of Mark Hoyt, 45:1-3, 22-23. And AHCCCS' actuary stated that it  
14 would be helpful in establishing actuarially sound capitation rates  
15 to consider data showing whether services prescribed in care plans  
16 of program contractors are actually being provided by the program  
17 contractors. Dep. of Hoyt, 70:5-11.

18 Nevertheless, AHCCCS does not know how many instances have  
19 occurred in which home care services prescribed in care plans were  
20 not provided to HCBS eligible recipients. Defendants' Responses to  
21 Plaintiffs First Set of Interrogatories (Ds' Responses to Ps' 1st  
22 Interrogs), Response No. 4. AHCCCS does not have a monitoring  
23 system to determine how often home care services were not provided  
24 for lack of available workers, and it does not track information on  
25 the program contractors' waiting lists. Ds' Responses to Ps' 1st  
26 Interrogs, Response No. 3. AHCCCS does not know how long the

1 average wait is for full implementation of an HCBS recipient's care  
2 plan. Ds' Responses to Ps' 1st Interrogs, Response 9. And  
3 although AHCCCS, in response to this lawsuit, began to manually  
4 track whether the services prescribed for the named plaintiffs were  
5 actually being provided, it categorically stated that its program  
6 contractors' computerized systems are unable to tabulate this kind  
7 of information for the rest of the population entitled to HCBS  
8 services. Ds' Responses to Ps' 1st Interrogs , Response 18.

9 Nor does AHCCCS track member complaints regarding failure of  
10 program contractors to provide services in their care plans. Ds'  
11 Responses to Ps' 1st Interrogs, Response 19. AHCCCS states that in  
12 1999, out of an ALTCS population of 27,809 , it only received 220  
13 member complaints, half of which came from community based  
14 settings, but it is abundantly clear that members are generally  
15 unaware that they can or should complain to ALTCS when they fail to  
16 get authorized services to which they are entitled, and therefore  
17 AHCCCS would never learn of members' complaints. Statement of  
18 Facts, ¶¶ 97-101; Ds' Responses to Ps' 1st Interrogs, Response, 19.

19 AHCCCS' Case Management Service Review (CMSR) purports to  
20 monitor case management/service plan issues once a year, but there  
21 are only 3 to 4 AHCCCS staff who perform these reviews for all  
22 Program Contractors in the ALTCS program. Ds' Responses to Ps'  
23 1st Interrogs, Response No. 23. The CMSR, a small random sample of  
24 all ALTCS program contractors services is completely inadequate,  
25 and indeed is not designed to examine unavailability of services.  
26 Statement of Facts, ¶¶ 102-106. AHCCCS also conducts Operational

1 And Financial Reviews of HCBS program contractors. However these  
2 do not distinguish whether the client resides in an HCBS or  
3 institutional setting. AHCCCS claims it cannot do this because it  
4 would have to substantially increase the sample size analyzed and  
5 it lacks the resources to do so. Id., ¶ 107.

6 Moreover, even if the sample size of these operational and  
7 financial reviews were increased to more accurately monitor the  
8 situations of clients in HCBS settings, it would not solve the  
9 problem. AHCCCS fails to take any enforcement action against  
10 program contractors with respect to the unavailability of attendant  
11 care services. Id., ¶ 112, 113. In fact, the Director of AHCCCS  
12 does not know whether there have ever been any penalties imposed on  
13 program contractors for not providing adequate services to HCBS  
14 recipients. Deposition of Phyliss Irene Biedess, 30:14-20.

### 15 3. Recent Changes Made In the ALTCS HCBS System

16 Since this lawsuit was filed, AHCCCS increased its fee-for-  
17 service rates and capitation rates for ALTCS services on October 1,  
18 2000 and again October 1, 2001.<sup>2</sup> See Ds' Responses to Ps'1<sup>st</sup>  
19 Interrogs, Response No. 17. However, AHCCCS' rate increases for

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20 <sup>2</sup> ALTCS has liberalized several other aspects of the HCBS system since this lawsuit was  
21 filed. First, it clarified that beneficiaries should not be denied eligibility solely because the cost of  
22 HCBS services exceeds 80% of the cost of institutional services. Ds' Responses to Ps' 1st Interrogs,  
23 Response No. 12; Attachments G to Ds' 1st Responses and K to Ds' Initial Disclosures. Second,  
24 ALTCS reworded some information to clarify the requirement that program contractors have backup  
25 workers available seven days a week. Deposition of Alan Shafer, 70:2-8. Third, Effective October 1,  
26 2000, AHCCCS began requiring program contractors to report information on the timeliness of  
27 service implementation for newly enrolled members on a monthly basis to be compared against an  
28 AHCCCS standard of 30 days. Ds' Responses to Ps' 1st Interrogs, Response No. 17. However, no  
such standard or requirement for reporting on timeliness of services exists for tracking new services  
for existing members. Ds' Responses to Ps' 1st Interrogs , Response No. 9.

1 contract year ending 2001 (CYE02) are still inadequate to assure  
2 that Arizona has Medicaid payment rates which will enlist enough  
3 providers to give the quality HCBS services to which the eligible  
4 elderly and physically disabled in Arizona are entitled. AHCCCS  
5 calculates its HCBS capitation rate to be paid to its program  
6 contractors by multiplying the cost of the services by the use  
7 rate. Deposition of Branch Patrick McNeil, 39-49. But the methods  
8 and procedures AHCCCS uses to arrive at both the cost and quantity  
9 components to calculate its capitation rate are flawed because  
10 AHCCCS fails to collect accurate data on the cost of providing HCBS  
11 services and also fails to collect data on the actual number of  
12 needed services. Therefore, AHCCCS cannot reasonably determine  
13 what adequate payment rates should be.

14 II. LEGAL ARGUMENT

15 Defendants repeatedly fail to provide HCBS services specified  
16 in beneficiaries' case management plans. Defendants are thus  
17 violating the federal Medicaid statute and regulations, the  
18 Americans With Disabilities Act, and the Rehabilitation Act.  
19 Further, when defendants fail to provide HCBS services, they refuse  
20 to provide beneficiaries with a denial notice. That refusal  
21 violates the Due Process Clause of the Fourteenth Amendment to the  
22 U.S. Constitution, and the federal Medicaid statute and  
23 regulations. As discussed below, plaintiffs are entitled to  
24 summary judgment on all of their claims.

25 Summary judgment must be granted if there is no genuine issue  
26 as to any material fact and the moving party is entitled to a

1 judgment as a matter of law. Fed. R. Civ. P. 56(c). "[T]he mere  
2 existence of some alleged factual dispute between the parties will  
3 not defeat an otherwise properly supported motion for summary  
4 judgment; the requirement is that there be no genuine issue of  
5 material fact." Anderson v. Liberty Lobby, Inc., 477 U.S. 242,  
6 247-48 (1986). A material fact is one that "might affect the  
7 outcome of the suit under the governing [substantive] law." Id. at  
8 248. A dispute about a material fact is genuine if "a reasonable  
9 jury could return a verdict for the nonmoving party." Id. at 248.

10 A. VIOLATION OF FEDERAL MEDICAID REQUIREMENTS

11 1. Obligation Of AHCCCS To Comply With Medicaid Program  
12 Requirements

13 Medicaid is a joint federal-state program that provides  
14 medical services to certain low-income individuals, e.g. those who  
15 are elderly, disabled, or children. 42 U.S.C. ' 1396 et seq.  
16 States can freely chose whether or not to participate in the  
17 Medicaid program, but "[o]nce a State voluntarily chooses to  
18 participate in Medicaid, the State must comply with the  
19 requirements of Title XIX and applicable regulations." Alexander  
20 v. Choate, 469 U.S. 287 n.1, 105 S.Ct. 712, 714 n. 1 (1985).

21 Arizona has elected to participate in the Medicaid program.  
22 Home and community based services for persons at risk of  
23 institutionalization are a mandatory Medicaid service.

24 **(a) Contents.** A State plan for medical assistance must--  
25 (10) provide--  
26 (D) for the inclusion of home health services for any

1 individual who, under the State plan, is entitled to  
nursing facility services; . . . .

2  
3 42 U.S.C. § 1396a(a)(10)(D).

4 In determining whether the state has complied with the federal  
5 statutes at issue here, the courts have declined to give Chevron  
6 deference to the state's interpretations of the statutes, but  
7 interpret them de novo. Orthopaedic Hospital v. Belshe, 103 F.3d  
8 1491, 1495 (9th Cir. 1997), cert. denied, 522 U.S. 1044 (1998),  
9 Lewis v. Hegstrom, 767 F.2d 1371, 1396 (9th Cir. 1985).

10 2. Medicaid Assistance Must Be Furnished With Reasonable  
11 Promptness To Eligible Individuals. 42 U.S.C.  
§1396a(a)(8).

12 This Medicaid statute requires that covered health services  
13 such as HCBS home care "shall be furnished with reasonable  
14 promptness to all eligible individuals". 42 U.S.C. § 1396a(a)(8).  
15 The right to received Medicaid services with "reasonable promptness"  
16 is enforceable under 42 U.S.C. § 1983. See, e.g., Doe v. Chiles,  
17 136 F.3d 709, 715-719 (11th Cir. 1998); Lewis v. New Mexico Dep't of  
18 Health, 94 F.Supp. 2d 1217, 1233-1236 (D.N.M. 2000); Sobky v.  
19 Smoley, 855 F.Supp. 1123, 1146-1147 (E.D.Cal. 1997). See also,  
20 Jane Perkins and Randolph T. Boyle, Addressing Long Waits For Home  
21 And Community Based Care Through Medicaid and the ADA, 45 St. Louis  
22 Univ. L.J. 117, 126 (2000).

23 This Medicaid statutory provision is given more explicit  
24 meaning by regulatory interpretation. 42 C.F.R. § 435.930 explains  
25 that the state must "[f]urnish Medicaid promptly to recipients  
26 without any delay caused by the agency's administrative procedures,"



1 2000)(waiting lists for waiver services must move at a reasonable  
2 pace, defined as 90 days). See also Jefferson v. Hackney, 406 U.S.  
3 535, 545 (1972) (interpreting parallel section of Aid to Families  
4 With Dependant Children statute.)

5 3. The State Must Continue Providing Services To An Eligible  
6 Individual Until That Individual Becomes Ineligible. 42  
7 C.F.R. § 435.930(b).

8 As explained above, both named and class plaintiffs frequently  
9 find themselves suddenly stranded without home care services when  
10 their workers quit or are transferred to other patients.  
11 Significant periods typically follow in which no home care services  
12 are provided to plaintiffs by their HCBS program contractors.  
13 Statement of Facts, ¶¶ 13-15, 17, 21, 24, 28, 31, 35, 39-42, 46,  
14 48, 50, 54-55, 57, 60-61, 64,71-72, 76. The defendants have not  
15 adopted reasonable tools for monitoring and correcting this  
16 dreadful problem. Id., ¶¶ 95-113. Instead ALTCS officials accept  
17 that when “you are working with a managed care program . . . there’s  
18 always going to be a difference between what you, maybe,  
19 authorized, versus what’s been received.” Deposition of Alan  
20 Shafer, 18:24-25, 19:1-4.

21 AHCCCS’ laissez faire policy with respect to monitoring the  
22 performance of its program contractors has been noted and  
23 criticized in several expert studies of the program. A Kaiser  
24 Family Foundation study of AHCCCS found that “in a capitated  
25 medical care program it is of special importance to assure that  
26 beneficiaries are receiving appropriate treatment.” Statement of

1 Facts, ¶ 122. The Arizona Auditor General issued a report in 1999  
2 that found that AHCCCS' monitoring process should be improved "to  
3 better ensure home health clients receive quality care." Id., ¶  
4 123. Finally, a 6 year study of Medicaid managed care programs  
5 like AHCCCS concluded this year by Mathematica Policy Research,  
6 Inc. found that monitoring of plan performance by states is  
7 critical to assure access to care and quality of care. Id., ¶ 121.

8 Defendants' acceptance of deficiencies in service to  
9 beneficiaries clearly violates the requirement of 42 C.F.R. §  
10 435.930(b) that Medicaid services continue until an eligible  
11 individual becomes ineligible for Medicaid.

12 4. The Defendants Must Have Methods And Procedures To  
13 Assure That Payment Rates Are Consistent With Quality Of  
14 Care And Supply Sufficient Numbers Of Home Care Workers.  
42 U.S.C. § 1396a(a)(30)(A)

15 a) The Statutory Mandate Of Equal Access To Services  
16 Is Not Met

17 A state Medicaid program like AHCCCS must:

18 "provide methods and procedures relating to utilization of,  
19 and the payment for, care and services available under the  
20 plan . . . to assure that payments are consistent with  
21 efficiency, economy, and quality of care and are sufficient to  
22 enlist enough providers so that care and services are  
23 available under the plan at least to the extent that such care  
24 and services are available to the general population in the  
25 geographic area."

26 42 U.S.C. § 1396a(a)(30)(A).

27 The courts have consistently held that reimbursement by state  
28 Medicaid programs must be adequate to provide beneficiaries with  
the range of Medicaid covered services. A number of cases brought

1 by providers have found hospital rates unlawfully low. Wilder v.  
2 Virginia Hosp. Ass'n, 496 U.S. 498, 500 (1990). Ohio Hosp. Ass'n v.  
3 Ohio Dep't of Human Services, 62 Ohio St. 3d 97, 105, 579 N.E. 695,  
4 698 (Ohio St.Ct. 1991). These decisions were based on both §  
5 1396a(a)(30)(A) and § 1396a(a)(13)(A) (the Boren Amendment, which  
6 specifically addressed reimbursement for hospital services).

7 Section 1396a(a)(30)(A) of the Medicaid statute was amended in  
8 1989 to include the requirement now found in the last sentence--  
9 that state payments must be "sufficient to enlist enough providers  
10 so that care and services are available under the plan at least to  
11 the extent that they are available to the general population in the  
12 geographic area." Omnibus Budget Reconciliation Act of 1989, Pub.  
13 L. No. 101-239, § 6402(a). Prior to this change in the Medicaid  
14 statute, the Medicaid regulations at 42 C.F.R. § 447.204 had  
15 imposed a similar requirement that "payments must be sufficient to  
16 enlist enough providers so that services under the plan are  
17 available to recipients at least to the same extent that those  
18 services are available to the general population."

19 Congress explained that this beefed-up requirement of access  
20 to services was necessary because it had found that states were  
21 improperly limiting payment rates to Medicaid providers as a  
22 "method of controlling program costs." Report of the House Budget  
23 Committee on H.R. 3299 (Sept. 20, 1989), reprinted in 1989 U.S.  
24 Code Congressional and Administrative News, 2115-2118. The  
25 Committee report went on to observe that "without adequate payment  
26 levels, it is simply unrealistic to expect physicians to

1 participate in the program . . . .”<sup>3</sup> Id.

2 \_\_\_\_\_  
3       <sup>3</sup> The legislative history also makes it clear that the  
4 relevant community comparison group does not include individuals  
5 who lack health insurance: “The Committee expects that the  
6 Secretary, in determining whether services are available to  
7 Medicaid beneficiaries at least to the extent that services are  
8 available to the general population, will compare the access of  
9 beneficiaries to the access of other individuals in the same  
10 geographic area with private or public insurance coverage. . . .  
11 It is obvious that Medicaid beneficiaries are likely to have better  
12 access to care than individuals without insurance coverage and  
13 without the ability to pay for services directly. The question  
14 which the Secretary must ask is whether Medicaid beneficiaries have  
15 access to provider services that is at least as great as that of  
16 others in the area who have third party coverage.” Id., 2116, 2117.

17 The courts have also held that the term “general population” means  
18 individuals with insurance coverage. Arkansas Medical Soc’y, Inc.  
19 v. Reynolds, 6 F.3d 519, 527 (8th Cir. 1993); Pennsylvania  
20 Pharmacists Ass’n v. Houstoun, 2000 WL 730344, at \*6 (E.D. Pa.  
21 2000); Clark v. Kizer, 758 F. Supp. 572, 576 (E.D. Cal. 1990),  
22 aff’d in part, vacated in part on other grounds sub nom. Clark v.  
23 Coye, 967 F.2d 585 (9th Cir. 1992).



1 their HCBS program contractors offends any standard of care  
2 quality. Statement of Facts, ¶¶ 15, 17, 35, 40, 41, 42, 46, 61,  
3 100. As noted above, ALTCS Clinical Quality Management manager,  
4 Susan Luark, testified that the numerous cases in which HCBS  
5 beneficiaries' care plans were not filled for lack of home care  
6 workers violated AHCCCS quality of care standards. Dep. of Luark,  
7 117:2-6; 123:7-10; 127:8-11; 135:9-13; 139:4-7.

8 In order to pay sufficient rates, the Ninth Circuit has held  
9 that the state must use a methodology that considers the costs to  
10 providers of delivering quality services. To do so, the state must  
11 “undertake responsible cost studies that will provide reliable data  
12 as to the [provider’s] costs in providing services . . . .”  
13 Orthopaedic Hospital, 103 F.2d at 1495-1500.

14 Other Circuit courts have held that states violate Section  
15 1936a(a)(30)(A) of the Medicaid statute if they do not use a  
16 methodology for provider reimbursement that considers the relevant  
17 factors of “equal access, efficiency, economy, and quality of care  
18 . . . when setting reimbursement rates.” Arkansas Medical Society,  
19 6 F.3d at 530. The Seventh Circuit held that a cost study did not  
20 have to be completed before rates were set, so long as the state  
21 conducted studies shortly thereafter to find out whether “the  
22 prices elicited enough medical care” and then adjusted rates based  
23 on the studies. Methodist Hospital v. Sullivan, 91 F.3d 1026, 1030  
24 (7th Cir. 1996).

25 The Third Circuit also held that no particular procedural  
26 requirement was imposed by Section 1396(a)(30)(A), so long as the

1 “process of decision-making is reasonably sound” and assures future  
2 results in compliance with the statutory factors of “economy,  
3 efficiency, quality of care, and access.” Rite Aid of  
4 Pennsylvania v. Houston, 171 F.3d 842, 851-857 (3d. Cir. 1999). In  
5 Rite Aid, Pennsylvania was held to have satisfied the Medicaid  
6 statute by considering wholesale average prices, federal upper  
7 limits and private pricing service guidelines, payments by other  
8 states and payors, and the quality of care delivered.

9           b) Defendants Have Not Adopted An Effective Rate  
10           Setting Methodology

11           For many years prior to the filing of this lawsuit, defendants  
12 did not use any procedure that applied the 30(A) factors when they  
13 set ALTCS capitation rates. AHCCCS implemented its HCBS payment  
14 rates in 1989 based upon limited data from other states, and since  
15 1989, those rates were updated primarily based on inflation.  
16 Defendants’ Response to Plaintiffs’ 4<sup>th</sup> Production of Document  
17 Request (D’s Response to P’s 4th RFP).

18           Further, when AHCCCS rebased the rates for Maricopa County in  
19 CYE01, the costs of services were calculated based upon financial  
20 data as reported by the program contractors -- what the contractor  
21 says it paid to provide the services to members, and not based upon  
22 the program contractors’ encounter data, which is an actual record  
23 of which health services were utilized. Dep. of Hoyt, 15:17-24.  
24 AHCCCS’ actuary admitted that the “financial experience ought to  
25 represent- it ought to crosswalk to the encounters, really but it

26  
27  
28

1 doesn't always." Id., 33:1-3.<sup>4</sup> When this lawsuit was filed,  
2 AHCCCS had never completed a study of the costs of HCBS services in  
3 Arizona. Statement of Facts, ¶ 144.

4 Far from conducting cost studies to determine whether rates  
5 were adequate to provide enough workers, a response approved in  
6 Methodist Hospital, 91 F.3d at 1030, defendants simply did not  
7 collect data that would force them to acknowledge the existence of  
8 this severe access problem. ALTCS' own actuary testified that it  
9 would be helpful in establishing actuarially sound rates if the  
10 encounter data also reflected underservicing due to inadequate wage  
11 levels to fill care plans. Dep. of Hoyt, 70-71.

12 The final step in the AHCCCS rate setting process is budget-  
13 oriented negotiations between defendants and their program  
14 contractors. Deposition of Shafer, 14-16. Numerous courts have  
15 held that such "budgetary considerations cannot be the conclusive  
16 factor in decisions regarding Medicaid." Beno v. Shalala, 30 F.3d  
17 1057 (1069) (9th Cir. 1994). See also cases cited in Arkansas

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18 <sup>4</sup> Hoyt also admitted that AHCCCS does not have the best  
19 encounter data for HCBS costs per member, and recommended that in  
20 order to improve the HCBS encounter data which is "generated by the  
21 providers themselves" AHCCCS should "educate providers and possibly  
22 - not only putting provisions in those contracts that they report,  
but also eventually incorporating some type of sanction if they  
don't." Dep. of Hoyt, 34:15-17.

23  
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25  
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1 Medical Society, 6 F.3d at 531. Temple University v. White, 941  
2 F.2d 201 (3d Cir. 1991), cert. denied, 502 U.S. 1032 (1992), AMISUB  
3 (PSL), Inc. v. Colorado Dep't of Social Serv., 879 F.2d 789, 800-801  
4 (10th Cir. 1989) cert. denied, 496 U.S. 935 (1990).

5       Once an ALTCS contract has been signed, AHCCCS leaves most of  
6 the responsibility for determining whether beneficiaries actually  
7 receive prescribed services up to the program contractors  
8 themselves. Dep. of Shafer, 118:14-22. During the two years in  
9 which this lawsuit has been pending, no program contractor has been  
10 given a poor performance rating or otherwise penalized for failing  
11 to fill beneficiary care plans. Id., 140-141. See the description  
12 of ALTCS' failure to monitor its program contractors supra, 11-13.

13       Plaintiffs asked Dr. Dorie Seavey, a labor economist, to study  
14 the ALTCS reimbursement system for HCBS workers. Dr. Seavey's  
15 report contains nine points:

- 16
- 17 1. HCBS home-care-related service rates are inadequate;
  - 18 2. HCBS rates are lower than private pay or Medicare
  - 19 rates; 3. HCBS paraprofessional wages are strikingly
  - 20 uncompetitive within Arizona's overall low-wage markets;
  - 21 4. Beyond wages, problematic non-wage job characteristics
  - 22 significantly decrease the appeal of these jobs,
  - 23 hindering recruitment and retention; 5. Program
  - 24 contractor profit incentive combined with low level
  - 25 monitoring creates perverse service delivery incentives;
  - 26 6. The HCBS component of ALTCS capitation rates does not
  - 27 appear to be economically sound; 7. AZ state data
  - 28 collection concerning HCBS service delivery outcomes and
  - provider workforce is very spotty and insufficient for
  - use in monitoring; 8. Higher wage rates offered by HCBS
  - subcontractors would increase the prospective pool of
  - workers; and, 9. Improving other aspects of overall
  - compensation will make paraprofessional health care jobs
  - more attractive, and will have favorable impacts on the
  - availability of workers and the likelihood of retaining
  - them.

1 Report of Seavey, May 1, 2001, Appendix 26.

2 c) The Increase In ALTCS Capitation Rates Effective  
3 October 1, 2001 Does Not Cure Defendants'  
4 Violations of 42 U.S.C. § 1396a(a)(30)(A).

5 An annual increase in ALTCS capitation rates went into effect  
6 on October 1, 2001. Supra, 13-14. For six reasons, this increase  
7 does not cure defendants' violations of 42 U.S.C. §  
8 1396a(a)(30)(A). First, the new rates are not based on the actual  
9 costs of providing HCBS services. In 2001, EP&P Consulting, Inc.  
10 (EP&P) did a "Home-and Community-Based Services Rate Study" for  
11 AHCCCS. Statement of Facts, ¶ 143. However, the rate increases  
12 recommended by EP&P and relied on by AHCCCS were not based on  
13 provider cost data produced in response to the EP&P survey. Id.,  
14 ¶¶ 145-148. Thus, defendants are continuing to violate the Ninth  
15 Circuit's requirement that Medicaid programs, in setting rates,  
16 "must rely on responsible cost studies . . . that provide reliable  
17 data." Orthopaedic Hospital v. Belshe, 103 F.3d 1491, 1496 (9th  
18 Cir. 1997).

19 Second, the new rates are not based on either of the following  
20 categories of data: (1) the availability in Arizona of HCBS  
21 services under Medicare and private insurance; and (2) the rates  
22 paid in Arizona for HCBS services by Medicare and insurance  
23 companies. EP&P did not examine whether AHCCCS members are able to  
24 receive the same amount of HCBS services as is available to the  
25 general population in Arizona. Deposition of Yvonne Powell,  
26 166:19. Nor did EP&P did collect any comparative data on private

1 sector rates for HCBS services. Id. at 165:22. AHCCCS does not  
2 collect data on rates paid to HCBS workers by non-ALTCS providers  
3 and thus cannot compare those rates to rates paid by ALTCS  
4 providers. Ds' Responses to Ps' 3rd RFP, Response 9. Lacking  
5 information on payment rates and the availability of services under  
6 Medicare and private insurance, AHCCCS cannot ensure compliance  
7 with the equal access requirement of § 1396a(a)(30)(A).

8 Third, in setting the new capitation rates, defendants  
9 continued to ignore the amount of HCBS services required by case  
10 management plans; instead, they focused on the amount of HCBS  
11 services actually provided. Statement of Facts, ¶¶ 95, 125, 141.  
12 Defendants' failure to effectively monitor whether beneficiaries  
13 receive all the services to which they are entitled (Id., ¶ 122-  
14 124), continues.

15 Fourth, although AHCCCS increased the fee-for-service rate for  
16 attendant care by 22.7%, it increased the HCBS components of the  
17 capitation rates for non-ventilator dependent beneficiaries by only  
18 15.3%. Statement of Facts, ¶ 135. Since attendant care services  
19 account for the vast majority of AHCCCS's HCBS costs (Id., ¶ 138),  
20 the 15.3% increase is likely too low to attract a sufficient number  
21 of attendant care workers for compliance with § 1396a(a)(30)(A).

22 Fifth, defendants are still failing to ensure that wages and  
23 benefits for HCBS workers are sufficient to enlist enough workers  
24 to comply with § 1396a(a)(30)(A). Effective October 1, 2001,  
25 AHCCCS began requiring program contractors to pass through 11.7%  
26 percent of the 15.3% HCBS rate increase to providers and to ensure

1 that providers pass through some portion of that 11.7% increase to  
2 HCBS workers. Statement of Facts, ¶ 139. However, AHCCCS has no  
3 written plan or protocol for monitoring the pass through, and has  
4 failed to specify what portion of the 11.7% increase must be passed  
5 through to the underpaid HCBS workers. Id., ¶ 140.

6 Sixth, defendants still have not adopted procedures that will  
7 assure adequate rates are paid and home care services delivered in  
8 future years. Id., ¶ 149.

9 5. HCBS Beneficiaries Must Be Able To Freely Choose Medical  
10 Assistance At Home As An Alternative To Institutional  
Care. 42 U.S.C. § 1396n(c)(2)(C) and (d)(2)(C).

11 Another provision in the Medicaid statute that is applicable  
12 here is the requirement that when a state covers both institutional  
13 and alternative home care, it must allow individuals to choose which  
14 kind of care they will receive. The courts have held that if one of  
15 the choices is underfunded and thus unavailable, the beneficiary's  
16 right to freely choose is violated. Cramer v. Chiles, 136 F.3d 709  
17 (11th Cir. 1998), Martinez v. Ibarra, 759 F.Supp. 664 (D.Colo.  
18 1991), Benjamin H. v. Ohl, No. 3:99-0338, 1999 US Dist. LEXIS 22454 and  
19 1999 US Dist LEXIS 22469 (S.D.W.Va. July 15, 1999). Here the  
20 defendants' failure to adequately fund and monitor the home care  
21 component of ALTCS deprives plaintiffs of their right to freely  
22 choose to receive services in the community rather than in a nursing  
23 home.

24 6. The Arizona State Plan Requires That HCBS Services Be  
25 Provided To Eligible Persons.



1 “segregation’ of persons with disabilities as a ‘form of  
2 discrimination,’ and referred to discrimination that persists in the  
3 area of ‘institutionalization.’ §§ 12101(a)(2),(3), (5).” Olmstead  
4 v. L.C., 527 U.S. 581, 119 S.Ct. 2176 (1999).

5 Regulations implementing the anti-discrimination provision of  
6 the ADA applicable to public entity programs (Title II) require that  
7 “[a] public entity shall administer services, programs, and  
8 activities in the most integrated setting appropriate to the needs  
9 of qualified individuals with disabilities.” 28 C.F.R. § 35.130(d).  
10 This regulation, which articulates the “community integration  
11 mandate” of the ADA, is entitled to deference, and should be given  
12 “controlling weight unless arbitrary, capricious, or manifestly  
13 contrary to the statute.” Chevron U.S.A., Inc. v. Natural Resources  
14 Defense council, Inc. 467 U.S. 837, 844 (1984).

15 In its seminal Olmstead decision, the Supreme Court applied the  
16 “community integration mandate” of the ADA to hold that unnecessary  
17 institutionalization of disabled individuals constitutes prohibited  
18 discrimination. Olmstead v. L.C., 527 U.S. 581, 119 S.Ct. 2176  
19 (1999).<sup>6</sup> Identifying the policies underlying the ADA, the Court  
20 noted that institutionalization “perpetuates unwarranted assumptions

21 \_\_\_\_\_  
22 <sup>6</sup> Recently, in Board of Trustees of the University of Alabama  
23 v. Garrett, \_\_\_ U.S. \_\_\_, 121 S. Ct. 955 (2001), the Supreme Court held  
24 that Congress did not have authority to waive state immunity from  
25 suits for damages under Title I of the ADA (involving claims by  
26 state employees for employment discrimination). Garrett does not  
27 affect Olmstead claims involving injunctive relief for state  
28 services arising under Title II of the ADA. Id. at 960 n.1, 968  
n.9.

1 that these individuals are incapable or unworthy of contributing to  
2 life in the community.” Id., at 600. Moreover, segregation of  
3 disabled individuals in institutions prevents them from enjoying the  
4 family contacts and social, work, economic, educational and cultural  
5 opportunities of every day life. Id., at 601.

6 The two plaintiffs in Olmstead had been confined in a Georgia  
7 psychiatric hospital long after mental health professionals  
8 determined that they could be released, because of the long waiting  
9 lists for admission to community based treatment programs. The  
10 Supreme Court affirmed the Eleventh Circuit holding that the ADA  
11 requires states to provide community-based treatment for persons  
12 with mental disabilities when determined appropriate by treatment  
13 professionals. Id., at 607.

14 The Court recognized that the ADA does not require a state to  
15 “fundamentally alter” its programs in order to deinstitutionalize  
16 disabled individuals, citing 28 C.F.R. § 35.130(b)(7). If the state  
17 could show that, “in the allocation of available resources,  
18 immediate relief for the plaintiffs would be inequitable given the  
19 responsibility the State has undertaken for the care and treatment”  
20 of persons with similar disabilities. Id. at 604.

21 It is clear that the shortage of home care workers in the  
22 Arizona HCBS program forces some recipients into nursing homes.  
23 Recipients are often told by their case managers that if they are  
24 not satisfied, e.g. with home care workers who don’t show up in to  
25 help them out of bed, they can go into nursing homes. Alan Shafer,  
26 ALTCS Manager, testified in his deposition that the alternative

1 offered HCBS recipients who cannot get along without reliable home  
2 care is institutionalization. Dep. of Shafer, 149:23. Furthermore,  
3 Ann Meyer, Executive Director of DIRECT, states in her declaration  
4 that individuals living in nursing homes are unable to move back  
5 into the community because of the well-known unreliability of ALTCS  
6 HCBS services. Statement of Facts, ¶ 76. Defendants' failure to  
7 cure the deficiencies in HCBS undoubtedly deprives Arizona HCBS  
8 beneficiaries of their right under the Medicaid statute to receive  
9 services in a community setting.

10 A similar situation was presented in Helen L. v. Didario, 46  
11 F.3d 325 (3d. Cir. 1995), cert. denied sub nom. Pennsylvania Sect'y  
12 of Public Welfare v. Idell S., 516 U.S. 813. Plaintiff was a 43 year  
13 old nursing home resident paralyzed from the waist down. Although  
14 she was capable of residing in the community, she was unable to do  
15 so because the state did not fund its attendant care program  
16 adequately and she was placed on a waiting list. Helen L., 46 F.3d  
17 at 329. The Third Circuit held that the failure of the state to  
18 provide services to plaintiff in the community violated the  
19 integration mandate of the ADA.

20 The court rejected the state's argument that providing  
21 additional attendant care services to plaintiff would violate the  
22 "fundamental alterations" limitation in the ADA, since the cost of  
23 providing additional services in the community was less than the  
24 cost of providing the services in an institution and would not alter  
25 the "essential nature" of the program. Id., at 325. See also  
26 Rolland v. Celluci, 52 F.Supp. 2d 231, 237, and Lewis v. New Mexico

1 Dept. of Health, 94 F.Supp.2d 1217 (D.N.Mex. 2000), aff'd on other  
2 grounds, \_\_F.3d\_\_, 2001 WL 930006 (10th Cir. 2001).

3 Like the plaintiff in Helen L., plaintiffs here ask only that  
4 AHCCCS “fulfill its own obligations under state law” (id., at 338),  
5 by providing them with the home care services prescribed in their  
6 care plans. The home care benefit is one to which plaintiffs are  
7 entitled under the Medicaid statute; however, the community  
8 integration mandate of the ADA adds an extraordinary impetus for the  
9 state to ensure that its benefits are fully and unstintingly  
10 available. Currently, defendants fall far short of meeting that  
11 obligation.

12 D. FAILURE TO PROVIDE HOME CARE SERVICES PRESCRIBED IN PLAINTIFFS’  
13 CARE PLANS VIOLATES SECTION 504 OF THE REHABILITATION ACT OF  
14 1973, AT 29 U.S.C. § 794 AND IMPLEMENTING REGULATIONS, AT 28  
C.F.R. § 41.51 (d) AND 42 C.F.R. § 84.4(b)(1)(iii) AND (b)(2).

15 For the reasons discussed above regarding the ADA, defendants  
16 are also violating section 504 of the Rehabilitation Act of 1973, 29  
17 U.S.C. § 794, and implementing regulations. Section 504 states in  
18 relevant part:

19 No otherwise qualified individual with a disability in  
20 the United States, as defined in section 705(20) of this  
21 title, shall, solely by reason of her or his disability,  
22 be excluded from the participation in, be denied the  
benefits of, or be subjected to discrimination under any  
program or activity receiving Federal financial  
assistance . . . .

23  
24 29 U.S.C. § 794. The elements of a section 504 claim, as shown by  
25 the above statutory language, are: (1) the plaintiff is an  
26 “individual with a disability,” as that term is defined in 29 U.S.C.

1 § 705(20); (2) the plaintiff is "otherwise qualified" to participate  
2 in the program or activity; (3) the program or activity receives  
3 Federal financial assistance; and (4) the plaintiff, solely by  
4 reason of her or his disability, is being excluded from the  
5 participation in, being denied the benefits of, or being subjected  
6 to discrimination under the program or activity. Each of these four  
7 elements is met in this case.

8 First, plaintiffs are individuals with disabilities within the  
9 meaning of 29 U.S.C. § 705(20)(B). That section defines the term  
10 "individual with a disability" to include a person who "has a  
11 physical or mental impairment which substantially limits one or more  
12 of such person's major life activities." Plaintiffs are  
13 substantially limited in various major life activities, including  
14 caring for themselves, walking, performing manual tasks, and  
15 working.

16 Second, plaintiffs are "otherwise qualified" to participate in  
17 ALTCS and receive HCBS services. The named plaintiffs have been  
18 found eligible for HCBS services. Further, the Court certified a  
19 class consisting of all persons in the State of Arizona who have  
20 been or will be eligible for HCBS services from AHCCCS, but are not  
21 provided with the full amount of such services prescribed in their  
22 care plans. Order Certifying a Class Action at 7. Third, the  
23 program at issue in this case--ALTCS--receives Federal financial  
24 assistance.

25 Fourth, for the reasons discussed above regarding plaintiffs'  
26 ADA claim, defendants' failure to provide HCBS services constitutes

1 disability discrimination. Like the ADA, section 504 requires that  
2 services be provided in the most integrated setting appropriate to  
3 the person's needs. Makin v. Russell, 114 F.Supp.2d 1017, 1036 (D.  
4 Haw. 1999). Regulations implementing section 504 explicitly require  
5 that services be provided in the most integrated setting appropriate  
6 to the person's needs. 28 C.F.R. § 41.51(d); 45 C.F.R. §  
7 84.4(b)(2). Further, the U.S. Department of Health and Human  
8 Services has issued a letter stating that the integration mandate as  
9 interpreted by Olmstead applies to section 504.

10 Section 504 and the ADA use the same definition of  
11 disability. Title II of the ADA extends Section 504's  
12 prohibition of discrimination in Federally assisted  
13 programs to all activities of State governments,  
14 including those that do not receive Federal financial  
assistance. Although the Olmstead decision interpreted  
the ADA, unjustified segregation by a Federally funded  
program would also constitute disability discrimination  
under Section 504.

15 Letter from U.S. Dep't of H.H.S. (Health Care Financing  
16 Administration and Office for Civil Rights) to State Medicaid  
17 Directors, Olmstead Update No. 2 (July 25, 2000), answer to question  
18 15, available at <http://www.hcfa.gov/medicaid/smd72500.htm>.

19 Since the four elements of a section 504 claim are met in this  
20 case, Plaintiffs are entitled to injunctive and declaratory relief  
21 against the three defendants pursuant to 29 U.S.C. §§ 794 and  
22 794a(a)(2). Further, plaintiffs are entitled to such relief against  
23 defendant Biedess under 42 U.S.C. § 1983. See Ransom v. Arizona  
24 Board of Regents, 983 F. Supp. 895, 903-04 (D. Ariz. 1997) (holding  
25 that section 504 is enforceable under 42 U.S.C. § 1983).

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1 E. FAILURE TO PROVIDE DENIAL NOTICES TO HCBS BENEFICIARIES WHEN  
2 THE HOME CARE SERVICES PRESCRIBED IN PLAINTIFFS' CARE PLANS ARE  
3 NOT PROVIDED VIOLATES DUE PROCESS, THE FEDERAL MEDICAID  
4 STATUTE AND REGULATIONS.

5 Defendants' refusal to require its program contractors to give  
6 notice and hearing rights when they fail to provide home care  
7 services to which plaintiffs are entitled violates numerous federal  
8 and state laws.

9 The due process clause of the U.S. Constitution applies to the  
10 failure of ALTCS program contractors to provide home care services  
11 because the contractors have assumed the State's obligation to  
12 provide these services. Perry v. Chen, 985 F.Supp. 1197, 1203  
13 (D.Ariz. 1996). Due process clearly includes notice and an  
14 opportunity for the beneficiary to appeal. Mathews v. Eldridge, 424  
15 U.S. 319, 334-335 (1976). See also Grijlva v. Shalala, 946 F.Supp.  
16 747 (D.Ariz. 1996), aff'd, 152 F.3d 1115 (9th Cir. 1998), vacated  
17 and remanded, 119 S.Ct. 1573 (1999), remanded and judgment vacated,  
18 185 F.2d 1075 (9th Cir. 1999), settlement approved, Order Re Class  
19 Action Settlement Agreement, CIV 93-711 TUC ACM (D.Ariz. Dec. 4,  
20 2000); J.K. v. Dillenberg, 836 F.Supp. 694 (D.Ariz. 1993).

21 The notice itself must be sufficiently detailed to be  
22 meaningful. Verbal explanations from the beneficiary's case worker  
23 do not meet due process standards. Rodriguez by Corella v. Chen,  
24 985 F.Supp. 1189, 1194-1195 (D.Ariz. 1996), appeal dismissed, 121  
25 F.3d 716 (9th Cir. July 23, 1997).

26 The requirement for a fair hearing opportunity set out in the  
27 Medicaid statute at 42 U.S.C. § 1396a(a)(3) also includes the

1 necessary precondition that notice be given. The federal Medicaid  
2 regulations requiring that program beneficiaries be given notice and  
3 hearing rights, 42 C.F.R. § 431.200 et seq., are also applicable.  
4 Perry v. Chen, 985 F.Supp. at 1204.

5 The AHCCCS administration takes the position that notice is not  
6 required because there has been no official denial when it fails to  
7 provide authorized services. But the strong policy reasons for  
8 requiring notice apply whenever there is a deprivation of property,  
9 whether the deprivation was deliberate or negligent. Thus, notice  
10 was required of a caseworker's "adverse action" even when there had  
11 been no official denial of a Medicaid covered service. Boatman v.  
12 Hammons, 164 F.3d 286, 288-289 (6th Cir. 1998) (caseworker denial of  
13 transportation assistance, only covered when not otherwise  
14 available).

15 The underlying reasons for requiring notice generally focus on  
16 protection of the beneficiary, particularly of his/her right to due  
17 process when services are denied. However, in this situation where  
18 the state has failed to monitor whether its program contractors are  
19 actually delivering home care services to beneficiaries, notice to  
20 the beneficiary would serve another useful purpose. Since  
21 beneficiaries who object to the lack of services would be able to  
22 appeal to AHCCCS, giving notice to them would provide defendants  
23 with information about the extent of the deficits in program  
24 contractors' performance.

#### 25 CONCLUSION

26 The defendants' failure to adopt reasonable procedures to

