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

T.B. by and through his parents THOMAS BOYCE and MARGARET BOYCE, **Q.G.** by and through his parents MICHAEL GOLDBERG and MAYUMI GOLDBERG, **M.K.** by and through her parents BRADLEY KISH and MARY KISH, **X.N.** by and through his parents FRANCISCO NEVAREZ and LISETTE NEVAREZ, **S.P.** by and through her parents FRANK PETERSON and CORELYN PETERSON, **O.W.** by and through his parents, JEFFREY WELLMAN and AMY WELLMAN, individually and on behalf of a class,	)	No. 12-5356
Plaintiffs,	)	Judge: Robert W. Gettleman
vs.	)	Magistrate: Sidney I. Schenkier
JULIE HAMOS, in her official capacity as Director of the Illinois Department of Healthcare and Family Services,	)	
Defendant.	)	

PLAINTIFFS' MEMORANDUM OF LAW
IN SUPPORT OF CLASS CERTIFICATION

Now comes the Plaintiffs', by and through their attorneys, Robert H. Farley, Jr., Ltd., Cahill & Associates and Michelle N. Schneiderheinze and files this Memorandum of Law in support of the Plaintiffs' Motion for Class Certification as follows:

INTRODUCTION

The Plaintiffs and Class, consist of approximately 1,050 medically fragile disabled children who currently receive funding from the Defendant for skilled nursing services at their home at an average monthly cost between $11,000 to $16,000, depending upon their medical

needs, so that they do not have to be institutionalized or hospitalized for their entire life at a rate of approximately $55,000 per month. The Plaintiffs' funding from the Defendant comes from the State of Illinois "Medicaid Home and Community-Based Services (HCBS) Waiver for Children that are Medically Fragile, Technology Dependent" program (MF/TD) and Medicaid.

Since 1985 and prior to the passage of the Americans with Disabilities Act (ADA), the State of Illinois has been able to successfully provide through the MF/TD Waiver and Medicaid, home and community-based services for children who are medically fragile, technology dependent "to allow eligible children to remain in their own homes rather than in an institutional setting."[1] The Defendant states:

> Currently, [Illinois] serves medically fragile and technology dependent children in two different ways: approximately 550 children are served by the Medically Fragile, Technology Dependent Waiver ("MFTD Waiver") and approximately 500 other technology dependent children under Medicaid, who receive in-home services but do not meet the institutional level of care to qualify for services under the MFTD Waiver.[2]

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[1] See Exhibit "A" - MF/TD Waiver at page 3, Sec. 2. The development of community based services for medically fragile children, also known as the "Katie Beckett Waiver" was championed by President Ronald Reagan in 1981. Katie Beckett was 3 years old at that time and had been hospitalized almost since birth and qualified for Medicaid. Katie's parents wanted to manage her care at home with a ventilator, but under existing Medicaid rules, if she had been taken home, her parents' income would have counted against her, and would have lost eligibility for Medicaid. Her hospital care was costing six times as much as home care would have cost. President Reagan cited Katie's case as an example of irrational federal regulation that caused "tremendous expense to the taxpayers." The rules, he said, forced her to stay in the hospital even though she would be better off at home. In 1982, Medicaid policy fundamentally shifted to allow people with significant health care needs and disabilities to receive care at home. See www.nytimes.com/2012/05/23/us/katie-beckett-who-inspired-health-reform-dies-at-34.html. See also, www.hhs.gov/news/press/2012pres/05/20120519a.html.

[2] See Exhibit "B" - HFS - "Questions and Answers on the Medicaid Program for Medically Fragile and Technology Dependent Children" at No. 2.
(See: www2.illinois.gov/hfs/agency/Pages/MFTD.aspx)

Effective September 1, 2012, the State of Illinois is unraveling 27 years of community based services to medically fragile children by making draconian cuts to Medicaid services to the Plaintiffs and putative Class which puts them at risk of institutionalization in violation of the Americans with Disabilities Act, Rehabilitation Act and Medicaid. The State of Illinois readily acknowledges that "Illinois is making several significant changes to the state's Medicaid program for children who are technology dependent" because "[t]he Medicaid program is on the brink of collapse."[3] The net effect of these changes is to place the medically fragile children at risk of institutionalization.

The Plaintiffs have brought this action to enjoin the policy and/or practices of the Defendant to either eliminate or reduce the Medicaid benefits of medically fragile children in the MF/TD Waiver and in the Private Duty Nursing (PDN) program. The elimination or reduction in funding will either result in the Plaintiffs and others similarly situated becoming institutionalized or if the medically fragile children remain in their family home without sufficient skilled nursing care, then that person faces a strong possibility of imminent death or a life threatening episode.

The Plaintiffs claim that the Defendant's policy to eliminate or reduce Medicaid funding

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[3] See Exhibit "C" - On June 14, 2012, Governor Quinn signed into law the "Save Medicaid Access and Resources Together Act" (SMART) (Public Act 097-0689). The Public Act states that the purpose of the SMART Act is "to address the significant spending and liability deficit in the medical assistance program budget of the Department of Healthcare and Family Services."

See Exhibit "D" - The MF/TD program has been in place years before Illinois fiscal crisis and the cost of the MF/TD program has been relatively unchanged since 2004 as the average cost per person served in 2004 was $173,772 and in 2010 was $188,210. The Total Annual Liability in 2004 was approximately 93 million dollars as compared to 117 million dollars in 2010. With federal financial participation in the program, Illinois is reimbursed one half (1/2th) of the total costs by Medicaid. (See: www.hfs.illinois.gov/assets/ccmn_facesheet_history.pdf)

for medically fragile children violates the Americans with Disabilities Act, 42 U.S.C. Sec. 12132; Section 504 of the Rehabilitation Act, 29 U.S.C. Sec. 794(a); and Title XIX of the Social Security Act ("Medicaid Act") 42. U.S.C. Sec. 1396 *et. seq*; Early and Periodic Screening, Diagnostic, and Treatment Services, 42 U.S.C. Sec. 1396d(r) ("EPSDT Provisions"); and 42 U.S.C. Section 1983.

CLASS DEFINITION

The Plaintiffs seek certification as a class action pursuant to Rule 23(b)(2) of the Federal Rules of Civil Procedure. The proposed class is defined as follows:

> All medically fragile and technology dependent children who are either enrolled or seek enrollment in either the State of Illinois' Medically Fragile, Technology Dependent Medicaid Waiver (MF/TD) or who are either enrolled or seek enrollment under the State of Illinois Medicaid (Private Duty Nursing - "PDN") Services for children, who receive in-home services but do not meet the institutional level of care to qualify for services under the MF/TD Waiver.

ARGUMENT

Parties seeking class action certification must first satisfy the provisions of Rule 23(a) of the Federal Rules of Civil Procedure. Then, in addition, the case must fit within at least one of the three subcategories under Rule 23(b). *Rosario v. Lividitis*, 963 F.2d 1013, 1017 (7th Cir. 1992), *cert. denied*, 506 U.S. 1051, 113 S. Ct.972 (1993). All four 23 (a) prerequisites are quite undoubtedly satisfied here, and this case falls squarely under the 23 (b)(2) category.

On a motion for class certification, the Court must accept as true all facts alleged in Plaintiffs' complaint. See *Eisen v. Carlisle & Jacquelin*, 417 U.S. 156, 177-178, 94 S. Ct. 2140, 2152 (1974) ("We find nothing in either the language or history of Rule 23 that gives court any authority to conduct a preliminary inquiry into the merits of a suit in order to determine whether

it may be maintained as a class action."); *Gammon v. GC Services Limited Partnership*, 162 F.D.R. 313, 315, n. 2 (N.D. Ill. 1995) (When evaluating a motion for class certification, the Court accepts all well-pleaded facts as true."); *Pertiz v. Liberty Loan Corp.*, 523 F.2d 349, 353-54(7th Cir. 1975); *Gomez v. Illinois State Bd. Of Educ.*, 117 F.R.D. 394, 396 (N.D. Ill. 1987): *Newburg on Class Actions*, Sec. 3.20, p. 3-124 ("It is settled law that any preliminary inquiry into or consideration of the merits of litigation is improper in connection with a determination of the propriety of a class action,") Moreover, "the interests of justice require that in a doubtful case...any error, if there is to be one, should be committed in favor of allowing a class action." *Eisenberg v. Gagnon,* 766 F.2d 770, 785 (3rd Cir. 1985), *cert. denied*, 474 U.S. 946 (1985); *Esplin v. Hirschi*, 402 F.2d 94, 101 (10th Cir), *cert denied*, 394 U.S. 928 (1969); *Tapken v. Brown*, 1992 WL 17894, *26 (S.D. Fla); *Horton v. Goose Creek Independent School District*, 690 F.2d 470, 487, n. 32 (5th Cir. 1982), *cert. denied*, 463 U.S. 1207 (1983); *Brown v. Cameron-Brown Co.*, 92 F.R.D. 32,50 (E.D. Va. 1981).

Additionally, civil rights cases alleging discriminatory policies or practices are "by definition" class actions, provided they meet the other requirements of Rule 23(a). *General Telephone Co., v. Falcon,* 457 U.S. 147, 157 (1982); see also *Robert E. v. Lane,* 530 F.Supp. 930, 944 (N.D. Ill. 1980) (a case alleging civil rights violations represent a "prototypical candidate" for class certification). Class certification is routinely allowed in civil rights cases alleging states' violations of the community integration mandates of the Americas with Disabilities Act. See *Colbert v. Blagojevich,* 2008 U.S. Dist. LEXIS 75102, *28 (N.D. Ill. Sept. 29, 2008) (J. Lefkow) (certifying class consisting of "all Medicaid-eligible adults with disabilities in Cook County, Illinois, who are being, or may in the future be, unnecessary confined to nursing

facilities and who, with appropriate supports and services, may be able to live in a community setting").

CLASS CERTIFICATION GRANTED IN ILLINOIS ON BEHALF OF MEDICALLY FRAGILE CHILDREN IN *HAMPE v. HAMOS*

In *Hampe v. Hamos,* 2010 U.S. Dist. LEXIS 125858, * 19 (N.D. Ill. 2010), the District Court certified the following class:

> All persons who are enrolled or will be enrolled or were enrolled in the State of Illinois' Medically Fragile, Technology Dependent Medicaid Waiver Program (MF/TD) and when they obtain the age of 21 years are subjected to reduced Medicaid funding which reduces the medical level of care which they had been receiving prior to 21 years.

For the reasons set forth in this Memorandum, this Court should likewise certify a class of medically fragile children who are risk of institutionalization due to the Defendant's policy and/or practice to eliminate or reduce Medicaid funding.

1. Plaintiff Has Established The Prerequisites For A Class Action Pursuant To Rule 23(a)

A. Numerosity

The Class is so numerous that joinder of all persons is impracticable. The Defendant, the Illinois Department of Healthcare and Family Services has stated in June, 2012, the following:

> Currently, [Illinois] serves medically fragile and technology dependent children in two different ways: approximately 550 children are served by the Medically Fragile, Technology Dependent Waiver ("MFTD Waiver") and approximately 500 other technology dependent children under Medicaid, who receive in-home services but do not meet the institutional level of care to qualify for services under the MFTD Waiver.[4]

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[4] See Exhibit "B" - HFS - "Questions and Answers on the Medicaid Program for Medically Fragile and Technology Dependent Children" at No. 2. (See: www2.illinois.gov/hfs/agency/Pages/MFTD.aspx)

The Defendant has also prepared a "Fact Sheet" for both programs for fiscal year 2010 which reflects that 622 were enrolled in the MF/TD Waiver and 527 persons were enrolled in the Private Duty Nursing (PDN) Services for Children. See Exhibit "E" - www.hfs.illinois.gov/assets/ccmn_mftd_hcbs_factsheet.pdf and See Exhibit "F" - www.hfs.illinois.gov/assets/ccmn_pdnfactsheet.pdf

The Defendant testified before the Illinois House of Representatives Executive Committee on May 24, 2012, that the State estimates that 36 medically fragile children will not qualify for home and community based services as their family income exceeds 500% of the Federal Poverty Rate ("FPR"). She acknowledged that some families "are just over that 500%."

The class members have limited financial resources and are unlikely to institute individual actions.

Courts have ruled that a class action can proceed with a group which would encompass the size of the persons either enrolled in the MF/TD Waiver and the PDN Program or even eliminated from the MF/TD Waiver. See *Barner v. City of Harvey,* 1997 U.S. Dist. LEXIS 3570, No. 95 C 3316, 1997 WL 139469, at *3 (N.D. Ill. Mar. 25, 1997) (class of 13 sufficiently numerous); *Davy v. Sullivan,* 354 F.Supp. 1320 (M.D. Ala. 1973) (class of 10 adequate); *Hampe v. Hamos,* 2010 U.S. Dist. LEXIS 125858, *7 (N.D. Ill. 2010) ("Generally, a class of forty plaintiffs is sufficiently numerous for Rule 23(a) purposes. . . citing to *Swanson v. Am. Consumer Indus.,* 415 F.2d 1326, 1333 (7th Cir. 1969).

Case law has also recognized that courts should make "common assumptions" to support a finding of numerosity. *Grossman v. Waste Management, Inc.*, 162 F.R.D. 322, 329 (N.D. Ill. 1995). *The numerosity requirement should be construed liberally in civil rights actions.* Jones *v.*

Diamond, 519 F.2d 1090, 1100 (5th Cir, 1975).

Other circumstances also point to impracticability of joinder. As Medicaid recipients, class members are located throughout the state and do not have the financial means to bring individual lawsuits. *Fields v. Maram,* 2004 U.S. Dist. LEXIS 16291, *18 ("Because the class members reside throughout the state, and because they are disabled and therefore are often of limited financial resources, joinder would be particulary difficult in this case."). Finally, judicial economy plainly would be served by consolidating the actions of all similarly-situated persons rather than having them litigate individually. *Arenson v. Whitehall Convalescent & Nursing Home,* 164 F.R.D. 659, 663 (N.D. Ill. 1996). Accordingly, in this case, numerosity is satisfied because the joinder of all individuals affected by the Defendant's policy is impracticable.

B. Commonality

Rule 23(a) requires that there "need be only a single issue common to all members of the class." *Edmondson v. Simon,* 86 F.R.D. 375, 380 (N.D. Ill. 1980); *Hispanics United v. Vill. of Addison,* 160 F.R.D. 681, 688 (N.D. Ill. 1995). "A common nucleus of operative fact is usually enough to satisfy the commonality requirement of Rule 23(a)(2)." *Rosario v. Livaditis,* 963 F.2d 1013, 1018 (7th Cir. 1992). See also *Lightbourn v. County of El Palso,* 118 F.3d 421, 425 (5th Cir. 1997) ("The commonality test is met when there is at least one issue, the resolution of which will affect all or a significant number of the putative class members.") (citations omitted); *Baby Neal v. Casey,* 43 F.3d 48, 55 (3rd Cir. 1994) (commonality met where "named plaintiffs share at least one question of fact or law with the grievances of the prospective class"); *Marisol A. v. Guiliani,* 126 F.3d 372, 375 (2nd Cir. 1997) (class must "share a common question of law or fact").

In fact, "[w]hen the party opposing the class has engaged in some course of conduct that effects a group of persons and gives rise to a cause of action, one or more of the elements of that cause of action will be common to all of the persons affected." *Newburg on Class Actions*, Sec. 3.10, p 3-51. So long as one issue of law or fact is common to the class, "the presence of individual questions will not prevent satisfaction of the Rule 23 (a) (2) prerequisite." *Id.* at p. 3-60. See also *Ivy v. Meridian Coco-Cola Bottling Co.*, 108 F.R.D. 118, 123 (S.D. Miss. 1985) (holding that commonality and typicality were satisfied in an employment discrimination case despite the defendant's argument that individual questions would predominate concerning each hiring decision); *Patrykus*, 121 F.R.D. at 361 (holding that "[d]ifferences in individual cases concerning treatment or damages does not defeat commonality"); *Krislov v. Rednour*, 946 F.Supp. 563, 568 (N.D. Ill 1996).

Even when the effect on each class member differs, an allegation that the defendant's discriminatory policy or practice affects the class as a whole will suffice to prove commonality of claims. *Rosairio v. Livaditis,* 963 F.2d 1013, 1017 (7th Cir. 1992) ("The fact that there is some factual variation among class grievances will not defeat a class action.") (citing *Patterson v. General Motors Corp.,* 631 F.2d 476, 481 (7th Cir. 1980) *cert. denied,* 451 U.S. 914 (1980)). Thus, even if each class member's remedy differs, there is commonality if the injury flows from the same discriminatory acts or omissions. See *Marisol A. v. Guiliani,* 126 F.3d 372, 376 (2nd Cir. 1997) (in class action involving foster children, "[t]he unique circumstances of each child do not compromise the common question of whether, as plaintiffs allege, defendants have failed to meet their federal and state law obligations.")

The common questions of law and fact in the present case are as follows:

(a) Whether the Defendant violated the ADA and Rehabilitation Act for medically fragile and technology dependent children by reducing the level of funding to a nursing facility level of care as opposed to a hospital level of care rate which places the Plaintiffs and Class at risk of institutionalization.

(b) Whether the Defendant violated the ADA and Rehabilitation Act for medically fragile and technology dependent children by reducing the level of funding to a nursing facility level of care as opposed to a hospital level of care rate and whether the reduction of results in the denial of medically necessary services and a risk of institutionalization.

(c) Whether the Defendant violated the ADA and Rehabilitation Act for medically fragile and technology dependent children by excluding all medical fragile children with parental incomes exceeding 500% of the federal poverty rate for home and community-based services.

(d) Whether the ADA and Rehabilitation Act permits the Defendant to reduce the level of funding to a nursing facility level of care as opposed to a hospital level of care which results in a reduction of medical services for disabled persons even though there has been no change in their medical needs.

(e) Whether a fundamental alteration of the Illinois disability programs would occur if the Defendant provided funding to continue the same level of services for the Plaintiffs and the putative class.

(f) Whether the Illinois disability programs can reasonably accommodate a modification to their existing programs to allow the Plaintiff and putative class to continue to receive the same level of care in the community.

(g) Whether the Medicaid Act permits Illinois to impose cost sharing or co pays on children with parental incomes exceeding 150% of the federal poverty rate for home and community-based services.

(h) Whether the Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) provisions are mandated by a persons enrollment in the MF/TD Waiver and whether the EPSDT provisions require the furnishing of all medically necessary skilled nursing services irrespective of whether there is a cap or limit on skilled nursing services based on a nursing facility level of care.

The common questions of fact and law predominate over questions affecting only individual class members.

Accordingly, this Court should find that commonality exists.

C. Typicality

Typicality determines whether a sufficient relationship exists between the injury to the named plaintiff and the conduct affecting the class, so that the court may properly attribute a collective nature to the challenged conduct. *General Telephone Company of Southwest v. Falcon*, 457 U.S. 147, 152 (1982). When it is alleged that the same unlawful conduct was directed at or affected both the named plaintiff and the class sought to be represented, the typicality requirement is met irrespective of varying fact patterns which underlie individual claims. *Id*; *see also Robidoux v. Celani*, 987 F.2d 931, 936-937 (2nd Cir. 1998); *Baby Neal ex rel Kanter v. Casey*, 43 F.3d 48, 56 (3rd Cir. 1994). Courts should look to the elements of the cause of action that the class representative must prove in order to establish the defendant's liability. If they are substantially the same as those needed to be proved by the class members' claims, the representative's claim is typical. *Johns v. DeLeonardis*, 145 F.R.D. 480, 483 (N.D. Ill. 1992).

As with commonality, typicality does not require that all class members suffer the same injury as the named plaintiff. "Instead, we look to the defendant's conduct and the plaintiff's legal theory to satisfy Rule 23(a)(3)." *Rosario v. Livaditis,* 963 F.2d 1013, 1018 (7th Cir. 1992); see also *De La Fuente v. Stokely-Van Camp,* 713 F.2d 225, 232 (7th Cir. 1983) (typicality satisfied regardless of whether "there are factual distinctions between the claims of the named plaintiffs and those of other class members. Thus, similarity of legal theory may control even in the face of differences of fact.").

The Plaintiffs' claims are typical of the class members' claims because they are based on the same factual, legal and remedial theories as the claims of the Plaintiff Class. The Plaintiffs'

and Class members are qualified persons with a disability under the ADA and Section 504 of the Rehabilitation Act.

The Plaintiffs, medically fragile persons, on behalf of himself and others similarly situated, have been found by the State of Illinois to be eligible and have been enrolled in the Illinois MF/TD Waiver and also receive Medicaid funded services. The Defendant is eliminating all persons whose family income exceeds 500% of the FPR from the MF/TD Waiver. The Defendant is reducing all MF/TD Waiver and Private Duty Nursing (PDN) benefits from a hospital level of care to a nursing facility level of care which will result in approximately a 50% reduction of medical benefits, without any change in their medical condition. All the Plaintiffs and Class are at risk of institutionalization due to the Defendant's policy and practices. The reduction in funding will either result in the Plaintiffs and others similarly situated becoming institutionalized (hospitalized) or if they remain in their family home without sufficient skilled nursing care, then that person faces a strong possibility of imminent death or life threatening episode.

Because the named Plaintiff and the Class share the same deprivations of federal rights, typicality is met here.

D. Adequacy of representation

The two factors that are universally recognized as the guidelines for adequate representation are: 1) the representative must not have interests antagonistic to or conflicting with the interests of the class, and 2) the representative must appear able to prosecute the action vigorously through qualified counsel. *Newberg on Class Actions*, Sec. 3.22, p. 3-126. See also *Prudential*, 148 F.3d at 312; *Amchen Products, Inc. v. Windsor*, 521 U.S. 591, 626, n. 20, 117

S.Ct. 2231 (1997). *In re United Energy Corp. Solar Power Modules Tax Shelter Invs. Secs. Litig.*, 122 F.R.D. 251, 257 (C.D. Cal. 1988) (holding that the plaintiffs were adequate representatives for the class where they expressed an interest in and understanding of the case and participated in depositions). The party opposing a class has the burden to establish that representation is inadequate. *Lewis v. Curtis*, 671 F.2d 779, 788 (3rd Cir. 1982), *cert. denied*, 459 U.S. 880, 103 S.Ct. 176 (1982).

The Plaintiffs are adequate representatives of the putative class. The ability of the Plaintiffs to represent the class goes to whether they have "sufficient interest in the outcome to insure vigorous advocacy," *Rosario,* 963 F.2d at 1018, as well as any interests "antagonistic to the interests of the class." *Riordan,* 113 F.R.D. 60, 64 (N.D. Ill. 1986). Courts may deny certification based on grounds of antagonism only if that antagonism "goes to the subject matter of the litigation." *Id.* Potential conflicts that are remote or speculative will not defeat class certification. *Hispanics United,* 160 F.R.D. at 689.

In this case, the Plaintiffs' interests are entirely coextensive with those of the class. The Plaintiffs and the putative class share the same claim to prevent the Defendant from eliminating or reducing the current level of medical funding in order to avoid institutionalization (hospitalization). The Plaintiffs and the putative class share the same claim to avoid remaining in the community with no funding or reduced funding without sufficient skilled nursing care, which puts them at risk of death or a life threatening episode. There are no conflicts or antagonism, whether actual or apparent, between the named Plaintiffs and the class.

Counsel for the Plaintiffs are experienced civil rights attorneys with experience in complex class action litigation. Robert H. Farley, Jr. has been class counsel in *Hampe v. Hamos,*

No. 10-3121 (Judge Hibbler); *Bullock v. Sheahan*, No. 04 C 1051 (Judge Bucklo); *Streeter v. Sheriff of Cook County,* No. 08-732 (Judge Castillo); *Phipps v. Sheriff of Cook County,* No. 07-3889 (Judge Bucklo); and *Gary v. Sheahan*, No. 96 C 7294 (Judge Coar). Mary Denise Cahill has been class counsel in *Hampe v. Hamos,* No. 10-3121 (Judge Hibbler) and *Watson v. Sheahan* (Judge Bucklo). Michelle N. Schneiderheinze is experienced in federal litigation.

2. Plaintiffs Meet The Requirements Of Rule 23(b)(2)

Plaintiffs meets the requirements of Rule 23(b)(2), which allows courts to certify a class if the defendant "has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole." Fed.R.Civ.Proc.23(b)(2). Civil rights cases against parties charged with broad-based discrimination are "prime examples" of actions under Rule 23(b)(2). *Amchem Products v. Windsor,* 521 U.S. 591, 613 (1997). The Defendant has refused and/or failed to provide the medically necessary home and community-based services in violation of the rights of all class members under various federal statutes and regulations.

This case is exemplary of a Rule 23(b)(2) action because the Defendant's policies and practices affect all members of the class as well as the named Plaintiff, the remediation of which is well-suited for and requires declaratory and injunctive relief. Indeed, it is commonplace for courts to certify classes under Rule 23(b)(2) in cases where Medicaid recipients seek to enforce their rights to benefits. See *Doe by Doe, v. Chiles*, 136 F.3d 709, 712 (11th Cir. 1998); *Marisol v. Guiliani,* 126F.3d 372, 278 (2nd Cir. 1997); *Baby Neal v. Casey,* 43 F.3d 48, 64 (3rd Cir. 1994); *Hampe v. Hamos,* 2010 U.S. Dist. LEXIS 125858, * 19 (N.D. Ill. 2010); *Boulet v. Cellucci,* 107 F.Supp.2d 61, 81 (D. Mass. 2001); *Benjamin H. v. Ohl,* 1999 U.S.Dist.LEXIS 22454, **11-12

(S.D.W.V. Oct. 8, 1999); *Memisovski v. Maram,* 2004 U.S.Dist.LEXIS 16722 (N.D. Ill. 2004); and *Fields v. Maram,* 2004 U.S.Dist.LEXIS 16291 (N.D. Ill. 2004). See also, *Bzdawka v. Milwaukee County,* 238 F.R.D. 469, 476 (E.D. Wis. 2006) (class of elderly disabled persons in claim under ADA integration mandate); *Makin v. Hawaii,* 114 F.Supp. 2d 1017, 1020 (D. Haw. 1999) (class of persons living at home certified in claim under ADA integration mandate).

CONCLUSION

Wherefore, for the foregoing reasons, the Plaintiff respectfully request that this Court grant Plaintiff's Motion for Class Certification and certify the proposed class.

Respectfully submitted,

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

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CERTIFICATE OF SERVICE

I, Robert H. Farley, Jr., one of the Attorneys for the Plaintiffs', deposes and states that he caused the foregoing Plaintiffs' Memorandum of Law in Support of Class Certification to be served by electronically filing said document with the Clerk of the Court using the CM/ECF system, this 9th day of July, 2012, and will cause the foregoing Plaintiffs' Memorandum of Law in Support of Class Certification, to be served on the named Defendant, by hand delivering a copy to the office of the Defendant, Julie Hamos at 401 S. Clinton, Chicago, Illinois on July 10, 2012.

/s/ Robert H. Farley, Jr.

EXHIBIT "A"

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

Two significant changes have been made in the waiver renewal:

1) Institutional Cost Comparison: The Department of Healthcare and Family Services (HFS) is removing the ICF/MR institutional level of care as a cost comparison for this waiver. Illinois has studied options for cost comparison including skilled nursing facilities and exceptional care, rehabilitation, ventilator, children's and general hospitals. A blend of hospital and skilled nursing facilities has been selected as the cost comparison for the waiver renewal. Historically, Illinois has used a combined cost comparison of an ICF/MR skilled nursing facility for pediatrics (SNF/Ped) and hospital level of care. In recent discussions with CMS, we learned that the ICF/MR cost comparison cannot be combined with hospitals for persons with disabilities with the exception of waivers for individuals with brain injury.

2) Objective Assessment Tool for Waiver Eligibility: HFS has developed, is testing and plans to implement an objective level of care instrument to determine waiver admissions and continued eligibility by September 2007. Historically, HFS has based medical eligibility determinations on medical information, physician recommendations, and clinical information.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State of Illinois** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):

HCBS Waiver for Children that are Medically Fragile, Technology Dependent

C. **Type of Request: renewal**

Migration Waiver - this is an existing approved waiver

Renewal of Waiver:

Provide the information about the original waiver being renewed

submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

- **§1915(b)(1) (mandated enrollment to managed care)**
- **§1915(b)(2) (central broker)**
- **§1915(b)(3) (employ cost savings to furnish additional services)**
- **§1915(b)(4) (selective contracting/limit number of providers)**

A program authorized under §1115 of the Act.

Specify the program:

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Illinois home and community-based services (HCBS) waiver for children who are medically fragile, technology dependent (MFTD) was created to allow eligible children to remain in their own homes rather than in an institutional setting. The waiver is administered through the Medicaid agency with day to day operations and case management provided by the University of Illinois, Division of Specialized Care for Children at Chicago (DSCC).

DSCC is the Title V CSHCN (Children with Special Health Care Needs) agency for Illinois providing care coordination for families and children with special health care needs. DSCC's experience with children with special health care needs dates back to 1937. DSCC's Home Care program was established in 1985 when the MFTD waiver was initially approved. Services are coordinated by a network of professional staff located in 13 regional offices throughout the state.

Under the HCBS waiver's Home Care Program (HCP), DSCC offers coordination and support for in-home medical care. Nursing is the primary service received by waiver participants, although it is not a waiver service. Waiver services include: respite, specialized medical equipment and supplies, environmental modifications, family training, nurse training, placement maintenance counseling, and medically supervised day care. The child's resources are considered, but parental income is not counted for Medicaid financial eligibility.

DSCC accepts referrals for the development of applications for waiver services. This includes assessing the home and gathering information necessary to prepare a comprehensive individual waiver application and Medical Plan of Care (MPC), including cost comparison with the appropriate institutional setting which demonstrates the cost benefits of home care. DSCC submits the application to HFS on behalf of the child and family. HFS determines the medical eligibility for the waiver, approves the MPC and all redeterminations. DSCC maintains daily contact with HFS regarding changes in each waiver participant's medical condition or other situations that may impact the waiver participant's MPC.

DSCC provides utilization review, care coordination and conducts ongoing quality assurance activities of nursing agency and home medical equipment providers. DSCC utilizes a variety of reports to track timeliness of processing applications and redeterminations, service needs, utilization of services and unusual incidents. DSCC meets quarterly with HFS to discuss quality assurance reports, incidents, abuse, neglect and other policy issues. The waiver program is small, serving approximately 530 children. It is operated with intensive case management and collaborative, on-going communications between DSCC and HFS.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. **Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.

B. **Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and

EXHIBIT "B"

Questions and Answers on the Medicaid Program For Medically Fragile and Technology Dependent Children

We understand you have concerns regarding the restructuring of the program for medically fragile and technology dependent children. We will do our best to answer your questions, but some questions cannot be answered yet as we are still in the process of finalizing the program's restructuring. Please note that the state law and federal parameters under which the program will operate will not take effect until September 1, 2012.

Information is available on the fact sheet and in the question and answers below. The fact sheet can be found at HFS Budget Web site. As more details become final, we will post additional notifications on our Web site.

If you have additional questions, please e-mail them HFS.Director.MFTD@illinois.gov. We will compile these questions and post answers on our Web site to those questions to which we are able to respond. Please know that our staff will not be able to respond to verbal questions on the telephone. We ask for your patience and will make every effort to work with you in transitioning your child if your child will be affected by the restructuring.

Select the Frequently Asked Question to view answer.

1. **Why is this program changing?**
   The Medicaid program is on the brink of collapse. Changes were necessary to save the Medicaid program and these changes can be found in the SMART Act (Public Act 097-0689 pdf). One of the changes in the SMART Act was a modification to the program for medically fragile and technology dependent children, found on Pages 81 and 82. A copy of the SMART Act can be found on the HFS Budget Web site.
2. **Why do you call this a new program?**

   This is not a new program; rather, it is a restructuring of two existing programs.

   Currently, the state serves medically fragile and technology dependent children in two different ways: approximately 550 children are served by the Medically Fragile, Technology Dependent Waiver ("MFTD Waiver") and there are approximately 500 other medically fragile and technology dependent children under Medicaid who receive in-home services but do not meet the institutional level of care to qualify for services under the MFTD Waiver. The restructured program will use a consistent assessment and care coordination to assist children and their families. The restructured program will also incorporate a philosophy of consumer/family direction and shared financial responsibility, meaning that families will also have more flexibility in accessing and using services.
3. **I would like a copy of the proposed State Plan Amendment.**

   The state has not submitted a draft State Plan Amendment at this time. The state has submitted a waiver document, but this document is a draft and, therefore, not final. Draft documents are exempt from release under the Freedom of Information Act (5 ILCS 140/7). HFS will release these documents when they are finalized with the federal government. Please note that HFS had months of stakeholder input that we took into account when developing these documents (see #12).
4. **I would like to know the individual Medicaid costs for my client or child.**

   HFS would very much like to give you this. The total cost of Medicaid services is $187 million for both groups of medically fragile and technology dependent children. Individual cost data is protected by privacy laws. HFS wants to assure that these laws are followed when sharing protected health information. HFS will publicize the process to request this information on our Web site.
5. **How is the change of level of care to nursing facility in the waiver going to affect my child?**
   The change to nursing facility level of care in the waiver will not affect your child's eligibility for the program. Under a waiver, states are required to demonstrate cost-neutrality on an aggregate basis, not for each individual child. To establish the cost neutrality of the MFTD waiver, the costs of home and community-based services will be compared to the costs of nursing facility services for a population with similar needs as the MFTD population. Individual eligibility and the available services under the restructured MFTD program will be assessed individually, based on medical need, as described in #6 and #7 below.
6. **What is the Level of Care Tool for the restructured MFTD program?**

   The level of care tool will be the standardized assessment tool that determines eligibility and medical necessity for services available under the restructured MFTD program. The "level of care" in this context should not be confused with the level of care required by the federal government in waivers.
7. **How are the services changing?**

   Services provided through the program will continue to be based on medical necessity, which will be determined consistently through the level of care tool described above. In the context of this standardized assessment tool, "level of care" means the amounts and types of services necessary to meet the varied medical needs of individual children.

   Private duty nursing, the most widely used service by medically fragile and technology dependent children, including those children who currently use the MFTD Waiver, will continue to be available to all eligible children, when medically necessary, under the Early Periodic Screening, Diagnosis & Treatment (EPSDT) requirements.

   In fact, most of the medically necessary services to be provided by the restructured program will be available as a result of the State Plan and EPSDT requirements, not the MFTD Waiver. The only services remaining under the MFTD Waiver in its current draft form are home modifications, specialized medical equipment, nurse training, family training, placement maintenance counseling, and medically supervised day care. The most used of these services are the Environmental Accessibility Adaptations (EAA) and Specialized Medical Equipment and Supplies (SMES). These services will continue as waiver services, with limits. The total cost for purchase of all EAA and SMES purchases, rental, and repairs may not exceed $25,000 over five years. Respite has been eliminated as a waiver service, as families will have

more flexible use of nursing hours based on a monthly service allocation and creation of a flexible account that allows families to bank up to a week's worth of unused hours to be used for respite.

8. **What are my co-pays going to be?**

   The proposal is for families with income at or over 150% Federal Poverty Level to pay co-pays. The co-pays will be the maximum allowed by federal law, as required by the SMART Act. The amount of co-pay has not yet been finalized. Cost-sharing is an essential component in the SMART Act. With the Medicaid program on the brink of collapse, the legislature imposed co-pays for most, if not all, Medicaid services, to the extent permitted by law.

9. **Why was an income cap of 500% Federal Poverty Level imposed?**
   Because of the budget crisis, the legislature imposed income caps for this program. HFS estimates that 95% of families will continue to be eligible to receive services that are medically necessary. It is possible that there is legislative interest to raise this income cap, if additional revenues are identified. Due to the fiscal resources available to the state at this time, it is unlikely that this program will revert to a program for all families of all incomes.

10. **Will the proposed changes have a transition period for families who will not qualify? What is the transition plan?**
    Transition plans will be developed for children who no longer qualify. HFS will make every effort to work with families to make referrals to other programs and services for which your child may be eligible. If you receive a notification that your child is going to lose eligibility, you will also be informed of your right to request a fair hearing.

11. **Will the children currently in the waiver be eligible until their next renewal date, or are they going to be reevaluated on September 1, 2012?**
    Financial eligibility will be reviewed prior to September 1, 2012. However, a child's level of care eligibility will be determined at the time of the child's annual reassessment.

12. **How did the state include families in the decision-making process?**
    HFS engaged in meetings with families and other stakeholders, including doctors, therapists and other healthcare providers, for many months prior to and during the legislative session to brainstorm about ways to make this program more efficient and responsive to individual children and family needs. Many of the suggestions received by the department were incorporated into the proposed program redesign, including cost sharing, the flexibility to bank unused hours, and the use of paraprofessional staff to deliver care.

EXHIBIT "C"

AN ACT concerning public aid.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Short title. This Act may be referred to as the Save Medicaid Access and Resources Together (SMART) Act.

Section 5. Purpose. In order to address the significant spending and liability deficit in the medical assistance program budget of the Department of Healthcare and Family Services, the SMART Act hereby implements changes, improvements, and efficiencies to enhance Medicaid program integrity to prevent client and provider fraud; imposes controls on use of Medicaid services to prevent over-use or waste; expands cost-sharing by clients; redesigns the Medicaid healthcare delivery system; and makes rate adjustments and reductions to update rates or reflect budget realities.

Section 10. The Illinois Administrative Procedure Act is amended by changing Section 5-45 as follows:

(5 ILCS 100/5-45) (from Ch. 127, par. 1005-45)

Sec. 5-45. Emergency rulemaking.

(a) "Emergency" means the existence of any situation that any agency finds reasonably constitutes a threat to the public

this Article shall not be affected by the receipt by the person of donations or benefits from fundraisers held for the person in cases of serious illness, as long as neither the person nor members of the person's family have actual control over the donations or benefits or the disbursement of the donations or benefits.

(Source: P.A. 96-20, eff. 6-30-09; 96-181, eff. 8-10-09; 96-328, eff. 8-11-09; 96-567, eff. 1-1-10; 96-1000, eff. 7-2-10; 96-1123, eff. 1-1-11; 96-1270, eff. 7-26-10; 97-48, eff. 6-28-11; 97-74, eff. 6-30-11; 97-333, eff. 8-12-11; revised 10-4-11.)

(305 ILCS 5/5-2b new)

Sec. 5-2b. Medically fragile and technology dependent children eligibility and program. Notwithstanding any other provision of law, on and after September 1, 2012, subject to federal approval, medical assistance under this Article shall be available to children who qualify as persons with a disability, as defined under the federal Supplemental Security Income program and who are medically fragile and technology dependent. The program shall allow eligible children to receive the medical assistance provided under this Article in the community, shall be limited to families with income up to 500% of the federal poverty level, and must maximize, to the fullest extent permissible under federal law, federal reimbursement and family cost-sharing, including co-pays, premiums, or any

other family contributions, except that the Department shall be permitted to incentivize the utilization of selected services through the use of cost-sharing adjustments. The Department shall establish the policies, procedures, standards, services, and criteria for this program by rule.

(305 ILCS 5/5-2.1d new)

Sec. 5-2.1d. Retroactive eligibility. An applicant for medical assistance may be eligible for up to 3 months prior to the date of application if the person would have been eligible for medical assistance at the time he or she received the services if he or she had applied, regardless of whether the individual is alive when the application for medical assistance is made. In determining financial eligibility for medical assistance for retroactive months, the Department shall consider the amount of income and resources and exemptions available to a person as of the first day of each of the backdated months for which eligibility is sought.

(305 ILCS 5/5-4) (from Ch. 23, par. 5-4)

Sec. 5-4. Amount and nature of medical assistance.

(a) The amount and nature of medical assistance shall be determined ~~by the County Departments~~ in accordance with the standards, rules, and regulations of the Department of Healthcare and Family Services, with due regard to the requirements and conditions in each case, including

EXHIBIT "D"

Medically Fragile Technology Dependent (MFTD) HCBS Waiver History

	Enrolled	Average PMPY*	Total Annual Liability
2000	275	$157,773	$43,387,550
2001	349	$145,845	$50,899,772
2002	415	$150,332	$62,387,651
2003	489	$162,432	$79,429,209
2004	536	$173,772	$93,141,712
2005	576	$160,225	$92,289,404
2006	595	$163,296	$97,161,019
2007	611	$167,583	$102,393,354
2008	641	$167,860	$107,598,048
2009	629	$178,448	$112,243,830
2010	622	$188,210	$117,066,489

*Per Member Per Year

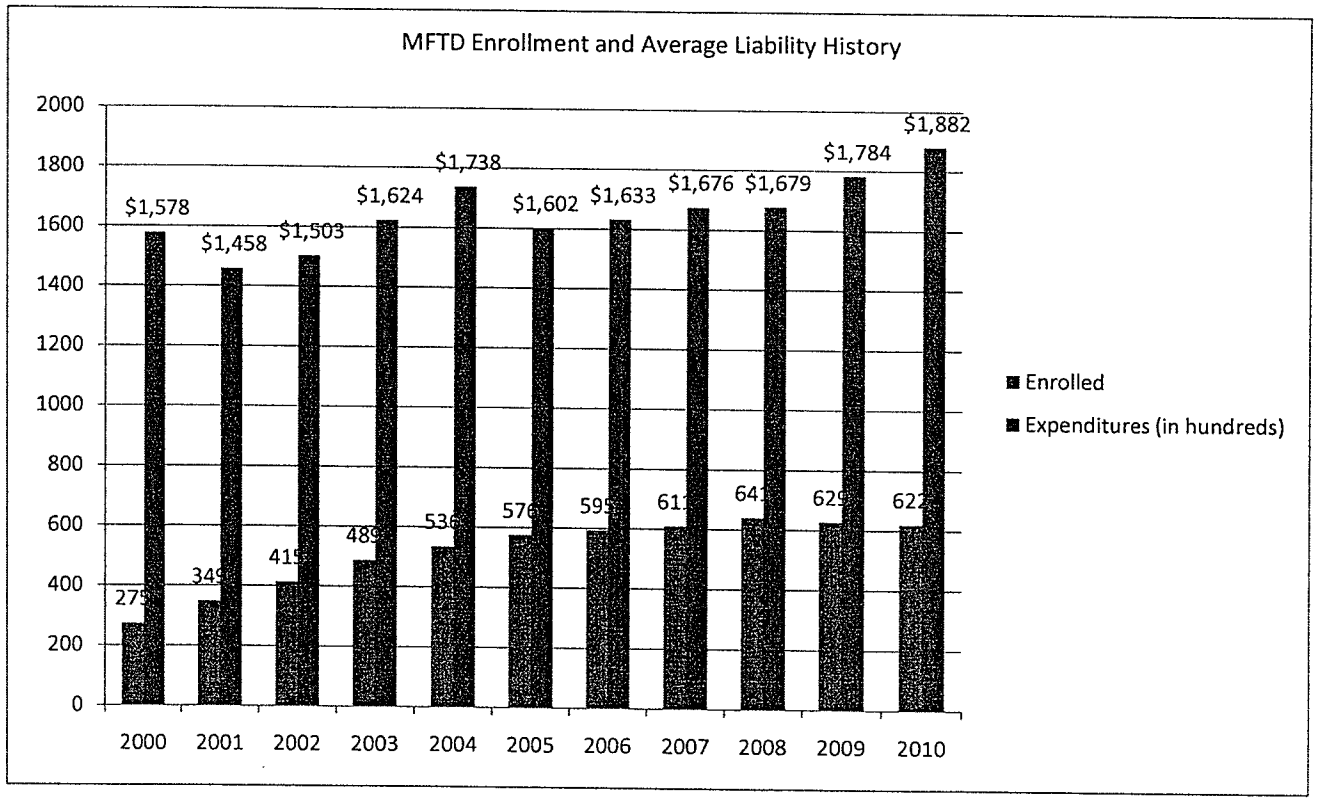

EXHIBIT "E"

FACT SHEET

Medically Fragile, Technology Dependent
Home and Community-Based Services (HCBS) Waiver for children under age 21

Program Overview:

This program helps families care for children (birth up to age 21) who are medically fragile and technology dependent. The program offers care coordination and services to support the family by providing care for their child at home. In-home nursing services are available based on the medical needs of the child or youth. The Division of Specialized Care for Children (DSCC) manages the day to day operations of this program on behalf of the administering agency, Illinois Department of Healthcare and Family Services (HFS). The services are offered through a federal 1915(c) HCBS waiver. A waiver is a federally approved program that allows states the flexibility to design and cover services that may not otherwise be available under the state's Medical Programs to defined disability groups. The services must be designed to assist individuals to remain in their own home or live in a community setting rather than in an institution, such as a nursing facility or hospital. The cost of the services must be cost neutral to the state. The program is similar to the "Katie Beckett" waiver in other states, but this waiver is unique to Illinois.

Expenditures for State Fiscal Year 2010:
Medicaid Liability: $117,066,489
Number enrolled: 622
*Ave. cost pmpy**: $ 188,210
*Per Member Per Year

Eligibility Criteria:

- Children or youth ages birth to 21 years that meet the medical criteria, as determined by their health condition and technology needs, as evaluated by professionals(a minimum score of 50 on level of care screening assessment). The Department's eligibility criteria can be found under 89 Ill. Admin. Code 120.530.
- The family is willing and able to care for the child in their home to the fullest extent possible.
- The family is able to safely care for the child in the family's home.
- A determination is made that without the in-home support services provided through the waiver program, the child would be at risk to be in an institutionalization in a skilled nursing facility or a hospital.
- The estimated cost of the in-home support services is not greater than the cost of the institutional level of care appropriate to the child's medical need.
- Parental income is not considered, but the child's income is considered in the financial income requirements.

Services:

- All Medical services available under the Illinois Medicaid program such as hospitalizations, doctor visits, and medications are covered, unless the services are covered by the child's insurance.

- Services include shift nursing care in the home, provided by registered nurses, licensed practical nurses and certified nurse's aide from an approved nursing agency. The number of hours provided per week is determined by the assessment of the child's medical and nursing care needs.
- Medical equipment and supplies prescribed by the child's physician.
- Minor home modifications needed to provide access, accommodate needed medical equipment, or to assure the child's safe access and safety in the home.
- Family training that includes instruction about treatments and use of equipment as well as Cardiopulmonary Resuscitation (CPR).
- Respite (nursing) care in the child's home or in a designated community-setting to periodically relieve the family of care-giving responsibilities.
- Medically supervised day care offering technological support and nursing care provided in a licensed medical day care setting. (Currently there are no licensed providers in Illinois.)
- Placement maintenance counseling providing short-term, issue-specific family or individual counseling for the purpose of maintaining the child in the home placement.
- Nurse training to provide child specific training for the in-home nurses in the use of new or unique equipment or special needs of the child.

Services Setting:

- Individual homes
- Licensed Children's Community-Based Health Care Center
- Medically Supervised Day Care

How to Access Services:

Point of Entry – University of Illinois at Chicago, Division of Specialized Care for Children (DSCC) 13 Regional Offices or contact DSCC at 1-800-322-3722.

Additional information on this program can be found at http://www.uic.edu/hsc/dscc/ which includes:

- Application forms (print & mail)
- DSCC Regional Office locator (Zip code – maps)
- More information on the home care program

Medicaid Link and program information: **http://www.hfs.illinois.gov/hcbswaivers/tdmfc.html**

Maximum Waiver Capacity:

700

Unduplicated Waiver Recipients:

As of May 1, 2011, 565 children have been served in waiver year beginning 9/1/10 and ending 8/31/11. Of this number 498 are currently active.

Initial Approval Date:

July 1, 1985 Renewed: 09/01/2007–08/31/2012

EXHIBIT "F"

FACT Sheet
Private Duty Nursing (PDN) Services for Children under Age 21

Program Overview:
Illinois Department of Healthcare and Family Services (HFS) Division of Medical Program provides services to children under age 21 who have been determined to have extensive medical needs, requiring ongoing skilled nursing in the home setting. Children must meet Medicaid eligibility and live in a private home. Children may be wards of the Department of Children and Family Services or served under the Adoption Assistance Program. Children receiving this PDN may not be concurrently served under the Medically Fragile, Technology Dependent (MFTD) Home and Community-Based Services (HCBS) waiver. Services are prior approved initially for 60 days with two 60-day renewal periods. After the first 180 days of service, cases are reviewed on 6-month or annual schedules depending on the medical stability of the child. Services are provided by approved Home Nursing Agencies licensed by the Department of Public Health.

Expenditures for State Fiscal Year 2010:
Medicaid Liability: $70,564,825
Number enrolled: 527
*Ave. cost pmpy**: $ 133,899
*Per Member Per Year

Eligibility Criteria:
- Children under the age of 21 who have extensive medical needs and require ongoing skilled nursing care as determined by the Department's prior approval process.
- U.S. Citizen or legal alien
- Be a resident of the State of Illinois
- Under age 21
- Eligible for the Medical Assistance Program
- Prior approved for services by the Department
- Physician order and justification for services

Services:
- **Skilled Nursing Services –** services are provided in a child's home by licensed nursing personnel (Registered Nurse or Licensed Practical Nurse) employed by an approved Home Nursing Agency. Services include initiation and implementation of restorative/palliative nursing procedures, coordination of plan of care and patient/family instruction.
- **Home Health Aide Services** – services are provided in a child's home by certified nurses' aides. Services include providing or assisting with personal care, bathing, mobility/transfers, and other Activities of Daily Living (ADLs).

Services Setting:
- Individual homes

How to Access Services:
Point of Entry –Physicians, hospital social workers or enrolled Home Nursing agencies may contact HFS at 877-782-5565.