No. 02-3657

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

DONNA RADASZEWSKI, guardian for ERIC RADASZEWSKI,

Plaintiff-Appellant,

v.

JACKIE GARNER, Director, Illinois Department of Public Aid,

Defendant-Appellee.

Appeal From The United States District Court
For The Northern District of Illinois,
Eastern Division

Case No. 01 CV 9551
The Honorable Judge John W. Darrah

REPLY BRIEF OF PLAINTIFF-APPELLANT, DONNA RADASZEWSKI

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I. Eric Is Not Receiving New Services

For years Eric has been successfully treated at home through nursing services paid for by Illinois in the Medicaid waiver program for medically fragile children. The purpose of the program, clearly articulated in DPA's regulation, is to prevent unnecessary institutionalization of the disabled participants, provided that home based care is cost effective. 89 Ill.Admin.Code §140.645.

Eric is living proof that treatment in a segregated setting, away from his family, consigned to an institution, is unnecessary for him. The cost considerations built into the children's waiver program continue to apply to these children as they turn 21. He continues to have the same needs. Illinois will still pay for their long-term care at the institution they require--whether hospital or nursing facility. Illinois' unexplained policy, however, is to impose a cap on the cost of their home-based services at a level that makes it impossible for the neediest of these children, like Eric, to remain at home as they turn 21, even though the cost remains less than institutional care.

This court has recently confirmed that the Rehabilitation Act and the ADA entitle persons with disabilities to care in the least restrictive environment. *Bruggeman v. Blagojevich*, 324 F.3d 906 (7th Cir. 2003). Defendant does not dispute that Eric is eligible for Medicaid long term care services in an institutional setting, whether in a hospital or nursing facility.

Defendant does not dispute that Eric needs the 16 hours a day nursing care he receives at home, and that if he doesn't continue to receive those services at home, he will have to go to an institution -- a hospital-- to get the nursing care he needs in order to survive. Defendant does not dispute that the services are a cost effective alternative to institutional care. Defendant argues, however, that Illinois' policy of discontinuing payment for the cost effective nursing care Eric has received at home and requiring Eric to go to an institution is not the unjustified isolation of a person with disabilities prohibited under *Olmstead*, because Illinois does not have an existing community-based program that permits such extensive home-based nursing services for adults. Defendant's argument is not consistent with *Olmstead* and not supported by the state's own regulations for the HSP program.

Defendant tries to marginalize Eric's case, mis-characterizing it as an attempt to require Illinois to provide any and all services needed to allow the disabled to live at home. (Def .Brief., p. 15.) Plaintiff seeks continuation of the nursing services Eric has received in his home with Medicaid payment since 1995.[1] He was eligible to receive those services because of the state's own determinations that: (1) this care was appropriate for him, and (2) that it was cheaper to provide the care to Eric in his home than it would be to pay for the alternate, institutional level of care he otherwise requires.

Defendant's main argument, however, is that in order to state a claim of

[1] Defendant refers to the nursing services Eric needs as "shifts." Plaintiff is unclear as to the source or authority for referring to the services in terms of shifts. Plaintiff seeks the specific services DPA approved for Eric in the children's waiver program-- 16 hours/day nursing services with 336 hours each year of respite services to relieve his parents.

discrimination under *Olmstead*, the state must have an existing home care program that meets all of Eric's needs without any modification or adjustment in the program. Defendant argues that Illinois has no such program because once Eric turned 21, he was no longer eligible for the waiver program for children. Defendant argues that Eric cannot meet the eligibility requirements for the Home Services Program (HSP) for adults, because the cost of the nursing services Eric needs exceeds the cap the state has established for that program. Ergo, defendant argues, Eric cannot meet the eligibility requirements of any community-based program, and must go to an institution if he must rely on Medicaid payment for his care. According to defendant, the state can set any criteria it wishes for its home based programs and not run afoul of *Olmstead*. Eric is not entitled to care in the least restrictive environment, irrespective of how cost effective home-based care is for him.

Olmstead, however, does not support defendant's argument that the state must have an existing community-based program that meets every need of the person with disabilities, with no modification or accommodation in any state policy or practice. States do not have free rein to establish criteria for community-based programs that have the effect of unnecessarily segregating persons with disabilities in institutions, and then turn around and claim they are beyond the reach of the ADA because the institutionalized, disabled person cannot meet the eligibility requirements of the community-based program. If that were true, no case would ever progress to evaluation of fundamental alteration described in *Olmstead*. Indeed, the *Olmstead* plaintiffs could not have made out a claim, since Georgia argued that one of the criteria for community placement was funding for the placement and that the

plaintiffs weren't eligible for placements unless and until funding for those specific placements became available. *Olmstead v. L.C.* , 527 U.S. 581, 594 (1999). There were no "existing" community-based services that would encompass the *Olmstead* plaintiffs at the time they filed their lawsuit. The ramification of defendant's existing community-based service argument is that there could never be any *Olmstead* claims, because logically, existing home-based programs would either meet the needs of persons with disabilities who are institutionalized (or at risk of it), or the persons with disabilities would not meet the eligibility criteria for the home-based programs.

Defendant describes footnote 14 of the majority's opinion in *Olmstead* as the "key factor" set out in the case, in support of his claim that there must be an existing home-based program that meets Eric's needs without any modification in order for plaintiff to state a claim under *Olmstead*. (Def. Brief, p. 160.) In footnote 14, however, the Court is not referring to the existing community-based services the state in fact provides. The Court is referring to the existing, segregated services the State provides. The Court was responding to the dissent's suggestion that the decision imposed on states the duty to provide a certain level of benefits to persons with disabilities. Justice Ginsburg responded in footnote 14 that the ADA does not "require states to provide a certain level of benefits to individuals with disabilities" but explained that with respect to services they do provide, they must adhere to non-discrimination principles outlined in her opinion. In other words, if a state limited Medicaid payment for hospital care to 14 days per year, as in *Alexander v. Choate*, 469 U.S. 287 (1985), a person with disabilities would not have a claim to 365 days of home based-

care as an alternative to hospital care, since the ADA does not guarantee a level of care. But where, as here, the state does provide long-term institutional care 365 days per year, but refuses to pay for cost effective home-based services as an alternative to that care, the question becomes not whether, but where the state provides services, and the anti-segregation principles absent fundamental alteration set out in *Olmstead* apply.

The Ninth Circuit Court of Appeals recently decided this very issue in *Townsend v. Quasim*, ___ F.3d ___, 2003 WL 1989623 (9th Cir., 2003). Levi Townsend, in his eighties, a bi-lateral amputee with diabetic peripheral vascular disease, was in a community-based care program Washington State made available to persons with disabilities as an alternative to the long term institutional care they would otherwise require. Washington gave the community-based care choice only to persons who were categorically eligible for Medicaid. For those whose incomes exceeded the categorically needy level, but who met the qualifications for Medicaid as medically needy, Washington offered long term care in an institutional setting only. When Mr. Townsend's income increased slightly above the categorically needy level, the state sent him a notice that within 30 days he would have to leave the successful community care setting in which he had been receiving care and enter a nursing home or lose Medicaid payment for his care.

In defending against Mr. Townsend's *Olmstead* claim, Washington argued that it had no existing community-based program for the medically needy, and that *Olmstead* applied only where the state had such an existing program. The *Townsend* court examined the ADA, the integration regulation, and the Court's rationale in *Olmstead*, and concluded that the

state's policy of providing long term care services in a segregated setting only is a form of discrimination based on disability. It held that the ADA required reasonable modification of policies having this segregating effect unless the state could show such modification would fundamentally alter the nature of the services offered by the state. The appropriate focus is on whether the state provides the needed services in a segregated setting, but not in an integrated one, and why this segregation is necessary:

> The precise issue is not whether the state must provide the long term care services sought by Mr. Townsend and the class members–but in what location these services will be provided. Mr. Townsend simply requests that the services he is already eligible to receive under an existing state program ... be provided in the community-based home where he lives, rather than the nursing home setting the state requires. See *Helen L. v. DiDario*, 46 F.3d 325, 337-39 (state violated the ADA's integration mandate by not providing state-funded attendant care services for which plaintiff was eligible in her own home, rather than a nursing home).

The court rejected Washington's "no existing community care" defense, concluding that:

> Characterizing community-based provision of services as a new program of services not currently provided by the state fails to account for the fact that the state is already providing those very same services. If services were determined to constitute distinct programs based solely on the location in which they were provided, *Olmstead* and the integration regulation would be effectively gutted. States could avoid compliance with the ADA simply by characterizing services offered in one isolated location as a program distinct from the provision of the same services in an integrated location.

2003 WL 1989623 at *5.

That is just what defendant is attempting to do here, by characterizing the in-home nursing services as a distinct service, when what Eric needs, at home or in an institution, is skilled nursing services. Eric does not need any of the residential services of an institution. He only needs nursing care. To get the Medicaid payment he needs for that care, Illinois now requires him to go to an institution. Under *Olmstead*, that practice violates the ADA,

unless the state can show a fundamental alteration is required.

Defendant argues that plaintiff has failed to state a *prima facie* claim under *Olmstead*, because its officials have not found Eric eligible for home-based services in excess of the cap. (Def. Brief, p. 24.) This however, is just another way of stating defendant's argument that Illinois must have an existing community care program that meets Eric's needs. Its officials find that Eric isn't eligible for services in excess of the cap, because they impose the cap, not because he doesn't require continuation of the same level of nursing services the state had approved for him for years as a cost effective alternative to institutional care. The Court in *Olmstead* stated that placement in a community setting is in order when the state's "treatment professionals have determined that community placement is appropriate." 527 U.S. 581, 587. Its further explanation of this criterion makes clear that it was concerned with the medical opinions of the state's public health officials as to whether community-based treatment would help the person with disabilities, not state officials' opinions as to eligibility criteria related only to affirming a policy of segregation. The Court elaborated that courts could normally defer to the "reasonable medical judgments of public health officials" as to whether the persons with disabilities consigned to an institution could benefit from and handle community based care. *Olmstead v. L.C.*, 527 U.S. 581, 602. See also, *Pennsylvania Protection and Advocacy v. Department of Public Welfare of Pennsylvania*, 243 F.Supp.2d 184, 190-192 (M.D. Pa. 2003), following the same interpretation. As described above and in plaintiff's opening brief, Illinois has confirmed its approval of home-based services as appropriate and beneficial for Eric for years. It is this fact which makes it so difficult to understand the

state's action to end those services when he turned 21.[2]

II. Illinois Statutory Provisions and Administrative Rules Authorize the state to Pay for the Services Eric Needs in His Home

Illinois has an existing program that can cover the in-home nursing care Eric needs. As defendant acknowledges at pages six and 22 of his brief, IDPA is willing to provide nursing services to Eric in his home through the HSP. In her administrative decision regarding the services Eric could receive when he turned 21 issued in 2000, defendant's

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[2] In the first section of his argument, defendant discusses Section 504 and the ADA without regard to the Supreme Court's *Olmstead* decision. Def . Br. 12-14. Defendant notes that in enacting the ADA, Congress explicitly expressed its intent that the ADA be interpreted consistently with *Alexander v. Choate*, H.R. Rep. 101-485(II), 101 Cong., 2d Sess. 84 (1990). Defendant appears to be suggesting that Congress was endorsing that part of the Court's decision in *Alexander* regarding even-handed treatment of the disabled, an argument rejected by the Court in *Olmstead*. Rather, that Congressional Report made reference to the decision in *Alexander* in the context of defining what services constituted discrimination under Title II of the ADA, including the notion that discrimination could be shown by disparate impact, not just intentional conduct:

> Subparagraph 102(b)(3) incorporates a disparate impact standard to ensure that the legislative mandate to end discrimination does not ring hollow. This standard is consistent with the interpretation of section 504 by the U.S. Supreme Court in *Alexander v. Choate*, 469 U.S. 287 (1985). The Court in *Choate* explained that members of Congress made numerous statements during passage of section 504 regarding eliminating architectural barriers, providing access to transportation, and eliminating discriminatory effects of job qualification procedures. The Court then noted: "These statements would ring hollow if the resulting legislation could not rectify the harms resulting from action that discrimination by effect as well as by design." 469 U.S., at 297.

H.R. REP. 101-485(II)(reprinted in 1990 U.S.C.C.A.N. 343), see also H.R. REP. 100-711, 1988 U.S.C.C.A.N. 2173, 2186, with respect to the Fair Housing Amendments, "discrimination against handicapped persons is not limited to blatant, intentional acts of discrimination. Acts that have the effect of causing discrimination can be just as devastating as intentional discrimination. In *Alexander v. Choate*, the Supreme Court observed that discrimination on the basis of handicap is "most often the product, not of invidious animus, but rather of thoughtlessness and indifference–of benign neglect."

predecessor stated: "All parties are in agreement that the grievant is eligible for Home Service program services." (A. P - 41). Defendant argues that state rules establish a cap for the HSP, called a service cost maximum (SCM), equal to an amount that would not exceed the cost of care in a nursing facility. In support of the assertion of the existence of such a limitation, defendant cites four Illinois administrative rules: 89 Ill. Admin. Code §§676.10, 676.30(j), 682.100(g) and 682.100(h). First, none of the rules cited uses the cost of care in a nursing facility as a limitation. Second, a review of the underlying statute and Illinois rules pertaining to the HSP indicates that in fact no such limitation exists but rather that IDPA has discretion to negotiate an appropriate rate of reimbursement, so long as the amount does not ultimately exceed the amount that would be charged by a hospital - the same approach to reimbursement that IDPA offered to Eric before he turned 21.

A. The Cited Rules

None of the four rules cited mentions a cost limitation pegged to what IDPA would pay at a nursing home, as defendant asserts. Administrative rule §676.10 describes the purpose and types of home services programs stating in subsection (a) that the HSP waiver is designed to prevent unnecessary institutionalization of individuals who "may instead be satisfactorily maintained at home at a lesser cost to the state." Rule §676.30(j) is one of the definitions contained in the Definition rule for HSP's and defines the "Home Services Program (HSP)" as "a state and federally funded program designed to allow Illinois residents, who are at risk of unnecessary or premature institutionalization, to receive necessary care and services in their homes, as opposed to being placed in an institution." Rule §682.100(g)

appears in the HSP eligibility section entitled "General Eligibility Criteria," and states that a customer must "obtain certification from a physician . . . that the individual is in need of long-term care and this care can safely and adequately be provided in the individual's home. . . ." Subsection (h) provides that the customer "not require in-home services that are expected to cost more than the cost the state would pay for institutional care for an individual with a similar DON score." As will be discussed directly below, state administrative rules would establish that SCM as the cost of a hospital.

B. The Statute and Administrative Rules Do Not Limit Reimbursement for HSP Nursing Services to the Cost at a Nursing Home

The Illinois Public Aid Code authorizes IDPA to obtain a waiver from The United States Department of Health and Human Services "to allow payment for home and community-based services . . . ." 305 ILCS 5/5-5a. Under Illinois law, another agency, the Illinois Department of Human Services (DHS), administers the program. 20 ILCS 2405/3(f). The statute directs DHS to establish a program of services to prevent unnecessary institutionalization of . . . persons in need of long term care who are established as . . . disabled as defined by the Social Security Act, thereby enabling them to remain in their own homes or other living arrangements." 20 ILCS 2405/3(f). Among the services that DHS is authorized to reimburse are home nursing services. 20 ILCS 2405/3(f)(2).

The statute provides a cost limitation for these services:

> The services shall be provided to eligible persons to prevent unnecessary or premature institutionalization, to the extent that the cost of the services, together with the other personal maintenance expenses of the persons, are reasonably related to the standards established for care in a group facility appropriate

to their condition.

20 ILCS 2405/3(f). Thus, the statute establishes two requirements that are relevant here: the cost of services is subject to limitation standards [set by DHS] and those limitations are pegged to the group facility appropriate to the recipient's medical condition, not limited to the cost of services at a nursing home. IDPA determined that the group facility appropriate to Eric's condition is a hospital when it approved him for nursing services before he was age 21.

DHS has promulgated rules that establish relevant standards. They indicate that in the presence of exceptional circumstances, the rate is set to meet the medical needs of the recipient, subject to the statutory limitation just described. DHS rules establish service cost maximums using a system of determination of need (DON). 89 Ill. Admin. Code. §§679.20 establishes the process for determining a recipient's need; 89 Ill. Admin. Code. §§679.30 establishes a scoring system based upon that process; and 89 Ill. Admin. Code. §§679.50 sets service cost maximums based upon the DON score. The maximum amount for an individual served under the HSP is presently $2,329.00 each month. 89 Ill. Admin. Code §679.50(b). That amount is far less than what a person such as Eric needs to remain in the community. However, both the statute and the administrative rules recognize that there are individuals with substantial medical needs. Accordingly, the legislature has provided in the context of nursing homes the concept of "exceptional care" providing that the rate of payment to the nursing home "shall be negotiated with the facilities offering to provide the exceptional medical care." 305 ILCS 5/5-5.8a(a). The statutory subsection concludes by

stating that "[p]ayment for exceptional medical care shall not exceed the rate that the Illinois Department [IDPA] would be required to pay under the Medical Assistance Program *for the same care in a hospital*." (Emphasis added). Subsection (b) of the statutory provision directs IDPA to adopt rules in order to implement the statutory mandate.

Still in the context of nursing homes, IDPA has established by rule the "Exceptional Care Program." 89 Ill. Admin. Code §140.569. The rule defines "exceptional medical care" as "the level of care with extraordinary costs related to services which may include nurse, ancillary specialists services, and medical equipment and/or supplies that have been determined to be a medical necessity." 89 Ill. Admin. Code §140.569 (a)(2). That subsection goes on to explain that this category may include "persons who are in need of exceptional care services and who would otherwise be in an alternative setting at a higher cost to the Department [IDPA]." IDPA had previously determined Eric eligible for the Children's Medically Fragile, Technology Dependent, Disabled Persons Under 21 waiver, a requirement of which is that the cost of providing medical services to Eric in his home would be less than the cost to the state if those services were provided in a hospital, the level of care that the Department had determined that Eric needed. Thus, under the statute and regulation, IDPA is authorized to pay a nursing home up to the amount that it would reimburse a hospital for Eric's exceptional medical services.

The exceptional care procedures for nursing homes are also utilized in making payments for medical services in a person's home under the HSP. While the SCM for in-home services is generally limited by the DON score as discussed above at a maximum of

$2329.00 a month, DHS, by administrative rule, has provided for an exceptional care rate in the following terms: "Cases involving ventilator dependent customers and other customers with exceptional care needs whose need for care cannot be met by the SCM may have a rate established by Department of Public Aid (DPA) per 89 Ill. Admin. Code §684.70(c). 89 Ill. Admin. Code §682.520(c). The language "and other customers with exceptional needs" was added by an amendment to this rule adopted on and made effective as of May 26, 2000. 24 Ill. Reg. 7724. Eric is a customer with exceptional care needs as defined in 89 Ill. Admin. Code §140.569(a). Section 684.70(c) permits the SCM to be exceeded utilizing a higher rate established by IDPA. The exceptional care rate that the statute authorizes, as discussed directly above, can be as much as what it would cost the state to provide services to Eric in a hospital. As defendant explains in his brief at page 6, IDPA utilizes exceptional care procedures in determining services that will be offered under the HSP at home.

> In February 2000, ORS determined that Eric's complex medical diagnosis made him eligible for "exceptional care" in a nursing facility and thus he was eligible for an SCM of $4,593 per month for in-home services instead of the standard SCM of $1,857 allowed for a DON score of 70.

Def. Brief, p. 6. Defendant's description of the procedure is correct. The limitation he states, as the above argument indicates, is wrong. Illinois law does provide for a person such as Eric to receive services at home under the HSP as needed so long as the state would save money. The record on appeal in this judgment on the pleadings indicates that it would.

III. IDPA Changed its Rules During the Course of this Litigation.

Defendant's argument that Eric is seeking a new service not offered in this state, overlooks the fact that when Eric's mother brought this lawsuit after Eric turned 21, state law provided for nursing services at home for all persons, both under and over age 21. Both in its State Medicaid Plan and in the Illinois Administrative Code, IDPA authorized, without any limitation based upon age, nursing services in a person's home. The Illinois Supreme Court has found that Illinois' State Medicaid Plan is an administrative rule. *Senn Park Nursing Center v. Miller*, 104 Ill. 2d 169, 470 N.E.2d 1029, 1034 (1984).

Under procedures established by the United States Department of Health and Human Services (HHS), a state, utilizing a pre-printed template provided by HHS, checks which Medicaid services it will provide. For each service chosen, the state can attach a page indicating any limitations it is establishing for the service. The Illinois Plan in effect when Eric turned 21 checked private duty nursing services as a medical service that the state would provide. IDPA then set forth the limitations that would apply to this service in the authorized attachment, none of which are based upon age:

> 8. PRIVATE DUTY NURSING SERVICES
>
> Provided only when recommended by the physician. Requires prior approval. Services cannot be covered if provided by a relative.

The Attachment (Add. - 8-9) included in a second paragraph the following additional language which the Department had added to its description of limitations on services, because under the Medicaid Statute, 42 U.S.C. §1396d(r)(5), any such limitations could not

apply to medically necessary services for children under age 21:

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

This same language disclaiming any limitations for children under age 21 was added, for example, to the limitations on Home Health Services, described in the same attachment to the plan. (See Add.9).

Similarly, IDPA's published rules also provided for in-home nursing services and private duty nursing services. 89 Ill. Admin. Code §§140.435 and 140.436. Neither of those regulations, (Add.-10-13) contained any limitations based upon age. After Ms. Radaszewski filed suit in state court in this matter alleging that IDPA followed an unwritten policy to impose additional restrictions that eliminated nursing services at home for persons aged 21 or older (App. p. A-13), and alleged a violation of the Illinois Administrative Procedure Act, 5 ILCS 100/5-5 *et seq. (APA)*, defendant sought and obtained approval from HHS to change its State Medicaid Plan and eliminate private duty nursing as a covered Medicaid service. Defendant's predecessor then unsuccessfully argued in state court that Ms. Radaszewski's case was moot. Instead the state trial court enjoined the modification of Eric's nursing services, finding that defendant had not complied with the requirements of the APA. Thereafter, IDPA began the administrative process which amended administrative rules 89 Ill. Admin. Code §§140.435 and 140.436 to eliminate the provision of nursing services at a person's home.

Thus, the facts here are more extreme than in *Olmstead*. There Georgia provided services in an institutional setting but failed to allow disabled persons who needed those services to receive them in the community. Here state law provided for the necessary services in the community but IDPA has sought to eliminate the community as a place where a disabled person such as Eric can receive the services. More so than in *Olmstead*, IDPA's affirmative actions seeking to remove the community as a place where such services can be obtained is a violation of Title II of the ADA and section 504 of the Rehabilitation Act.

IV. Whether It Is a Fundamental Alteration for the State to Provide Nursing Services to Eric in His Home Is a Factual Question that Is Inappropriate for Disposition by Judgment on the Pleadings.

Defendant argues, at p. 25 of his brief, that the plaintiff's case was subject to dismissal even if she alleged a set of facts constituting a *prima facie* case, unless she could plead facts which show that the modifications she seeks are reasonable. Defendant then goes on to characterize the modifications sought by the plaintiff as "facially unreasonable", and further states that they would "completely change the HSP's modest focus and purpose". (Def. Brief, p. 25) Defendant offers no authority whatever for his statement that the nursing services plaintiff seeks would completely change the focus and purpose of the HSP and children's waiver programs. He then states that the focus and purpose of the HSP program is "to cover a modest mix of homemaking and personal care services for disabled individuals who would otherwise have to be in a nursing facility, regardless of their financial eligibility for Medicaid." (Def. Brief, p. 25) As described above, the purpose of the home-based programs, as articulated in Illinois' authorizing legislation and in the administrative

regulations, is to prevent unnecessary institutionalization where to do so is cost-effective. The regulatory framework of the HSP authorizes the services Eric needs at home to avoid institutionalization.

Defendant's characterization of a modification as bringing about a complete change in focus of a program, without any evidentiary basis to support that statement, is entirely without merit. If anything, the record on defendant's motion for judgment on the pleadings shows that continuing Eric's home-based nursing services would be a cost savings for the state. As described in plaintiff's opening brief at page 20, Illinois does not own and operate the long-term care institutions Eric would need to go to, so it does not finance both the operation of long-term care institutions as well as that of a home-based program, as was the case in *Olmstead*. Here the state will either pay the institutional provider for Eric or pay less for nursing to provide him with in-home care. Illinois need only increase the unnecessary cap it has imposed as the slight modification required here, and it has the authority to do so under its existing program. Plaintiff has met the requirements for pleading a *prima facie* case that only reasonable accommodation need be made to accommodate Eric's needs for continued home-based care.

At the very least, this is a disputed, factual issue that cannot be decided in a motion for judgment on the pleadings. This Court has determined that a reasonable modification or accommodation inquiry is a highly fact-specific inquiry and requires balancing the needs of the parties. An accommodation is unreasonable if it imposes undue financial or administrative burdens on the defendant. A court may look at financial and administrative

costs and burdens in deciding this issue. *Oconomowoc Residential Programs, Inc. v. City of Milwaukee*, 300 F.3d 775, 784 (7th Cir. 2002); *Dadian v. Village of Wilmette*, 269 F.3d 831 (7th Cir. 2001).

Other courts have declined to rule on a summary basis absent a factual inquiry concerning whether the sought for service was a reasonable modification, or a fundamental alteration of, the state's program. See *Wong v. Regents of University of California*, 192 F.3d 807 (9th Cir. 1999); *Martin v. Taft*, 222 F.Supp.2d 940 (S.D. Ohio 2002); *Lewis v. New Mexico Dept. of Health*, 94 F.Supp.2d 1217, 1238-39 (D.N.M. 2000); and *Makin v. Hawaii*, 114 F. Supp.2d 1017, 1033-36 (D. Hawaii 1999). In all these cases the courts declined to rule on a motion to dismiss or motion for summary judgment on the grounds that the determination of reasonable accommodation or fundamental alteration are factual inquiries which render them inappropriate for summary disposition.[3]

The district court below was wrong to have dismissed this case on a motion for judgment on the pleadings, without having taken any evidence on the question of the reasonableness of the proposed modifications. The district court's failure to take evidence on this issue contravenes *Olmstead,* and should, therefore, be reversed and remanded.

V. The Court Below Relied Upon this Court's Decision in *Walker v. Snyder* and did not

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[3] Defendant cites *Pennsylvania Protection and Advocacy, Inc. v. Dept. of Public Welfare*, 243 F.Supp.2d 184 (M.D. Penn. 2003), on p. 18 of his brief, indicating that court found in favor of the defendant on summary judgment based on a defense that the state lacked the resources for the community based program which plaintiff sought. However, there was a detailed statement of undisputed facts which formed the basis of the summary judgment motion in that case.

Adequately consider the Supreme Court's Decision in *Olmstead* in Rendering Judgment Regarding Plaintiff's Claim of a Violation of Title II of the ADA

The district court dismissed the plaintiff's ADA claim based on this Court's decision in *Walker v. Snyder*, 213 F.3d 344 (7th Cir. 2000). Subsequently, the central holding of *Walker v. Snyder* -- that a state cannot be sued in federal court for prospective relief under Title II of the ADA -- was overturned by this Court's decision in *Bruggeman v. Blagojevich* , 324 F.3d 906 (7th Cir. 2003). It is the plaintiff's position that because the district court dismissed her Title II ADA claim based on a decision which was subsequently reversed by this Court, this case should be remanded to the district court for reconsideration of plaintiff's ADA claim in light of *Bruggeman v. Blagojevich.* The district court never reached the merits of plaintiff's Title II ADA claim. When this Court reversed the district court's decision in *Bruggeman,* it commended to the parties and the district court the U.S. Supreme Court decision of *Olmstead v. L.C.*, 527 U.S. 581 (1999), in which the Supreme Court indicated the purpose of the ADA and the integration regulation associated with it was prevention of isolation or segregation of disabled individuals. Considering that the district court, in dismissing plaintiff's claims, did not so much as mention *Olmstead*, it would seem appropriate to remand this case with directions to reconsider in light of *Bruggeman* and *Olmstead*.

CONCLUSION

For all of the foregoing reasons, Donna Radaszewski, plaintiff-appellant in this case, respectfully requests this Court to reverse the decision of the court below entering judgment on the pleadings against her.

Respectfully submitted,

_____

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ATTORNEY'S CERTIFICATION UNDER RULES 32(a)(7)(B)

I certify as counsel for plaintiff that this brief submitted in support of plaintiff's appeal satisfies the type-volume limitation set forth in Federal Rule of Civil Procedure 32(a)(7)(B). Specifically, the brief contains 5628 words, exclusive of the Table of Contents and the Table of Authorities.

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ADDENDUM

Addendum

Addendum of Cited Statutory and Regulatory Provisions

305 ILCS 5/5-5a

§§ 5-5a. Waiver for home and community-based services. The Department shall apply for a waiver from the United States Health Care Financing Administration to allow payment for home and community-based services under this Article.
The Department, in cooperation with the Department on Aging, the Department of Human Services and any other relevant State, local or federal government agency, may establish a nursing home pre-screening program to determine whether the applicant, eligible for medical assistance under this Article, may use home and community-based services as a reasonable, lower-cost alternative form of care. For the purpose of this Section, "home and community-based services" may include, but are not limited to, those services provided under subsection (f) of Section 3 of the Disabled Persons Rehabilitation Act

305 ILCS 5/5-5.8a(a)

(a) For the provision of exceptional medical care, the Illinois Department of Public Aid may make payments only to skilled nursing facilities that substantially meet the licensure and certification requirements prescribed by the Department of Public Health. Only the Department of Public Health shall be responsible for determining whether licensure and certification requirements for skilled nursing care facilities have been substantially met. The rate of payment shall be negotiated with the facilities offering to provide the exceptional medical care. A facility's costs of providing exceptional care shall not be considered in determining the rate of payment to skilled nursing facilities under Sections 5-5.3 through 5-5.5. Payment for exceptional medical care shall not exceed the rate that the Illinois Department would be required to pay under the Medical Assistance Program for the same care in a hospital.

20 ILCS 2405/3(f)

§§ 3. Powers and duties. The Department shall have the powers and duties enumerated herein:

(f) To establish a program of services to prevent unnecessary institutionalization of persons with Alzheimer's disease and related disorders or persons in need of long term care who are established as blind or disabled as defined by the Social Security Act, thereby enabling them to remain in their own homes or other living arrangements. Such preventive services may include, but are not limited to, any or all of the following:
(1) home health services;
(2) home nursing services;
(3) homemaker services;
(4) chore and housekeeping services;
(5) day care services;
(6) home-delivered meals;

(7) education in self-care;
(8) personal care services;
(9) adult day health services;
(10) habilitation services;
(11) respite care; or
(12) other nonmedical social services that may enable the person to become self-supporting.
The Department shall establish eligibility standards for such services taking into consideration the unique economic and social needs of the population for whom they are to be provided. Such eligibility standards may be based on the recipient's ability to pay for services; provided, however, that any portion of a person's income that is equal to or less than the "protected income" level shall not be considered by the Department in determining eligibility. The "protected income" level shall be determined by the Department, shall never be less than the federal poverty standard, and shall be adjusted each year to reflect changes in the Consumer Price Index For All Urban Consumers as determined by the United States Department of Labor. Additionally, in determining the amount and nature of services for which a person may qualify, consideration shall not be given to the value of cash, property or other assets held in the name of the person's spouse pursuant to a written agreement dividing marital property into equal but separate shares or pursuant to a transfer of the person's interest in a home to his spouse, provided that the spouse's share of the marital property is not made available to the person seeking such services.
The services shall be provided to eligible persons to prevent unnecessary or premature institutionalization, to the extent that the cost of the services, together with the other personal maintenance expenses of the persons, are reasonably related to the standards established for care in a group facility appropriate to their condition. These non-institutional services, pilot projects or experimental facilities may be provided as part of or in addition to those authorized by federal law or those funded and administered by the Illinois Department on Aging.
Personal care attendants shall be paid:
(i) A $5 per hour minimum rate beginning July 1, 1995.
(ii) A $5.30 per hour minimum rate beginning July 1, 1997.
(iii) A $5.40 per hour minimum rate beginning July 1, 1998.
The Department shall execute, relative to the nursing home prescreening project, as authorized by Section 4.03 of the Illinois Act on the Aging, written inter-agency agreements with the Department on Aging and the Department of Public Aid, to effect the following: (i) intake procedures and common eligibility criteria for those persons who are receiving non- institutional services; and (ii) the establishment and development of non- institutional services in areas of the State where they are not currently available or are undeveloped. On and after July 1, 1996, all nursing home prescreenings for individuals 18 through 59 years of age shall be conducted by the Department
The Department is authorized to establish a system of recipient cost-sharing for services provided under this Section. The cost-sharing shall be based upon the recipient's ability to pay for services, but in no case shall the recipient's share exceed the actual cost of the services provided. Protected income shall not be considered by the Department in its determination of the recipient's ability to pay a share of the cost of services. The level of cost- sharing shall be adjusted each year to reflect changes in the "protected income" level. The Department shall deduct from the recipient's share of the cost of services any money expended by the recipient for disability-related expenses.

The Department, or the Department's authorized representative, shall recover the amount of moneys expended for services provided to or in behalf of a person under this Section by a claim against the person's estate or against the estate of the person's surviving spouse, but no recovery may be had until after the death of the surviving spouse, if any, and then only at such time when there is no surviving child who is under age 21, blind, or permanently and totally disabled. This paragraph, however, shall not bar recovery, at the death of the person, of moneys for services provided to the person or in behalf of the person under this Section to which the person was not entitled; provided that such recovery shall not be enforced against any real estate while it is occupied as a homestead by the surviving spouse or other dependent, if no claims by other creditors have been filed against the estate, or, if such claims have been filed, they remain dormant for failure of prosecution or failure of the claimant to compel administration of the estate for the purpose of payment. This paragraph shall not bar recovery from the estate of a spouse, under Sections 1915 and 1924 of the Social Security Act and Section 5-4 of the Illinois Public Aid Code, who precedes a person receiving services under this Section in death. All moneys for services paid to or in behalf of the person under this Section shall be claimed for recovery from the deceased spouse's estate. " Homestead", as used in this paragraph, means the dwelling house and contiguous real estate occupied by a surviving spouse or relative, as defined by the rules and regulations of the Illinois Department of Public Aid, regardless of the value of the property.
The Department and the Department on Aging shall cooperate in the development and submission of an annual report on programs and services provided under this Section. Such joint report shall be filed with the Governor and the General Assembly on or before March 30 each year.
The requirement for reporting to the General Assembly shall be satisfied by filing copies of the report with the Speaker, the Minority Leader and the Clerk of the House of Representatives and the President, the Minority Leader and the Secretary of the Senate and the Legislative Research Unit, as required by Section 3.1 of the General Assembly Organization Act, and filing additional copies with the State Government Report Distribution Center for the General Assembly as required under paragraph (t) of Section 7 of the State Library Act.

89 Ill. Admin code 140.569(a)

a) Exceptional Care Program
1) Pursuant to Section 5-5.8a of the Illinois Public Aid Code [305 ILCS 5/5-5.8a], the Department may make payments for exceptional care services to nursing facilities ("providers") that meet licensure and certification requirements as may be prescribed by the Department of Public Health and are enrolled in and meet participation requirements of the Medical Assistance Program pursuant to Sections 140.11 and 140.12.
2) Exceptional medical care is defined as the level of care with extraordinary costs related to services which may include physician, nurse, ancillary specialist services, and medical equipment and/or supplies that have been determined to be a medical necessity. This shall apply to Medicaid patients who are being discharged from the hospital or other setting where Medicaid reimbursement is at a rate higher than the exceptional care rate for related services or to persons who are in need of exceptional care services who would otherwise be in an alternative setting at a higher cost to the Department and Medicaid eligible residents transitioning from Medicare to

Medicaid while in the nursing facility. This includes but is not limited to head-injured persons, ventilator dependent persons or persons with HIV/AIDS.
3) The Department shall negotiate rates with facilities requesting payment for exceptional care services (see Section 5-5.8a of the Public Aid Code [305 ILCS 5/5-5.8a]). In determining the rates of payment, the Department shall consider data collected from exceptional care providers during fiscal year 1994, any intervening rate adjustments (including any updates for inflation) and the average cost of each service category for the geographic area in which the facility is located. After approval of negotiated rates, the Department shall annually update a facility's rates for inflation.

89 Ill. Admin. Code §676.10

a) The Department of Human Services (DHS) Home Services Program (HSP) is a Medicaid Waiver Program (42 CFR 440.180) designed to prevent the unnecessary institutionalization of individuals who may instead be satisfactorily maintained at home at a lesser cost to the State.
b) The Medicaid Waiver for the State of Illinois is administered by the Illinois Department of Public Aid (DPA), as the State's approved Medicaid agency. The operational responsibility for HSP, with the exception of hearings on customer appeals (see 89 Ill. Adm. Code 510), rests with DHS.
c) Although DHS shall be responsible for ensuring that the funds available under the HSP are administered in accordance with all applicable laws, DHS shall not have control or input in the employment relationship between the customer and the personal assistants.

89 Ill. Admin Code §676.30(j)

For the purposes of this Subchapter, unless otherwise stated, the following terms shall have the following meanings.

j) Home Services Program (HSP) - a State and federally funded program designed to allow Illinois residents, who are at risk of unnecessary or premature institutionalization, to receive necessary care and services in their homes, as opposed to being placed in an institution.

89 Ill. Admin Code §§682.100(g) & (h).

In order to receive services through HSP a customer must:

g) obtain certification from a physician or from a neuropsychologist for a person with a brain injury, with DHS assistance, that the individual is in need of long-term care and this care can safely and adequately be provided in the individual's home as provided in the HSP Service Plan developed for the individual; and
h) not require in-home services that are expected to cost more than the cost the State would pay for institutional care for an individual with a similar DON score.

89 Ill. Admin Code §679.20

The DON is comprised of three sections which are:
a) the Mini-Mental Status Examination section, as developed by the University of Illinois - Chicago, School of Public Health, which is used to determine the individual's cognitive functioning, and therefore the ability of the individual to adequately respond to the DON questions about his or her functioning capacity in the completion of the DON. Home Service Program staff may choose to not administer the MMSE if interaction with the customer, during the interview to gather demographic information, reveals no cognitive problems. The Mini-Mental Status Examination section shall not be administered to individuals who:
1) are 12 years of age or younger;
2) manifest, or have been diagnosed with, mental retardation or a related condition that results in impairment of a person's general intellectual functioning; or
3) manifest adaptive behavior and require services similar to an individual with mental retardation.
b) Part A which measures the individual's need for care in the completion of ADLs; and
c) Part B which measures the individual's unmet need for care in the completion of ADLs.

89 Ill. Admin. Code §679.30

a) An individual receiving a 14 or more on the Mini-Mental Status Examination shall receive "zero" points towards his/her column A score. An individual receiving less than 14 points shall receive an additional "10" points added to his/her column A score for the determination of eligibility and a SCM.
b) The remaining two sections of the DON measure the individual's ability to complete the ADLs. The ADLs are specifically: eating, bathing, grooming, dressing, transferring, incontinence care, preparing meals, being alone, telephoning, managing money, routine health care tasks (or those health care tasks not requiring specialized training), specialized health care tasks (or those requiring assistance from trained medical practitioners), necessary travel outside the home, laundry, and housework.
1) Part A of the DON measures the individual's need for assistance in the completion of each of the ADLs on the following rating scale.
A) "0" - the individual can perform all essential components of the ADL with or without an existing assistive device;
B) "1" - the individual can perform most of the ADL, with or without an existing assistive device, but requires some supervision and/or assistance to ensure the task is fully completed;
C) "2" - the individual requires a great deal of supervision and/or assistance, with or without existing assistive devices, in the completion of the essential components of the task; and
D) "3" - the individual cannot perform any of the essential components of the task, with or without existing assistive devices and requires constant supervision and/or assistance.
2) Part B of the DON measures the individual's unmet need for care in the completion of the ADLs on the following scale.

A) "0" - the individual has no unmet need for care in that the individual needs no assistance in completion of the essential components of the task, or family and/or other resources already provide for this task;
B) "1" - the individual's need for assistance in the completion of the task is met at least 50% of the time, and, without periodic assistance, there is a risk to the individual's health and safety;
C) "2" - the individual's need for assistance in the completion of the task is met less than 50% of the time and, without assistance, there is moderate risk to the individual's health and safety; and
D) "3" - the individual's need for assistance in the completion of the task is seldom (less than 10% of the time) or never met and, without assistance, there is extreme risk to the individual's health and safety.
c) In administering the DON for children, the assessor should ensure the ratings given reflect limitations due to the individual's disability and not the individual's age and/or the additional burden placed on the caregiver.
1) On Part A, determine if a child of the individual's age should be able to complete all or part of the task. If the inability to perform the task relates only to the individual's age, a score of "zero" should be given. Otherwise, score "1", "2", or "3" according to the individual's impairment level.
2) On Part A, determine the additional burden placed on a caregiver providing the service. If, because of the individual's age, there is no increased burden, a score of "0" should be given. If there is an increased burden on the the caregiver due to the individual's disability, score "1" "2", or "3" according to the increased level of burden in providing the task.

89 Ill. Admin Code 679.50(b)

a) For each individual meeting the minimum required DON scores for eligibility (see 89 Ill. Adm. Code 682), there is a corresponding Service Cost Maximum (SCM) for his/her DON score which is the maximum amount that may be expended for services through HSP for an individual who chooses HSP services over institutionalization. This amount directly corresponds to the amount the State would expect to pay for the nursing care component of institutionalization if the individual chose institutionalization.
b) The SCMs for individuals served under the HSP Medicaid Waiver are:

Total DON Score SCM
29 through 32 $1114
33 through 40 $1280
41 through 49 $1424
50 through 59 $1705
60 through 69 $2004
70 through 79 $2167
80 through 100 $2329

89 Ill. Admin Code §682.50(c)

c) Cases involving ventilator dependent customers and other customers with exceptional care

needs whose need for care cannot be met by the SCM may have a rate established by Department of Public Aid (DPA) per 89 Ill. Adm. Code 684.70(c).

89 Ill. Admin Code §684.70(c)

c) The SCM may be exceeded for ventilator assisted individuals (VAIs) who are receiving HSP services but have had established, through DPA, a higher rate less the cost of supplies and equipment established by DPA for institutional placement. In such cases, the amount that may be expended for HSP services shall not exceed the special care rate established for that customer by DPA.