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 C 5356
Plaintiffs,	)	Judge Robert W. Gettleman
vs.	)	Magistrate Judge Sidney I. Schenkier
JULIE HAMOS, in her official capacity as Director of the Illinois Department of Healthcare and Family Services,	)	
Defendant.	)	

DEFENDANT'S RESPONSE IN OPPOSITION TO PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER

NOW COMES Defendant, JULIE HAMOS, in her official capacity as Director of the Illinois Department of Healthcare and Family Services, by and through her attorney, LISA MADIGAN, Attorney General of Illinois, and hereby responds to Plaintiffs' Motion for Temporary Restraining Order, as follows:

I. INTRODUCTION.

Plaintiffs are Medicaid-eligible children who participate in the Home and Community-Based Services Medicaid Waiver for Medically Fragile, Technology Dependent children ("MF/TD" or "MF/TD waiver"). Public Act 97-689, effective June 14, 2012, promulgated the

Save Medicaid Access and Resources Together ("SMART") Act *reprinted in* 2012 Ill. Legis. Service, P.A. 97-689 (S.B. 2840) (Westlaw 2012). Among other things, the SMART Act authorized a program, subject to federal approval, to allow Medicaid-eligible children who are disabled and medically fragile and technology dependent to receive medical assistance in the community. Public Act 97-689, Sec. 75, codified at 305 ILCS 5/5-2b (Westlaw 2012). Participation in the program will be limited to children of families with income up to 500% of the federal poverty level. *Id.* Section 5/5-2b also directs Defendant to maximize, to the fullest extent permitted under federal law, federal reimbursement and family cost sharing, including co-pays, premiums or any other family contributions. *Id.* All Plaintiffs seek a declaration that the "planned reduction or reduction or denying ... existing benefits of the MF/TD waiver and Medicaid" violates the ADA, the Rehabilitation Act and certain federal regulations, the Medicaid Act and 42 U.S.C. § 1983. *T.B. v. Hamos*, No. 12 C 5356, U.S. Civil Docket at Doc. No. 1, page 53 (hereafter "*T.B.* Civil Docket at ___"). All Plaintiffs seek permanent injunctive relief requiring Defendant to "restore the level of Medicaid funding to maintain the existing medical services for the Plaintiffs ... in the MF/TD waiver and Medicaid." *T.B.* Civil Docket at 1, page 54.

II. STATEMENT OF FACTS.

All the named Plaintiffs are Medicaid-eligible children alleged to be medically fragile. *T.B.* Civil Docket at 1, ¶¶ 39(a), 45, 46(a), 52, 53(a), 63, 64(a), 74, 75(a), 85, 86(a), 96. All the named Plaintiffs reside in the family home. *Id.* at 1, ¶¶ 39(e), 46(e), 53(g), 64(h), 75(g), 86(g). All the named Plaintiffs receive in-home nursing services, *Id.* at 1, ¶¶ 39(a), 45(a), 53(a), 64(a), 75(a), 86(a), and all the named Plaintiffs participate in the MF/TD waiver. *Id.* at 1, ¶¶ 40, 47, 54, 65, 76, 87.

Four of the named Plaintiffs, M.K., X.N., S.P. and O.W., alleged that their families' incomes are greater than 500% of the federal poverty level. *Id.* at 1, ¶¶ 53(f), 56, 64(g), 67, 75(f), 78, 86(f), 89. All Plaintiffs alleged that the passage of the SMART Act together with the Defendant's efforts to amend Illinois' Title XIX State Medicaid Plan and renew the MF/TD waiver would result in reductions of their current level of skilled nursing and Medicaid benefits in violation of the ADA, Rehabilitation Act, the "integration" regulations and the Medicaid Act. *Id.* at 1, ¶¶ 43, 50, 61, 72, 83, 94, 173-208.

III. ARGUMENT.

PLAINTIFFS FAIL TO MEET THE REQUIREMENTS OF Fed. R. Civ. P. 65.

The court stated at a status hearing on October 25, 2012 that it is limiting its consideration of Plaintiffs' Motion for Temporary Restraining Order and Preliminary Injunction, *T.B.* Civil Docket at 6, to deciding whether a temporary restraining order should issue against Defendant. In light of the court's stated intention, Defendant confines her arguments to those matters that are properly addressed to a motion for temporary restraining order. Defendant reserves the right to modify her arguments, or raise new arguments as the situation warrants if the case proceeds to an evidentiary hearing on the Plaintiffs' Motion for Preliminary Injunction.

Pursuant to Fed. R. Civ. P. 65, the purpose of a temporary restraining order is to preserve the *status quo* and prevent irreparable harm just so long as is necessary to hold a hearing on a motion for preliminary injunction and no longer. *Granny Goose Foods, Inc. v. Brotherhood of Teamsters*, 415 U.S. 423, 439 (1974). The *status quo* is the last actual, peaceable, uncontested status which preceded the pending controversy. *LaRouche v. Kezer*, 20 F.3d 68, 74 n.7 (2nd Cir. 1994). Since a temporary restraining order is not the same as a preliminary injunction, *Granny Goose*, 415 U.S. at 439-45, the court's inquiry here is properly focused on what acts of

Defendant should be restrained in order to preserve the *status quo*. As the following will demonstrate, Defendant has done nothing to create any imminent risk of irreparable injury to any Plaintiff.

The *status quo* here is that all named Plaintiffs are Medicaid-eligible and are participating in MF/TD. Any change to their Medicaid eligibility or their participation in MF/TD is entirely dependent on approvals from the United States Department of Health and Human Services. As of this filing, those federal approvals have not been granted and Defendant has not been given to believe that any federal action is imminent. There is nothing for this court to restrain and the federal injunction power is not properly invoked where, as here, the only allegations regarding injury to the Plaintiffs are speculative. *Winter v. Natural Resources Defense Council, Inc.*, 55 U.S. 7, 22 (2008) (injunction will not issue simply to prevent the possibility of some remote future injury) (internal citations omitted). Accordingly, the Plaintiffs' Motion for Temporary Restraining Order should be denied for want of equity.

A. Plaintiffs Have No Reasonable Likelihood Of Success On The Merits Because the Statutes and Regulations On Which Plaintiffs Base Their Claims Do Not Assure Maintenance Of Medicaid Services Previously Provided To Them.

The relevant portion of the ADA states:

> [N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

42 U.S.C. § 12132 (Westlaw 2012).

The ADA defines a "qualified individual with a disability" as one who "with or without reasonable modifications to rules, policies, or practices … meets the essential eligibility

requirements for the receipt of services or the participation in programs or activities provided by a public entity." 42 U.S.C. § 12131(2) (Westlaw 2012).

The relevant portion of the Rehabilitation Act states:

> [N]o otherwise qualified individual with a disability ... shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance ...

29 U.S.C § 794(a) (Westlaw 2012).

Neither the ADA nor the Rehabilitation Act guarantee any particular level of medical care for disabled persons, *nor assure maintenance of service previously provided. Rodriguez v. City of New York*, 197 F.3d 611, 619 (2nd Cir. 1999) (citing *CERCPAC v. Health and Hospitals Corp.*, 147 F.3d 165, 168 (2nd Cir. 1998) (emphasis added). *Accord*: *Alexander v. Choate*, 469 U.S. 287 (1985); *Olmstead v. L.C.*, 527 U.S. 581 (1999); *Talton v. Kinkade*, 2012 WL 5305334 (W.D. Mo. October 25, 2012).

In *CERCPAC*, 147 F.3d at 167-68, the Second Circuit affirmed dismissal of a complaint filed on behalf of four children with developmental disabilities that challenged closure of the Children's Evaluation and Rehabilitation Clinic on ADA and Rehabilitation Act grounds. All children alleged that their health and safety depended upon a continuous course of specialized diagnostic, treatment and rehabilitative services from the clinic. *Id.* The children challenged the clinic's closing, not because its absence would have deprived disabled children of medical services available to non-disabled children, but because the closure would reduce or eliminate some services. *Id.* The court, relying on *Alexander v. Choate*, 469 U.S. 287 (1985), found that the disability statutes do not guarantee any particular level of medical care, nor do they assure that a service once provided will be continued. *Id.* The court also declined to speculate that certain medical and/or specialized services might need to be provided as a reasonable

accommodation to a child's disability because there were no allegations that certain medical or specialized services were routinely being denied. *Id.* Conclusory allegations, like the allegations in the *T.B.* Complaint, that reduction or elimination of a Medicaid benefit previously enjoyed by disabled persons will lead to "institutionalization," or "deterioration of health" or "death" do not suffice to invoke the remedies that these statutes provide.

When these authorities are applied to the named Plaintiffs, it is evident that they are not likely to succeed on the merits of their ADA and Rehabilitation Act claims. First, the *T.B.* Complaint is nothing more than conclusions and speculation that implementation of 305 ILCS 5/5-2b and/or changes to the MF/TD waiver, including its possible non-renewal, may cause injuries to the named Plaintiffs. As such, Plaintiffs' speculation and conjecture do not trigger the remedies of the disability statutes. Second, nothing in the disability statutes eliminated Defendant's discretion to reduce optional Medicaid services. Third, the Medicaid Act, 42 U.S.C. § 1396 *et seq.*, contains intricate funding and service provisions. Plaintiffs are not arguing, and cannot argue, that the passage of the Rehabilitation Act or the passage of the ADA were accompanied by any amendments to the Medicaid Act that altered the basic concept of cooperative federalism, *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 17-27 (1981); *Harris v. McRae*, 448 U.S. 297 (1980), that the passage of these statutes implicitly amended the Medicaid Act, that Congress amended Title XIX to alter the basic concept of cooperative federalism in response to any judicial interpretation of the Rehabilitation Act or ADA, or that the disability statutes obligated the State to furnish every conceivable Medicaid service in the least restrictive environment. *Cf. Pennhurst*, 451 U.S. at 18 (we find nothing in the Developmentally Disabled Assistance and Bill of Rights Act or its legislative history to suggest that Congress intended to require the States to assume the high cost of providing "appropriate

treatment" in the "least restrictive environment" to mentally disabled citizens). Plaintiffs also do not argue that either the Rehabilitation Act or the ADA, directly or implicitly, altered the Defendant's understanding in accepting federal funds under a Spending Clause statute regarding the Medicaid agency's prerogatives and discretion over optional Medicaid services. *Pennhurst, Id.* at 24; *see also Planned Parenthood of Indiana v. Commissioner of Indiana Dept. of Health,* ___ F.3d ___, 2012 WL 5205533 *6 (C.A. 7th (Ind.) October 23, 2012) (in the context of legislation adopted under the spending power, this rigorous approach reflects concerns about federalism and reinforces the principle that Congress must clearly express its "intent to impose conditions on the grant of federal funds so that the States can knowingly decide whether to accept those funds") (citing *Pennhurst*, 451 U.S. at 24). Similarly, nothing in the disability statutes alters Defendant's authority under the Medicaid Act to set financial eligibility standards that are consistent with its requirements. 305 ILCS 5/5-2b, to the extent that it would limit participation in a program to children whose family income is less than 500% of the federal poverty level, is about eligibility, not access. *See Talton v. Kinkade*, 2012 WL 5305334 *4 (W.D. Mo. October 25, 2012).

Finally, nothing in the disability statutes alters Defendant's authority under the Medicaid Act to require cost-sharing. In this connection, Plaintiffs cited to the wrong provision of the Medicaid Act. *T.B.* Civil Docket at 6, ¶ 14; 1, ¶ 18. 42 U.S.C. § 1396o-1 clearly permits Defendant to require the cost-sharing contemplated in 305 ILCS 5/5-2b, which ties cost sharing to that which is "permissible under federal law."

2. The "Integration" Mandates Claim.

The integration regulations, 28 C.F.R. §§ 35.10(d) and 41.51(d) (Westlaw 2012) do not impose any affirmative obligations on the Defendant independent of the ADA and the

Rehabilitation Act. Regulations creating rights independent of any federal statute are not enforceable laws. *Mungiovi v. Chicago Housing Authority*, 98 F.3d 982, 983-84 (7th Cir. 1996). In *Alexander v. Sandoval*, 532 U.S. 275, 285-93 (2001), the Supreme Court held that federal agencies were authorized to "effectuate" Title VI by issuing regulations, but that they could only effectuate rights already created by statute and could not themselves create new rights or rights of action. *See also Olmstead v. L.C.*, 527 U.S. 581, 592 (1999). In this context, Defendant reiterates that the Supreme Court declined to find any intent on Congress' part to obligate the states to fund every conceivable service for disabled persons in the least restrictive environment. *Pennhurst*, 451 U.S. at 18. The integration regulations create new rights and new causes of action that the ADA and Rehabilitation Act themselves do not recognize because the text of the Acts of Congress does not support the principle embodied in the regulations. The integration regulations are not enforceable and do not authorize the relief Plaintiffs seek here.

3. The Medicaid Act Claims.

Plaintiffs allege that Defendant violated the Early and Periodic Screening, Detection and Treatment ("EPSDT") provision of the federal Medicaid Act. 42 U.S.C. §§ 1396a(a)(43); 1396d(r) (Westlaw 2012). Title XIX requires a State participating in the Medicaid program to include EPSDT as part of its Title XIX State Medicaid Plan. 42 U.S.C. § 1396a(a)(43) (Westlaw 2012). Section 1396a(a)(43) states, in pertinent part, that with respect to EPSDT the single state Medicaid agency shall:

> (B) provid[e] or arrang[e] for the provision of such screening services in all cases where they are requested,
>
> (C) arrang[e] for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services ...

42 U.S.C. § 1396a(a)(43)(B), (C) (Westlaw 2012). At 42 U.S.C. § 1396d(r)(5), the Act of Congress defines the term "early and periodic screening, diagnostic, and treatment services" to include, among other things:

> (5) Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State [Medicaid] plan.

42 U.S.C. § 1396d(r)(5) (Westlaw 2012). Under EPSDT, an eligible child shall be examined periodically to determine the existence of any physical or mental illnesses or conditions. Under EPSDT, a Medicaid-eligible child shall receive treatment allowable in 42 U.S.C. § 1396d(a) to correct or ease the conditions discovered through the periodic screenings, *whether the State includes the corrective services in its State Medicaid plan or not.* (Emphasis supplied). 42 U.S.C. § 1396d(r)(5) (Westlaw 2012).

First, as the statutory language cited above establishes that even a mandatory Medicaid service, like EPSDT for children under the age of twenty-one, is limited to those who demonstrated "need" for the service. In particular, the Medicaid Act, at 42 U.S.C. § 1396a(a)(10)(A) requires that mandatory Medicaid services be furnished when medical need has been established, but the Medicaid Act does not prevent Defendant from imposing utilization controls on EPSDT. *See Bontrager v. Indiana Family and Social Services Administration*, ___ F.3d ___, 2012 WL 4372524 *4 (CA 7th (Ind.) September 26, 2012) (even though a State is required to cover medically necessary treatment in those service areas in which a State opts to provide coverage, federal regulations grant the State considerable leeway in carrying out its plan). EPSDT is a separate mandate to provide certain Medicaid services to children under the age of 21. 42 U.S.C. § 1396 *et seq.* Congress did not create EPSDT to clothe the Medicaid

agency with the authority to operate home and community-based services programs. 42 U.S.C. §§ 1396a(a)(43); d(r) (Westlaw 2012). Rather, that authority lies in 42 U.S.C. § 1396n(c) (Westlaw 2012). There is no reason for EPSDT or 42 U.S.C. § 1396d(a) to exist if the State is obligated to make the entire basket of every conceivable medical service accessible to each Medicaid-eligible individual, or to furnish whatever benefits and services it takes to keep a child from "institutionalization."

Home and community-based waiver services pursuant to 42 U.S.C. § 1396n(c) are optional Medicaid services. 42 U.S.C. § 1396a(a)(10)(A)(ii)(VI) (Westlaw 2012). State participation in the Section 1396n(c) waiver program is entirely voluntary and a federal court lacks authority to order the State Medicaid agency to operate a Medicaid waiver in a manner that eliminates the State's discretionary authority under Section 1396n(c). *Skandalis v. Rowe*, 14 F.3d 173, 181-83 (2nd Cir. 1994). Similarly, the Medicaid Act, as it pertains to Medicaid waivers, was intended by Congress to allow States "to redraw the financial eligibility requirements that would otherwise apply ..." *Skandalis*, 14 F.3d at 181-82 (there is nothing unreasonable in the State making the assumption that people with more income are marginally more likely as a group to have the personal and family resources that would enable them to achieve home care at private effort and expense). As a matter of federal Medicaid law, it is Congress' intent that the poorest individuals should have priority when allocating scarce resources available for providing medical assistance to the needy. *Skandalis*, *Id.* at 183 (citing *Camacho v. Perales*, 786 F.2d 32, 38 (2nd Cir. 1986)).

Second, Plaintiffs are not likely to prevail on their 42 U.S.C. § 1396a(a)(8) claims. Section 1396a(a)(8), the "reasonable promptness" provision, requires Title XIX State Medicaid plans to "provide that all individuals wishing to make application for medical assistance under

the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals." 42 U.S.C. § 1396a(a)(8) (Westlaw 2012). The allegations of the *T.B.* Complaint do not set forth any facts that remotely come within the ambit of the statutory language quoted. Moreover, Section 1396a(a)(8) does not create enforceable rights to: 1) services for which an individual is not eligible, 2) optional Medicaid services that the State Medicaid agency declined to cover, or 3) Medicaid services without co-pays or cost-sharing permitted under federal law. *See Doe v. Kidd*, 501 F.3d 348 (4th Cir. 2007); *Sabree ex rel. Sabree v. Richmond*, 367 F.3d 180 (3rd Cir. 2004); *Bryson v. Shumway*, 308 F.3d 79 (1st Cir. 2002); *Doe ex rel. Doe v. Chiles*, 136 F.3d 709 (11th Cir. 1998); *Bertrand v. Maram*, 2006 WL 2735494 at *5 (N.D. Ill. September 25, 2006) *affirmed Bertrand ex rel. Bertrand v. Maram*, 495 F.3d 452 (7th Cir. 2007).

B. Adequacy Of The Remedy At Law.

Defendant concedes that Plaintiffs have no adequate remedy at law to secure funds from Defendant to defray any out-of-pocket costs they would incur for in-home private duty nursing.

C. Plaintiffs Failed To Establish That They Will Suffer Irreparable Harm If A Temporary Restraining Order Is Not Granted.

Under 42 U.S.C. § 1396n(c), States may apply to the Secretary of HHS for a "waiver" to allow the State to make medical assistance payments for home or community-based services approved by the Secretary and provided pursuant to a written plan of care to Medicaid-eligible individuals with respect to whom there has been a determination that, but for the provision of such services, the individuals would require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded ("ICF/MR") the cost of which could be reimbursed under the State's Title XIX plan. 42 U.S.C § 1396n(c)(1). Illinois has in effect a federally-approved Medicaid waiver to provide to allow eligible medically fragile and

technology dependent children, *i.e.*, persons up to age twenty-one, to remain in their homes, known as the Illinois Section 1915(c) Home and Community-based Services Waiver for Children that are Medically Fragile, Technology Dependent. Indeed, once the Secretary of HHS approves the waiver pursuant to 42 U.S.C. 1396n(c), the federally-approved waiver document controls all the terms and conditions for all home and community-based services offered. *Bertrand v. Maram*, 2006 WL 2735494 at *6 (N.D. Ill. September 25, 2006) *affirmed Bertrand ex rel. Bertrand v. Maram*, 495 F.3d 452 (7th Cir. 2007). Once the federal government approves the home and community-based services waiver, courts will not second-guess or undo its provisions. *See Id.* The Defendant's proposed renewal to the MF/TD Waiver is under discussion with representatives from the federal Centers for Medicare and Medicaid Services. All the named Plaintiffs alleged that they are presently participating in MF/TD. *T.B.* Civil Docket at 1, ¶¶ 40, 47, 54, 65, 76, 87.

Under the MF/TD Waiver, the services are respite, specialized medical equipment and supplies, environmental modifications, family training, nurse training, placement maintenance counseling and medically supervised day care. Excerpt of MF/TD Waiver attached as Defendant's Exhibit A. Nursing is the primary service received by waiver participants, but "*it is not a waiver service.*" *Id.* (Emphasis supplied). Private duty nursing is an optional Medicaid service, 42 U.S.C. § 1396d(a)(8); 1396a(a)(10)(A), and Illinois declined to cover private duty nursing in its Title XIX State Medicaid Plan. Excerpt of Illinois' Title XIX State Medicaid Plan attached as Exhibit B. The named Plaintiffs receive private duty nursing through EPSDT. Plaintiffs' arguments and affidavits pertaining to the consequences to their health are wholly conclusory and speculative.

Furthermore, there are no named Plaintiffs receiving private duty nursing who are not participating in MF/TD, even though the *T.B.* Complaint seeks relief on behalf of such individuals. *T.B.* Civil Docket at 1, pages 53-54. None of these individuals has set forth any facts showing how implementation of 305 ILCS 5/5-2b, or how any changes to MF/TD, will cause any injury to them. It is apparent that if such individuals do not qualify to participate in MF/TD, the results of the waiver renewal process can have no effect on them. Similarly, if they would not qualify for the program envisioned by 305 ILCS 5/5-52b Act because they are not medically fragile and technology dependent, the parameters of that program can have no effect on them.

Finally, since Plaintiffs failed to meet the three threshold criteria of Rule 65, it is not necessary for the court to consider whether the grant of any equitable relief will cause any irreparable harm to Defendant or whether any untoward consequences will befall the public by granting or denying equitable relief. *Promatek Industries, Ltd. v. Equitrac Corp.*, 300 F.3d 808, 811 (7th Cir. 2002). If this court believes that it is necessary to weigh the balance of hardships, then under the *Promatek* sliding scale, the following factors weigh much more heavily in Defendant's favor because Plaintiffs are not likely to succeed on the merits. The concepts of irreparable injury to the Defendant and the public interest are related. First, if this court were to grant the preliminary injunction requested, Defendant would certainly not be able to recover from Plaintiffs any of the funds it would have to expend under a temporary restraining order or injunction, if Defendant were to prevail after a trial on the merits. Second, if an order granting or denying injunctive relief will have consequences beyond the private parties to the suit, that interest, called the "public interest," must be reckoned into the court's decision. *Roland Machinery Co. v. Dresser Industries, Inc.*, 749 F.2d 380, 388 (7th Cir. 1984). When, as here, the

nonmoving party establishes that the equitable relief asked would adversely affect a public interest for whose impairment an injunction bond cannot compensate, the injunction must be denied, no matter how inconvenienced the Plaintiff is. *Yakus v. United States*, 321 U.S. 414, 440-41 (1944). As previously stated, Defendant cannot reasonably expect to recover from Plaintiffs any of the funds she would be required to expend under any injunction or restraining order, to the detriment of the funding of the Medicaid program. An injunction order would also interfere with the authority of the responsible actors in the State of Illinois (and the U.S. Congress, as well), to allocate public funds and make political decisions, like the decision whether to cover optional Medicaid services. Plaintiffs cannot ask the court to make political decisions, like whether Illinois should cover optional Medicaid services that, by Act of Congress, are committed to the discretion State officials, or whether individuals who can afford to pay for healthcare should be obligated to do so. *DaimlerChrysler Corp. v. Cuno*, 547 U.S. 332, 345 (2006) (citing *ASARCO, Inc. v. Kadish*, 490 U.S. 605, 615 (1989) (Kennedy, J.)).

IV. CONCLUSION.

WHEREFORE, for the foregoing reasons, Defendant respectfully requests that Plaintiffs' Motion for Temporary Restraining Order be denied.

Respectfully submitted,

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November 2, 2012

CERTIFICATE OF SERVICE

I, Karen Konieczny, an attorney of record for Defendants, hereby certify that, on November 2, 2012, true and correct copies of the foregoing **DEFENDANT'S RESPONSE IN OPPOSITION TO FOR TEMPORARY RESTRAINING ORDER WITH EXHIBITS** were served upon the following counsel of record through the District Court's Electronic Case Filing system.

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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
Base Waiver Number: 0278
Amendment Number

(if applicable):

Effective Date: *(mm/dd/yy)*

Waiver Number: IL.0278.R03.00
Draft ID: IL.02.03.00
Renewal Number: 03

D. **Type of Waiver** *(select only one)*:
Regular Waiver

E. **Proposed Effective Date:** *(mm/dd/yy)*
09/01/07
Approved Effective Date: 09/01/07

1. Request Information (2 of 3)

F. **Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

- [x] **Hospital**

  Select applicable level of care

  - (●) **Hospital as defined in 42 CFR §440.10**
    If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
  - ( ) **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

- [x] **Nursing Facility**

  Select applicable level of care

  - (●) **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**
    If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
  - ( ) **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

- [ ] **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

  If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

1. Request Information (3 of 3)

G. **Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities
Select one:

- (●) **Not applicable**
- ( ) **Applicable**

  Check the applicable authority or authorities:

  - [ ] **Services furnished under the provisions of §1915(a) of the Act and described in Appendix I**
  - [ ] **Waiver(s) authorized under §1915(b) of the Act.**

    Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been 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 reevaluation of level of care.

C. **Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished

EXHIBIT B

State Illinois

7. HOME HEALTH SERVICES

a.b. and c.

Services are provided on a short-term, intermittent basis to facilitate clients transitioning from a more acute level of care. Services must be provided only on direct order of a physician, and require prior approval unless the client is eligible for these benefits under Medicare.

Limits on services or treatments are not applicable to EPSDT (Healthy Kids) clients. All services or treatments which are medically necessary to correct or lessen health problems detected or suspected by the screening process must be provided to individuals under age 21.

d.

Services available only when provided by a Home Health Agency, or by a registered nurse when no home health agency exists in the area. Services require aon direct order of a physician, and with prior approval unless the client is eligible for these benefits under Medicare.

Limits on services or treatments are not applicable to EPSDT (Healthy Kids) clients. All services or treatments which are medically necessary to correct or lessen health problems detected or suspected by the screening process must be provided to individuals under age 21.

~~8. PRIVATE DUTY NURSING SERVICES~~

01/01 ~~Provided only when recommended by the physician. Requires prior approval. Services cannot be covered if provided by a relative.~~

~~Limits on services or treatments are not applicable to EPSDT (Health Kids) clients. All services or treatments which are medically necessary to correct or lessen health problems detected or suspected by the screening process must be provided to individuals under age 21.~~

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SUPERSEDES
TN# 00-10