



All individuals who are or will be enrolled in the Indiana Aged and Disabled Waiver program and who receive or will receive attendant care waiver services, and to whom the Indiana Family and Social Services Administration has applied or will apply the forty (40) hour a week cap on attendant care waiver services.

3. Additionally, Edna Chadwell brings this action as an individual petition for judicial review of a final agency action pursuant to Indiana Code § 4-21.5-5.3. However, both parties agree that the merits of Ms. Chadwell's petition for judicial review are co-extensive with the plaintiffs' claims challenging the caps on attendant care services. These issues are therefore treated together.
4. As noted above, the parties have filed cross-motions for summary judgment. Insofar as neither party has argued that there exists a disputed issue of material fact, this case is now before the Court for its ruling

The plaintiffs have also moved to strike the defendants' response to their summary judgment motion and the defendants' designation of evidence. This request is treated separately below.

#### **MOTION TO STRIKE**

5. The facts as they relate to the plaintiffs' Motion to Strike are not in dispute.
6. The plaintiffs' Motion for Summary Judgment in this cause was filed on September 9, 2009. However, not until October 27, 2009—fifteen (15) days after the deadline for responding to the plaintiffs' motion—did the defendants seek an extension of this deadline.

#### **Legal Conclusions**

7. Both the Indiana Supreme Court and the Indiana Court of Appeals have been eminently clear that when *no* action is taken within thirty (30) days of the date on

which a motion for summary judgment is filed, Indiana's trial courts have no discretion whatsoever to consider belatedly filed documents. In *Borsuk v. Town of St. John*, 820 N.E.2d 118 (Ind. 2005), the Indiana Supreme Court resolved a split amongst panels of the Court of Appeals by holding that

[w]hen a nonmoving party fails to respond to a motion for summary judgment within 30 days by either filing a response, requesting a continuance under Trial Rule 56(I), or filing an affidavit under Trial Rule 56(F), the trial court cannot consider summary judgment filings of that party subsequent to the 30-day period.

*Id.* at 124 n.5 (citing *Desay v. Croy*, 805 N.E.2d 844, 848–49 (Ind. Ct. App. 2004)). *Borsuk* concluded that “since the 30-day period lapsed with no filings, the trial court should not have admitted any of the [defendant’s] subsequent briefs or affidavits.” *Id.* This rule was reaffirmed by the Indiana Supreme Court more recently in *HomeEq Servicing Corp. v. Baker*, 883 N.E.2d 95, 98–99 (Ind. 2008), and *Monroe Guaranty Insurance Co. v. Magwerks Corp.*, 829 N.E.2d 968, 974 (Ind. 2005), and by the Indiana Court of Appeals in *Simon Property Group, L.P. v. Acton Enterprises, Inc.*, 827 N.E.2d 1235, 1239 (Ind. Ct. App. 2005), *trans. denied*. In *Acton Enterprises*, the court explained that under these circumstances “the trial court lacks discretion to extend the time for filing summary judgment responses and materials.” *Id.*; *see also Miller v. Yedlowski*, 916 N.E.2d 246, 252 (Ind. Ct. App. 2009) (holding that a “trial court lacked discretion to grant [an] extension [for responding to a summary judgment motion] because [the request] was made after the time for a response had expired” and that the order granting the extension was therefore a “nullity”).

The fact of the matter is that Trial Rule 56(I) requires that any request for an extension of time to respond to a summary judgment motion must be “*made within the applicable time limit.*” IND. R. TRIAL P. 56(I) (emphasis added).

The defendants’ three (3) arguments in opposition to the Motion to Strike, although considered by the Court, do not overcome the trial rule(s) and cases cited above discretion” to grant such a request). If trial courts lack discretion to grant an extension under these circumstances, then the parties can certainly not acquiesce to one.

8. Accordingly, the plaintiffs’ Motion to Strike must be granted, and the defendants’ response to the plaintiffs’ summary judgment motion and their designation of evidence, in its entirety, must be stricken from the record.

#### **FINDINGS OF FACT**

##### *Facts Concerning the Agency’s Policies*

###### *A. Operation of the Aged and Disabled Waiver Program*

9. The Indiana Family and Social Services Administration operates five (5) Medicaid waiver programs, two (2) of which—including the Aged and Disabled Waiver—are operated by its Division of Aging. Dep. of Karen Filler (“Filler”), at 12–13. These waiver programs provide services that are not available through traditional Medicaid programs and that are offered to permit a disabled individual to receive services in the community rather than in an institution. *Id.* at 13.
10. Each waiver program in Indiana is required to be renewed every five (5) years, at which point an application must be submitted to—and approved by—the U.S. Department of Health and Human Services. *Id.* at 33–34. During 2009, there are over eight thousand (8,000) available slots in Indiana for the Aged and Disabled

Waiver, and by 2012 the Indiana Family and Social Services Administration anticipates that there will be more than thirteen thousand (13,000) available waiver slots. *Id.* at 26.

11. In order to become enrolled in the Aged and Disabled Waiver program, an individual visits his or her local Area Agency on Aging, which is a local non-profit organization that contracts with the Division of Aging to provide case management services. *Id.* at 14, 22–23. There are currently sixteen (16) Area Agencies on Aging in Indiana, each of which serves a specific region consisting of several counties. *Id.* at 23.
12. In order to determine whether a given individual is eligible for the Aged and Disabled Waiver program, a case manager employed by a local Area Agency on Aging utilizes an eligibility screen on a computer program known as INsite. *Id.* at 14–17 & Exh. 3. Using this screen, the case manager must determine that the individual has one (1) of the following:
  - One or more conditions listed in Section 1 of the eligibility screen, which is labeled “Severe Medical Conditions,” and which determines whether the individual “is eligible for Nursing Facility Admission and may be eligible for Medicaid Waiver Services under the Aged and Disabled . . . Waiver.”
  - Three (3) or more conditions listed in Section 2A of the eligibility screen, which is labeled “Substantial Medical Conditions Including Activities of Daily Living,” and which determines whether the individual “is eligible for Nursing Facility Admission or Medicaid waiver.”

*Id.* at 15–16 & Exh. 3. This eligibility screen is used to determine whether an individual meets nursing facility level-of-care, which is required for the receipt of waiver services. *Id.* at 16–18.

13. “Nursing facility level-of-care” refers to a determination that if an individual were not receiving services in the community, he or she would require institutionalization. *Id.* at 18. The ultimate decision on whether an individual is eligible for the Aged and Disabled Waiver program is made by the Area Agencies on Aging, and then reviewed by the Division of Aging. *Id.* at 16, 18.
14. Following a determination that an individual is eligible for waiver services, the local Area Agency on Aging is then responsible for assessing the needs of a particular individual and creating a plan of care and a cost comparison budget to be submitted to the Division of Aging for review. *Id.* at 14.
15. The plan of care contains a description of the services to be received by a waiver recipient, and in creating a plan of care the case manager is responsible for assessing the needs of an individual before submitting the proposal to the Division of Aging. *Id.* at 42–44. In so doing, the case manager evaluates what services are necessary in order for an individual to remain safely in the community, and the case manager generally has available to him or her the individual’s medical records and/or medical histories. *Id.* at 42, 44.
16. Although the Division of Aging generally does not review an individual’s actual medical records prior to evaluating or denying a plan of care and cost comparison budget, it has always retained the ability to seek additional information from the case manager about a given case. *Id.*

*B. Implementation of the Caps on Attendant Care Services*

17. In the spring of 2008, the Indiana Family and Social Services Administration submitted to the U.S. Department of Health and Human Services a renewal

application for the Aged and Disabled Waiver program, which was approved by the federal government on May 22, 2008. *Id.* at 34–36 & Exhs. 7–8. According to this approved waiver application, the only provision of the Medicaid Act that is waived is Section 1902(a)(10)(B) of the Social Security Act (codified at 42 U.S.C. § 1396a(a)(10)(B)), such that the agency may therefore “provide . . . services . . . that are not otherwise available under the approved Medicaid State plan” to waiver enrollees. *Id.* at 37–39 & Exh. 7 p.5.

18. For the first time, this application—which took effect on July 1, 2008—placed a cap on the amount of attendant care services that an individual enrolled in the waiver program may receive: no disabled individual may receive more than forty (40) hours each week in attendant care services. *Id.* at 60–61 & Exh. 7 p. 33.
19. These caps were never promulgated pursuant to Indiana’s rule-making process. Stipulation of Facts, ¶ 5.
20. Attendant care services are services that primarily involve hands-on assistance for aging adults and persons with disabilities, and include assistance in such activities as bathing, shaving, oral hygiene, transferring, ambulating, toileting, eating, preparing meals, and running errands. Dep. of Filler, at 45–48 & Exhs. 7 pp. 32–33 & 10. This new cap on attendant care services was instituted as an attempt by the Indiana Family and Social Services Administration to ensure that individuals were receiving as much assistance as possible through traditional state plan services before they began using waiver services. *Id.* at 62.<sup>1</sup>

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<sup>1</sup> State plan services are Medicaid services not offered through the waiver program, but those requiring an individual to obtain prior authorization before receiving the services. Dep. of Filler, at 79; *see also* IND. ADMIN. CODE, tit. 405, r. 5-3-1, *et seq.*

21. However, the Division of Aging has—and has always had—the authority to deny a proposed plan of care if it believed that the individual and his or her case manager might be able to receive assistance through traditional state plan services even though that individual was requesting services through the waiver program, or if it believed that too many services were being requested. *Id.* at 62–63. The agency had no other reason for imposing these caps. *Id.* at 63.
22. The agency implemented the new caps by having case managers download a patch for their computers that would make it impossible for them to apply for services on behalf of any individual that were over the cap amount. *Id.* at 66–68 & Exh. 12. Case managers were required to download this patch by June 30, 2008, and the following day—July 1, 2008—the cost comparison budgets for individuals receiving services over the cap amounts were automatically reduced to come into compliance with the new caps. *Id.* at 70–71 & Exh. 12.

C. *Notice Procedures*

23. When an individual's Cost Comparison Budget and Plan of Care is either approved or denied, a Notice of Action—State Form 46015—is generated by the agency and sent to the case manager and the individual. *Id.* at 56–57. The stated reason for denying a Cost Comparison Budget is selected from a list of pre-stated reasons in the agency's computer system. *Id.* at 57–58.
24. The reason for denying a Cost Comparison Budget is almost always stated as simply “Denial of Annual Cost Comparison Budget.” *Id.* at 57–58 & Exh. 11. Although Karen Filler has seen denials with citations to state or federal law, this is not a requirement of the notices. *Id.* at 58–59 & Exh. 11.

25. Thus, in issuing notices of action denying Cost Comparison Budgets that sought more than forty (40) hours a week in attendant care services from the waiver program, the agency does not provide any citation to legal authority supporting the basis for the denial. *Id.* (Staggs); Aff. of Chadwell, ¶ 8 & Exh. 2 p.14 (Chadwell); Aff. of Colegrove, ¶ 6 & Exh. 2 (Colegrove); Aff. of Wheeler, ¶¶ 6–7 & Exh. 1 (Rieken); Notice of Action: S.M., at 1 (class-member S.M.).

*Facts Concerning the Plaintiffs and the Class*

*A. Facts Concerning the Class*

26. Prior to the enactment of the new cap on attendant care services, the agency undertook no studies or other research to determine how many waiver enrollees would be affected by the new caps. *Id.* at 76–77. Nor were any studies or other research undertaken to determine how many individuals affected by the caps could obtain adequate assistance through traditional state plan services, or to determine how many future applicants for waiver services would be affected by the caps. *Id.*

27. However, during the years before July 1, 2008, numerous individuals received attendant care services through the waiver program in an amount greater than forty (40) hours each week:

<b>DATE</b>	<b>RECIPIENTS RECEIVING SERVICES IN EXCESS OF CAP</b>	<b>TOTAL WAIVER ENROLLEES</b>	<b>PERCENTAGE OF WAIVER ENROLLEES IN EXCESS OF CAP</b>
July 1, 2003	25	3,278	0.08%
January 1, 2004	105	3,324	3.16%
January 1, 2005	89	3,085	2.88%
January 1, 2006	120	3,159	3.80%
January 1, 2007	170	4,335	3.92%
January 1, 2008	103	5,913	1.74%

July 1, 2008	103	6,143	1.68%
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Dfts.’ Responses to Pltfs.’ Interrogatories (Exh. 10), ¶ 2; Defts.’ Supplemental Answer to Interrogatory No. 1 of Pltfs.’ First Set of Interrogatories (Exh. 11), ¶ 1. Indeed, on or around July 1, 2009, there were approximately one hundred one (101) seriously disabled individuals whose services were automatically reduced to come into compliance with the new caps. Dep. of Filler, at 75–76 & Exh. 13. The services of these individuals were reduced as follows:

HOURS REDUCED EACH MONTH	ATTENDANT CARE SERVICES REDUCTIONS
0 to 5 hours	22
6 to 10 hours	11
11 to 20 hours	15
21 to 30 hours	13
31 or more hours	40
<u>Total Reductions</u>	<u>101</u>

*Id.*; see also *id.* at 77 & Exh. 14 (listing the individuals affected by the new caps on waiver services).

28. Following a preliminary injunction in December of 2008 in this case, the agency (temporarily) removed the patch on case managers’ computers that prohibited service requests in excess of the cap amount. *Id.* at 69. Thus, as of March 27, 2009, numerous individuals were able to receive attendant care services in excess of the cap amount—at least seventeen (17)—although this patch will be reinstalled in the event that the agency prevails in this case. *Id.* at 69 & Exh. 16. Each of these individuals is someone who the agency determined could not obtain traditional state plan services in order to replace waiver services lost as a result of the new caps. *Id.* at 143 & Exh. 16.

29. The agency cannot ensure that any disabled individual who previously received more than forty (40) hours each week in attendant care services will be able to receive sufficient state plan services in order to make up the difference or to ensure that they can be serviced safely in the community. *Id.* at 85.
30. There are several reasons that waiver services might be available to such a person when state plan services are not: (a) no provider of state plan services may be able to accommodate the number of hours that a client needs; (b) particularly in rural areas of Indiana, there may be no nearby provider of state plan services; or (c) no provider of state plan services may be in a position to take on new clients. *Id.* at 84–85. Moreover, the ability of waiver recipients to obtain state plan services is further limited by the fact that while any provider enrolled in the Medicaid program to provide the relevant state plan services may provide waiver services, not all providers of waiver services are also licensed to provide state plan services. *Id.* at 138–39.

*B. Facts Concerning the Named Plaintiffs*

31. Each of the named plaintiffs is a seriously disabled individual who meets nursing facility level-of-care and is presently enrolled in the Aged and Disable Waiver program. Edna Chadwell and Christine Staggs have been diagnosed with cerebral palsy, and Ms. Chadwell has also been diagnosed with quadriplegia. *Aff. of Chadwell*, ¶ 2; *Aff. of Staggs*, ¶ 2. John Rieken shares this latter diagnosis. *Aff. of Wheeler*, ¶ 2. William Colegrove has been diagnosed with muscular dystrophy. *Aff. of Colegrove*, ¶ 2. Richard Matula, Gregory West, and Scott McNichols have all suffered traumatic brain injuries. *Aff. of Matula*, ¶ 2; *Aff. of*

West, ¶ 2; Aff. of McNichols, ¶ 2. Gregory West has also been diagnosed with multiple sclerosis. Aff. of West, ¶ 2. Ila Otermat—who was ninety-five (95) years old in 2008—has been diagnosed with several disabilities related to her age. Aff. of Otermat, ¶ 2.

32. Most of the named plaintiffs are confined to a wheelchair, and all require significant assistance with nearly all of their activities of daily living. Aff. of Chadwell, ¶¶ 2–3, 5; Aff. of Colegrove, ¶¶ 2, 5; Aff. of Staggs, ¶¶ 2, 5; Aff. of Wheeler, ¶¶ 2, 8; Aff. of Otermat, ¶¶ 2, 9; Aff. of Matula, ¶¶ 2, 5; Aff. of West, ¶¶ 2, 5; Aff. of McNichols, ¶¶ 2, 5. None of the named plaintiffs or their guardians desire that they be institutionalized. Aff. of Chadwell, ¶ 18; Aff. of Colegrove, ¶ 9; Aff. of Staggs, ¶ 11; Aff. of Wheeler, ¶ 10; Aff. of Otermat, ¶ 14; Aff. of Matula, ¶ 7; Aff. of West, ¶ 7; Aff. of McNichols, ¶ 8. Notwithstanding this desire, this is a virtual certainty if their attendant care hours are reduced to come into compliance with the new caps. Aff. of Chadwell, ¶ 18; Aff. of Colegrove, ¶ 9; Aff. of Staggs, ¶ 11; Aff. of Wheeler, ¶ 10; Aff. of Otermat, ¶ 14; Aff. of Matula, ¶ 7; Aff. of West, ¶ 7; Aff. of McNichols, ¶ 8. However, Ms. Chadwell—for one—has already decided that she would prefer to die with dignity than submit to institutionalization. Aff. of Chadwell, ¶ 18.

33. Prior to the implementation of the caps on attendant care services, seven (7) of the eight (8) named plaintiffs were receiving services in excess of the cap amount. Aff. of Chadwell, ¶ 4 (70 hours each week); Aff. of Colegrove, ¶ 4 (112 hours each week); Aff. of Staggs, ¶ 4 (70 hours each week); Aff. of Wheeler, ¶ 5 (154 hours each week); Aff. of Otermat, ¶ 4 (55 hours each week); Aff. of Matula, ¶ 4

(more than 40 hours each week); Aff. of West, ¶ 4 (56 hours each week). Scott McNichols, who was a new applicant to the waiver program in August of 2008—following the implementation of the caps but before the issuance of the preliminary injunction in this case—was simply told that he could not even apply for more than forty (40) hours a week. Aff. of McNichols, ¶ 4.

34. Several of the named plaintiffs demonstrate the impossibility of receiving traditional state plan services to replace the attendant care services that they have been receiving. In Edna Chadwell's case, for instance, the fact that she lives in rural Clay County means that no providers willing to provide state plan services can be found. Chadwell Case Notes (Exh. 13-A), at 215–17, 221–23, 225; Chadwell Plans of Care (Exh. 13-B), at 778, 798, 809–11; Chadwell Miscellaneous (Exh. 13-C), at 656, 2612; Chadwell Hearing Tr., at 12, 31–33, 36–39 & Exh. 7.<sup>2</sup> William Colegrove, who lives in rural Knox County, can likewise not locate a provider capable of providing prior authorization services. Colegrove Miscellaneous (Exh. 15-C), at 3. In a similar vein, John Rieken cannot obtain traditional state plan services as a result of his location in Carroll County and the inability of local providers to provide services. Rieken Case Notes (Exh. 16-A), at 335–36, 339, 349; Rieken Plans of Care (Exh. 16-B), at 1059. While a provider capable of providing state plan services was able to be located for Ila Otermat, this provider has only been able to provide services for two (2) hours each week—significantly fewer hours than she requires. Otermat Case Notes (Exh. 17-A), at 539; Otermat Plans of Care (Exh. 17-B), at 1506, 1514, 1533;

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<sup>2</sup> Wherever available, page citations are to the Bates-stamped page number in the lower-right of the page.

Otermat Miscellaneous (Exh. 17-C), at 509–10; Aff. of Otermat, ¶ 7. Christine Staggs, on the other hand, according to the agency simply does not qualify for traditional state plan services. Staggs Case Notes (Exh. 14-A), at 379, 382; Staggs Plans of Care (Exh. 14-B), at 952.

35. Similar circumstances exist for many unnamed members of the certified class, who are identified herein (and in the documents accompanying the present motion) only by their initials. Traditional state plan services are “not a working option” for class-member W.J.B. Details Concerning Over-Limit Clients (Exh. 21-C), at 2272, 3248; Dep. of Filler, at 142–43 & Exh. 16 p. 5–7. Class-member L.R. already received some prior authorization services and was willing to reduce her attendant care hours but not to the degree required by the agency. Details Concerning Over-Limit Clients, at 2341; Dep. of Filler, at 142–43 & Exh. 16 p.13. Class-member S.M. is ineligible for prior authorization services because the provider with whom she resides does not permit services to be provided in the home. Details Concerning Over-Limit Clients, at 2341; Dep. of Filler, at 142–43 & Exh. 16 p.13. Class-member A.M. is in a unique position in that finding *any* provider, let alone one providing state plan services, is inherently difficult because her deafness mandates that they be able to speak sign language, and she has therefore been required to continue receiving services over the cap level with her current waiver provider. Dep. of Filler, at 142–43 & Exh. 16 pp. 17–18. And class-member C.B., like many of the named plaintiffs, has been unable to find a provider capable of providing state plan services to replace the waiver services

that she has been receiving in excess of the cap amounts. Dep. of Filler, at 142–43 & Exh. 16 pp. 22–23.

C. *Facts Concerning Edna Chadwell*<sup>3</sup>

36. Edna Chadwell is a forty-six (46) year old female who has been diagnosed with spastic cerebral palsy, hypertension, and quadriplegia. Chadwell Hearing Tr. & Exh. A (Record 69). She lives alone, and has no friends or family-members to assist with her care. *Id.* She requires assistance with range of motion, meal preparation and set-up, peri-care, toileting, transfers, and “all activities of daily living,” although she does not require 24-hour care. *Id.*
37. Ms. Chadwell’s Cost Comparison Budget for July 1, 2007, through February 29, 2008, included three hundred ten (310) hours per month of attendant care services through Indiana’s Aged and Disabled Waiver program. *Id.* (Record 70). At the time of Ms. Chadwell’s redetermination in March of 2008, she requested to maintain three hundred ten (310) hours per month in attendant care services. *Id.* However, this request was denied and Ms. Chadwell was advised the agency had established new guidelines of approving no more than 120 hours per month of attendant care services, with certain exceptions of up to 160 hours per month. *Id.* (Record 71). Her revised request was therefore approved for the maximum of 160 hours per month (or 40 hours per week) of attendant care services. *Id.*

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<sup>3</sup> Insofar as the present action arises both as a class action challenge to the caps presently at issue and as a petition for judicial review on behalf of Ms. Chadwell, Ms. Chadwell’s facts are treated at greater length. This is particularly so given that, as it relates to her judicial review, this Court may not consider facts outside of the agency record. IND. CODE § 4-21.5-5-11.

38. Ms. Chadwell and her case manager have been unable to locate traditional state plan services to replace the lost attendant care services, “as there are no available providers in Ms. Chadwell’s rural community.” *Id.* (Record 72). Indeed, Ms. Chadwell’s case manager contacted at least thirty (30) providers in order to inquire into whether they could provide prior authorization services to Ms. Chadwell. *Id.* at 37–39 & Exh. 6 (Record 44–46, 94–95). None were able to do so: many were not certified to provide prior authorization services; others indicated that they did not have sufficient time or staff in order to travel to Ms. Chadwell’s home in Carbon, Indiana; and others simply did not respond to messages. *Id.*

39. On April 9, 2008, Ms. Chadwell appealed the reduction in her services. *Id.* An administrative fair hearing was conducted before an Administrative Law Judge (ALJ) on June 12, 2008, and on July 25, 2008, the ALJ issued a decision favorable to the agency. ALJ Decision (Record 114–20). In so deciding, the ALJ found that Ms. Chadwell was limited by the maximum of 160 hours of attendant care services per month. *Id.* (Record 118). On July 30, 2008, Ms. Chadwell sought agency review of the ALJ decision (Record 121–27), and agency review was denied on August 22, 2008 (Record 129). Ms. Chadwell timely petitioned for judicial review on August 27, 2008.

*Incorporation*

40. Each finding of fact shall be deemed a conclusion of law to the extent necessary.

**CONCLUSIONS OF LAW**

41. The plaintiffs and the class have raised four (4) separate claims, each of which is treated independently below.

Standard of Review

42. The standard for the granting of summary judgment in Indiana is clear:

Summary judgment is appropriate only if no genuine issues of material fact exist and the moving party is entitled to judgment as a matter of law. Neither the trial court, nor the reviewing court, may look beyond the evidence specifically designated to the trial court.

*Best Homes, Inc. v. Rainwater*, 714 N.E.2d 702, 705–06 (Ind. Ct. App. 1999) (citing *Barnes v. Antich*, 700 N.E.2d 262, 265 (Ind. Ct. App. 1998)).

Promulgation (Indiana Code § 4-22-2-13, et seq.)

43. The plaintiffs' first claim arises under Indiana Code § 4-22-2-13, et seq., which requires that administrative "rules" be formally promulgated pursuant to Indiana's rule-making process. It is undisputed in this case that the forty-hour-a-week caps on attendant care services have never been formally promulgated by the defendant agency. Therefore, if these caps qualify as administrative "rules," they are void and the plaintiffs must prevail.
44. State administrative law defines a "rule" as "the whole or any part of an agency statement of general applicability" that "has or is designed to have the effect of law" and that "implements, interprets, or prescribes[] law or policy[] or the organization, procedure, or practice requirements of an agency." IND. CODE § 4-22-2-3(b). A review of prior jurisprudence discloses that the caps in question here are most assuredly a "rule."
45. In *Blinzinger v. Americana Healthcare Corp.*, 466 N.E.2d 1371 (Ind. Ct. App. 1984), for example, the court was faced with the question of whether a rate fee

directive adopted by the Indiana Department of Public Welfare was an administrative rule. The court found that the challenged policy was indeed a rule because (a) the directive was an “agency statement of general applicability to a class,” (b) it “is and was applied prospectively,” (c) it was “applied as though it had the effect of law,” and (d) it “affects substantive rights of certified Medicaid providers.” *Id.* at 1375 (finding that the directive in question was not promulgated and was therefore void and without effect).

46. In *Indiana Dep’t of Env’tl. Mgmt. v. AMAX, Inc.*, 529 N.E.2d 1209 (Ind. Ct. App. 1988), the Indiana Court of Appeals similarly concluded that certain guidelines adopted by the Water Pollution Control Board were invalid because they were “rules” that were not adopted in accordance with the procedures of state administrative law. According to the court, “[t]he agency prepared the guidelines for prospective use and apparently applied them to each business that applied for the exemption.” *AMAX*, 529 N.E.2d at 1212. The court continued:

[W]e do not accept the state’s argument that the [agency’s] guidelines constituted an internal policy. Rather, the evidence as reported in the findings reveals that the [agency] followed the guidelines in determining whether or not to allow tax exemptions for businesses. Although the guidelines may have served some internal purpose such as streamlining the review of exemption petitions, it is clear that the guidelines primarily impacted the businesses which petitioned for exemption in that they improperly had the effect of law upon those parties.

*Id.* at 1213. Under this precedent, if the primary impact of an agency policy is external to the agency, and has the effect of law, the policy is an administrative rule subject to invalidation if it is not promulgated according to the state’s rulemaking procedures.

47. Given this, it is clear that the caps presently at issue constitute an administrative “rule” rather than mere internal policy. Specifically:

- The caps constitute an agency statement of general applicability to all Medicaid recipients enrolled in or eligible for attendant care services through the Aged and Disabled Waiver program.
- The caps were adopted and are applied prospectively, and apply to all Medicaid recipients who are enrolled in or eligible for attendant care services through the Aged and Disabled Waiver program even after the date of the caps’ adoption by the State.
- The primary impact of the caps is external, for they affect the services for which a waiver applicant or recipient is eligible, and therefore do not relate solely to internal policy, internal agency organization, or internal procedure.
- The caps implement the policy of the State with respect to the provision of Medicaid waiver services.
- The caps are intended to have the effect of law and are applied with the effect of law.
- The caps affect the substantive rights of Medicaid recipients, for a Medicaid recipient enrolled in the Aged and Disabled Waiver program may not receive services in excess of the caps.

48. This is a conclusion that is tacitly admitted by the defendants, for their primary argument appears to be not that the caps need not be promulgated but that they already have been. This, however, is erroneous.

49. The defendants argue that a rule promulgated in 2006 essentially incorporated the caps into Indiana administrative law. Specifically, on September 27, 2006, the Indiana Family and Social Services Administration promulgated a rule containing the following language:

- (a) All service and programmatic definitions, as well as provider qualifications for the nursing facility level of care Medicaid waivers, which include aged and disabled . . . , are found in and the same as those in the following CMS Medicaid Waiver documents . . . as follows:

(1) Indiana home and community based services for the aged and disabled (A&D), CMS control number #0210.920.R2.

IND. ADMIN. CODE tit. 460, r. 1.2-3-1; *see also* 20060927-IR-460050119FRA (Sept. 27, 2006) (Final Rule).

50. Of course, not until the defendants submitted a Medicaid waiver renewal application on May 16, 2008, were the caps presently at issue even contemplated. Dep. of Filler, at 34–36 & Exhs. 7–8. Not until July 1, 2008, did these caps actually go into effect. *Id.* And, finally, although the promulgated rule purports to incorporate a waiver with CMS control number #0210.920.R2, the waiver renewal that for the first time included a forty-hour-a-week cap on attendant care services actually possesses CMS control number #0210.90.R3. *Id.* at 34–36 & Exh. 8.
51. The promulgated rule incorporates *an entirely different waiver than the one presently at issue*. It incorporates a waiver program that does not possess any cap on attendant care services. The defendants' argument therefore flounders on the fact that what has been incorporated has absolutely nothing to do with the caps on attendant care services presently at issue.
52. Finally, to the extent that the defendants argue for a blanket exception to the promulgation requirement for policies related to Medicaid waiver programs, there is no authority in Indiana law or the laws of any other jurisdiction for such an exception. To the contrary, the plaintiffs have directed the Court to at least one case from a State employing similar administrative rules to Indiana in which policies related to waiver programs were deemed to require promulgation. *See*

*Cholvin v. Wisconsin Dep't of Health & Family Servs.*, 2008 WL 2833923, ¶¶ 18–34 (Wis. Ct. App. July 24, 2008). Indeed, the defendants' argument in this respect is inherently contradictory, for in 2006 they *did* promulgate a rule (noted above) related to Medicaid waiver programs, and, indeed, it appears that the caps at issue may even be violative of this promulgated rule (which is an issue that this Court need not and does not decide).

53. Under such circumstances, the caps on attendant care services qualify as a “rule” under Indiana law. Insofar as they have not been properly promulgated, these caps are void and without effect.

*Americans with Disabilities Act of 1990 (42 U.S.C. § 12132) and Rehabilitation Act of 1973 (29 U.S.C. § 794)*

54. The plaintiffs' next claim rises under the Americans with Disabilities Act of 1990 and the Rehabilitation Act of 1973. Both parties agree that the analysis under both statutes is the same, and they are therefore treated simultaneously.

*A. Background to the Statutes and the Olmstead Test*

55. Title II of the Americans with Disabilities Act of 1990 provides that “no 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. The statute defines a “qualified individual with a disability” as an individual 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). The term “public entity,” in turn, is defined to include “any

State or local government,” as well as “any department, agency, special purpose district or other instrumentality of a State . . . or local government.” 42 U.S.C. § 12131(1).

56. Section 504 of the Rehabilitation Act, 29 U.S.C. § 794(a), likewise prohibits such discrimination by any entity receiving federal funding, and may be construed as co-extensive to the Americans with Disabilities Act. *See, e.g., Sanchez v. Johnson*, 416 F.3d 1051, 1062 (9<sup>th</sup> Cir. 2005) (citing, *inter alia*, *Barnes v. Gorman*, 536 U.S. 181, 184–85 (2002)). The Indiana Family and Social Services Administration receives federal funding, and is therefore subject to the requirements of the Rehabilitation Act. IND. CODE § 12-15-1-1, *et seq.*; *Curtis v. Roob*, 891 N.E.2d 577, 578 (Ind. Ct. App. 2008) (“Medicaid is a federal-state cooperative program to provide medical assistance to persons with insufficient resources or income to pay for the services they need.”).
57. Moreover, both the Americans with Disabilities Act and the Rehabilitation Act contain a provision requiring a state agency to administer its programs and activities “in the most integrated setting appropriate to the needs of qualified handicapped persons.” 28 C.F.R. § 41.51; *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 592 (1999).
58. In *Olmstead*, the United States Supreme Court examined the terms and legislative history of the ADA, along with the integration mandate reflected in its implementing regulations, and concluded that the “unjustified institutional isolation” of a disabled individual receiving medical care from the State amounts to an actionable form of discrimination under Title II. *Olmstead*, 527 U.S. at

597–603. That is so “even in the absence of traditional proof that the disabled person is being treated differently from a nondisabled person who is otherwise similarly situated.” *Radaszewski v. Maram*, 383 F.3d 599, 607–608 (7<sup>th</sup> Cir. 2004) (citing *Olmstead*, 527 U.S. at 598).

59. In view of the integration mandate, the *Olmstead* Court held that a State is obliged to provide community-based treatment for individuals with disabilities, so long as (a) the State’s treatment professionals find that such treatment is appropriate, (b) the affected individuals do not oppose community-based treatment, and (c) placement in the community can be reasonably accommodated, taking into account the State’s resources and the needs of others with similar disabilities. *Olmstead*, 527 U.S. at 607.

*B. Application of the Olmstead Test*

60. The first two (2) prongs of this test may not be seriously contested: the State has approved each of the named plaintiffs and class-members for community-based services under the Aged and Disabled Waiver program, and continues to approve them for such services; and clearly the plaintiffs do not oppose community-based treatment. The defendants likewise do not dispute that the plaintiffs’ placement in the community may be reasonably accommodated.
61. The only issue, therefore, is whether this accommodation will result in a fundamental alteration of Indiana’s Aged and Disabled Waiver program. The parties agree that this is an affirmative defense on which the defendants bear the burden. This burden has not been met at present.

*C. Fundamental Alteration Defense*

62. Initially, the defendants did not plead their “fundamental alteration” defense as an affirmative defense in their Answer. As a result, it is waived. See IND. R. TRIAL P. 8(C); *Joyner v. Citifinancial Mortg. Co.*, 800 N.E.2d 979, 982 (Ind. Ct. App. 2003). See also *Colorado Cross Disability Coalition v. Hermanson Family Ltd. Partnership I*, 264 F.3d 999, 1004 (10<sup>th</sup> Cir. 2001) (specifically addressing the “fundamental alteration” defense).
63. Waiver notwithstanding, the defendants’ argument is not persuasive. This argument may be characterized in one (1) of three (3) ways.
64. a. *First*, the defendants rely on language in *Olmstead* itself to insist that its waiver program is a “comprehensive, effectively working plan” to de-institutionalize individuals. Initially, not only is it not clear that the Aged and Disabled Waiver program is such a plan for the class-members in this case, but it is clear that it is not: the undisputed facts of this case are not only that the waiver program will *not* result in de-institutionalization but that it will actually result in the *re-institutionalization* of persons against their will. Such a program does not appear to have ever been upheld against attack under the ADA.
65. The cases interpreting the “fundamental alteration” defense in the context of *Olmstead* claims thus fall into two (2) categories: either (a) the plaintiffs sought an increase in available slots in a waiver program, or (b) they sought services sufficient to permit them to remain in the community after they were already being served in the community. The defendants’ most blatant flaw here is that they rely exclusively on cases that fall into sub-category (a) when this case falls squarely within sub-category (b). Thus, they rely on *Arc of Washington State*,

*Inc. v. Braddock*, 427 F.3d 615 (9<sup>th</sup> Cir. 2005), and *Sanchez v. Johnson*, 416 F.3d 1051 (9<sup>th</sup> Cir. 2005), both of which concerned attempts by the plaintiffs to actually increase *enrollment* in a waiver program. This is not such a case.

66. To the contrary, both parties have cited a series of cases concerning decreases in *services* in the context of *Olmstead* claims. See *Radaszewski ex rel. Radaszewski v. Maram*, 383 F.3d 599 (7<sup>th</sup> Cir. 2004); *Fisher v. Oklahoma Housing Authority*, 335 F.3d 1175 (10<sup>th</sup> Cir. 2003); *Townsend v. Quasim*, 328 F.3d 511 (9<sup>th</sup> Cir. 2003); *Helen L. v. DiDario*, 46 F.3d 325 (3d Cir. 1995). In *none* of these cases did the courts determine the defendants' "fundamental alteration" defenses persuasive.
67. Indeed, in *Crabtree v. Goetz*, 2008 WL 5330506 (M.D. Tenn. Dec. 19, 2008), the federal court reached the precise issue presented by this case, holding invalid a 35-hour-a-week cap on services. The logic of *Crabtree* and similar cases is persuasive and flows directly from the Court's decision in *Olmstead*.
68. b. *Second*, the defendants' argument appears, to a certain extent, to simply be a reiteration of its waiver service limits themselves. That is, they appear to argue that eradicating the caps presently at issue would result in a "fundamental alteration" of their waiver program simply because their waiver program possesses the caps presently at issue. This is quite clearly circular logic, and the Court is not persuaded. Were this a "fundamental alteration" entailed, then *Olmstead* would be an entirely hollow promise to severely disabled persons.

69. The Court is not persuaded by the defendants' assertion that they should at least be permitted a certain amount of leeway simply because the federal government approved their waiver application. This is so for several reasons:

- Clearly, and most importantly, even the federal government does not possess the authority to violate federal law.
- Additionally, the undisputed facts of this case are that the defendants did not conduct any surveys or other research into the effect of imposing the caps on waiver enrollees until long after their waiver application was approved; as such, any decision by the federal government was made without the knowledge that the waiver application would result in the re-institutionalization of many enrollees.
- And finally, the plaintiffs have brought claims under both federal *and* state law, and the federal government was likely unaware—and certainly not an authority on—Indiana law even at the time of approval.

70. c. *And third*, the defendants appear to assert a cost-based defense, which is generally what a “fundamental alteration” defense will entail. First of all, such a defense requires actual evidence and, as noted above, the defendants' designation of evidence must be stricken. For that reason alone, they have failed to carry their burden. Every bit as importantly, though, is that they have explicitly jettisoned any cost-based explanation for the forty-hour-a-week caps on attendant care services. Thus, Karen Filler testified in her 30(B)(6) deposition as follows:

Q: Is the cost of receiving services in the community ever considered by the state in determining whether to approve or deny a given application [for waiver services]?

A: No.

Dep. of Filler, at 53. To the contrary, Ms. Filler explained that the *only* reason for the caps was the agency's desire that more individuals request prior authorization

services. The defendants may not assert this reason during discovery and then rely on a cost-based defense on summary judgment.

71. Moreover, the defendants' arguments are inherently contradictory. On the one hand, their argument under the ADA and the Rehabilitation Act requires them to demonstrate a significant outlay in additional state funding that would result in a fundamental alteration of their program—that is, they must demonstrate that numerous persons will be affected by the caps (and numerous services therefore provided). But on the other hand, part of their argument under state and federal Medicaid law is that these caps are permissible precisely because they affect so few persons. The defendants may not have their cake and eat it too.
72. Indeed, the defendants' initial plan was never to entirely foreclose the plaintiffs' receipt of services in the community. To the contrary, their plan was simply to force waiver enrollees to utilize traditional state plan services, and the forced institutionalization of the plaintiffs results simply from the defendants' belated realization that traditional state plan services are not available in all locations and to many waiver enrollees. Dep. of Filler, at 62. Under such circumstances, the observation in *Townsend v. Quasim*, 328 F.3d 511 (9<sup>th</sup> Cir. 2003), that there exists a crucial distinction between *whether* services will be provided and *where* they will be provided is just as applicable to the distinction between whether services will be provided through the waiver program or through the prior authorization program. Surely this distinction does not result in a fundamental alteration of the entire program. See *Helen L. v. DiDario*, 46 F.3d 325, 338 (3d Cir. 1995)

(rejecting an argument that a fundamental alteration would result were a state forced to move funds from one “separate line[]” of its budget to another).

73. The plaintiffs assert that a “fundamental alteration” will not result unless and until the total cost of providing care to waiver enrollees in the community exceeds the total cost of providing care to waiver enrollees in institutional settings. While that has a certain appeal as a bright-line rule, it is not an issue that the Court need reach at present. It is clear that, at the very least, a “fundamental alteration” will not result if the defendants are forced to implement their waiver program without the caps on attendant care services.

74. The plaintiffs are therefore entitled to judgment on their claims under the ADA and the Rehabilitation Act.

*State and Federal Medicaid Law*

75. The plaintiffs’ third legal claim arises under both Indiana and federal Medicaid law.

*A. Background to Medical Necessity Requirement of Medicaid Law*

76. Federal law requires that a service reimbursed by Medicaid “be sufficient in amount, duration, and scope to reasonably achieve its purpose.” 42 C.F.R. § 440.230(b). It also specifies that the State “may not arbitrarily deny or reduce the amount, duration, or scope of a required service ... to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.” 42 C.F.R. § 440.230(c).

77. In *Weaver v. Reagen*, 886 F.2d 194 (8<sup>th</sup> Cir. 1989), the Eighth Circuit Court of Appeals, in ordering the state to provide Medicaid coverage for an anti-AIDS

- medication, noted that these federal regulatory provisions require “that a state Medicaid plan provide treatment that is deemed ‘medically necessary’ in order to comport with the objectives of the [Medicaid] Act.” *Id.* at 198; *see also Beal v. Doe*, 432 U.S. 438, 444 (1977) (noting that “serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage”).
78. Recent Indiana jurisprudence underscores this notion that federal law does not permit the state to deny Medicaid payment for medically necessary covered services. *See Thie v. Davis*, 688 N.E.2d 182 (Ind. Ct. App. 1997), *trans. denied*; *Davis v. Schrader*, 687 N.E.2d 370 (Ind. Ct. App. 1997); *Coleman v. Indiana Family & Soc. Servs. Admin.*, 687 N.E.2d 366 (Ind. Ct. App. 1997).
79. In *Thie*, for example, the court held that if medically necessary treatments are excluded from Medicaid coverage, then the coverage is not sufficient in amount, duration and scope to fulfill the purpose of providing the service, as required by federal regulation. *Thie*, 688 N.E.2d at 186. In both *Thie* and *Coleman*, the court of appeals focused specifically on whether dentures could be denied to Medicaid recipients where the evidence demonstrated that the dentures were a medical necessity. In both cases the recipients sought dentures. In both cases the evidence demonstrated that the dentures were a medical necessity. In both cases Medicaid authorities denied coverage to the recipients solely because dentures were categorically excluded from coverage, even though Indiana chose to cover other dental services. However, in both cases, the court held that the state must provide Medicaid payment for medically necessary dentures.

80. In so doing, the Indiana Court of Appeals noted that

the State may limit Medicaid expenditures and Medicaid coverage so long as the limitations are consistent with federal Medicaid law. The federal law allows the State to decline to cover dental services. If, however, the State opts to cover dental services, the federal law requires that medically necessary dental treatments be covered.

*Id.*; see also *Schrader*, 687 N.E.2d at 372 (finding that “[t]o be sufficient in amount, duration, and scope, the State Medicaid program must cover medically necessary treatments”); *Coleman*, 687 N.E.2d at 368 (holding that “the State may limit coverage by excluding optional service categories and by narrowing the definition of medical necessity; however, once the State chooses to provide coverage within an optional category, the State must cover medically necessary treatments within that category”).

81. The *Thie* court reached an identical conclusion with regard to Indiana Medicaid law.

*B. Application of Medicaid Law to Waiver Programs*

82. The defendants’ primary argument as it relates to the plaintiffs’ claims under state and federal Medicaid law is not that it is providing payment for medically necessary services but simply that this requirement does not apply in the context of Medicaid waiver programs. Insofar as the defendants’ other arguments were previously rejected by *Thie* and its progeny—which are, of course, binding on this Court—this argument is treated at greatest length.

1. Application of Federal Medicaid Law

83. The defendants spend the most time arguing that federal Medicaid law does not apply to Medicaid waiver programs, but instead only applies to so-called “state plan” or “prior authorization” services. However, the Court is not persuaded.
84. The Court notes at the outset that the parties have cited only one case that reached this precise issue, and in that case the Tenth Circuit Court of Appeals decided not only that federal Medicaid law in general applies to waiver programs but that the “medical necessity” requirement in particular does. Thus, in addressing the *identical* argument, the Tenth Circuit in *Fisher v. Oklahoma Health Care Authority*, 335 F.3d 1175 (10<sup>th</sup> Cir. 2003), noted as follows:

Citing no authority, the defendants essentially argue that this waiver of comparability forecloses all of the plaintiffs’ arguments under the Medicaid statute because the . . . benefits under the waiver program are not required to be comparable to those outside the waiver program.

. . . Simply put, comparability is not at issue. The plaintiffs’ Medicaid claims do not hinge upon a comparison of benefits in and outside of the waiver program. Rather, they allege violations of the Medicaid statute in absolute terms. Although courts have understood the waiver of comparability to allow for more stringent *eligibility* requirements for the waiver program than the Medicaid as a whole, we do not understand the waiver of comparability to give the state virtual *carte blanche* to disregard all the requirements of the Medicaid statute as to participants in a waiver program.

*Fisher*, 335 F.3d at 1186 n.12 (citation and quotation omitted) (emphasis in original). In *Fisher*, the plaintiffs argued specifically that a cap on services under a waiver program “violate[d] the Medicaid Act’s . . . ‘medical necessity’ standard[.]” *Id.* at 1185. The defendants’ fundamental error in the present case is therefore in arguing, essentially, that waiver programs need not abide by federal Medicaid law, and that a state therefore has “*carte blanche*” to disregard these requirements. This is not so.

85. This conclusion flows directly from the statute itself. Thus, the code provision specifically permitting a state to adopt a waiver program provides that “a State plan . . . may *include* as ‘medical assistance’ under such plan payment for part or all of the cost of home or community-based services”—that is, a waiver program. 42 U.S.C. § 1396n(c)(1) (emphasis added). “State plan services” are not independent from “waiver services”; to the contrary, they *include* them, and “waiver services” are therefore merely a subset of “state plan services.”
86. Just as importantly, although the defendants attempt to minimize the import of their argument, it is clear that their argument—if accepted—would result, at the very least, in the entirety of 42 U.S.C. § 1396a(a) being deemed inapplicable to waiver programs. This is because this entire—and extremely lengthy—statute is preceded by the typical language for spending clause legislation: “The State plan for medical assistance must . . . .” However, refusing to apply this statute to waiver programs would prove non-sensical.
87. After all, 42 U.S.C. § 1396n(c)(3)—which permits States to create waiver programs such as the one presently at issue—by its terms permits States to “waiver” one of three provisions of 42 U.S.C. § 1396a(a) in the context of their particular waiver program: they may waive the requirements of 42 U.S.C. § 1396a(a)(1) (related to statewideness), 42 U.S.C. § 1396a(a)(10)(B) (related to comparability), or 42 U.S.C. § 1396a(a)(10)(C)(i)(III) (related to certain income and resource requirements). It is undisputed in this case both that Indiana has chosen to waive the comparability requirement of 42 U.S.C. § 1396a(a)(10)(B)

and that none of these “waivable” sections are those from whence the “medical necessity” requirement derives.

88. However, as noted above, if the defendants’ argument were meritorious, then *none* of 42 U.S.C. § 1396a(a) would be applicable to Medicaid waiver programs. This would make entirely unnecessary and superfluous a statute permitting three (3) very specific subsections of that statute to be waived in this limited context. Insofar as this Court must, of course, presume that Congress did not enact a meaningless statute, the defendants’ argument may not be meritorious.

2. Application of Indiana Medicaid Law

89. The defendants’ argument that the requirement of Indiana Medicaid law that all “medically necessary” covered services be provided is also tenuous.
90. This argument can be summarized as follows: according to the defendants, Indiana Code § 12-15-21-3 simply does not apply to Medicaid waiver programs. However, they provide no support whatsoever for this argument.
91. To the contrary, there is absolutely nothing in this statute that would limit its scope to non-waiver programs. Indeed, the defendants at present do not dispute that Medicaid waiver services are still “Medicaid services” such that they fall within the ambit of this code section. Moreover, Indiana law makes clear that Indiana Code § 12-15-1-1, *et seq.*, applies to the administration of the *Medicaid* program as a whole. IND. CODE § 12-15-1-1 (speaking of the administration of “the Medicaid program under 42 U.S.C. 1396 *et seq.*”).

92. As such, regardless of whether federal Medicaid law makes a “medical necessity” requirement applicable to waiver programs, it is clear that Indiana Medicaid law does.

*C. Medical Necessity Requirement in this Case*

93. Having decided that a requirement that “medically necessary” services be covered is applicable to Medicaid waiver programs, this Court is bound by the decisions in *Thie v. Davis*, 688 N.E.2d 182 (Ind. Ct. App. 1997), *trans. denied*, *Davis v. Schrader*, 687 N.E.2d 370 (Ind. Ct. App. 1997), and *Coleman v. Indiana Family & Soc. Servs. Admin.*, 687 N.E.2d 366 (Ind. Ct. App. 1997). The defendants’ remaining arguments have previously been resolved by Indiana’s appellate courts and, while they may certainly argue to the Indiana Court of Appeals that this precedent should be overturned, that is for that court to decide.

94. Thus, the defendants raise three (3) additional arguments that can easily be disposed of:

- a. *First*, citing decisions from other jurisdictions, they argue that the “medical necessity” requirement permits a State Medicaid agency to enact standards such that it provides *most* services for *most* people. As at present, the defendants in *Thie* itself argued that the “medical necessity” requirement “allows exclusion of medically necessary treatment if the exclusions are designed to provide the most services for those persons most in need.” *Thie*, 688 N.E.2d at 186 (internal quotation omitted). This argument was soundly rejected in *Thie*, in which the Court held unequivocally that “[t]he statute . . . establishes a precept: medically necessary treatment must be covered.” *Id.*
- b. *Second*, the defendants argue that “medically necessary” services need not be covered in so-called “optional” service categories. This, too, was answered by the Indiana Court of Appeals in *Thie*, which itself concerned dental services, an optional service category. *Id.* at 184–86 (concluding that “[t]he federal law allows the State to decline to cover dental services [but i]f . . . the State opts to cover dental services, the federal law requires that medically necessary dental services be covered”). At oral argument on the parties’ cross-motions for summary judgment, counsel for the defendants argued that “optional services”

is a term of art in Medicaid law and does not apply to waiver services. The Court cannot, however, agree. It does not appear that the term “optional services” appears in either 42 U.S.C. § 1396a or 42 U.S.C. § 1396d, and it is clear that waiver services are “optional” within the normal understanding of the word. Therefore, the defendants’ argument here was answered by *Thie*, and provided that a State elects to provide services in an optional category it must cover all medically necessary services in that category.

- c. *Third*, the defendants argue—without any supporting evidence—that “attendant care” services may not even lend themselves to a determination of “medical necessity.” However, this argument can carry little weight, for Karen Filler—the defendants’ own witness—testified that these services were determined (at least prior to the 2008 amendments to the waiver program) on the basis of the State’s determination of what was necessary for an individual to remain safely and securely in the community. This is a determination of the proper “amount, duration, and scope” of that service. Moreover, were the defendants’ argument meritorious, then it was also necessarily apply to “home health services,” which are the prior authorization equivalent of attendant care services. However, following *Beal*, *Thie*, and their progeny, there can be no doubt that such a standard applies in this context.
95. Consequently, the “medical necessity” standard applies to the services presently at issue. Insofar as the defendants do not even attempt to argue that the forty-hour-a-week caps on attendant care services comport with such a standard, the plaintiffs are entitled to judgment on their claims under state and federal Medicaid law.

#### Notice Procedures

96. Finally, the plaintiffs argue that the notices issued by the Indiana Family and Social Services Administration to deny or reduce services under the waiver program to persons subject to the cap violate federal Medicaid law. The Court agrees.
97. Federal Medicaid law requires that any individual who suffers an adverse action on his or her eligibility for Medicaid services be provided with a notice detailing the reasons for the adverse action and the individual’s right to appeal the adverse

action and request an administrative fair hearing. 42 C.F.R. § 431.206(d). This notice must contain, *inter alia*, “[a] statement of what action the State . . . intends to take,” “the reasons for the intended action,” and “[t]he specific regulations that support, or the change in Federal or State law that requires, the action.” 42 C.F.R. § 431.210.

98. An “action” refers to “a termination, suspension, or reduction of Medicaid eligibility or covered services.” 42 C.F.R. § 431.201.

99. It is undisputed in this case that the notices issued by the agency do not contain a citation to “[t]he specific regulations that support, or the change in Federal or State law that requires,” the reduction in services. Controlling regulations may be read in only one manner, and it is clear that these notices must contain such a citation.

100. The defendants’ only argument that they are complying with this law is that it simply does not apply to waiver programs. As noted above, however, it is clear that it does.

101. The plaintiffs are therefore entitled to judgment on their notice claim as well.

*Incorporation*

102. Any conclusion of law shall be deemed a finding of fact to the extent necessary.

**SUMMARY JUDGMENT AND ORDER**

For the foregoing reasons,

**IT IS THEREFORE ORDERED** that the plaintiffs’ Motion to Strike is hereby GRANTED, and that the defendants’ response in opposition to the plaintiffs’ Motion for

Summary Judgment and the defendants' two-volume designation of evidence are hereby STRICKEN from the record in their entirety.

**IT IS FURTHER ORDERED** that the defendants' Motion for Summary Judgment is hereby DENIED.

**IT IS FURTHER ORDERED** that the plaintiffs' Motion for Summary Judgment is hereby GRANTED.

**IT IS FURTHER ORDERED** that Edna Chadwell's Individual Petition for Judicial Review of Final Agency Action is hereby GRANTED.

**IT IS FURTHER ORDERED** that the following relief shall, and hereby does, issue in this case:

I. PETITION FOR JUDICIAL REVIEW

A. The action and/or inaction of the Indiana Family and Social Services Administration limiting the attendant care hours available to petitioner Edna Chadwell through the Aged and Disabled Waiver program is hereby set aside.

B. This cause is therefore remanded to the agency with instructions that it approve Ms. Chadwell for at least seventy (70) hours each week in attendant care services.

II. DECLARATORY RELIEF

A. A declaratory judgment is entered pursuant to Rule 57 of the Indiana Rules of Trial Procedure as follows:

It is declared that the defendants' practice or policy whereby individuals enrolled or who will be enrolled in Indiana's Aged and Disabled Waiver program are not permitted "attendant care" hours in excess of forty (40) hours per week is violative of the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, and Indiana and federal Medicaid law.

B. A declaratory judgment is also entered pursuant to Rule 57 of the Indiana

Rules of Trial Procedure as follows:

It is declared that the defendants' unpromulgated practice or policy whereby individuals enrolled or who will be enrolled in Indiana's Aged and Disabled Waiver program are not permitted "attendant care" hours in excess of forty (40) hours per week is violative of Indiana Code § 4-22-2-1, *et seq.*, insofar as the practice or policy was not properly promulgated by the Indiana Family and Social Services Administration.

C. A declaratory judgment is also entered pursuant to Rule 57 of the Indiana

Rules of Trial Procedure as follows:

It is declared that the defendants' practice or policy whereby individuals enrolled or who will be enrolled in Indiana's Aged and Disabled Waiver program and who receive or will receive notices of adverse action as a result of a limit on the amount of services that they may receive under the waiver program but without providing the individuals with the information enumerated in 42 C.F.R. § 431.210 is violative of federal Medicaid law.

III. INJUNCTIVE RELIEF

A. The defendants are hereby permanently enjoined from enforcing the forty-hour-a-week caps on attendant care services against individuals enrolled in or who will be enrolled in Indiana's Aged and Disabled Medicaid Waiver Program.

B. The defendants are further permanently enjoined from issuing notices of adverse action as a result of a limit on the amount of services that a waiver enrollee may receive under the Indiana's Aged and Disabled Medicaid Waiver Program without providing the enrollee with the information enumerated in 42 C.F.R. § 431.210.

**SO ORDERED this the 8<sup>th</sup> day of March, 2010.**

March 8, 2010  
Date

J. Blaine Allen  
Judge, Clay County Superior Court

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