Case No. 19-1244

In the United States Court of Appeals
For the Seventh Circuit

KAREN VAUGHN,

Plaintiff/Appellee,

v.

JENNIFER WALTHALL, in her official capacity as Secretary of the Indiana Family and Social Services Administration, *et al.*,

Defendants/Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF INDIANA, NO, 1:16-CV-03257-JMS-DLP
HONORABLE JANE MAGNUS-STINSON

APPELLEES' BRIEF

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APPEARANCE & CIRCUIT RULE 26.1 DISCLOSURE STATEMENT

Appellate Court No: 19-1244

Short Caption: Vaughn v. Walthall

To enable the judges to determine whether recusal is necessary or appropriate, an attorney for a non-governmental party, amicus curiae, intervenor or a private attorney representing a government party, must furnish a disclosure statement providing the following information in compliance with Circuit Rule 26.1 and Fed. R. App. P. 26.1.

The Court prefers that the disclosure statements be filed immediately following docketing; but, the disclosure statement must be filed within 21 days of docketing or upon the filing of a motion, response, petition, or answer in this court, whichever occurs first. Attorneys are required to file an amended statement to reflect any material changes in the required information. The text of the statement must also be included in the front of the table of contents of the party's main brief. **Counsel is required to complete the entire statement and to use N/A for any information that is not applicable if this form is used.**

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(1) The full name of every party that the attorney represents in the case (if the party is a corporation, you must provide the corporate disclosure information required by Fed. R. App. P. 26.1 by completing item #3):

Karen D. Vaughn

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

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(3) If the party, amicus or intervenor is a corporation:

i) Identify all its parent corporations, if any; and

N/A

ii) list any publicly held company that owns 10% or more of the party's, amicus' or intervenor's stock:

N/A

(4) Provide information required by FRAP 26.1(b) – Organizational Victims in Criminal Cases:

N/A

(5) Provide Debtor information required by FRAP 26.1 (c) 1 & 2:

N/A

Attorney's Signature: /s/ Mark W. Sniderman Date: 2/10/2020

Attorney's Printed Name: Mark W. Sniderman

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ☑ **No** ☐

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Attorney's Signature: /s/ Sarah Grusin Date: 2/10/2020

Attorney's Printed Name: Sarah Grusin

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N/A

Attorney's Signature: /s/ Martha Jane Perkins Date: 2/10/2020

Attorney's Printed Name: Martha Jane Perkins

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ☐ **No** ☑

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N/A

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Attorney's Printed Name: Elizabeth Edwards

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Regulations

Administrative Materials

Other Authorities

JURISDICTIONAL STATEMENT

The jurisdictional statement submitted by Defendants-Appellants ("the State") is complete and correct.

ISSUES ON REVIEW

1. Whether the State failed to satisfy its affirmative obligation to provide Karen Vaughn services in the most integrated setting in violation of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

2. Whether, by merely authorizing, but not actually providing for in-home nursing services for years on end, the State violated the Medicaid requirement that medical assistance be provided with "reasonable promptness." 42 U.S.C. § 1396a(a)(8).

3. Whether the district court's injunction requiring the State to provide for in-home services within a specified timeframe was appropriately tailored to remedy the nearly three-year delay in receiving those services and the unnecessary institutionalization Karen has suffered.

STATEMENT OF THE CASE[1]

Karen Vaughn's Unnecessary Institutionalization

Karen Vaughn enjoys visiting with friends and socializing on the balcony of her own home. ECF 36-2 at 10, 21, 82. She has also had quadriplegia for nearly 40 years. *Id.* at 27. In 2012 she received a tracheostomy and began using a ventilator at night. *Id.* at 10.

During her decades of living at home, Karen used Medicaid-funded services from home-health providers to assist in nearly all of her activities of daily living,

[1] Short form citation are as follows: The district court docket: "ECF __," utilizing the ECF-generated page numbers; Brief of Defendants-Appellants: "State Br. at __"; State's short appendix: "SA at __"; State's separate appendix (Doc. 19): "State App. at __"; Plaintiff-Appellee's appendix: "Vaughn App. at __."

including personal care, providing passive range of motion exercises, transportation, suctioning secretions from her tracheostomy, and placing her on and off the ventilator. *Id.* at 11-13. She also has a water bed at home, which helps alleviate pressure and prevents bed sores. *Id.* at 14.

In January of 2016, Karen was authorized for 20.5 hours a day of in-home nursing care. ECF 116-1 at 7. On occasion her nursing shifts were not staffed, so she relied on friends to help with tasks such as preparing meals and suctioning. ECF 36-2 at 10, 16-17; ECF 116-1 at 8.

That same month, Karen contracted pneumonia and was hospitalized in the intensive care unit. ECF 36-2 at 19; ECF 61-2 at 16. In such an institutional setting such as a hospital or nursing home, Karen was at ongoing risk of skin ulcers, pneumonia, and infections. ECF 47-1 at 2. Although she was medically ready to be discharged within a week and the necessary in-home services were approved, Karen was unable to go home because the nursing care she needed was not in place. ECF 36-2 at 20-21, 23; ECF 47-1 at 6. Karen herself searched for Medicaid-participating nurses. ECF 36-2 at 20. Staff at the hospital contacted home health agencies. ECF 55-2 at 43. Staff at the Indiana Family and Social Services Administration (FSSA) contacted over fifty agencies. ECF 36-1 ¶¶ 12-13. None of these efforts were successful. *Id.*; ECF 55-2 at 43.

On April 12, 2016, Karen sent a letter to FSSA stating that the agency had failed to provide for the home and community-based services identified in her plan of care. ECF 47-1 at 6. She stated that she had been forced to stay in the hospital

against her will because FSSA had not "produce[d] a provider or providers able to meet [her] needs." *Id.* She asked that FSSA keep her plan of care in effect and that it authorize 24-hours of in-home care each day, made up of 22 hours of nursing services and 2 hours of attendant care. *Id.*

In addition, Ms. Vaughn suggested specific accommodations that she thought would help her return home. *Id.* Specifically, she asked to be allowed to "directly hire and train" staff rather than work through a home health agency. *Id.* This approach to service-delivery is often referred to as "self-direction" or "participant-directed services" because a person is typically given a budget to use to meet her needs by directly paying for care staff and other services. *See* 42 C.F.R. § 441.505. Direct hiring of staff under self-direction often helps avoid agency overhead costs. Ms. Vaughn also requested that the State provide support for self-directing her services, including payroll for directly hired staff and the ability to hire a dedicated case manager. ECF 47-1 at 6. Finally, Karen requested that she be able to hire "qualified staff for the level of service I believe most appropriate to my needs." *Id.*

Dr. Chad Trambaugh, one of Karen's doctors, and Karen Stricker, the hospital's social worker, submitted a letter in support of Karen's requests. ECF 55-2 at 43. They explained that Karen "absolutely does not need to be placed in a skilled nursing facility" and that "any lay person could be taught to safely provide her care," including placing Karen on and off the ventilator. *Id.*

Karen never received a written response to her April 12, 2016 request. ECF

36-2 at 45; ECF 47-1 ¶ 8; Vaughn App. at 7-8. Instead, more than two months later, staff from FSSA met with Ms. Vaughn, her doctors, hospital staff, and her legal counsel to discuss her plan of care. ECF 36-1 ¶ 14. FSSA did not grant any of Karen's requested accommodations. *See* ECF 47-1 ¶ 8. Rather, FSSA staff continued to contact the same list of home health agencies without success. ECF 36-1 ¶¶ 12-13, 15-16; ECF 47-1 at ¶ 6.

In mid-November 2016, Karen was discharged from the hospital and sent to a nursing home. ECF 47-1 ¶4. On November 30, 2016, Karen filed a complaint in district court, bringing claims based on the Americans with Disabilities Act (ADA), § 504 of the Rehabilitation Act, and the reasonable promptness provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(8). ECF 1. She alleged that her unnecessary institutionalization was due to failures of the State, including its failure to timely provide for community services in the most integrated setting appropriate to her needs. *Id.* at 1.

Karen remained institutionalized while this case was pending. ECF 93-1. In February 2017, she was readmitted to the hospital for treatment of a decubitus ulcer that required surgery. ECF 36-2 at 23-24. After she recovered, she was again medically-ready to return home as confirmed by her treating physician, Dr. Trambaugh. *Id.* at 25; ECF 61-2 at 42. Her doctor explained that none of her conditions, including autonomic hyperreflexia, required her to remain in an institution. ECF 61-2 at 31. Dr. Trambaugh also testified that long-term placement in a facility, such as a skilled nursing facility or hospital, is not the best medical

option for Karen; that she would be at continuous risk of nosocomial infections if she resided in such a facility, which would compromise her respiratory function and pose a risk to her life; and that Karen is better off living at home, given sufficient qualified aide staff. *Id.* at 44-45; *see also* ECF 47-2 ¶¶ 5-7.

During this time, despite Karen's April 2016 request to keep her plan of care in place, FSSA had suspended the plan of care "due to the hospitalization and nursing facility stay." ECF 36-1 ¶ 17. The suspension of services meant that she no longer had a case manager to help coordinate her care. *Id.* In the spring of 2017, Karen was connected to one of the State's Area Agencies on Aging, CICOA Aging and In-Home Solutions ("CICOA"), to help prepare a new plan of care and coordinate services under the Money Follows the Person ("MFP") program. *Id.* MFP is a funding source targeted to help transition people who have been institutionalized to the community. *Id.* CICOA prepared a new plan of care, which contained restrictions requiring Ms. Vaughn to use exclusively agency-based nursing services; FSSA approved the plan of care in Spring 2017. *Id.*

Once again, the State failed to provide for the services identified in the approved plan of care. *Id.* Karen remained in the hospital until December 2017, when she was transferred to a nursing facility in Centerville, Indiana, an hour's drive from her home and friends in Indianapolis. ECF 47-1 ¶¶ 1, 10. Throughout this litigation, Karen made clear that she is "open to anything that would get [her] back home." Vaughn App. at 14. As Karen puts it, "you don't live in a facility. You exist." ECF 36-2 at 30. She continued to exist at the Centerville nursing facility for

the remainder of the proceedings below, until the State, under threat of contempt, finally complied with the district court injunction entered on February 6, 2019. *See* ECF 136-1 at 1. Since that time, Karen has been living and receiving services at home. *See* State Br. at 18.

Background on the Federal Medicaid Program

Medicaid is a joint federal-state program, providing medical assistance to certain low-income individuals. 42 U.S.C. §§ 1396-1396w-5. "A state's participation in the Medicaid program is completely voluntary. However, once a state elects to participate, it must abide by all federal requirements and standards as set forth in the Act." *Collins v. Hamilton*, 349 F.3d 371, 374 (7th Cir. 2003).

Participating states receive matching federal funding for Medicaid services. 42 U.S.C. § 1396b. To receive federal funding, each state must submit a State plan and receive approval of that plan from the Secretary of Health and Human Services (HHS). *Id*. § 1396-1. In addition, matching federal funding is available for "payments made . . . [f]or services provided within the scope of the Federal Medicaid program and made under a court order." 42 C.F.R. § 431.250(b)(2).

States also have the option to implement home and community-based waiver programs. *See* 42 U.S.C.§§ 1396n(c)-(e). "The word 'waiver' is used because the default assumption under Medicaid is that these kinds of services will be delivered in institutions," but Congress created these options to "waive" the institutional requirement. *Steimel v. Wernert*, 823 F.3d 902, 906 (7th Cir. 2016). States submit detailed applications for each waiver program to HHS. *Id.* at 907.

The Medicaid Act requires participating states to furnish medical assistance with "reasonable promptness to all eligible individuals." 42 U.S.C. § 1396a(a)(8). Medical assistance must be provided "without any delay caused by the agency's administrative procedures." 42 C.F.R. § 435.930.

Indiana's Medicaid-Funded Home Health Services

FSSA provides Medicaid-funded home health care services in both the state Medicaid plan and waivers. Through the state plan, Indiana provides up to 16 hours of skilled nursing services for individuals who require 24-hour monitoring. ECF 36-3 at 144. These services must be authorized by the state Medicaid agency prior to receipt and are sometimes referred to as "prior authorization" services. *Id.*

FSSA also operates a waiver called the "Aged and Disabled" waiver (the "A&D Waiver"). *See Steimel*, 823 F.3d at 907-08 (describing the waiver). The waiver is administered by the Division of Aging, a subdivision of FSSA. ECF 36-1 ¶¶ 1, 5. A&D waiver services include "attendant care services," which involve hands-on assistance with daily activities like bathing, oral hygiene, meal preparation, and assistance with household tasks. ECF 36-4 at 48-49. The A&D Waiver generally does not provide nursing services. *Id.* at 77-78 (including nursing only as respite care); *see also* State Br. at 5. "Waiver participants may also use services provided through the state's traditional Medicaid plan," including prior authorization services. *Steimel*, 823 F.3d at 907.

FSSA also operates another federally-funded program, the MFP program. ECF 36-1 ¶ 17; *see also* SA at 5 n.2. The program includes targeted case

management and other supports to help transition those who have been in an institution for at least 90 days to community settings. ECF 36-1 ¶ 17.

The State's CHOICE Program

FSSA's Division of Aging also administers the Community and Home Options to Institutional Care for the Elderly and Disabled ("CHOICE") program. Ind. Code § 12-10-10-6. Under the CHOICE program, the Division of Aging "*shall* administer the program and *shall* . . . [h]ave self-directed care options and services available for an eligible individual who chooses self-directed care services." *Id.* § 12-10-10-6(9) (emphasis added). CHOICE also authorizes, "[o]ther services necessary to prevent institutionalization of eligible individuals when feasible." *Id.* § 12-10-10-2(8). The Division of Aging is required to contract with Area Agencies on Aging, such as CICOA, to administer CHOICE funds and develop "policies and procedures for coordinating CHOICE with the Medicaid waivers and other funding sources for in-home and community-based services." 45 I.A.C. 1-5-3(a).The Division of Aging is also required to "[a]pprove the selection of community and home care services providers based upon criteria developed by the division." Ind. Code § 12-10-10-6(4).

The Summary Judgment Proceedings

Karen filed her complaint on November 30, 2016. ECF 1. She asked the district court to "permanently enjoin Defendants from further violating her rights under the ADA, Section 504 and the Medicaid Act [42 U.S.C. § 1396a(a)(8)]." *Id.* at 15. She sought an order requiring FSSA to "provide Vaughn with treatment services that are consistent with the professional judgment of her treating

professionals" and to "identify and adequately fund an appropriate community provider . . . and to provide her with community-supportive living services." *Id.* She also requested that she be permitted to self-direct her home health care. *Id.* at 16.

The parties filed cross-motions for summary judgment. Citing only its own Medicaid Manual, the State argued that allowing non-nurses to provide services to Karen would fundamentally alter the Medicaid program. ECF 37 at 12-13; ECF 55 at 12. The State presented no other argument or evidence to support a fundamental alteration defense, including no information regarding costs or the needs of other individuals with disabilities. *See* ECF 27 at 12-13; ECF 55 at 13-17.

On June 1, 2018, the district court granted summary judgment in favor of Karen on all claims. The court explained that the central question for her ADA and Rehabilitation Act claims is whether Karen's "placement [at home] can reasonably be accommodated, taking into account the resources available to the State and the needs of others with physical disabilities." SA at 19. The district court rejected the State's narrow reading of Karen's reasonable accommodation requests, noting that "she seeks whatever reasonable accommodation is necessary in order to provide her with care in a community-based setting," and emphasizing that the State could "explor[e] or implement[] other accommodations." *Id.* at 20.

The district court also rejected the State's fundamental alteration defense, noting the lack of evidence and argument to support it. First the court noted that "Defendants do not contend that resource constraints render unreasonable any accommodation that Ms. Vaughn seeks." *Id.* The district court underscored the lack

of any evidence or argument about how any of Karen's requests "would negatively impact the provision of care to other individuals with physical disabilities." *Id.*

Finally, the district court rejected the argument that altering the requirement to utilize non-nurses would fundamentally alter the Medicaid program. As the district court explained, the "sole identifiable source" of that requirement in the summary judgment record was the State's own Medicaid Manual. *Id.* at 21-22. Citing *Steimel*, the district court concluded that the need to modify a state's own policies does not establish a fundamental alteration. *Id.* at 22.

The district court also concluded that the State violated the Medicaid Act. The court observed that all parties "agree that Ms. Vaughn has experienced a delay in the provision of services." *Id.* at 29. And the district court concluded that, as with the ADA and 504 claims, the State's administrative choices had prevented Karen from receiving "medical assistance with reasonable promptness." *Id.* (quoting 42 U.S.C. § 1396a(a)(8)).

The district court ordered the parties to confer on a plan of care without the restrictions the State had imposed in the earlier plans. *Id.* at 32. The court directed the parties to meet with a Magistrate Judge to discuss options "in addition to her requested reasonable accommodations," including "other avenues, such as the 'MFP' program." *Id.* at 33. The district court instructed the parties to "entertain and discuss all feasible options." *Id.* The district court found that "time is of the essence in this matter" because "continued institutionalization . . . poses continuing and real threats to [Karen's] health or her life. . . . [T]he goal for all parties should

be to get Ms. Vaughn to a home-based setting as expediently as possible." *Id.*

The Remedy Proceedings

The parties were unable to reach agreement. The State continued the same actions it had previously—calling the same list of Medicaid participating home health agencies looking for agency-based nursing. ECF 95-1 ¶¶ 17-20; *see also* State Br. at 12-13.

The parties proceeded to a remedy hearing. In her briefing and testimony, Ms. Vaughn identified numerous pathways for providing her care at home, including the self-direction and nursing delegation she had previously requested, as well as the use of the MFP and CHOICE programs. ECF 117 at 7-11. She presented a plan of care, which she had developed with her care manager at CICOA, to provide 24 hours of services each day and permit her to use self-direction and nurse delegation. ECF 93-1 at 17-18. The plan of care also included a daily summary of Karen's needs. *Id.* at 19. The plan of care and daily summary were approved by her CICOA care manager and the physician at the Centerville nursing facility. *Id.* at 93-1 at 10. Though she provided these specific suggestions, Karen confirmed that she would be "open to anything that would get [her] back home." Vaughn App. at 14.

At the remedy hearing the State took the position that cost was not an issue, declaring that that "it is the state's position that the money remains there," once providers are located. *Id.* at 44; *see also* SA at 26 ("Defendants clearly indicated at the hearing in this matter that resource allocation is not an issue in this case.").

The testimony at the remedy hearing revealed, however, that contrary to the district court's order, the State had not explored "all feasible options," SA at 33, for getting Karen home. No one considered whether the CHOICE program could be used to provide Karen services at home. *See* Vaughn App. at 17-27, 37-38. Nor had the State considered how to utilize the MFP program in combination with state plan or waiver services. *Id.* at 36-38. The State had not undertaken any efforts to modify the A&D waiver. *Id.* at 41-42. In short, the State had failed to coordinate among its various programs at all. *Id.* at 32 ("Q: . . . have you ever sat down to say how can we solve this problem and get this person home? A: No."). Amy Rapp, the care management director at the FSSA's Division on Aging, testified that even the efforts to call home health agencies had "stopped about a year ago." *Id.* at 35.

The district court found, based on this testimony, that the State had established a "bureaucratic quagmire," and its efforts to coordinate internally had been "paltry." SA at 42-43; *id.* at 47. The court rejected the State's characterization of its efforts as "exhaustive," *id.* at 48, and highlighted that when the State "received no affirmative responses" from home health agencies, it should have recognized "that further action by them was necessary to secure the integrated care to which Ms. Vaughn is entitled." *Id.* at 44. The court found, instead, that "Defendants were content to stop trying." *Id.* The court emphasized that the State was well-aware that its program could not meet the needs of "patients who are dependent on ventilators" and to accept the State's position about the appropriate scope of relief would give it "*carte blanche* to design and implement waiver

programs that eviscerate the integration mandate for individuals with certain types of disabilities." *Id.* at 48-49 (citing *Steimel*, 823 F.3d at 917-18). The district court stressed that, while the State argued that Ms. Vaughn's various proposed injunctions were vague, it had "not offered any alternative formulation." *Id.* at 50.

The district court entered a permanent injunction requiring the State to ensure Ms. Vaughn receives care in the most integrated setting and receives the State-approved medically necessary services with reasonable promptness. The court ordered the State to "arrange for Ms. Vaughn, within 21 days, the provision of the home health and attendant care services represented on" the daily summary that had been approved by her case manager. *Id.* at 54-55.

The State's Actions Following the Injunction

Following the injunction, the State took the very same steps it had taken in the past: calling Medicaid-participating home health agencies to seek agency-based nurses to staff Karen's plan of care. *See* ECF 126 ¶¶ 6-11; *see also* State Br. at 16. The State did not attempt to utilize the CHOICE or any other program. It did not explore self-directed care options. It did not investigate alternative payment structures or heightened rates. In short, the State did not go outside the lines it had drawn for itself.

The State filed a status report on January 30, 2019—after the Court's 21-day deadline—reporting that Karen remained institutionalized. ECF 126. On February 1, 2019, following a telephonic status conference, the district court entered an order stating that "Defendants are not in compliance with the

permanent injunction" and noting that it was "now two days past the 21-day mark, and Ms. Vaughn remains institutionalized." ECF 131 at 1. The district court "found Ms. Vaughn's health, and indeed her life is at risk in her continued placement." *Id.* at 2. The district court emphasized the thrust of its injunction was to "get Ms. Vaughn home, and do it now." *Id.*

The district court observed that any present time-crunch was of Defendants' making and that "they could and should have . . . undertaken," efforts earlier. *Id.* at 2. In fact "[s]even months transpired between the Court's Order on Summary Judgment and its Order granting a permanent injunction, and every action listed by Defendants in their status report could have been initiated immediately after," the summary judgment decision. *Id.* The court then set a new deadline of February 8, 2019, and directed that if the deadline was not met, the defendants would be ordered to show cause why they should not be held in contempt. *Id.* at 4.

Only then did the State take steps that finally allowed Karen to go home: the State entered into a contract with a home health agency, TenderCare, to provide 24-hours a day of nursing services. ECF 136-1 at 1, 4-5. On appeal, the State argues that this modification of its own choosing was unreasonable and that the State should not be required to actually ensure that Karen can receive services at home, in the most integrated setting. The State asks this Court to reverse the district court's decision, and, ultimately, send Karen back to an institution because the programs they have designed cannot serve her at home.

SUMMARY OF ARGUMENT

The district court properly granted summary judgment to Karen Vaughn to end the unnecessary and harmful institutionalization that segregated her from her community in violation of the ADA and Section 504 of the Rehabilitation Act. The State repeatedly failed to meet its affirmative obligation to provide Ms. Vaughn with community-based services that were appropriate for her, that she and her providers requested, and that would not cause a fundamental alteration to the State's programs.

Although cost was not an issue, the State refused to make any modifications whatsoever to address Karen's plight, leaving her stuck in a hospital and unable to go home. The State argues it should not have to make any modification because, on paper, it had approved the in-home services Karen requested. But this is not enough. Programs, which "in practice" result in institutionalization violate the integration mandate. *Steimel,* 823 F.3d at 918. The State was required to make modifications to ensure Karen received services in the least restrictive setting, unless providing those services would fundamentally alter its programs.

The State has not met its burden. The State raises the specter of safety concerns regarding nurse delegation in particular, but those concerns are not supported by competent evidence and ignore the undisputed testimony of Karen's treating physician. The district court properly found that the State's intransigence and failure to navigate its self-created bureaucratic quagmire necessitated a permanent injunction requiring the State to "arrange for Ms. Vaughn, within 21

days, the provision of home health and attendant care services," that she needed.

The district court properly concluded that the State violated the Medicaid reasonable promptness provision. The State does not dispute that Ms. Vaughn experienced a three-year delay in receiving in-home services. Instead, the State improperly attempts to shift focus to whether the State's *actions* were reasonable. The proper question for this Court, however, is whether the *services* were delivered reasonably promptly. Because the answer is clearly no, summary judgment was appropriate.

Finally, the district court carefully tailored its injunction and struck a careful balance between giving the State discretion over its programs while offering guidance on specific steps it could take. The problems the State complains of on appeal are consequences of the State's own choices not the text of the injunction. This Court should affirm.

ARGUMENT

I. Summary Judgment Was Appropriate.

The Court reviews the grant of summary judgment de novo, viewing evidence in the light most favorable to the State. *Steimel*, 823 F.3d at 910. Summary judgment was appropriate on the ADA, Section 504, and Medicaid Act claims because undisputed evidence demonstrates that the State failed for years to provide for Ms. Vaughn's needed in-home services, resulting in her unnecessary and harmful institutionalization. Even now, she only receives in-home nursing services because of the district court's orders.

A. The District Court Properly Found that Karen's Unnecessary Institutionalization Violated the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

The ADA's integration mandate prohibits discrimination in the form of unjustified segregation of persons with disabilities.[2] *Steimel*, 823 F.3d at 910 (citing *Olmstead v. L.C. ex rel. Zimring,* 527 U.S. 581, 597-603 (1999)). The *Olmstead* Court identified "two evident judgments" in the integration mandate: institutional placement of those who can be in the community perpetuates unwarranted assumptions about worthiness and capability to participate in community life, and institutional placement "severely diminishes the everyday life activities of individuals, including family relations, social contacts . . . and cultural enrichment." *Olmstead,* 527 U.S. at 600-01; *see also* Br. of the United States as Amicus Curiae Supporting Plaintiffs, *Disability Rights New Jersey, Inc. v. Velez*, No. 05-4723 (D. N.J. Sept. 24, 2010), 10-20 https://www.ada.gov/olmstead/documents/drnj_amicusbrief.pdf (discussing legislative history and purpose of the ADA and integration mandate).

The Court in *Olmstead* set forth the test for determining whether the ADA's integration mandate is violated. States must provide community-based treatment for persons with disabilities when (1) the State's treatment professionals determine that such placement is appropriate; (2) the affected persons do not oppose community-based services; and (3) the placement can be reasonably accommodated,

[2] Title II of the ADA and Section 504 of the Rehabilitation Act are typically read together. *Steimel*, 823 F.3d at 909. That is what this brief does.

taking into account the resources available to the State and the needs of others with disabilities. *Olmstead*, 527 U.S. at 607. This Court in *Steimel* interpreted the third part of the test to be a holistic evaluation that calls for a sensitive balance between the interests of the state and those of people with disabilities. 823 F.3d at 915.

The first two parts of the *Olmstead* test are not disputed in this case. Instead, the State focuses on the reasonable accommodation prong and, more specifically, on two of Karen's suggestions for possible accommodations—nurse delegation and self-directed care. In doing so, the State portrays Karen's requests too narrowly and ignores its obligation under the ADA. Ms. Vaughn is not required to make all possible suggestions for how to provide her community services until she hits on one the State finds reasonable. That was the State's responsibility. Moreover, the limited arguments the State does make regarding nurse delegation and self-directed care are insufficient to support a fundamental alteration defense.

1. Karen's Request to Receive Services in the Community was a Reasonable Assertion of her Civil Rights.

Karen Vaughn requested to return home with roughly the same nursing services the State had authorized before she went into the hospital. ECF 116-1 at 11; ECF 47-1 at 6. Contrary to the State's position that she sought only two specific modifications—nursing delegation and self-directed care—she repeatedly requested that the State modify FSSA policies, practices, and procedures to provide her with community-based services. ECF-1 at 12; ECF 47-1 at 6; ECF 48 at 22.[3] Ms. Vaughn

[3] The district court rejected the State's narrow characterization, explaining that Karen "seeks whatever reasonable accommodation is necessary in order to provide her with care in a community-based setting." SA at 20.

emphasized that she was "open to anything that would get me back home." Vaughn App. at 14.

Ms. Vaughn's request to return home with community-based services is the extent of her burden. Following that request, it was the *State's* burden to establish that the community based services were an unreasonable modification of its programs. *Steimel,* 823 F.3d at 916; *Townsend v. Quasim*, 328 F.3d 511, 517 (9th Cir. 2003) (holding plaintiff can prove state violated Title II of the ADA, unless state can demonstrate that provision of community-based services would be a fundamental alteration). These arguments are waived because the State failed to develop them below. *Coleman v. Hardy,* 690 F.3d 811, 818-19 (7th Cir. 2011).

It is true that, Karen identified two doctor-approved specific modifications: (1) self-directed care and (2) delegating suctioning and ventilator monitoring to trained non-nurses. These suggestions were reasonable accommodations based on Ms. Vaughn's own experience and knowledge of various in-home services and programs. *See, e.g.*, ECF 471- ¶¶ 3-9; 93-1 at 1-5. The State's emphasis on these two suggestions, however, is a red herring. In fact, those were just two options Ms. Vaughn suggested. She also sought to use existing state programs, such as MFP, to coordinate her care and to use other State programs, like CHOICE, so that she could leave the institution. *See* ECF 117 at 7-11; ECF 93-1. By offering various specific suggestions on how she could return home, Ms. Vaughn was doing the creative thinking about *how* the State could modify its programs; thinking that the State should have been doing.

"It is enough for the plaintiff to suggest the existence of a plausible accommodation, the costs of which, facially do not exceed its benefits." *Henrietta D. v. Bloomberg,* 331 F.3d 261, 280 (2d Cir. 2003); *see also Guggenberger v. Minnesota*, 198 F.Supp.3d 973, 1030 (D. Minn. 2016) (finding plausible allegation of reasonableness of accommodation was sufficient). Contrary to the State's implication, it was not up to Ms. Vaughn to enumerate possible ways for the State to adjust its own policies and practices until she identified one the State thought was reasonable. *See Henrietta D.,* 331 F.3d at 280; *U.S. v. Mississippi*, 400 F.Supp.3d 546 (S.D. Miss. 2019) (*Olmstead* plaintiffs were not responsible for proving the reasonableness of a modification, only that it was plausible; the risk of nonpersuasion falls on the defendant).

2. The District Court Correctly Found that the State's Programs in Practice Caused Karen's Unnecessary Institutionalization

On paper, the State's various programs—MFP, CHOICE, A&D Waiver, and state plan services—should have met Ms. Vaughn's needs. But programs on paper are insufficient. *Steimel,* 823 F.3d at 918 (finding that programs that in practice segregate people with disabilities from the community violate the integration mandate). The State's ADA obligations are affirmative ones and when it fails in meeting these obligations, the "cause of that failure is irrelevant." *Bennett-Nelson v. Louisiana Bd. of Regents*, 431 F.3d 448, 454–55 (5th Cir. 2005); *see also Hampe v. Hamos*, 917 F.Supp.2d 805, 818 (ND. Ill. 2013). The State did not meet its

affirmative ADA obligations in this case because its "programs in practice" resulted in Karen's unnecessary institutionalization. *Steimel,* 823 F.3d at 918.

The district court's summary judgment opinion noted several ways in which the State failed to make reasonable accommodations for Karen—all of which the State ignores in its opening brief. To begin with, the district court highlighted Karen's undisputed testimony that she never received a written response to her reasonable accommodation request. *See* SA at 7-8 (citing ECF 36-2 at 45). The record also shows that the State did not continue her plan of care when she was hospitalized, and for a period of time, she did not have a case manager to help coordinate services. ECF 36-1 ¶ 17. These failures contributed to her lengthy institutionalization and are precisely the type of "indifference" and "benign neglect" Congress intended to address in the ADA. *Alexander v. Choate*, 469 U.S. 287, 295 (1985). *See also* Ltr. from Timothy M. Westmoreland, Dir. Ctr. for Medicaid & State Operations Health Care Financing Admin. & Thomas Perez, Dir. Office for Civil Rights to State Medicaid Dirs. (Jan. 14, 2000) ("Olmstead Ltr. 2"), https://www.nasddds.org/uploads/documents/Olmstead_letter_2.pdf ("States must also be responsive to institutionalized individuals who request that their situation be reviewed to determine if a community setting is appropriate").

Second, the district court emphasized the undisputed fact that the State refused to modify its Medicaid program, including the A&D waiver, in *any way* to enable Karen to receive home-based services. *See* SA at 7. The district court observed that the State had not explored using, or modifying, other Medicaid

programs, such as the MFP program. *See id.* at 5, 19-20. Yet, as this Court has noted the State itself "designs, applies for . . . and executes its waiver programs," and can make such modifications. *Steimel*, 823 F.3d at 918; *id.* at 916 ("If the state's own criteria could prevent the enforcement of the integration mandate, the mandate would be meaningless.").

Third, it is undisputed that the State refused to go *outside* the bounds of its current Medicaid program. As the district court explained, the State "failed to modify FSSA policies, practices, and procedures to provide [Ms.] Vaughn with community-based services." SA at 20. No one ever offered to utilize the CHOICE program, although it is also run by FSSA and interacts with the Medicaid program.[4] The district court, thus, properly concluded that the State operated only "[w]ithin the bounds of the current Medicaid programs, as administered by FSSA." SA at 9. As the district court explained in greater detail during the remedy phase, "[i]t appears that Ms. Vaughn would be eligible for [CHOICE], if anyone had considered her as having applied for it." SA at 45. Thus, as the district court concluded, the failure to utilize the CHOICE program was further evidence of the State's ongoing failure to meet its obligations under the ADA. *Id.* at 47.

Finally, the State makes much of its calls to home health agencies seeking to locate nurses, State Br. at 8-12, 16, 18, 20, 30-31, 33. But whether the State made

[4] The State argued during the remedy phase that the CHOICE cannot be combined with Medicaid services. The State's assertion is wrong. As the district court pointed out, state statute expressly contemplates coordination. SA at 11-12. Notably, the State failed to address the CHOICE program at all in its opening brief, and any arguments about that program have been waived. *E.g., Carroll v. Lynch*, 698 F.3d 561, 564 n. 2 (7th Cir. 2012).

some reasonable efforts or had good intentions is not the appropriate standard. *See Frederick L. v. Dep't of Pub. Welfare of Pa.*, 422 F.3d 151, 158–59 (3rd Cir. 2005) ("General assurances and good-faith intentions . . . are simply insufficient guarantors in light of the hardship daily inflicted upon patients through unnecessary and indefinite institutionalization."); *Fisher v. Oklahoma Health Care Auth.*, 335 F.3d 1175, 1182 (10th Cir. 2003) (that the state's "actions were merely 'reasonable' does not constitute a defense.").

Moreover, the fact the State repeatedly called agencies but could not find nurses put the State on notice that its in-home nursing services were not actually available to those whom it had found needed them.[5] Indeed, both below and here, the State's briefing appears to acknowledge that its Medicaid home health program cannot serve individuals, such as Ms. Vaughn, who rely on ventilators. *See* ECF 55 at 12; State Br. at 13 (noting that "[m]ost providers cited their lack of 'vent trained' and skilled nursing staff" as the reason for not taking Ms. Vaughn's case). In order words, by its own acknowledgment, the State's program tends to impermissibly "screen out" trach- and vent-dependent individuals and prevent them from "fully

[5] On appeal, the State for the first time claims that nurses were deterred by Karen's intermittent hospitalizations. *See* State Br. at 9. First, this is a new argument and has been waived. *Coleman*, 690 F.3d at 818. Second, while the State cites record evidence describing Karen's hospitalizations, it cites nothing to support the assertion that those hospitalizations impacted the availability of nurses. Finally, federal guidance suggests that this is precisely the kind of problem states can resolve through reasonable modifications, such continuing payment for home care providers during hospitalizations. *See* Ltr. from Timothy M. Westmoreland, Dir. Ctr. for Medicaid & State Operations Health Care Financing Admin. to State Medicaid Dirs., Attachment 3-2 (July 25, 2000) ("Olmstead Ltr. 3"), https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd072500b.pdf).

and equally enjoying" the State's community-based programs. *See* 28 C.F.R. § 35.130(b)(8).

In sum, the State was fully aware that its "programs in practice," resulted in unnecessary institutionalization for Karen—and likely for other ventilator-dependent individuals. *Steimel*, 823 F.3d at 918. But the State did nothing to ensure that its programs actually provided the community-based care it agreed was needed. The district court was on solid ground concluding that simply calling home health agencies, without modifying its programs or policies, was insufficient under the ADA.

3. The State Failed to Establish a Fundamental Alteration Defense.

It was the State's burden to accommodate Karen by providing for nursing services at home, rather than in a hospital or nursing facility, unless that change "would fundamentally alter their programs." *Steimel*, 823 F.3d at 916; *see also Townsend*, 328 F.3d at 517; 28 C.F.R. § 35.130(b)(7); *Brown v. D.C.*, 928 F.3d 1070, 1078 (D.C. Cir. 2019) (collecting cases). To assess whether an accommodation will work a fundamental alteration, the State must answer the question: "[W]hat effect will changing the state's practices have on the provision of care to the [disability population], taking into account the resources available to the state and the need to avoid discrimination?" *Steimel*, 823 F.3d at 915 (*citing Olmstead,* 527 U.S. at 603).

Here "the state has produced no evidence that anything approaching a fundamental change would occur if," Karen receives nursing services in the community, rather than in a hospital. *Steimel*, 823 F.3d at 915. *See* SA at 19-20. In

the absence of any evidence, this is "not a close case." *Steimel,* 823 F.3d at 915. To begin with, the State does not raise the existence of a functioning *Olmstead* plan as a defense. Thus, "it must make every modification to its policies and procedures requested by an institutionalized disabled individual who wishes to, and could, be cared for in the community" unless the modification would limit the State's ability to provide services for other people with disabilities. *Brown,* 928 F.3d at 1078 (citing *Olmstead*, 527 U.S. at 604); *see also Frederick L.,* 422 F.3d at 157; U.S. Dep't of Justice, Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.* at q. 13 [hereinafter DOJ Q&A], https://www.ada.gov/olmstead/q&a_olmstead.htm#_ftnref14.

The State did not meet its burden here. Rather than address the central issue of how providing Ms. Vaughn's nursing services at home would impact its programs, the State focuses myopically on two of the ideas she proposed: nurse delegation and self-directed care. State Br. at 22-30. As shown below, the arguments the State has made do not satisfy its burden, and the district court correctly rejected them.

a. The State's Obligations Extend Beyond its Medicaid Program.

A state's *Olmstead* obligations do not begin and end at the Medicaid program. While Medicaid may be a resource-conscious solution to providing necessary medical services, "[a] state's duties under the ADA are wholly distinct from its obligations under the Medicaid Act." *Davis v. Shah,* 821 F.3d 231, 264 (2d Cir. 2016). *See also* DOJ Q&A at q.7 ("A state's obligations under the ADA are

independent from the requirements of the Medicaid program," and states may be required to provide "services beyond what a state currently provides under Medicaid."); Ltr. from Timothy M. Westmoreland, Dir. Ctr. for Medicaid & State Operations Health Care Financing Admin. to State Medicaid Dirs. (Jan. 10, 2001) ("Olmstead Ltr. 4"), https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd011001a.pdf.

Here, there were various options open to the State for accommodating Ms. Vaughn's request. The state-based CHOICE program could be used without modification to provide Karen services in the community. *See* SA at 44. The CHOICE program covers a wide array of services, including home health services and "other services necessary to prevent institutionalization of eligible individuals when feasible." Ind. Code § 12-10-10-2. The CHOICE program also allows the State to negotiate the reimbursement rates for CHOICE services. *Id.* § 12-10-10-12.

It is not an alteration at all, let alone a fundamental one, for the State to use its existing programs for their specified purpose, even if those programs are outside the Medicaid program. *See Marlo M. ex rel. Parris v. Cansler*, 679 F.Supp.2d 635 (E.D.N.C. 2010) (finding *Olmstead* violation when state funds that supplemented Medicaid services were cut); *Knowles v. Horn*, No. CIV.A. 3:08-CV-1492, 2010 WL 517591, at *4 (N.D. Tex. Feb. 10, 2010) (finding ADA violation when state denied state funded program to supplement Medicaid services for individual with complex nursing needs). Notably, the State's Brief fails to contend with this aspect of the district court's decision or even mention the CHOICE program at all (thereby

waiving any argument, *see Carroll,* 698 F.3d at 564 n. 2. The District Court was correct to find that Ms. Vaughn's claim under the ADA applied to all of the state's existing health care programs. SA at 50-51, n. 5.

b. Meeting ADA Obligations Can Have a Cost, But the State Said Cost is Not an Issue.

ADA compliance may demand from states "substantial short-term burdens, both financial and administrative to achieve the goal of community integration." *U.S. v. Mississippi*, 400 F.Supp.3d at 477 (citations omitted). As this Court noted in *Steimel*, "if every alteration in a program or service that required the outlay of funds were tantamount to a fundamental alteration, the ADA's integration mandate would be hollow indeed." 823 F.3d at 915 (*quoting Fisher,* 335 F.3d at 1183); *Radaszewski v. Maram*, 383 F.3d 599, 613-14 (7th Cir. 2004) (reversing dismissal of plaintiff's ADA claim, noting that, even though the state may have to "substantially increase" the level of expenditures to cover the cost of plaintiff's 24–hour in-home care (by three to four times the approved amount), that alone would not defeat the ADA claim because, to rule otherwise would make the ADA "hollow indeed.") (internal quote omitted); *see also Pa. Prot. & Advocacy, Inc. v. Dep't of Pub. Welfare*, 402 F.3d 374, 380 (3d Cir. 2005) (collecting cases); *Townsend,* 328 F.3d at 520 (ADA relief warranted "even if extension of community-based long term care services to the medically needy were to generate greater expenses for the state's Medicaid program."); *Hampe*, 917 F.Supp.2d at 822 ("[A] state cannot avoid correcting an ADA violation simply by replying that compliance would be too costly.") (internal quote omitted). Thus, to establish a fundamental alteration defense based on costs,

the State must show that the requested "modification would be so costly as to require an unreasonable transfer of the State's limited resources away from other disabled individuals." *Brown,* 928 F.3d at 1078 (citing *Olmstead*, 527 U.S. at 604).

In the district court, the State presented no evidence or argument that the cost of providing nursing services for Ms. Vaughn at home would have any impact on the State's ability to provide services to others. In fact, as the district court concluded, the State rejected the contention that "resource constraints render unreasonable any accommodation that Ms. Vaughn seeks." SA at 19. To the contrary, the State acknowledged that Ms. Vaughn had previously been approved for approximately $395,000 per year for in-home services and that there was no reason to believe that similar amounts would be disapproved now. *Id.*; *See also* Vaughn App. at 44.

On appeal, the State now laments the cost of providing Karen's nursing services at home. This passing invocation of "scare resources" is insufficient. State Br. at 39, 43-44. The record does not support the argument, and the State cannot introduce it for the first time on appeal. *Brown v. Auto. Components Holdings, LLC,* 622 F.3d 685, 691 (7th Cir. 2010).

To sum up, the State did not contest cost as an issue before the district court. And while there will be costs associated with ADA compliance, multiple circuit courts, including this one, have held that states may be required to spend money to accomplish community integration in circumstances like this. *See M.R. v. Dreyfus,* 697 F.3d 706, 736 (9th Cir. 2012) (granting preliminary injunction to prevent a rate

reduction in Washington's home and community-based services program); *Doe v. Kidd*, 419 F. App'x 411, 418–19 (4th Cir. 2011) ("it would be quite appropriate and within the equitable powers of the district court to order Defendants to finance a [community-based] placement of Doe's choice"); *Knowles*, 2010 WL 517591, at *4 (noting that if existing Medicaid cost caps are a problem, a state "can apply to the United States Secretary of Health and Human Services to amend the current Cost Cap."); *Nelson v. Milwaukee Cty.*, No. 04-cv-0193, 2006 WL 290510, at *4 (E.D. Wis. Feb. 7, 2006) (plaintiffs' request "to order defendants to increase payments to Family Care providers," to avoid institutionalization stated a claim under the ADA).

c. Modifying the State's Medicaid Program is Not a Fundamental Alteration.

Next, the State asserts, without citation, that "a change to a Medicaid plan that requires federal approval certainly constitutes a fundamental alteration." State Br. at 30; *see also id.* at 4-7, 44-45. Not so. This Court has repeatedly held that a state may have to modify its Medicaid program to comply with the ADA. *See Steimel,* 823 F.3d at 907; *Radaszewski,* 383 F.3d at 614. The State "cannot avoid the integration mandate by painting itself into a corner and then lamenting the view." *Steimel*, 823 F.3d at 918.

Moreover, the fact that CMS has approved a particular waiver design or particular rates does not insulate the State from needing to modify those policies to avoid ADA liability. *See Steimel,* 823 F.3d at 907; *Pashby v. Delia,* 709 F.3d 307 (4th Cir. 2013). The State's arguments on this point mirror those raised in *Steimel*,

where, as here, the State attempted to avoid the ADA claim by arguing that it hands were tied by CMS approval. State Br. at 3, 15, 18-19, 33, 43. *Steimel* rejected that argument because the State "creates the waiver programs," though they are ultimately approved by CMS, and "[i]f the state's own criteria could prevent the enforcement of the integration mandate, the mandate would be meaningless." *Steimel,* 823 F.3d at 916. Thus, even if the State did need to modify its Medicaid state plan, A&D waiver, or other Medicaid-funded services in order to accomplish Ms. Vaughn's community placement—whether by modifying its rates, permitting self-directed care, or something else entirely—the modification does not establish a fundamental alteration defense.

This Court should also reject the State's efforts to characterize Ms. Vaughn's request for community placement as a request for the State to create *new* services. *See* State Br. at 28. As in *Steimel* and other ADA cases, Ms. Vaughn is requesting access to the State's home and community-based services program and to have those services actually available to her. The State already provides in-home nursing services, as well as opportunities for self-direction, through its Medicaid state plan, the A&D waiver, and the CHOICE program. Under *Olmstead*, the State must provide the services it offers in the least restrictive setting. *See Steimel*, 823 F.3d at 914 (comparing cases requiring a new service and state's *Olmstead* obligations). The State, therefore, may be required to modify its programs to make existing services available in the least restrictive setting. *Id.* at 907; *Radaszewski,* 383 F.3d at 614.

Finally, the State complains that it had to modify its Medicaid program by

executing an "entirely unique" contract with TenderCare. State Br. at 18. This does not come close to establishing a fundamental alteration. Single case agreements for individual services are common in Medicaid and often happen when an individual needs a specific service or provider out of state or outside of Medicaid managed care network.[6] *See, e.g.,* Ctrs. for Medicare & Medicaid Servs., *Medicaid Provider Enrollment Compendium* 89 (2018), https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf. Regardless, even if a single case agreement were an alteration to Indiana's normal course of business, this is exactly what a reasonable accommodation is: as a change to existing programs, policies, and procedures to accommodate an individual's needs. 28 C.F.R. § 35.130(b)(7)(i). To allow any change or unique circumstance—including one as small as drafting a contract—to be a fundamental alteration would swallow the obligations of the ADA in its entirety. *Radaszewski,* 383 F.3d at 614.

d. Permitting Karen to Utilize Nurse Delegation Would Not Fundamentally Alter the State's Medicaid Program.

Delegation of skilled-care tasks to non-skilled providers was a possible

[6] Indiana's managed care contracts require single case agreements in certain instances, for instance, to ensure continuity of care. *See, e.g.*, Contract 18225, Amendment #10, between Indiana's FSSA and Anthem 50 (Aug. 23, 2019), http://www.state.in.us/fssa/files/Anthem124060-010.pdf ("The Contractor is permitted to establish single case agreements and shall make commercially reasonable attempts to contract with providers from whom an enrolled member is receiving ongoing care."); Cenpatico Provider Manual: State of Indiana 37 (2015), https://www.cenpatico.com/content/dam/centene/cenpatico/pdfs/0415-CBH-CP-P-JB-IN_ProviderManual_CBH-CP-P-JB_Rev-Oct-2015.pdf (Indiana Medicaid managed care company "arranges Single Case Agreements (SCA) . . . when the network is inadequate for their specific situation").

reasonable modification of the state's policies in Ms. Vaughn's case, according to her treating physician. ECF 48 at 6. Despite the State's protestations, nurse delegation is not a new concept for state Medicaid programs. In fact, it is specifically cited as a mechanism states can use to help meet the *Olmstead* principles in CMS guidance from nearly 20 years ago. *See* Olmstead Ltr. 3 at 14. States are, thus, permitted to receive federal Medicaid funds for skilled services provided pursuant to the authorization of a nurse by personal care or attendant care providers. *Id.* Other states not only allow nurse delegation, but participant-directed nurse delegation.[7]

In fact, since it filed this appeal, Indiana itself has proposed an amendment to its A&D Waiver to allow participant-directed nurse delegation. *See* Ind. Family & Social Servs. Admin., Public Notice Regarding Amendment to the Aged and Disabled Waiver, https://www.in.gov/fssa/files/Public%20Notice%20Regarding%20Amendment%20to%20the%20Aged%20and%20Disabled%20Waiver.pdf; Ind. Family & Social Servs. Admin., Proposed Aged & Disabled Waiver Amendment 127-31 (Dec. 3, 2019), https://www.in.gov/fssa/files/Aged%20and%20disabled%20waiver%20amendment%2012.3.PDF (collectively "Proposed A&D Waiver Amendment).[8] Even as they argue here that it is unreasonable to allow Ms. Vaughn to use nurse

[7] *See, e.g.,* Hawaii QUEST Approval at 68-69, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/hi/hi-quest-expanded-ca.pdf (allowing self-direction of nursing tasks delegated to non-nurse staff); Texas STAR+PLUS (expired), https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8400 (allowing self-direction of nurse-delegated tasks).

[8] The Court may take judicial notice of these documents published by an agency and available to the public. *See Indep. Tr. Corp. v. Stewart Info. Servs. Corp.*, 665 F.3d 930, 943 (7th Cir. 2012) ("A court may take "judicial notice of the indisputable facts that" documents in the public domain "exist [and] they say what they say.").

delegation and self-direction, the State is pursuing a project to provide exactly those options.

At any rate, here, the State argues that delegating skilled tasks to non-nurses is unreasonable because it is unsafe, exposes caregivers to liability, is not allowed under Indiana statutes and regulations, and is against medical standards. State Br. at 22-28. In the district court, however, the State relied solely on its own Medicaid Manual, which lists the restrictions without describing any basis for the restrictions. *See* ECF 37 at 12-13; ECF 55 at 15; *see also* SA 22-23. The district court was correct to conclude on the record before it that it was reasonable to modify this unexplained, agency-created policy. *Steimel*, 823 F.3d at 916. The State has waived its opportunity to present new evidence about the basis for this policy. *Puffer v. Allstate Ins. Co.*, 675 F.3d 709, 718 (7th Cir. 2012).

Even if this Court considers the new evidence cited by the State, it does not establish a fundamental alteration. First, the State claims that Ms. Vaughn's own plan of care from 2015-16 establishes a requirement that her tracheostomy and ventilator care requires skilled nursing. State Br. at 25 (citing ECF 116-1). In fact, the plan of care notes that, when nurses were unavailable for a shift, Ms. Vaughn's care was being performed by "alternate help (friends/family)" whom Karen trained herself. ECF 116-1 at 8; ECF 36-2 at 41-44. The State offers no rationale for why it is now unsafe for her to train individuals to provide the same care.

The State also argues, without citation, that nurse delegation "contravened then-prevailing medical standards." State Br. at 23. This claim is contradicted by

the testimony of Ms. Vaughn's own physician, Dr. Trambaugh, who said "any lay person could be taught how to provide her care," that operation of her nocturnal ventilator does not require a nurse, and that a nurse could regularly assess and advise Ms. Vaughn. ECF 55-2 at 43. Dr. Trambaugh also testified that the hyperreflexia (where the patient experiences overactive responses, such as twitching, and which the State now raises as a major safety concern in its brief) would typically receive no treatment or intervention at home. *Id.* at 26-27. The State failed to rebut any of Dr. Trambaugh's statements with any evidence either at the district court or in the current appeal.

Finally, the State argues that an unskilled provider would be subject to "civil and criminal liability." State Br. at 32. But, again, the State cites nothing specifically directing that ventilator or tracheostomy care can only be performed by someone with a nursing license. More importantly, the State's recitation of regulations and state laws, *see* State Br. at 25-26, ignores the Nurse Practice Act, which expressly permits delegation and which Ms. Vaughn raised below. *See* ECF 99 at 4 (citing Ind. Code § 25-23-1-27.1(b)(6)). Indiana's policies already permit unskilled workers to perform tasks when, as proposed here, they are "delegated or ordered" by a licensed health professional.

There is simply nothing unreasonable about allowing Ms. Vaughn to elect to use nurse delegation, as expressly contemplated by Indiana state law and Indiana's recently proposed A&D waiver amendment. As *Steimel* noted, the fact that the State may need to change its Medicaid manual—or other policies and practices—

simply does not constitute a fundamental alteration to its programs. *Steimel*, 823 F.3d at 915. The State's attempt to distinguish *Steimel* based on safety concerns fails because the State has not substantiated that concern and no record evidence rebutted the testimony of Karen's treating physician or the Nurse Practice Act.

The district court's granting of a permanent injunction on Ms. Vaughn's ADA and Section 504 claims should be affirmed.

B. The State Misconstrues the Reasonable Promptness Requirement of 42 U.S.C. § 1396a(a)(8).

The State does not dispute that Karen was without approved in-home nursing services for over three years. *See* SA at 29. Nor does the State argue that this years-long delay satisfies the Medicaid Act's requirement that states "furnish[] medical assistance with reasonable promptness to all eligible individuals." 42 U.S.C. §1396a(a)(8). Rightly so. Courts routinely find that years-long delays violate this reasonable promptness requirement. *See, e.g., O.B. v. Norwood*, 838 F.3d 837, 840 (7th Cir. 2016) (delay of almost one year in provision of private duty nursing services); *Chisholm ex rel. CC v. Gee*, No. CV 97-3274, 2017 WL 3730514, at *6 (E.D. La. Aug. 30, 2017) (delays of six months to one year for Applied Behavioral Analysis therapy). Summary judgment on the Medicaid claim was appropriate. *See Doe*, 419 F. App'x at 415 (affirming summary judgment for plaintiff because "Defendants' failure to provide . . . residential habilitation services . . . in a reasonably prompt manner constituted a violation of the Medicaid Act."). The Court's inquiry can end here.

As it cannot deny the long delay, the State is claiming that the district court

should be reversed because it tried. Specifically, the State "actively searche[d] for a home-healthcare provider," although it was "unable to find" one. State Br. at 30. This argument, however, mischaracterizes the reasonable promptness provision. Section 1396a(a)(8) requires a court to focus not on whether the State's *actions* were reasonable but on whether the Medicaid enrollee *received* "*medical assistance* with reasonable promptness." 42 U.S.C. §1396a(a)(8) (emphasis added).

The State's miscue stems from its persistent failure to acknowledge that "where the Medicaid Act refers to the provision of services, a participating State is required to provide (or ensure the provision of) services, not merely to pay for them." *O.B.*, 838 F.3d at 843 (internal quote omitted). The district court, following this reasoning, concluded that, although the State emphasized that it was prepared to pay for in-home services, it did not meet its obligation to ensure the actual provision of those services to Karen. SA at 29-30.

Rather than grapple with the statutory text or the district court's reasoning, the State clings to language in *O.B.* that the state must do "*something* rather than nothing." *See* State Br. at 30-31. The State reads far too much into that isolated phrase. First, in that section of the opinion, the Court was addressing the propriety of the *remedy* and whether it was sufficiently specific, not describing the elements of a reasonable promptness claim. *O.B.*, 838 F.3d at 842-43 (injunction was not improperly vague because, while it did not identify specific steps, it insisted that the "state do *something* rather than nothing."). Second, the State's reading would allow states to simply approve and offer to pay because that would be something rather

than nothing, regardless of the outcome. This reading would completely undermine *O.B.*'s holding that "medical assistance" includes providing for services, not just offering to pay for them. *See id.* (rejecting argument that state "gets to choose whether to pay for services or to provide services," because then "if it fails to provide services and no one fills the gap, it won't have to pay either."). Third, the State's narrow reading would run counter to cases establishing that reasonable promptness requires providing *all* necessary services; providing just some services promptly is not enough to avoid does not preclude a violation. *See, e.g.*, *Boulet v. Cellucci,* 107 F.Supp.2d 61, 79 (D. Mass. 2000) ("the fact that they have been receiving other services . . . cannot be sufficient to satisfy § 1396a(a)(8)"). In short, *O.B.* does not stand for the proposition that a state discharges its obligation under (a)(8) by simply doing something, rather than nothing at all. *See also Lewis v. New Mexico Dep't of Health*, 275 F.Supp.2d 1319, 1345 (D.N.M. 2003) (granting summary judgment on plaintiff's reasonable promptness claim despite fact that state had taken "remedial steps to shorten the time between allocation and the provision of services").

Finally, the State's invocation of a nursing shortage does not eliminate its obligation to comply with (a)(8). The State cites to a short passage in *O.B.* discussing the possibility of a nursing shortage. State Br. at 33 (citing *O.B.*, 838 F.3d at 842). However, this Court in *O.B.* rejected the nursing shortage argument as waived. *See O.B.*, 838 F. 3d at 842. The language the State cites is, therefore, dicta. But even in its brief discussion, *O.B.* acknowledged that the State's argument

must implicitly include a claim that "there is nothing the state can do about" the shortage. *O.B.* at 838 F. 3d at 842; *see also id.* (questioning Illinois' representation that it had taken many steps, noting that the State failed to actively recruit nurses, to explain how many nurses were available in the Medicaid program, how many were in the State as a whole, or whether it could recruit nurses from nearby states); *Chisholm*, 2017 WL 3730514, at *7 ("Even if . . . a major contributor to the delays is a dearth of qualified licensed professionals in Louisiana, the Department still must take efforts to mitigate this problem").

The district court here found that there were many things the State could do, notwithstanding the purported nursing shortage, and that the State's refusals to take any of those actions contributed to the delay in providing Karen's in-home services. SA at 31; *see also supra* at I.A.2. The Court, therefore, correctly concluded that, even assuming there was a shortage of nurses accepting Medicaid, merely confirming the problem by repeatedly calling the same list of home health agencies over and over again was insufficient to satisfy the State's obligation when there was substantially more the State could do. SA at 30-31.

In sum, it is undisputed that the State did not ensure physician-prescribed, state-approved services were provided to Karen at home and in a timely way. Therefore, summary judgment on the Medicaid claim was appropriate.

II. The Injunction Is Carefully Balanced and Well Within the District Court's Broad Remedial Authority.

The Court reviews the decision to grant a permanent injunction for abuse of discretion, reviewing factual findings for clear error and legal conclusions de novo.

Lacy v. Cook Cty., Illinois, 897 F.3d 847, 867 (7th Cir. 2018). When a permanent injunction has been issued based on a grant of summary judgment, the Court "must determine whether the plaintiff has shown: "(1) success, as opposed to a likelihood of success, on the merits; (2) irreparable harm; (3) that the benefits of granting the injunction outweigh the injury to the defendant; and, (4) that the public interest will not be harmed by the relief requested." *ADT Sec. Servs., Inc. v. Lisle-Woodridge Fire Prot. Dist.*, 672 F.3d 492, 498 (7th Cir. 2012).

The district court concluded that Karen had easily satisfied the factors. The district court affirmed that "there is no question here as to Ms. Vaughn's degree of success, . . . Defendants have discriminated against Ms. Vaughn, as a ventilator-dependent individual who desires to live and is capable of living in a home-based, integrated setting." SA at 15. Moreover, the district court found that the State had not "identified any hardship that they would suffer if injunctive relief were granted," and reiterated that the State had "assured the Court that there are no issues concerning the availability of funds." *Id.* at 6. Thus, the injunction was necessary in light of the district court's findings that "time is of the essence in this matter," and that "continued institutionalization . . . poses continuing and real threats to Ms. Vaughn's health or her life." SA at 32, 39; *see also* ECF 131 at 1. The State does not address these factors or contest the district court's findings under this standard. *See* State Br. At 33-42; SA at 39-41.

Instead, the State's arguments challenging the injunction repeatedly mischaracterize what the district court actually ordered, claim that the injunction is

simultaneously too prescriptive and too vague, and fault the district court for choices the State itself made to comply with the injunction. In fact, the district court's injunction was carefully tailored to address the violations and struck a careful balance between giving the State discretion over its own programs, while offering specific guidance on steps it could take.

A. The State Mischaracterizes the District Court's Injunction and Complains About its Own Choices.

The State claims throughout its brief that the district court ordered it to raise rates. *See, e.g.*, State Br. at 19 (district court "command[ed] the State in no uncertain terms . . . to raise rates"); *id.* at 34 ("Vaughn insisted that the district court compel the State to raise its rates. Ultimately that is what the district court did.") (internal citations omitted); *id.* at 43. That is not what the district court did. Rather, the text of the injunction states the State must "arrange for Ms. Vaughn, within 21 days, the provision of home health and attendant care services represented on" the daily summary approved by Karen's case manager. SA at 54. There is no mention of rates in the injunction.

The opinion accompanying the injunction likewise did not suggest that the State must raise rates. Rather, it suggested several other options available to the State to address the "bureaucratic quagmire" it had created and comply with the order. SA at 43; *id.* at 47 ("suggesting the State bring together "the officials of different divisions within FSSA . . . to discuss how their various programs . . . could coordinate to solve the problem of providing Ms. Vaughn with care in a non-institutional setting.").

The district court also explained that in its "view . . . the most expedient means of" complying with the order "would be to utilize the CHOICE and/or long-term care programs as supplements to Medicaid and waiver program offerings." SA at 50. The district court noted that the CHOICE program offers "self-directed care options" and emphasized that, although the order included the specific plan of care, "nothing precludes Defendants from instead allowing Ms. Vaughn to craft a mutually acceptable plan of self-directed care."[9] SA at 44, 52.

The State also could have complied with the injunction by permitting Karen to delegate her care to non-nurses. The State cannot dispute that this was feasible, because in December 2019, the State proposed an amendment to the A&D waiver to permit both delegation to non-nurses and self-direction of delegated services. *See* Proposed A&D Waiver Amendment. The State has not explained why it could not have taken this step or a similar proposed solution earlier in response to the district court's summary judgment and remedy decisions. The State's decision to wait to prepare the proposed waiver amendment is not a basis to reverse the district court's decision.

The State had other options as well, including recruiting nurses, *cf. O.B.*, 838 F.3d at 842, and educating the home health agencies on utilizing nurse delegation. *See* ECF 121 at 11. Finally, the State's own brief reveals additional options that it

[9] The CHOICE program could also be used for a broad range of services including a catch-all clause that allows for "[o]ther services necessary to prevent institutionalization of eligible individuals." Ind. Code § 12-10-10-2(8). The State also has the authority to negotiate reimbursement rates for services provided under the CHOICE program. Ind. Code § 12-10-10-12.

did not pursue. For instance, the State notes that some home health agencies "could only provide *some* care and would have to work in collaboration with another provider." State Br. at 16. The State does not explain why it ultimately chose to contract with just one agency, rather than coordinate among multiple agencies that were each willing to provide some care.

The State next complains about statements the district court made during a telephonic conference with counsel. State Br. at 43. To the extent the State is arguing that the questions a judge asks at a status conference can change the text of an injunction, it cites no authority for that proposition. Moreover, the State ignores the district court's statement during the same status conference that "[y]ou can get to where you need to go however you want," and that the State could change its approach over time. App. at 9 ("If you want to catch up to your scheme or whatever plans or changes you make in the long run, that is fine."). *See also* ECF 131 at 2 (the State "has time to sort out the details of her long-term programming after getting her home.").

Ultimately, the State itself chose to execute a contract with a single home health agency, TenderCare, at a heightened rate and to pay for those services out of state funds intended for administrative costs. The State was not required to use entirely state funds. Federal Medicaid regulations explicitly permit federal reimbursement for court-ordered services (in Indiana about 65% of each dollar) without HHS approval. *See* 42 C.F.R. § 431.250(b)(2); *see also Dozier v. Haveman*, No. 14-12455, 2014 WL 5480815, at *13 (E.D. Mich. Oct. 29, 2014) (state budgetary

concerns were mitigated because "at least some of these expenses can be reimbursed by the federal government.") (citing 42 C.F.R. § 431.250); *Chisholm ex rel. CC v. Kliebert*, No. CIV.A. 97-3274, 2013 WL 4089981, at *11 (E.D. La. Aug. 13, 2013) ("federal regulations implementing the Medicaid Act make it clear that CMS approval is not a prerequisite for obtaining federal financial participation in the cost of these services, because the services are being provided pursuant to this Court's . . . Order."); *Conlan v. Shewry*, 131 Cal. App. 4th 1354, 1372 (2005) ("Federal regulations indicate that federal funding is available for reimbursements made in response to this court's ruling . . . Courts in other states have imposed the same or similar requirements on their Medicaid programs and no one has suggested that those states have lost their federal funding," and collecting cases). The State's refusal to submit claims for that federal reimbursement is the State's choice, not a requirement of the district court's order.

Likewise, the State complains that it must use funds originally intended for administrative costs. But the district court's order did not require that outcome. In fact, the district court suggested the state could spend unused CHOICE funds that individual counties had reverted to the State. SA at 46. *See also* Ind. Code § 12-10-10-10 (CHOICE program funded through federal block grant money and is "to fund services . . . not otherwise reimbursable under the Medicaid program"); § 12-10-10-12 (under CHOICE program, "The office of the secretary, in consultation with the local area agencies on aging, shall negotiate reimbursement rates for services provided under this chapter."). The State's brief on appeal fails to even mention the

CHOICE program.

In short, the district court's order did not require the State to raise its rates. As the record and the court's opinions and injunction show, the State had numerous other options available to it, including the use of the CHOICE program.

B. The Injunction Struck an Appropriate Balance Between Flexibility and Offering Specific Guidance.

After complaining that the injunction was too specific because it required the State to take one particular action (raising its rates), the State makes an about-face and complains that the injunction was vague and overbroad. State Br. at 35. The injunction, however, struck an appropriate balance between giving the State sufficient direction to measure compliance with the court's order, while appropriately deferring to the State's discretion to operate its benefit programs.

First, the injunction was not overbroad. Courts have repeatedly cautioned district courts crafting injunctions to give the "widest latitude" to states to determine how best to comply with the court's orders. *See Rizzo v. Goode*, 423 U.S. 362, 378-79 (1976); *see also Huffman v. Pursue, Ltd.,* 420 U.S. 592, 603 (1975) (requiring federal courts to "abide by standards of restraint that go well beyond those of private equity jurisprudence" when asked to enjoin state officials); *Palmer v. City of Chicago*, 755 F.2d 560, 578 (7th Cir. 1985) (noting that injunction did "not intend to dictate" specific policy, and that "it is the defendants' responsibility, as public officials, to draft policies and internal guidelines").

While the State references some of this case law, it misses its significance. *See* State Br. at 35. It was precisely by *not* ordering the State to comply with the

injunction in a particular way that the district court preserved the State's discretion over its internal operations. *See Disabled in Action v. Bd. of Elections in City of New York,* 752 F.3d 189, 204 (2d Cir. 2014) ("restraint and initial deference to state institutional authorities in curing unlawful conditions are advisable as a matter of realism; federal courts lack the facilities or expertise to administer plans designed to assure that a state will provide acceptable services.") (internal quotes and alterations omitted).

Nor does the district court's restraint convert the injunction into an outcome-based remedy. Rather, giving the State "latitude to find mechanisms and make plans to correct the violations," demonstrates the "[p]roper respect for the State and for its governmental processes." *Brown v. Plata*, 563 U.S. 493, 543 (2011). Indeed, this Court has favorably described a similar injunction. *See, e.g.*, *Amundson ex rel. Amundson v. Wisconsin Dep't of Health Servs.*, 721 F.3d 871, 873 (7th Cir. 2013) ("[A] district judge might spell out the minimum housing required by federal law and leave it to [the state] to determine how to fulfil its obligations. That compliance with an injunction requiring performance, rather than payment, may turn out to be costly has never been an objection to the command to implement federal law."). That said, as described above, the district court did not leave the State in the dark.

Second, the State spends much time reciting the standard that injunctions must be tailored to the violation. *See* State Br. at 36-37. That is exactly what the injunction did here. The ADA violation the Court identified here was Karen's unnecessary institutionalization. *See* SA at 49 ("Defendants have discriminated

against Ms. Vaughn, as a ventilator-dependent individual who desires to live and is capable of living in a home-based integrated setting."). Requiring that Karen actually receive services at home, is not only tailored to the violation, it is *necessary* to remedy the violation and associated harms to Ms. Vaughn's physical and emotional health. *See* SA at 39-41. This is not the kind of inappropriate outcome-based injunction courts are concerned with, and in fact is common in the ADA context. *See, e.g.*, *Doe*, 419 F. App'x at 418–19 ("[I]t is still within the equitable powers of the courts to order Defendants to place Doe in an appropriate [community-based] program of her choice.").

The State next complains that the injunction improperly orders a specific level of benefits. State Br. at 38-39. But the district court was also well-founded in ordering the state to provide the services outlined in Karen's case-manager-approved plan of care, and ultimately ordering that they be provided within 21 days. Again, the State misstates the order. As the opinion accompanying the order notes, "medical necessity will dictate the specifics of Ms. Vaughn's care." SA at 52. The order, therefore, does not prescribe any particular level of benefits.

Finally, to the extent the State complains that the 21-day timeline is insufficient, *see* State Br. at 42, its argument ignores the seven-month period the State had to effectuate home-based care following the district court's summary judgment decision. *Cf. Brown*, 563 U.S. at 542 (two-year timeline for reducing prison population sufficient, in light of fact that the State already had time "to begin complying" with the earlier order of the lower court). Any need for last-minute

arrangements was a problem of the State's own making.

C. Even If The District Court Had Ordered A Direct Rate Increase That Would Be Within Its Authority.

Although the district court did not order the state to increase its rates, it would have been well within the court's power to do so. Rates and increased funding are common remedies under the ADA. The Court should reject the State's invitation to issue a sweeping decision declaring rate adjustment may never be authorized as a remedy in a case concerning the Medicaid program.

The court's remedial powers under the ADA are broad. *See, e.g., Disabled in Action*, 752 F.3d at 198, 202. And as described above, those powers include ordering relief that requires paying more for services than it otherwise would have. *See supra* at I.A.3.b. Federal guidance underscores the point. DOJ guidance explains that a state's "funding choices" may cause a violation of the integration mandate. *Steimel*, 823 F.3d at 911 (quoting DOJ Q&A). Guidance from the Health Care Financing Administration (the precursor agency to CMS), also specifically contemplates that states may change the design of their "payment methodologies" for nurse-delegated services to comply with the integration mandate, suggesting that rates for such services may be higher. Olmstead Ltr. No. 3 at 15. In short, the State must remedy discrimination caused by its funding choices. Where the funding choice is a low rate, that choice must be remedied.

Finally, relying on *Armstrong*, and dicta from *O.B.*, the State asks the Court to make a sweeping ruling that adjusting rates is foreclosed in any case addressing a state's Medicaid program. State Br. at 43-46. The State's reliance on *Armstrong* is

misplaced. *Armstrong* concerned a different legal claim (the availability of an implied cause of action or action in equity under the Supremacy Clause), brought by different plaintiffs (health care providers), and concerning a different Medicaid provision (42 U.S.C. § 1396a(a)(30)(A)). *Armstrong v. Exceptional Child,* 575 U.S. 320, 324-25 (2015). The Court held that private parties cannot use the Supremacy Clause as a cause of action to argue that at state's payment rates are preempted by § (30)(A). *Id.* at 327-329.

Armstrong has no bearing whatsoever on the long line of cases describing the broad remedial powers a court has following a violation of the ADA and the integration mandate. Indeed, "[a] state's duties under the ADA are wholly distinct from its obligations under the Medicaid Act," and the Court's remedial authority is likewise distinct. *Davis*, 821 F.3d at 264; *cf. Bayer v. Neiman Marcus Grp., Inc.*, 861 F.3d 853, 874 (9th Cir. 2017) ("For this court to adopt a per se limitation on the equitable powers granted to district courts by the ADA . . . would be manifestly inconsistent with the historic purpose of equity to secure complete justice.").

Furthermore, the conclusion that the Supremacy Clause does not create an implied cause of action says nothing about the remedial power courts have after finding violations of *other* provisions of the Medicaid Act, under other legal theories. Courts have held that those remedial powers are broad. *See Smith v. Miller,* 665 F.2d 172, 175 (7th Cir. 1981) (concluding that no provision of the Medicaid Act or the Constitution restricts the authority of the courts to award equitable relief); *see also Doe*, 419 F. App'x at 418–19 ("In actions brought under § 1983 in the

context of the Medicaid Act, the district courts are invested with broad equitable powers to style any appropriate remedial relief."). *Armstrong* simply does not consider, let alone limit, the remedies available following violations of other Medicaid provisions, such as the reasonable promptness provision here.[10]

CONCLUSION

For the foregoing reasons, the District Court's Summary Judgment Order and Permanent Injunction should be affirmed.

[10] Courts have ordered rate adjustments to remedy reasonable promptness violations, before and after *Armstrong*. *See, e.g.*, *Chisholm*, 2017 WL 3730514, at *7 (noting that "there is evidence that the reduced reimbursement rates have played a role in increasing the period class members must wait to receive ABA services," and that "The reimbursement rate for ABA services must not be set so low as to frustrate the reasonable promptness provision.") (quote omitted); *A. H. R. v. Washington State Health Care Auth.*, No. C15-5701JLR, 2016 WL 98513, at *13 (W.D. Wash. Jan. 7, 2016) (finding plaintiffs likely to succeed on reasonable promptness claim based on evidence that reimbursement rates were too low to secure in-home nurses); *Health Care For All, Inc. v. Romney*, No. CIV.A. 00-10833RWZ, 2005 WL 1660677, at *10 (D. Mass. July 14, 2005) ("Setting reimbursement levels so low that private dentists cannot afford to treat Medicaid enrollees effectively frustrates the reasonable promptness provision by foreclosing the opportunity for enrollees to receive medical assistance at all, much less in a timely manner.").

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-face requirements of Fed. R. App. P. 32(a)(5) and type-style requirements of Fed. R. App. P. 32(a)(6) because it was prepared using a proportionally spaced typeface, Microsoft Word, in 12-point Century Schoolbook font (11-point font in footnotes).

This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because it contains 13,302 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

/s/ Sarah Grusin
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CERTIFICATE OF SERVICE

I hereby certify that on February 10, 2020, I electronically filed the foregoing Brief of Appellees with the Clerk of the Court for the United States Court of Appeals for the Seventh Circuit by using the appellate *CM/ECF* system on February 10, 2010. I certify that all of the listed participants in the case are registered *CM/ECF* users and that service will be accomplished by the appellate *CM/ECF* system.

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