

March 2012

## Reconsidering *Makin v. Hawaii*: The Right of Medicaid Beneficiaries to Home-Based Services as an Alternative to Institutionalization

Elliott Schwalb

Follow this and additional works at: <https://readingroom.law.gsu.edu/gsulr>

 Part of the [Law Commons](#)

---

### Recommended Citation

Elliott Schwalb, *Reconsidering Makin v. Hawaii: The Right of Medicaid Beneficiaries to Home-Based Services as an Alternative to Institutionalization*, 26 GA. ST. U. L. REV. (2012).

Available at: <https://readingroom.law.gsu.edu/gsulr/vol26/iss3/10>

This Article is brought to you for free and open access by the Publications at Reading Room. It has been accepted for inclusion in Georgia State University Law Review by an authorized editor of Reading Room. For more information, please contact [mbutler@gsu.edu](mailto:mbutler@gsu.edu).

# RECONSIDERING *MAKIN V. HAWAII*: THE RIGHT OF MEDICAID BENEFICIARIES TO HOME-BASED SERVICES AS AN ALTERNATIVE TO INSTITUTIONALIZATION

Elliott Schwalb\*

## INTRODUCTION

When states restrict health services for disabled residents to institutional settings instead of providing equally effective community-based services, they run afoul of the Americans with Disabilities Act (ADA).<sup>1</sup> This was the essential holding of the 1999 case of *Olmstead v. L.C.*<sup>2</sup> Considered a landmark civil rights decision for residents who have disabilities,<sup>3</sup> *Olmstead* held that restrictive treatment regimes that confine the disabled to institutional settings without medical justification constitute a form of segregation that the ADA prohibits.<sup>4</sup> Under the ADA, states have a general obligation to provide services in the “most integrated setting” appropriate to disabled individuals, and to avoid reliance upon excessive institutionalization policies in their health programs.<sup>5</sup>

*Olmstead* has been heralded as the *Brown v. Board of Education* for people with disabilities residing in state psychiatric hospitals, institutions for mental retardation,<sup>6</sup> and nursing homes.<sup>7</sup> The analogy

---

\* Elliott Schwalb, J.D. graduated from New York University School of Law, J.D. 1992 and is a member of the New York and Georgia Bar. The views expressed in this article are the author's alone, and do not necessarily represent the views of any other entity or agency. This article is dedicated to Celeste Saul Jenks, Georgia State University College of Law (Class of 2003), who, through her personal example, inspired her many friends and colleagues throughout her brief life; and to Meg. This article was greatly enhanced by the generous efforts and insightful comments of the following individuals: Therese M. Day, Elisa Roberts, Professor Randall Hughes, Steven Schwartz and John Bayne.

1. Pub. L. No. 101-336, 104 Stat. 327 (1990) (codified at 42 U.S.C. § 12101, et seq. (2006)).

2. *Olmstead v. L.C.*, 527 U.S. 581 (1999).

3. See, e.g., Mary C. Cereto, *Olmstead: The Brown v. Board of Education for Disability Rights: Promises, Limits, and Issues*, 3 LOY. J. PUB. INT. L. 47 (2001); Melody Kubo, Case Note, *Implementing Olmstead v. L.C.: Defining “Effectively Working” Plans for Reasonably Paced Wait Lists for Medicaid Home and Community-Based Services Waiver Programs*, 23 U. HAW. L. REV. 731 (2001).

4. *Olmstead*, 527 U.S. at 600–01.

5. *Id.* at 581, 607.

6. Often denoted as “ICF-MRs” [Intermediate Care Facilities for the Mentally Retarded].

to *Brown* may be particularly apt in that, like *Brown*, the actual progress in deinstitutionalization of health facilities has fallen far short of its initial promise.<sup>8</sup> One primary reason that progress in deinstitutionalization has stalled arises from outside the ADA itself and relates to Medicaid's community-based waiver program, a primary mode of health care relied upon by disabled individuals. Medicaid's community-based waiver program is a service that allows individuals qualifying for institutional care under Medicaid to receive their care in their homes or in the community as an alternative. The current state of the law has largely been shaped by a case that arose in the Federal District Court in Hawaii,<sup>9</sup> *Makin v. Hawaii*, the subject of this article. *Makin* has had a substantial persuasive impact that has limited the growth of services under Medicaid's community-based waiver program and stymied the nation's deinstitutionalization efforts. The analysis and holding of *Makin* has received strong support from a number of subsequent decisions from across the country, including federal appellate decisions in four circuits, without any explicitly contrary decisions.<sup>10</sup> This article seeks to show that, despite reflecting the current state of the law, *Makin*'s analysis is ultimately unpersuasive and its analysis and holding should be rejected.

## I. THE *MAKIN V. HAWAII* DECISION

### A. Background and Factual Context

In terms of complexity and cost, Medicaid stands apart from the other programs that made up President Johnson's "Great Society"

---

7. Cereto, *supra* note 3; Samuel R. Bagenstos, *Justice Ginsberg and the Judicial Role in Expanding "We the People": The Disability Rights Cases*, 104 COLUM. L. REV. 49 (2004).

8. K. Charlie Lakin, Robert Pouty, Barbara Polister & Kathryn Coucouvanis, *States' Initial Response to the President's New Freedom Initiative: Slowest Rates of Deinstitutionalization in 30 Years*, 42 MENTAL RETARDATION 241 (2004). The New Freedom Initiative, promulgated under Executive Order 13217, directed the Executive branch to undertake "swift implementation of the *Olmstead* decision." *Id.*; Mark S. Salzer, Kat Kaplan & Joanne Atay, *State Psychiatric Hospital Census After the 1999 Olmstead Decision: Evidence of Decelerating Deinstitutionalization*, 57 PSYCHIATRIC SERVICES 1501 (2006).

9. *Makin v. Hawaii*, 114 F. Supp. 2d 1017 (D. Haw. 1999).

10. *See infra* notes 42–44.

program. Conceived as an “anti-poverty” program, today Medicaid is a key pillar of the nation’s health infrastructure, where access to health insurance is often tantamount to access to any health care at all. In a country where 20 percent of the population lacks any insurance, many health institutions are vitally dependent on Medicaid as a funding source for their services.<sup>11</sup> Medicaid is jointly financed by state and federal governments, with the federal share ranging from 50 to 83 percent, depending on the particular state’s per capita income relative to the national average.<sup>12</sup> There are basic federal rules and requirements under Medicaid law, but states have great discretion as to the specific services that will be covered, what population groups will be covered, and most of the operating details of the program. Medicaid is an entitlement program, requiring states to provide care to all who meet its terms of eligibility as a condition for the receipt of federal funds. The operating language for this entitlement, like other entitlement programs of the Social Security Act, is the statute’s requirement that such services must be furnished with “reasonable promptness.”<sup>13</sup>

Medicaid funding is a crucial component to realizing the deinstitutionalization objectives of the ADA, as interpreted by *Olmstead*, because it provides the lion’s share of the state’s health expenditures for individuals who have permanent disabilities (as defined by the Social Security Act). Justice Ginsburg’s plurality opinion in *Olmstead* recognized that state health resources “are not boundless.”<sup>14</sup> Under *Olmstead*, states have some latitude in how they structure their health care infrastructure to meet the ADA’s requirements. Taking into account issues of cost, fairness, and the overall health needs of their populations, states are permitted to defer

---

11. AUDRA WENZLOW, DAN FINKELSTEIN, BEN LE COOK, KATHY SHEPPERSON, CHRISTINE YIP & DAVID BAUGH, THE MEDICAID ANALYTIC EXTRACT CHARTBOOK 13 (2007), *available at* [http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/downloads/MAX\\_Chartbook\\_2007.pdf](http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/downloads/MAX_Chartbook_2007.pdf) (finding in 2002 that eighteen percent of the U.S. population was covered by Medicaid and that Medicaid accounted for fifteen percent of health expenditures).

12. 42 U.S.C. § 1396d(b) (2006).

13. 42 U.S.C. § 1396a(8) (2006); *see, e.g.*, *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17–18 (1981) (distinguishing a general federal grant program from an entitlement program such as the former AFDC [Aid to Families with Dependent Children] program.).

14. *See Olmstead v. L.C.*, 527 U.S. 581, 603–07 (1999).

immediate access to community-based services.<sup>15</sup> Approximately 64 percent of individuals with disabilities that are severe enough to prevent them from working rely on Medicaid for their health care.<sup>16</sup> The principal Medicaid program that finances community-based care is the Medicaid home and community-based waiver program (the “waiver program”).<sup>17</sup> However, not everyone who qualifies for these services gets them, which is in part the result of the *Makin* decision, its analysis, and other courts that have followed it.

Established in 1981, the waiver program authorizes individuals qualifying for institutional care to receive, as an alternative, a panoply of medical and personal services in their homes or other residential settings in the community. Waiver services are generally cheaper and more individually focused than services provided in institutions or nursing facilities.<sup>18</sup> The program represents a “waiver” of the general federal requirement that federal Medicaid funds be limited to services provided for “medical assistance,” as defined in the statute.<sup>19</sup> Congress recognized that such non-medical assistance could be the key to avoiding more costly medical institutional care.<sup>20</sup> In what has been somewhat confusing, the legislation providing for the waiver program also “waived” specific statutory provisions of the Medicaid Act, a key part of the analysis below.

Typically, when states seek federal approval for a waiver program, they set forth the maximum number of people who will be served at

---

15. This point was separately emphasized in J. Kennedy’s concurrence. *Olmstead*, 527 U.S. at 608 (Kennedy, J., concurring).

16. U.S. CENSUS BUREAU, PERSONS WITH WORK DISABILITY BY SELECTED CHARACTERISTICS, TABLE 541 (2005), <http://www.census.gov> (search “persons with work disability table 541”; then follow hyperlink).

17. 42 U.S.C. § 1396n(c) (2006).

18. Charlene Harrington, Terrance Ng, H. Stephen Kaye & Robert J. Newcomer, *Medicaid Home and Community Based Services: Proposed Policies to Improve Access, Costs, and Quality*, 19 PUB. POL’Y & AGING REP. 13, 15 (2009) (finding waiver services expenditures were \$44,000 per person lower than Medicaid institutional spending in 2002).

19. 42 U.S.C. § 1396a (2006) sets forth a number of services that are defined as “medical assistance.”

20. S. REP. NO. 97-139, at 481 (1981), *reprinted in* 1981 U.S.C.C.A.N. 396, 747–48. (“Certain associated services are not eligible for federal matching payments. However, these services, while not strictly medical in nature, may in fact contribute to improved health and could potentially postpone or prevent institutionalization. To the extent that institutionalization is deferred or avoided, certain cost savings may result.”).

any one time as part of the program, often called “slots.” An individual receiving a “slot” is assessed for services and based on the assessment, is provided a specific set of services determined necessary for him or her to reside safely in the community.<sup>21</sup> There are generally two types of waivers. The more common waivers are applicable to broader populations, such as the elderly, disabled and those with developmental disabilities.<sup>22</sup> It was the question of what limits are applicable to these waiver programs that was the subject of *Makin*. There are also “model waivers,” that are often referred to as demonstration programs, designed for individuals with specialized diseases and conditions that are expensive to treat, such as those for individuals who have severe brain and spinal cord injuries.<sup>23</sup>

Although *Olmstead* was decided under the 1991 ADA,<sup>24</sup> a general consensus had been brewing for decades before in the health industry and in the civil rights community disfavoring institutionalization as a skewed treatment regime that subordinated the interests of patients.<sup>25</sup> Interestingly, the waiver program itself was passed by the new Congress launched into office with the Reagan administration. It was enacted as much as a cost-savings and efficiency reform as for any other reason, as evident in the brief description of the program in the Conference Report accompanying the legislation:

---

21. See *Makin v. Hawaii*, 114 F. Supp. 2d 1017, 1021–22 (D. Haw. 1999).

22. See Centers for Medicare & Medicaid Services, [http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05\\_HCBSWaivers-Section1915\(c\).asp](http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp) (last visited Feb. 8, 2010).

23. *Bryson v. Shumway*, 308 F.3d 79, 83 (1st Cir. 2002), *remanded to No. 99-CV-558-SM*, 2006 WL 2805238 (D.N.H. Sept. 29, 2006).

24. Americans with Disabilities Act, Pub. L. No. 101-336, 104 Stat. 327 (1990) (codified at 42 U.S.C. § 12101, et seq. (2006)).

25. Judicial decisions reviewing the harms of institutionalization and questioning the authority of states to institutionalize their residents under constitutional principles and federal statutory law span several decades. The *Olmstead* decision may be seen as the latest incarnation in this now multi-decade trend. See, e.g., *Youngberg v. Romeo*, 457 U.S. 307 (1982); *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981); *Clark v. Cohen*, 794 F.2d 79 (3d Cir. 1986); *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), *aff'd sub nom*, *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1975); *Homeward Bound, Inc. v. Hisson Mem'l Ctr.*, No. 85-C-437, 1987 WL 27104 (N.D. Okla. July 24, 1987); *Thomas v. Johnson*, 557 F. Supp. 879 (W.D. Tex. 1983); cf. *Olmstead v. L.C.*, 527 U.S. 581, 599–601 (1999); *Frederick L. v. Dep't of Pub. Welfare*, 157 F. Supp. 2d 509, 528 (E.D. Pa. 2001) (citing U.S. Commission on Civil Rights' report describing a consensus disfavoring institutional care); Mark C. Weber, *Home and Community-Based Services, Olmstead, and Positive Rights: A Preliminary Discussion*, 39 WAKE FOREST L. REV. 269, 275–78 (2004).

*Committee Amendment* – The bill permits the Secretary to waive the current definition of covered medical services to include certain nonmedical support services, other than room and board, which are provided pursuant to a plan of care to an individual otherwise at risk of being institutionalized and who would, in the absence of such services, be institutionalized. Such services could include case management, supervised living, home services, and nonmedical rehabilitation services approved by the Secretary . . . . The committee expects that States which have been granted a waiver will examine innovative and cost-efficient means of rendering services to this population group.<sup>26</sup>

The need and demand for community-based waiver programs was apparent from its inception. By 1992, only eleven years later, there were 153 waiver programs operating in 48 states.<sup>27</sup> Today it is the preferred mode of care for many individuals who previously would have been left with the choice of institutionalization or going without any care at all.

In the thirty years of the waiver's existence, there has been a role reversal between states and the federal government as proponents of the program's growth. At one time, the federal agency with administrative authority over the program, the Health Care Financing System [now, The Centers for Medicaid and Medicare Services (CMS)] limited its growth through regulatory initiatives.<sup>28</sup> It is the federal government that now seeks to encourage greater use of the waiver program and deinstitutionalization, and generally it is the states that have been reluctant to transform their health infrastructure.<sup>29</sup> Having sealed the genie in the bottle in the first half of the program's history, however, the federal government has found it difficult to coax the genie back out.

---

26. H. R. REP. NO. 97-208, at 481–82 (1981), *reprinted in* 1981 U.S.C.C.A.N. 396, 747–48.

27. GENERAL ACCOUNTING OFFICE, GAO-03-576, LONG TERM CARE: FEDERAL OVERSIGHT OF GROWING MEDICAID HOME AND COMMUNITY-BASED WAIVERS SHOULD BE STRENGTHENED 11 (2003).

28. *See infra* notes 67–69.

29. *See* Exec. Order No. 13,217, 66 Fed. Reg. 33,155 (June 18, 2001). A list of current *Olmstead*-related lawsuits kept by the National Association of State Developmental Disabilities Services can be found at <http://www.nasddds.org/LitigationUpdates/index.shtml>.

The key case authorizing states to limit growth and availability of community based services was *Makin v. Hawaii*, the first case to address directly and decisively how, and whether, the waiver programs must follow Medicaid's general requirement that services be provided to beneficiaries with "reasonable promptness." *Makin* arose from a class action brought on behalf of individuals with developmental disabilities seeking Medicaid services from the state through its waiver program for individuals with developmental disabilities. The state had a waiting list of 801 individuals two months before the court's ruling, without any guidance as to when the services were to be provided.<sup>30</sup> The plaintiffs argued that the waiting list violated Medicaid's "reasonable promptness" requirement, but the court rejected this theory.<sup>31</sup>

The court's opinion in *Makin* has cast a shadow on access to community-based services, and under its persuasive authority, waiting lists for individuals with developmental disabilities and mental retardation have proliferated in most states.<sup>32</sup> A recent study found waiting lists in thirty-one states and that—across the country—some 73,000 individuals were on waiting lists for waiver services, representing fully one-third to one-half of those receiving services.<sup>33</sup> Generally, these states provide no time-limits for how long individuals must wait for services to be provided, and it is not uncommon for beneficiaries to wait for years without getting services, if they get services at all. As noted above, a large number of disabled individuals are dependent on waiver programs as their principal means of care.<sup>34</sup> Their right to non-institutional care has effectively been tethered to the holding of *Makin*, and subsequent cases that have followed its analysis. It is not just the developmentally disabled that are affected. Today, more people with physical disabilities, individuals with spinal cord injuries, and the

---

30. *Makin v. Hawaii*, 114 F. Supp. 2d 1017, 1023 (D. Haw. 1999).

31. *Id.* at 1030–31.

32. See Harrington et al., *supra* note 18.

33. See TARRIN BRAGDON, UNITED CEREBRAL PALSY (UCP), THE CASE FOR INCLUSION 2007: AN ANALYSIS OF MEDICAID FOR AMERICANS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES 16 (2007), <http://www.ucp.org/medicaid/fullreport.cfm>. Notably, ten states did not respond to the survey.

34. See U.S. CENSUS BUREAU, *supra* note 16.

frail elderly are often served in waiver programs at home for their care than in hospitals or nursing facilities.<sup>35</sup> Waiting lists have grown significantly in many states where individuals currently residing in institutions could safely return to homes and communities. Ten years after they were challenged in *Makin*, the practices of states maintaining indefinite wait lists is a common occurrence with Medicaid programs throughout the United States. This article analyzes that decision, and questions the court's analysis and legal conclusions.

*B. The Current State of the Law with Respect to Population Limits on Waiver Programs*

At issue in *Makin* was Medicaid's core entitlement mandating that services to beneficiaries be provided with "reasonable promptness." Specifically, 42 U.S.C. § 1396a(a) provides that "[a] state plan for medical assistance must—(8) provide . . . that such assistance shall be furnished with reasonable promptness to all eligible individuals."<sup>36</sup> The plaintiffs in *Makin* alleged that the State was violating Medicaid's reasonable promptness provision by maintaining a waiting list for services and not assuring that the services would actually be provided.<sup>37</sup> The State argued that the waiting list was not impermissible because federal law authorized "population limits" in waiver programs.<sup>38</sup> The court essentially agreed with this analysis:

The statute and regulations provide for limits on HCBS-MR services [home and community-based waiver services for the mentally retarded] and further provide they are not to be considered "available" under the statute when the slots are filled. See 42 U.S.C. § 1396n(c)(2)(C),(c)(9), (c)(10); 42 C.F.R. § 441.303(6). Therefore under the statute, the State need not

---

35. See, e.g., MARY JO GIBSON, STEVEN R. GREGORY, ARI N. HOUSER & WENDY FOX-GEORGE, AARP PUB. POL'Y INST., ACROSS THE STATES: PROFILES OF LONG TERM CARE (2004).

36. 42 U.S.C. § 1396a(a)(8) (2006).

37. *Makin v. Hawaii*, 114 F. Supp. 2d 1017, 1025 (D. Haw. 1999).

38. *Id.* at 1026.

provide services to new “eligible” individuals until slots become available.<sup>39</sup>

In supporting its analysis, the court referenced two instances in which the Medicaid statute explicitly mentioned limits. It found these provisions ambiguous, however, and it looked to the regulations to resolve the ambiguity:

Initially, section 1396n(c)(9) provides that if the State program “contains a limit on the number of individuals who shall receive” HCBS-MR services,” the State may substitute additional individuals to receive” the services to replace people who died or became ineligible for them. Second, section 1396n(c)(10) contains a limitation on the Secretary regarding the limits that he or she may allow a State to place on the programs. It sets a minimum number of individuals in a HCBS-MR program at 200 people. It is also important to note that there is no language in the statute providing for these “limits” on the ICF/MRs [institutional services], suggesting that there is reason to treat the programs differently. Thus, Congress has provided states with the authority to set limits on the amount of slots available in an HCBS-MR program, and at the very least, the statute is ambiguous concerning whether “limits” are allowed.

Fortunately, the agency regulations clear up any ambiguity or doubt that the statute may have created. In 42 C.F.R. § 441.303(6), the HCFA [Health Care Finance Administration] states that the State *must* provide the number of individuals that it intends to grant HCBS-MR services to in each of the years covered by the waiver application. Then, it states that “this number *will constitute a limit on the size of the waiver program*” unless the State requests a greater number and the Secretary approves it. Once the Secretary of HCFA [HHS] approves the number, it becomes the “population limit” on the HCBS-MR services. The court must defer to agency’s regulations since it

---

39. *Id.* at 1027.

does not contradict the intent or purpose of the statute. Thus, it is clear that the Medicaid statute and its regulations require the State to provide a number to the Secretary that will act as the limit on the State's HCBS-MR program every year. As a result, when the slots are filled by eligible individuals, the HCBS-MR program is no longer a "feasible alternative" available under the waiver. Stated differently, the HCBS-MR program is not an entitlement.<sup>40</sup>

In reaching its decision, the court relied upon regulation 42 C.F.R. § 441.303 to determine that states were authorized to have "population limits." Once these "population limits" were deemed proper, the Court effectively read the Medicaid statute to have made an implicit exception to its reasonable promptness provision permitting states to keep additional Medicaid beneficiaries indefinitely unserved on waiting lists.<sup>41</sup> Several subsequent decisions, including federal appellate court decisions, have reached the same conclusion, finding that the reasonable promptness provision does not require states to eliminate waiting lists for community services.<sup>42</sup> Some cases find the "reasonable promptness" requirement applicable only to any authorized, but unfilled slots below the "population limit," but without any legal obligation to increase these limits to meet the demands of those on the waiting list.<sup>43</sup> A few mostly pre-*Makin* district court cases suggest that the reasonable promptness requirement does apply to waiting lists. However, these cases do not

---

40. *Id.* at 1027–28 (emphasis in original).

41. *Id.* at 1028.

42. *Arc of Wash. State, Inc. v. Braddock*, 427 F.3d 615 (9th Cir. 2005); *Bertrand v. Maram*, 495 F.3d 452 (7th Cir. 2007) (stating that Illinois's adoption of "priority population criteria" complies with reasonable promptness criteria.); *cf. Bryson v. Shumway*, 308 F.3d 79, 83 (1st Cir. 2002) (analyzing a "model waiver" program, with separate requirements than the regular waiver programs); *see also Brown v. Tenn. Dep't of Fin. & Admin.*, 561 F.3d 542, 548 n.4 (6th Cir. 2009) (rejecting an anticipated argument by class Plaintiffs of the obligation to serve all eligible recipients in the state's waiver program); *Masterman v. Goodno*, No. 03-2939, 2004 WL 51271, at \*9 (D. Minn. Jan. 8, 2004) (asserting without analysis that Congress has allowed states to limit the number of people to be served under waiver).

43. *Boulet v. Cellucci*, 107 F. Supp. 2d 61, 77–79 (D. Mass. 2000); *Lewis v. N.M. Dep't of Health*, 275 F. Supp. 2d 1319, 1343 (D.N.M. 2003); *see M.A.C. v. Betit*, 284 F. Supp. 2d 1298, 1308 (D. Utah 2003).

fully analyze the issue because of their procedural context.<sup>44</sup> In *Arc of Washington State, Inc. v. Braddock*,<sup>45</sup> the Ninth Circuit followed essentially the same reasoning of *Makin v. Hawaii* with a more truncated analysis.<sup>46</sup> Thus, the *Makin* decision and its analysis represent the current state of the law.<sup>47</sup>

The consistency of *Braddock* and other post-*Makin* cases is somewhat surprising. After all, while the Medicaid statute is notoriously complex, the plain language of the statute does not actually exclude the waiver program from the “reasonable promptness” provision. The exception to the reasonable promptness requirement was created by the *Makin* court’s interpretation of a regulation, not statutory provisions which it found “ambiguous.”<sup>48</sup> Yet, this raises the question: what authority was there for the agency’s promulgation of 42 C.F.R. § 441.303 so as to create the exception to the statute’s “reasonable promptness” provision?

---

44. *Michele P. v. Holsinger*, 356 F. Supp. 2d 763, 769–70 (E.D. Ky. 2005) (denying motion to dismiss reasonable promptness claim); *McMillan v. McCrimmon*, 807 F. Supp. 475, 481 (C.D. Ill. 1992) (applying “reasonable promptness,” but not referencing a population cap); *Benjamin H. v. Ohl*, No. 3:99-0338, 1999 WL 34783552, at \*13 (S.D. W. Va. July 15, 1999) (finding the plaintiffs “likely to succeed” on reasonable promptness claim seeking preliminary injunction).

45. *Arc of Wash. State, Inc. v. Braddock*, 427 F.3d 615 (9th Cir. 2005).

46. The court reasoned:

As an alternative to institutionalized care for the disabled, the Medicaid statute and regulations allow states to apply for waiver programs for home and community-based care. However, Congress envisioned such programs as limited in scope, and therefore included the following language in 42 U.S.C. § 1396n(c), the waiver portion of the statute: (9) In the case of any waiver under this subsection which contains a limit on the number of individuals who shall receive home or community based services, the State may substitute additional individuals to receive such services to replace any individuals who die or become ineligible for services under the State plan. (10) The Secretary shall not limit to fewer than 200 the number of individuals in the State who may receive home and community-based services under a waiver under the subsection. The regulations implementing the statute go farther, requiring states to place a limit on the number of waiver program participants, and requiring states to adhere to the limitation . . . .

*Braddock*, 427 F.3d at 613.

47. See also *Kubo*, *supra* note 3, at 755–56 (summarizing then current cases).

48. See *Makin v. Hawaii*, 114 F. Supp. 2d 1017, 1027–28 (D. Haw. 1999).

## II. THE LEVEL OF JUDICIAL DEFERENCE THAT SHOULD BE ACCORDED THE REGULATION THAT *MAKIN* HELD AUTHORIZED POPULATION LIMITS AND ITS REGULATORY HISTORY

### A. *The Standard of Review for Administrative Agency Regulations*

The seminal case on executive agency rule-making, *Chevron U.S.A., Inc. v. Natural Resource Defense Council*, generally requires courts to defer to executive agencies' interpretive regulations within their statutorily delegated authority when confronted with legal questions not addressed in a statute.<sup>49</sup> *Chevron* requires courts to sustain such interpretations if they are within the range of reasonable interpretations.<sup>50</sup> However, this is a general rule, and not all agency interpretations are entitled to deference.<sup>51</sup> The *Makin* court's analysis overlooked an important part of the question by presuming deference to CMS's regulation 42 C.F.R. § 441.303 without first inquiring into its regulatory history and fully analyzing the level of deference to which the regulation was entitled.<sup>52</sup> Had it done so, that court may have reached a different conclusion.

The first step in the review of agency regulations "is whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter, for the Court as well as the agency, must give effect to the unambiguously expressed intent of Congress."<sup>53</sup> Where the question is not addressed in the statute, the next step is to determine if Congress made a delegation of authority for the agency to fill gaps in the statute. If Congress made such a delegation, "[s]uch legislative regulations are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute."<sup>54</sup> Such deference under *Chevron*, however, is warranted only "when it appears that Congress delegated

---

49. *Chevron U.S.A., Inc. v. Natural Res. Def. Council*, 467 U.S. 837 (1984).

50. *Id.* at 843–44.

51. *Gonzales v. Oregon*, 546 U.S. 243, 256 (2006).

52. *Makin*, 114 F. Supp. 2d at 1028 ("The Court must defer to the regulation because it does not contradict the intent and purpose of the statute."). This assertion is challenged throughout this article.

53. *Chevron*, 467 U.S. at 842–43.

54. *Id.* at 844.

authority to the agency generally to make rules carrying the force of law, and that the agency interpretation claiming deference was promulgated in the exercise of that authority. Otherwise the interpretation is entitled to respect only to the extent it has the power to persuade.”<sup>55</sup>

In order for such regulations to have the “force and effect of law” it is necessary to establish a nexus between the regulations and some delegation of the requisite legislative authority by Congress.<sup>56</sup>

Congressional delegations of authority to regulate need not always be explicitly expressed for judicial deference to be applied. If there is no expressed delegation, an “interpretive gap” in the statute, along with a delegation of policy-making authority, can still warrant administrative deference to a regulation as an implied delegation.<sup>57</sup> Where the statute is silent on a question and Congress has delegated to an agency the authority to promulgate regulations, *Chevron* requires that the agency’s rule be upheld so long as it is a reasonable construction of the statute. It need not be the construction most persuasive to a court. *Chevron* and its progeny recognize that an agency’s specialized experience in a particular area places such executive agencies in a better position to determine Congressional intent, and the policies most consistent with that intent.<sup>58</sup>

When there is no delegation, the regulation has only such persuasive authority as it derives from the circumstance surrounding its promulgation. “[T]he level of deference will depend upon the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade, if lacking power to control.”<sup>59</sup> An additional factor warranting deference is the degree the subject matter “necessarily requires significant expertise and entails

---

55. *Gonzales v. Oregon*, 546 U.S. 243, 256 (2006) (citations and internal quotations omitted).

56. *Chrysler Corp. v. Brown*, 441 U.S. 281, 304 (1979).

57. *Pauley v. Beth Energy Mines*, 501 U.S. 680, 696 (1991).

58. *Chevron*, 467 U.S. at 865.

59. *EEOC v. Arabian Oil Co.*, 499 U.S. 244 (1991) (citing *Gen. Elec. v. Gilbert*, 429 U.S. 125, 140–46 (1976) (quoting *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944))); accord *Heimermann v. First Union Mortgage Corp.*, 305 F.3d 1257, 1261 (11th Cir. 2002).

the exercise of judgment grounded in policy concerns.”<sup>60</sup> Finally, even after deference and respect are accorded, the agency’s interpretation must still be at least a reasonable one.<sup>61</sup>

*B. Did Congress Delegate to the Agency Authority to Set Limits on the Waiver Program?*

With this standard in mind, what level of deference should be accorded CMS’s regulation 42 C.F.R. § 441.303, which the *Makin* court held authorized states to establish strict population limits and, consequentially, waiting lists? This interpretation of the regulation, the court then viewed as authorizing the state to avoid Medicaid statute’s “reasonable promptness” requirement. Is rule 42 C.F.R. § 441.303 entitled to *Chevron* deference, effectively foreclosing judicial authority to question it?

The first problem in bestowing *Chevron* deference is that there does not appear to be a specific statutory delegation to CMS to promulgate regulations in the waiver. The statute provides the Secretary of the Department of Health and Human Services, which oversees CMS, with authority to *approve* waivers (subject to a range of assurances provided by the state), but does not specifically provide for rule-making authority. Under *United States v. Mead*,<sup>62</sup> *Chevron* deference does not apply unless Congress intended to delegate such authorization to the agency. “*Chevron* deference . . . is not accorded merely because the statute is ambiguous and an administrative official is involved. . . . [T]he rule must be promulgated pursuant to authority Congress has delegated to the official.”<sup>63</sup> Not only does the statute not explicitly delegate to CMS the authority to promulgate

60. *Pauley*, 501 U.S. at 697 (citing *Martin v. Occupational Safety & Health Review Comm’n*, 499 U.S. 144, 152–53 (1991)); *Aluminum Co. of Am. v. Cent. Lincoln People’s Util. Dist.*, 67 U.S. 380, 390 (1984); *accord Marsh v. Or. Natural Res. Council*, 490 U.S. 360, 377 (1989).

61. *Gen. Dynamics Land Sys. v. Cline*, 540 U.S. 581 (2004); *Christensen v. Harris County*, 529 U.S. 576, 591 (2000) (Scalia, J., concurring).

62. *United States v. Mead*, 533 U.S. 218, 226–27 (2000).

63. *Gonzales v. Oregon*, 546 U.S. 243, 258 (2006) (citing *Mead*, 533 U.S. at 226–27); *cf. Pub. L. No. 97-248*, § 122(g)(2), 96 Stat. 324, 363 (1982) (“[T]he Secretary of [HHS] shall, not later than September 1, 1983, promulgate such final regulations as may be necessary to set forth—(A) a description of the care included in ‘hospice care’ and the standards for qualifications of a ‘hospice program’ . . .”).

rules under the waiver, in several instances it actually *restricts* the Secretary from denying waivers to states.<sup>64</sup>

Although in 1935 Congress provided a general delegation of rule making authority in the Social Security Act (of which Medicaid is a part) to the Secretaries of Health, Education and Welfare,<sup>65</sup> Labor, and Treasury, not inconsistent with the Act,<sup>66</sup> there are several reasons to question this delegation as sufficient to bestow *Chevron* deference to CMS's waiver regulations. First, Medicaid did not exist at the time of this delegation, and it was in fact forty years before *Chevron* itself, when executive authority for rule-making was more circumscribed. Consistent with this period, the delegation is limited in scope to make rules "necessary for the *efficient administration* of the functions with which each is charged under this chapter."<sup>67</sup> "Efficient administration" appears more restrictive a delegation than other more expansive legislative delegations. By contrast, other statutes have explicitly invited agencies to exercise their discretion in shaping a program, such as by authorizing regulations which in the agency's "judgment" best "effectuate the purposes" of the statute,<sup>68</sup> or to make rules "necessary in the public interest to carry out the provisions of the Act."<sup>69</sup> Moreover, since the waiver program's provisions in 42 U.S.C. § 1396n waive other parts of the statute, any delegation ought to be strictly construed to avoid becoming an unconstitutional delegation of legislative power.<sup>70</sup>

### C. The Agency's Rationale for the Waiver Regulation and Its History

Even without an explicit legislative delegation, the regulation may still be entitled to deference on the basis of an implied grant of

---

64. See 42 U.S.C. § 1396n(c)(6), (c)(10) (2006).

65. The predecessor agency to the United States Department of Health and Human Services.

66. 42 U.S.C. § 1302(a) (2006).

67. *Id.* (emphasis added).

68. *Gonzales*, 546 U.S. at 259 (citing *Household Credit Serv., Inc. v. Pfenning*, 541 U.S. 232, 238 (2004)).

69. *Id.* at 258 (citing *National Cable & Telecomm. Ass'n v. Brand X Internet Serv.*, 545 U.S. 967, 980 (2005)).

70. *Cf. Whitman v. Am. Trucking Ass'n*, 531 U.S. 457, 468, 471 (2001) (discussing limits on Congress's power to delegate to agencies).

authority. Failing that, the regulation may still be determined to be persuasive, even if not entitled to *Chevron* deference. An agency's interpretation of a statute, reflected in a rule, may have such persuasive authority so as to be enforceable even without a delegation.<sup>71</sup>

Whether regulation 42 C.F.R. § 441.303 was the result of an implied delegated authority, or alternatively, in the absence of delegated authority, is supported by a nonetheless highly persuasive agency rationale, is a question best resolved by considering the agency's own reasoning in adopting "population limits."<sup>72</sup> 42 C.F.R. § 441.303 was promulgated on July 25, 1994 through a formal comment and rule making procedure.<sup>73</sup> These 1994 regulations made changes to an earlier version of the regulation, issued on June 1, 1988.<sup>74</sup> How did CMS explain the basis for the population limits in its regulations? Unfortunately, the only references to the provision on population caps are rather oblique. In response to one comment, CMS explained its reason for limiting the number served in the waiver to those set out in the waiver application:

Section 1915(c)(2)(D) of the Act requires that we assess the reasonableness of a State's estimate of the cost-neutrality of its program. If a State anticipates substantive changes in its cost and utilization estimates, we believe that the State should be required to submit amendments to explain the basis and extent of the changes the State's recomputed cost-effectiveness formula, based on the revised cost and utilization, must substantiate continued cost-neutrality.<sup>75</sup>

---

71. *EEOC v. Arabian Oil Co.*, 499 U.S. 244, 257 (1991) (citing *Gen. Elec. v. Gilbert*, 429 U.S. 125, 141-42 (1976)); *accord Heimermann v. First Union Mortgage Corp.*, 305 F.3d 1257, 1261 (11th Cir. 2002).

72. Under the Administrative Procedure Act, agencies are required to provide a general statement of a proposed regulation's basis and purpose when promulgated. *See Schiller v. Tower Semiconductor, Ltd.*, 449 F.3d 286, 297-98 (2d Cir. 2006).

73. 59 Fed. Reg. 37,702 (Sept. 25, 1994).

74. 53 Fed. Reg. 19,959 (June 1, 1988).

75. 59 Fed. Reg. 37,702, 37,708 (Sept. 25, 1994).

In another section, CMS also elaborated on its requirement that states report the number of people to be served in the waiver program:

Even though we have eliminated the “C” value (number of unduplicated waiver individuals a State intends to serve for each year of the waiver) from the equation, we will continue to require each state to report this information to us as part of a waiver request. This number may be revised when a State determines that it needs to increase or decrease the number of individuals it estimates it would serve under the waiver. We will include this number in our approval notices.<sup>76</sup>

What is especially notable is the absence of any assertion by CMS of a clear statutory basis for imposing population limits on waiver programs. In promulgating this regulation, CMS cited no statutory provision. It pointed to no “interpretive gap.” It referenced no legislative history. It divined no evidence of Congressional intent. This may be considered telling and convincing evidence that such limits are not based on the statute. In the absence of a statutory basis for the rule, its own authority to have set “population limits” is questionable. “[T]he mere promulgation of a regulation, without a concomitant exegesis of the statutory authority for doing so, obviously lacks the ‘power to persuade’ as to the existence of such authority.”<sup>77</sup>

Moreover, CMS uses the term “cost and utilization *estimates*” in the first paragraph, and the term “estimates” is repeated in the second paragraph. It does not use the terms population “limits” or “caps.” These estimates appear to be solely determined by states. The only limitations to the general waiver program expressed in the comments are in reference to demonstrating “cost neutrality,” an issue that Congress did reference pervasively in the statute.<sup>78</sup> It seems evident

---

76. 59 Fed. Reg. 37,702, 37,708–09 (Sept. 25, 1994).

77. Pub. Citizen v. U.S. Dep’t of Health & Human Servs., 332 F.3d 654, 661 n.9 (D.C. Cir. 2003) (quoting Adamo Wrecking Co. v. United States, 434 U.S. 275, 287 n.5 (1978)).

78. 42 U.S.C. § 1396n(c)(2)(D), (4)(A) (2006).

by the use of the term “estimates” that the language in the regulation was not designed to further a Congressional intent to limit the waiver population. Rather, these “population limits” merely appear to have been a means to demonstrate the waiver’s cost-neutrality.

Further support that the regulation’s limiting language was intended to be merely a procedure to demonstrate cost neutrality rather than to place a limit on population growth may be gleaned from the section heading of 42 C.F.R. § 441.303: “Supportive Documents Required.” That the population limits were merely a procedural requirement needed to demonstrate the program’s “cost neutrality” is supported by other narrative provided in the comments to the regulations. The 1985 comments to the predecessor regulation 42 C.F.R. § 441.303 similarly focused on “estimates” and demonstrating cost neutrality:

Section 441.303(f)(4) . . . requires States to specify the number of waiver clients actually being deinstitutionalized from certified facilities versus those diverted from admission. . . . States must also specify where the diverted individuals will be coming from and how many will come from each location. . . . These changes are a result of our experience dealing with waiver requests and are needed to determine whether the State’s estimates are reasonable.<sup>79</sup>

In reviewing the regulatory history of the waiver program, it is worth considering CMS’s history of making overly restrictive regulations. CMS itself recognized this history of preventing states from taking full advantage of the waiver program and contravening Congressional intent. The most vivid example of this is what was at one time referred to as the “cold bed test,” in which CMS required states to demonstrate that they had actual empty institutional slots or “beds” to match each waiver slot the state sought to provide:

---

79. 50 Fed. Reg. 10,013, 10,018 (Mar. 13, 1985).

We believe that the requirement that States establish that there would be sufficient institutional bed capacity for their waiver population in the event that there was no waiver should be rescinded. While this requirement served a sound analytical purpose as part of the cost-neutrality test in the early days of the program, our experience over the last several years has shown it to be of diminishing value. The requirement placed an unreasonable burden on States by requiring them to project the estimated development of additional institutional capacity. That additional burden was never the requirement's intent and its development was contrary to the interests of the States and the Federal Government.<sup>80</sup>

CMS also put a limitation on respite services, a type of service provided in waiver programs, without statutory authority for such limits, which Congress then eliminated in 1990 legislation.<sup>81</sup>

In summary, the 1994 promulgation of the home and community-based waiver program regulation, while consistent with CMS's history of overly-restrictive waiver provisions, does not evidence a belief that *Congress intended* states to have federally-imposed population caps in their standard waiver programs. Rather, it appears that the regulations demonstrate CMS's focus on cost neutrality, or the demonstration thereof, as its purpose in adopting the regulation, an issue for which there is abundant evidence of Congressional intent.

If the "caps" did not come from the 1994 language, did they come from the prior language? The 1985 regulation sets out a lengthy and complex formula for data that states must provide CMS in their waiver application.<sup>82</sup> However, the regulation makes no reference to "caps" or population limitations.<sup>83</sup> Rather than "limits" or "caps," the

---

80. 59 Fed. Reg. 37,702, 37,712 (Sept. 25, 1994).

81. *Id.* at 37,704.

82. The actual regulation as it existed prior to the 1994 change is included in Appendix I to this article.

83. 50 Fed. Reg. 10,026–27 (Mar. 13, 1985).

term used in the regulation is “estimates.” This term is used explicitly in reference to cost effectiveness.<sup>84</sup>

When one reviews CMS’s regulatory history for a rationale authorizing strict limits on the number of participants for the “thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade . . .”<sup>85</sup> one finds very little evidence to support such limitations. It is evident from the above regulatory history that it was the test of cost neutrality that CMS was most concerned about, not population limits *per se*.<sup>86</sup> In contrast to a provision of specific limits of participants in the waiver program, the evidence of Congressional intent to limit waiver programs on the basis of *cost-neutrality* is explicit in the language of the legislation, and manifested in its legislative history and CMS’s regulatory history.<sup>87</sup>

Thus, the *Makin* court’s view that the regulations evidenced a statutory intent for the waiver program to have fixed limits, and that such limits carved out an exception to the “reasonable promptness” provision, is not a position supported by CMS in its regulatory history. In the waiver’s regulatory history, CMS makes no pretense to speak for Congressional intent to establish mandatory limitations on the waiver program (with the exception of the model waiver program).<sup>88</sup> Rather, the regulatory history appears to support a waiver program that sets forth “estimates” of the number of beneficiaries, or at best, a “soft” cap on the number of participants: amendable, flexible, and limited only to the extent that they continue to meet the cost-effectiveness standard set out by Congress. The “limits” cited in the simplified version of 42 C.F.R. § 441.303 were merely an easy and convenient way for CMS to have states demonstrate cost neutrality. To the extent that the *Makin* court saw these limits as

---

84. See also 53 Fed. Reg. 19,959, 19,962 (June 1, 1988).

85. EEOC v. Arabian Oil Co., 499 U.S. 244, 257 (1991) (quoting *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944)).

86. See *supra* notes 59 and 60.

87. H. R. REP. NO. 97-208, at 481-82 (1981), reprinted in 1981 U.S.C.A.N. 396, 747-48.

88. See *infra* note 158.

Congressionally authorized, fixed and firm enough implicitly to avoid the “reasonable promptness” obligation, regulation 42 C.F.R. § 441.303 does not appear to have been drafted with the intention to support such an interpretation.

### III. SUPPORT IN THE STATUTE FOR FINDING A “REASONABLE PROMPTNESS” OBLIGATION

#### *A. Statutory Support for Inclusion of the “Reasonable Promptness” Requirement*

If regulation 42 C.F.R. § 441.303 cited by *Makin*, *Braddock*, *Bryson* and subsequent courts does not evidence a Congressional intent to impose numerical limitations on state waiver programs, how does the statute address the question of whether the “reasonable promptness” provision applies to waiver programs? The most compelling interpretation is also the most obvious interpretation. The “cardinal rule of statutory construction”—giving effect to the plain meaning of a statute—supports this inclusion:

[A] court should always turn first to one, cardinal canon before all others. We have stated time and time again that courts must presume that a legislature says in a statute what it means and means in a statute what it says there. . . . When the words of a statute are unambiguous, then this first canon is also the last: “judicial inquiry is complete.”<sup>89</sup>

Although the Medicaid statute is notoriously complicated, stripped away, the plain language of the statute does not exempt the waiver from the “reasonable promptness” provision. Specifically, 42 U.S.C. § 1396n(c)(1) includes home and community-based services as within the definition of “medical assistance.”<sup>90</sup> 42 U.S.C. § 1396a(8) requires “such assistance be provided with reasonable promptness.”<sup>91</sup>

89. *Conn. Nat’l Bank v. Germain*, 503 U.S. 249, 253–54 (1992) (citations omitted).

90. 42 U.S.C. § 1396n(c)(1) (2006).

91. *Id.* § 1396a(8).

The apparent presumption in *Makin* and other courts that Congress's failure to waive the "reasonable promptness" was an oversight is not supported from a review of the statute's context and legislative history. The language in the statute demonstrates that Congress was not unfamiliar with the requirements of the Medicaid statute and was specific about which provisions of the Act that it wanted waived. As set forth below, the "reasonable promptness" provision was not included among these:

A waiver granted under this subsection may include a waiver of the requirements of section 1396a(a)(1) of this title (relating to statewideness), section 1396a(10)(B) of this title (relating to comparability), and section 1396a(10)(C)(i)(1)(III) of this title (relating to income and resource rules applicable in the community).<sup>92</sup>

Under the maxim of statutory construction, *expression unius est exclusion alterius*, Congress's *exclusion* of the "reasonable promptness" provision from the list of statutory requirements that it authorized a state to waive in its waiver program should be viewed as an intention that it *not* be waived.<sup>93</sup> Further supporting the proposition that the statute's plain language was deliberate and reflective of Congressional intent is the fact that the waiver of one of the provisions listed above, the exclusion of income and resource provisions, was not in the original 1981 language of the waiver program. It was added in 1986.<sup>94</sup> By failing to also add an exemption for "reasonable promptness" when Congress added the income and resource exemption, a presumption arises that Congress did not view the failure to exempt reasonable promptness requirements in 1981 to be an "oversight." When Congress amends a section of the statute but

---

92. *Id.* § 1396n(c)(3).

93. *Cf. Russello v. United States*, 446 U.S. 16, 23 (1983) ("Where Congress includes particular language in one section but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion and exclusion." (quoting *United States v. Wong Kim Bo*, 472 F.2d 720, 722 (5th Cir. 1972))).

94. Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9411(c), 100 Stat. 1874 (1986).

leaves other language unchanged, it suggests that the original language was reflective of its true intent.<sup>95</sup>

In the face of such relatively clear provisions in the statute, there is a heavy burden that must be overcome to demonstrate that Congress did not in fact mean the words it used in the statute it enacted. “[R]epeals by implication are not favored’ and will not be presumed unless the ‘intention of the legislature to repeal [is] clear and manifest.’”<sup>96</sup> When other provisions of the statute are considered, particularly with respect to how the program is intended to operate, there is additional support for finding that Congress envisioned the reasonable promptness provision to apply to the waiver program.

*B. Support for the Inclusion of the Reasonable Promptness Obligation from Other Requirements Set Forth in the Waiver Statute*

Looking beyond the explicit inclusion of the “reasonable promptness” obligation in the language of the statute, other provisions provide additional contextual support for its inclusion. “It is a ‘fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme.’”<sup>97</sup> In particular, the waiver statute contains expansive notice provisions to inform large numbers of potential beneficiaries of the program, and the program’s provision for providing beneficiaries with alternatives to non-institutional placement suggest that Congress did not have an intent for fixed and inflexible population limits. On the other hand, excluding the reasonable promptness provision provokes substantial conflict with these provisions, suggesting that this was never intended.

As suggested in the portion of the statute reproduced below, it is apparent that Congress wanted notice of the waiver program to reach the broadest range of potential recipients. The statute sets forth as a condition of approval to operate a waiver program that notice to

---

95. See *Eidmann v. MSPB*, 976 F.2d 1400, 1406 (D.C. Cir. 1992).

96. *Nat’l Assoc. of Homebuilders v. Defenders of Wildlife*, 551 U.S. 644, 662 (2007) (citations omitted).

97. *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000) (citing *Davis v. Mich. Dep’t of Treasury*, 489 U.S. 803, 809 (1989)).

*potential beneficiaries* be provided, and for their choice of community services to be effectuated.<sup>98</sup> This provision is often referred to as the “freedom of choice” provision:

A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that – (C) such individuals who are determined to be likely to require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded are informed of the feasible alternatives, if available under the waiver, at the choice of such individuals, to the provision of inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded . . . .<sup>99</sup>

This “freedom of choice” provision was raised by the Plaintiffs in *Makin* as a separate legal basis to challenge the state’s waiting list. The Plaintiffs argued that by maintaining an indefinite wait list, the state’s waiver program was denying beneficiaries their choice as provided in the statutory language cited above.<sup>100</sup> The *Makin* court rejected this claim, but its analysis of the issue may be criticized for borrowing heavily from its earlier legal conclusion:

Though this requires the State to give the Plaintiffs a choice from among the services, it only requires it to allow a choice from among the “available” services. Unfortunately, when the spaces are filled in the HCBS-MR program, it is no longer “available” under the waiver. This remains the case regardless of whether there is a wait list for the services. Since no regulation or other law provides a different result regarding the “population limits” of the HCBS-MR programs and the Plaintiffs are not claiming that they have no other alternatives under the waiver program,

---

98. See *infra* note 115.

99. 42 U.S.C. § 1396n(c)(2)(C) (2006).

100. *Makin v. Hawaii*, 114 F. Supp. 2d 1017, 1032 (D. Haw. 1999).

the Plaintiffs have no valid “freedom of choice” cause of action under the Medicaid statute in this case.<sup>101</sup>

Thus, in the court’s view the “freedom of choice” provision, as well as the notice provision, is subject to slots being “available”: Medicaid beneficiaries are notified of community-based services only when the slots are “available” under the waiver.<sup>102</sup> This interpretation appears to presume a Congressional intent that beneficiaries should be notified of their rights under the program only when there are tangible alternatives readily available to them. An alternative reading of the provision is that it is designed for the state to develop its community-based resources to bring about beneficiaries’ choice of community based resources. Consumers are advised of the services that are provided (generally available) under the waiver, whether or not immediately accessible.

Reading “available” to mean “open slots available,” however, appears to ignore the word “feasible” in the state’s obligation to inform individuals of “feasible alternatives” under the waiver.<sup>103</sup> “[I]t is axiomatic that ‘all words and provisions of statutes are intended to have meaning and are to be given effect, and no construction should be adopted which would render statutory words or phrases meaningless, redundant or superfluous.’”<sup>104</sup> “Feasible” generally means “capable of being successfully done or accomplished.”<sup>105</sup> The *Makin* court’s interpretation appears to render this word as surplusage. The court’s interpretation appears to equate the word “alternatives” to “available slots” in the waiver program. But Congress’s use of the word “feasible” in the statutory language, “feasible alternatives,” suggests that Congress intended to advise and

---

101. *Id.*

102. *Id.*

103. 42 U.S.C. § 1396n(c)(2)(C) (2006).

104. *United States v. Caraballo*, 200 F.3d 20, 25 (1st Cir. 1999); *see also United States v. Menasche*, 348 U.S. 528, 538–39 (1955).

105. BLACK’S LAW DICTIONARY 739 (4th ed. 1957); *accord Am. Textile Mfr. Inst., Inc. v. Donovan*, 452 U.S. 490 (1981) (noting the statute’s use of the term “feasible” referred to the technical capability and precluded OSHA from adding economic considerations in its issuance of its cotton dust remediation rule).

enable consumers to choose services technically possible to be provided them under the waiver, even if not presently “available.” This language suggests that as long as the services in the waiver represent “feasible alternatives” to institutionalization, Congress wanted consumers aware of these alternative services, and to be given the choice of receiving them.<sup>106</sup>

The statute’s broad notice provision appears to conflict with the court’s construction permitting states to restrict the availability of slots. Because the “freedom of choice” provision is triggered when someone is “*likely*” to meet the level of care,<sup>107</sup> not *when* he or she meets the level of care, it applies even before individuals definitively qualify for waiver services. Such a broad notice requirement appears inconsistent with a construction that limits notice only when there are “available” slots. If the goal is to advise beneficiaries of only real, tangible, “available slots” as the *Makin* court’s interpretation seems to favor,<sup>108</sup> the statutory language would have been better served by advising consumers of alternatives only *after* they definitively qualified for services. In contrast, if “feasible alternatives” means services generally able to be provided under the waiver, notifying beneficiaries early, even before they definitively qualify, would apprise the state of the need to meet the projected growth in the program.

One can appreciate why the court would want to find the statute’s reference to “alternatives” to mean “available slots.” At first blush, this interpretation appears to permit the court to escape an underlying tension created after it determined that the waiver program is not bound to the reasonable promptness obligation. If “available under the waiver” means “generally available” under the waiver, the state’s compliance with the notice requirement would require it, confusingly, to inform potential beneficiaries of services under the waiver and their “right” to choice. However, in light of its earlier holding authorizing strict limits on the program, this would be appear to be a

---

106. 42 U.S.C. § 1396n(c)(3) (2006).

107. *Id.* § 1396n(c)(2)(C) (emphasis added).

108. *Makin v. Hawaii*, 114 F. Supp. 2d 1017, 1032 (D. Haw. 1999).

senseless act, because the state would not actually have to provide the services or effectuate their choice. By finding that “available under the waiver” means “open slots,” the court appears initially to have avoided this exercise in futility. However, rather than resolve this problem, this interpretation really only heightens it.

Because most waiver programs have populations in the thousands, there will inevitably be at least a few “available” slots under the waiver, as beneficiaries die, become too ill to stay on the waiver, or will, for a host of other reasons, become ineligible or unable to benefit from the program. Thus, even when a program appears to be generally full, there essentially will still be a few “available” slots.<sup>109</sup> Thus, even under the court’s reading limiting the notice requirement to “open slots,” the presence of a few slots still means that everyone “likely” to qualify for the services will still have to get notice. They will have to get the notice even though, without the reasonable promptness obligation, only a minute fraction may actually be able to access the services, and the state will not have any obligation to serve the other applicants.

This, in turn, leads to another equally daunting problem: how are the few slots “available” to be allocated? Are they to be provided on a “first come first served” basis; or based on urgency of medical need; cost or cost savings; or some combination of these? There is no provision in the statute resolving this question of prioritization, and the *Makin* court did not address this issue.<sup>110</sup> The presence of such vexing complications should be an additional basis to view the court’s interpretation as disfavored. “Congress . . . does not alter the fundamental details of a regulatory scheme in vague terms or ancillary provisions—it does not, one might say, hide elephants in mouseholes.”<sup>111</sup>

---

109. In the *Makin* decision the court itself noted in two instances that there were “a few remaining unfilled slots available” but left this issue as an outstanding unresolved issue of material fact. *Id.* at 1031 n.6. The same problem has been cited in other cases such as *Lewis v. N.M. Dep’t of Health*, 275 F. Supp. 2d 1319, 1334–35 (D.N.M. 2003).

110. *Makin*, 114 F. Supp. 2d at 1031 n.6.

111. *Whitman v. Am. Trucking Ass’n*, 531 U.S. 457, 468 (2001) (citations omitted).

These complications arise from the court's interpretation excluding the reasonable promptness language in the statute, and are all easily avoided with its inclusion. The broad notice of potential beneficiaries does not become a wasteful exercise in futility for the large number of individuals unable to have their choice effectuated by a state unwilling to expand its program. Rather, it informs the state of the projected needs for the program, and obligates the state to adjust its ratio of institutional versus community services in its Medicaid program to fit beneficiaries' desires. The substantial problem of having to find practical and legally supported methods to ration the services does not arise when the statute's plain language is given effect.

In the regulatory history of the waiver, CMS's interpretation of the "freedom of choice" provision, while not directly addressing these points, arguably provides some inconsistencies with the *Makin* court's interpretation subjecting the "freedom of choice" provision to "available slots." The agency explained:

Beneficiaries determined likely to require an SNF or ICF level of care must be informed of the feasible alternatives and given a choice as to which type of services to receive . . . . The determination of which long-term care options are feasible in a particular case should be based on the individual's needs, as determined by an evaluation. As with other services under Medicaid, a beneficiary who is not given the choice of home or community-based services as an alternative to SNF or ICF services may request a fair hearing under 42 C.F.R. Part 431, Subpart E, unless the reason for the denial is that the group of which the individual is a part is not included within the scope of the waiver (see 42 C.F.R. 431.220(b)). Since a finding that home or community-based services are not feasible in a particular case constitutes denial of services covered under the State's Medicaid plan, the Medicaid statute (section 1902(a)(3)) requires that applicants and beneficiaries be provided the procedural

protections of the Medicaid administrative hearing process as described in 42 CFR part 431, Subpart E.<sup>112</sup>

This language tends to support application of the reasonable promptness requirement to the waiver. It reflects the broad notice and hearing requirement for anyone denied his or her choice of home and community-based services, exempting only those seeking services not included in the scope of waiver program.<sup>113</sup> Second, the basis of denial of service embraced in this explanation focuses not on resources, but whether or not services are “feasible in a particular case.”<sup>114</sup> The emphasis on individual determinations, without reference to “quotas,” “caps,” or “resource limitations,” suggests that these are not proper justifications for denying individual choice.<sup>115</sup> Most compelling, however, is that it does not reference as a basis for the denial of notice or a hearing when slots are not “available.” And since this would be, by far, the largest and most obvious basis for potential beneficiaries to be denied services—if CMS believed this to be a legitimate reason for such denial—this omission should be viewed as a telling contradiction to the theory that the statute’s use of the language “feasible alternatives available under the waiver” is meant to equate with “open slots.”

*C. Applying the Reasonable Promptness Obligation Provides Consistency with Congress’s Anti-Discrimination Legislation and Policies Promoting Deinstitutionalization*

*1. The Tension Between the ADA’s “Integration Mandate” and Makin*

Giving effect to the “reasonable promptness” language in waiver programs would require a restructuring of state Medicaid programs,

---

112. 46 Fed. Reg. 48,532, 48,535–36 (Oct. 1, 1981).

113. *Id.*

114. *Id.*

115. *Cf. Ball v. Rodgers*, 492 F.3d 1094, 1107 (9th Cir. 2007) (sustaining District Court’s grant of an injunction and holding that “individuals have two explicitly identified rights—(a) the right to be informed of alternatives to traditional, long-term institutional care, and (b) the right to choose among those alternatives”); *Michele P. v. Holsinger*, 356 F. Supp. 2d 763, 769 (E.D. Ky. 2005).

as services expand to meet assessed need. Would such an expansion be an unwarranted additional burden on states? Such an expansion is in fact consistent with long-standing statutory precedents. It has been the reasoning and the holding of *Makin* that has conflicted with these statutes.

The *Makin* court's interpretation avoiding the reasonable promptness provision causes a basic conflict with the ADA's "integration mandate," which the court itself appears to have acknowledged.<sup>116</sup> The ADA generally requires states and other governmental entities to make "reasonable accommodations" to their programs to make them accessible to the disabled. *Olmstead*, decided under the ADA, held that institutionalizing individuals unnecessarily, i.e., withholding home or community-based medical treatment that is safe and appropriate to the individual, is a form of segregation prohibited by the ADA's integration mandate.<sup>117</sup> At the same time, Justice Ginsburg's plurality opinion recognized that cost considerations might make *immediate* deinstitutionalization too costly to be considered a "reasonable modification." "Sensibly construed, the fundamental-alteration component of the reasonable-modifications regulation would allow the State to show that, in the allocation of available resources, immediate relief for the Plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities."<sup>118</sup> The Court held that a state could meet the integration mandate of the ADA without immediate relief by having a "comprehensive, effectively working plan" to provide services.<sup>119</sup>

When Medicaid's "reasonable promptness" requirement is interpreted to be not applicable to waiver programs, substantial questions arise about Medicaid program's compliance with the

---

116. *Makin v. Hawaii*, 114 F. Supp. 2d 1017, 1033–35 (D. Haw. 1999).

117. *Cramer v. Chiles*, 33 F. Supp. 2d 1342, 1353–54 (S.D. Fla. 1999) (finding the use of Medicaid funds to continue to provide services in institutions and nursing homes without permitting Medicaid funded community placement violates the ADA).

118. *Olmstead v. L.C.*, 527 U.S. 581, 604 (1999).

119. *Id.* at 605–06.

ADA's integration mandate. Allowing states to set "population limits" in their waiver programs that are below their real need leaves individuals in institutions unable to move to non-restrictive environments in the community. Other individuals, unable to receive community-based services, are compelled to become institutionalized. As seen below, courts that have found population caps as authorized under Medicaid have struggled with this issue.

*Makin* considered the possibility of mandating increases in the waiver program to comply with the ADA's requirement that programs make "reasonable modification" to avoid discriminatory effects.<sup>120</sup> Ultimately, the court determined it lacked material facts sufficient to rule on the question on summary judgment.<sup>121</sup> Although *Makin* never reached the question, the court in *Braddock* did. Initially, it acknowledged the tension between the statutes, but left an unsatisfactory resolution when it simply held that compliance with the Medicaid statute dispensed with the need to comply with the ADA:

Thus, to the extent that the statutes point in opposite directions, one of them must prevail. In this case, the Medicaid statute should receive the laurel wreath because, "[w]here there is no *clear* intention otherwise, a specific statute will not be controlled . . . by a general one, regardless of the priority of enactment"[;] . . . "[i]t is a well established tenet of statutory construction that a specific statute controls over a general statute." If Arc [the Plaintiffs] were correct, the general ADA injunction against discrimination would repeal the specific Medicaid provisions for the limited waiver programs. That cannot be. In so stating, we do not mean that the ADA has nothing whatsoever to say about a state's obligation to provide community-based services to the

---

120. *Makin*, 114 F. Supp. 2d at 1033–35.

121. *Id.* at 1035.

disabled . . . . We merely state that the ADA does not overcome the specific cap provision in the Medicaid statute.<sup>122</sup>

The initial *Braddock* opinion was withdrawn after a rehearing was granted.<sup>123</sup> In the second *Braddock* opinion, the court simply found that even though the state had a population cap on its waiver program, it nonetheless had a “comprehensive, effectively working plan,” the defense that Justice Ginsburg’s opinion offered in *Olmstead*.<sup>124</sup> The *Braddock* court looked to the growth of the program over the years to find a “comprehensive, effectively working plan.”<sup>125</sup>

Washington’s HCBS program is substantial in size, providing integrated care to nearly 10,000 Medicaid-eligible disabled persons in the state . . . . The waiver program is full, and there is a waiting list that admits new participants when slots open up. . . . [A]ll Medicaid-eligible disabled persons will have the opportunity to participate in the program once space becomes available, based solely on their mental-health needs and position on the waiting list.

Further, the size of Washington’s HCBS program increased at the state’s request from 1,227 slots in 1983 to 7,597 slots in 1997 to 9,977 slots beginning in 1998 . . . . The annual state budget for community-based disability programs such as HCBS more than doubled from \$167 million in fiscal year 1994, to \$350 million in fiscal year 2001, despite significant cutbacks or minimal budget growth for many state agencies . . . . During the same period, the budget for institutional programs remained constant, while the institutionalized population declined by 20% . . . . Today, the statewide institutionalized population is less than 1,000.

The Department’s Division of Developmental Disabilities (DDD) has also seen its biennial budget grow steadily from \$750

---

122. *Arc of Wash. State, Inc. v. Braddock*, 403 F.3d 641, 644 (9th Cir. 2005) (citations omitted).

123. *Id.* at 616.

124. *Id.* at 621–22 (citing *Olmstead*, 527 U.S. at 605).

125. *Id.*

million in 1995 to over \$1 billion in 1999, making it one of the fastest growing budgets within the Department . . . . Family support services, given to families of DDD clients living at home, have grown even faster, benefitting from a 250% budget growth over five years . . . . There is thus no indication that the state is neglecting its responsibilities to the HCBS program relative to other programs.<sup>126</sup>

The same holding was made in *Sanchez v. Johnson*, another Ninth Circuit case decided a few months before.<sup>127</sup> Like the quoted section above, *Sanchez* also found a comprehensive, effective plan based on substantial increases in funding and case loads for community placement.<sup>128</sup>

Although these opinions cite indications of past progress, they do so vaguely without setting forth an objective level of progress necessary for a state to be deemed to have a “comprehensive, effectively working plan.”<sup>129</sup> The “plans” cited by the Ninth Circuit provide little indicia of future progress, contradicting the notion of a “plan” in its ordinary sense. The Third Circuit case, *Frederick L. v. Department of Public Welfare*, by contrast, rejected reliance of past progress alone in deinstitutionalization as evidence of a “comprehensive, effective, working plan.”<sup>130</sup>

[W]hat is needed at the very least is a plan that is communicated in some manner. The District Court accepted the Commonwealth’s reliance on past progress without requiring a commitment by it to take all reasonable steps to continue that

---

126. *Id.* at 621 (citations omitted).

127. *Sanchez v. Johnson*, 416 F.3d 1051, 1067 (9th Cir. 2005).

128. *Id.* (“California’s expenditures for individuals in community settings increased 196% [between 1991 and 2001], while caseload . . . increased fifty-five percent in the same period. . . . [Between 1996 and 2000], California reduced its institution population by twenty percent. DDS has also budgeted 42 new Community Care Facilities and ten new Intermediate Care Facilities, and anticipates a reduction in institutionalization that would allow it to close at least one Developmental Center by 2007.”) (internal quotation marks omitted).

129. *Id.*; *Braddock*, 427 F.3d at 621.

130. *Frederick L. v. Dep’t of Pub. Welfare*, 364 F.3d 487, 500 (3d Cir. 2004), *remanded*, No. 02-3721, 2004 U.S. Dist. LEXIS 17810 (E.D. Pa. Sept. 1, 2004), *vacated*, 422 F.3d 151 (3d Cir. 2005).

progress. Under the circumstances presented here, our reading of *Olmstead* would require no less.<sup>131</sup>

While past progress as in *Braddock* and future assurances as in *Frederick L.* may be indicators of a plan, they leave vague and unanswered the two most pertinent questions necessary for a court to determine the effectiveness of a state “plan”: (1) the factual question of how long must individuals wait to receive needed community based services; and (2) the legal question of whether this length of time is “reasonable.” A “plan” that cannot provide at least a rough or approximate timeframe that services will be provided to beneficiaries that are eligible and dependent upon them is really only a “plan” in name. Without answers to these questions, the ADA’s integration mandate looks less like a “mandate” and more like merely an aspiration.

Of course, if the “reasonable promptness” provision is read into the waiver program, the ADA’s integration mandate is readily achieved for many of those with disabilities who depend on Medicaid and are eligible for the waiver. When a state provides waiver services in “reasonably prompt” timeframes, it seems difficult to conceive how the state would not *also* meet the “reasonable modification” requirement of the ADA’s integration mandate. The symmetry of this construction is itself compelling. Because applying the Medicaid’s reasonable promptness provision in waivers would best effectuate the ADA’s integration requirement, and avoidance of the reasonable promptness language is likely to frustrate it, this interpretation, flowing from the statute’s plain language, should be the first and most favored interpretation. “When two statutes are capable of coexistence, it is the duty of the courts, absent a clearly expressed Congressional intention to the contrary, to regard each as effective.”<sup>132</sup> The ADA is clearly a statute of broad general

---

131. *Id.*

132. *Radzanower v. Touche Ross & Co.*, 426 U.S. 148, 155 (1976) (quoting *Morton v. Mancari*, 417 U.S. 535, 551 (1974)); *see also Powell v. U.S. Cartridge Co.*, 339 U.S. 497, 519 (1950) (holding that for two overlapping statutes covering the same subject matter, the interpretation that satisfies both statutes should be given effect, absent a showing of impossibility); *Schiller v. Tower Semiconductor, Ltd.*, 449

applicability. It is intended to “invoke the sweep of congressional authority, including the power to enforce the fourteenth amendment and to regulate commerce, in order to address the major areas of discrimination faced day-to-day by people with disabilities.”<sup>133</sup> It seems clear that Congress intended to reach all elements of society and government activity in passing the ADA. Undoubtedly this includes state Medicaid programs.

*2. Including the Reasonable Promptness Obligation in Waiver Programs Is Consistent with Congress’s Lengthy History Promoting Deinstitutionalization*

Beyond these general principles of statutory construction, the history of Congressional anti-discriminatory legislation suggests that making waiver services available to those eligible with reasonable promptness best comports with Congressional intent. The obligation of Medicaid programs to modify their programs to avoid discriminatory policies against the disabled did not merely arise with the ADA, but arises from earlier precedents. The ADA was essentially an extension of the Rehabilitation Act,<sup>134</sup> which prohibits recipients of federal funding from discriminating against the disabled, including state Medicaid programs.<sup>135</sup> The ADA extended the anti-discrimination provisions of the Rehabilitation Act throughout American society, irrespective of whether the program or activity received federal funds. And generally, the ADA’s and the Rehabilitation Act’s substantive terms are the same.<sup>136</sup>

When the ADA was passed, the legal obligation upon Medicaid programs to avoid discrimination against the disabled had already been long established by the Rehabilitation Act.<sup>137</sup> Thus, all state and

---

F.3d 286, 301 (2d Cir. 2006) (citing *St. Martin Evangelical Lutheran Church v. South Dakota*, 451 U.S. 772, 788 (1981)).

133. 42 U.S.C. § 12101(b)(4) (2006).

134. Pub. L. No. 93-112, 87 Stat. 394 (1973) (codified at 29 U.S.C. § 794 (2006)).

135. *Id.*

136. *Cf. Barnes v. Goorman*, 536 U.S. 181, 184–85 (2002); *Lovell v. Chandler*, 303 F.3d 1039, 1052 (9th Cir. 2002); *Helen L. v. DiDario*, 46 F.3d 325, 331–32 (3d Cir. 1995).

137. *Application of Certain Cross-Cutting Statutes Under the Omnibus Reconciliation Act of 1981*, 6 U.S. OP. OFF. LEGAL COUNSEL 83 (1982), available at 1982 WL 170674.

local government *applicants* for federal financial assistance were, and are, required to provide assurances that they will abide by the Rehabilitation Act's anti-discrimination provisions.<sup>138</sup> In fact, all Medicaid state plans must contain specific assurances that the state's Medicaid program will comply with the Rehabilitation Act.<sup>139</sup> By the time the waiver program came into existence in 1981, state Medicaid programs were already required to provide assurances that they would comply with the Act's anti-discriminatory provisions.

Not only had states long been required to operate their Medicaid program in a manner that avoided discrimination against the disabled, it was already established law that this compliance meant avoiding unnecessary institutionalization. The Rehabilitation Act's implementing regulations promulgated by the Department of Justice in 1981 contain its own integration mandate, substantially the same as in the ADA regulations: "Recipients shall administer programs and activities in the most integrated setting appropriate to the needs of qualified handicapped person."<sup>140</sup> Thus, the integration mandate (the ADA's version of which would ultimately be the subject of *Olmstead*) already existed in the Rehabilitation Act when Congress passed the ADA, and was already a condition for the receipt of state Medicaid funds.<sup>141</sup> The ADA specifically states that its implementing regulations should be consistent with the Rehabilitation Act regulations.<sup>142</sup> In actuality, the legislative history of the ADA records that the integration mandate received bipartisan endorsement. The majority report referenced the integration mandate in the education

---

138. OMB's Standard Form 424B requires an applicant to certify that he or she "will comply with all Federal statutes relating to non-discrimination. These include, but are not limited to . . . (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps . . . ."; see also U. S. OFFICE OF MANAGEMENT BUDGET CIRCULAR A-102 [hereinafter OMB].

139. See Letter from Health Care Fin. Admin., Ctr. for Medicaid and State Operations, to State Medicaid Director (Aug. 3, 1998).

140. 28 C.F.R. § 41.51(d); see *Helen L. v. DiDario*, 46 F.3d 325, 332-33 (3d Cir. 1995).

141. This assurance is typically provided in Section 7.2 of each state plan for medical assistance (Medicaid).

142. 42 U.S.C. § 12134(b) (2006). Note that the statute mistakenly refers to regulations promulgated by the Department of Health, Education, and Welfare instead of the Department of Justice.

context.<sup>143</sup> Support for the integration mandate echoed in the minority report.<sup>144</sup>

In addition, the “integration mandate,” while enforced as part of the ADA in the *Olmstead* decision, followed a legislative judgment made a decade before as part of the Social Services Block Grant.<sup>145</sup> Its purpose tracks closely the integration mandate as applied to institutionalization. The specific language of the statute states that its goal is “preventing or reducing inappropriate institutional care by providing for community-based care, home based care, or other forms of less intense care.”<sup>146</sup> When did this provision come about? It came about in 1981, as part of OBRA 1981, the same legislation that enacted 42 U.S.C. § 1396n, Medicaid’s community based waiver program, both becoming parts of the Social Security Act,<sup>147</sup> Medicaid being Title XIX,<sup>148</sup> and the Social Services Block Grant, Title XX.<sup>149</sup> As part of the same legislation, and as part of the same subject matter, the two provisions should be read together as an overarching consistent expression of Congressional intent to eliminate unnecessary institutionalization in federally-funded health care.

In light of this history, it cannot be considered a surprising or novel change in a state’s legal obligation to enforce the plain language of the Medicaid Act to provide alternatives to institutional care with “reasonable promptness.” The obligation for states to offer non-institutional alternative services for their disabled residents was fixed *before* the Medicaid waiver program. This program, along with the Social Security Block Grant program, merely provided funding

---

143. “The school bus transportation provided to children with disabilities must be provided in the most integrated setting possible.” H. REP. NO. 101-485 (II) (Conf. Rep.), *reprinted in* 1990 U.S.C.A.A.N. 267, 369.

144. “As with Section 504 of the Rehabilitation Act, integrated services are essential to accomplishing the purposes of Title II. As stated by Judge Mansmann in *ADAPT v. Skinner*, ‘the goal is to eradicate[e] the invisibility of the handicapped.’ Separate but equal services do not accomplish this central goal and should be rejected.” H. REP. NO. 101-485 (II), *reprinted in* 1990 U.S.C.A.A.N. 267, 473 (quoting *ADAPT v. Skinner*, 881 F.2d 1184, 1204 (3d Cir. 1989) (Mansmann, J., dissenting)).

145. 42 U.S.C. § 1397 (2006).

146. *Id.*

147. Pub. L. No. 97-35, § 2352, 95 Stat. 357 (codified at 42 U.S.C. §§ 1397–1397f (1981)).

148. 42 U.S.C. § 1396 (2006).

149. 42 U.S.C. § 1397 (2006).

sources for states to effectuate Congress's anti-discriminatory mandates on state programs and services.

From the Social Services Block Grant, the Rehabilitation Act, and the ADA, Congress has repeatedly reaffirmed intentions to deinstitutionalize our health system for our disabled residents. As seen above, discord with this policy arose not from Congress, but from the *Makin* decision and its interpretation of CMS's regulation. Since then, various circuit courts<sup>150</sup> have issued decisions along the lines of *Makin*, binding in those circuits, and CMS itself has clouded the issue through informal statements made in letters issued to state Medicaid Directors that appear to confuse CMS's administrative requirement in waiver applications, as asserted in this article, with the statutory mandates of the Medicaid Act.<sup>151</sup> Such informal guidance, not having gone through the administrative rule-making procedure set out under the Administrative Procedure Act,<sup>152</sup> and without a source of statutory authority, are neither controlling nor are they persuasive.<sup>153</sup>

#### IV. REVIEWING THE STATUTORY PROVISIONS THAT THE *MAKIN* COURT FOUND "AMBIGUOUS" AND AUTHORIZED AVOIDING THE "REASONABLE PROMPTNESS" OBLIGATION

What should one make of the statutory provisions cited by *Makin* as ambiguous enough to give rise to an "interpretive gap"—which it

---

150. Language in the Sixth Circuit case of *Brown v. Tenn. Dep't of Fin. & Admin.*, 561 F.3d 542, 548 n.4 (6th Cir. 2009), supports *Makin* although the issue was not technically before the Court. See also CHRISTIAN E. MAMMEN, USING LEGISLATIVE HISTORY IN AMERICAN STATUTORY INTERPRETATION 71 (2002).

151. See, e.g., Letter from Health Care Fin. Admin., Ctr. for Medicaid and State Operations, to State Medicaid Director, at 8–9 (Jan. 10, 2001), available at <http://www.cms.gov/smdl/downloads/smd011001a.pdf> ("May a State reduce the total number of people to be served under a HCBS waiver?" Yes. Under 42 C.F.R. 441.303(f)(6), states are required to specify the number of unduplicated recipients to be served under HCBS waivers.).

152. 5 U.S.C. §§ 551–559 (2006).

153. *Heintz v. Jenkins*, 514 U.S. 291, 298 (1995) ("We find nothing either in the Act or elsewhere indicating that Congress intended to authorize the FTC to create this exception from the Act's coverage—an exception that falls outside the range of reasonable interpretations of the Act's expressed language."); *Christensen v. Harris County*, 529 U.S. 576 (2000).

filled with its interpretation of CMS's regulation?<sup>154</sup> As noted earlier, the first reference, 42 U.S.C. § 1396n(c)(9), does not appear to make such limits mandatory, but makes them permissive, "in the case of any waiver which contains a limit on the number of individuals . . . ."<sup>155</sup> Because such limits are *optional*, the language should not be viewed to override the mandatory language of the "reasonable promptness" obligation. A state using "limits" can give effect to both provisions by setting limits to approximate needs.<sup>156</sup>

The second statutory reference to a limitation is indeed curious, but is considered to apply to the "model" waiver program: "The Secretary shall not limit to fewer than 200 the number of individuals in the State who may receive home and community-based services under a waiver under this subsection."<sup>157</sup> It prohibits the Secretary from denying state model waiver applications, if they have populations below 200 slots. This provision was, in fact, directly addressed by CMS in its 1994 regulatory history. In distinguishing the requirements of a model waiver from the general waiver program, the explanation offered further undermined the reasoning of *Makin*:

This amendment restricts the Secretary's power to limit the number of persons who can receive home and community-based waivers to no lower than 200. Again, in light of the history of the waiver program and the legislative history of the provision, *we interpret this amendment to restrict the Secretary's power to limit the number of participants in the model waiver program only. Historically, there has been no limit on the number of participants in the regular home and community-based waiver programs, whereas there has been a 50 person Federally-imposed limit on the number of persons who can participate in a model waiver.* Also Section 411(k)(10)(A) was aimed only at model waivers. We believe, therefore, that this provision enables the Secretary to limit the number of participants in a model home

---

154. See discussion *supra* Part I.B.

155. 42 U.S.C. § 1396n(c)(9) (2006).

156. 42 U.S.C. § 1396n(c)(2)(C) (2006).

157. 42 U.S.C. § 1396n(c)(10).

and community-based program to 200 persons, or any amount above 200. Through these regulations, the Secretary has opted to impose a maximum limit of 200 persons for any state waiver program. On an individual State basis, an approved State plan may contain a maximum limit that is lower than 200. Thus, no State may serve any more than 200 persons, but any State may be limited to a lower number as approved in its waiver program. *There is no comparable limit on regular waiver programs . . . .*<sup>158</sup>

Could Congress have really wanted *everyone* who could meet the cost neutrality criteria to get the option of getting alternative waiver services? It appears that CMS initially thought so, recognizing that Congress intended to cast the broadest possible net:

The House Report accompanying the House Omnibus Reconciliation Bill (H. Rep. 97-158, p. 316) notes that it has been estimated that a quarter of the current nursing home population do not need full-time residential care. Many elderly, disabled and chronically ill persons do not need full-time, residential care. Many elderly, disabled and chronically ill persons live in institutions not for medical reasons, but because of the paucity of health and social services available to them in their homes or communities, and the individual's inability to pay for those services or to have them covered by Medicaid when they do exist.<sup>159</sup>

Section 1915(c) of the Act has a target population consisting of beneficiaries who are or would be eligible for Medicaid in an institutional setting. The statute is not explicit on how beneficiaries are to be determined eligible for new services under the waiver. However, we believe that Congress did not intend that there would be a smaller population eligible for Medicaid for

---

158. 59 Fed. Reg. 37,702, 37,711 (Sept. 25, 1994) (emphasis added); see also *Bryson v. Shumway*, 308 F.3d 79, 89 (1st Cir. 2002).

159. 46 Fed. Reg. 48,532 (Oct. 1, 1981).

home and community-based services than for institutional long-term care.<sup>160</sup>

Perhaps Congress may not have fully appreciated the growth and popularity of the programs. But if the Medicaid Act already mandated that those states providing institutional care to all those requiring such services with reasonable promptness<sup>161</sup>—*with the majority of the costs being paid out of the federal government*—why would Congress *not* want states to make equally accessible to such beneficiaries the considerably less costly and more popular—and more consistent with the ADA—waiver services as an alternative? If Congress could have been a bit more explicit in making this now-critically important program part of the Medicaid benefit, it is just as compelling to ask, if Congress wanted to create the first exception to the entitlement program, would it not have been more clear about such a precedent-changing policy? It could have quite simply waived that “such assistance be furnished with reasonable promptness to all eligible individuals.”<sup>162</sup> But it did not; and the regulation that has served as the basis for *Makin* to find such caps asserts no pretense or basis for such an exception.<sup>163</sup>

Why would Congress reference numerical limits at all in the statute if states nonetheless have to provide services with “reasonable promptness”? These numbers might serve as planning devices for the purpose of developing provider capacity; the population limits might serve as vehicles for developing reasonable standards in care,<sup>164</sup> or to allow for capacity utilization targets—consistent with other Medicaid provisions.<sup>165</sup> Or the “population limits” might be simply one way, perhaps the most obvious way, to demonstrate that the waiver program is meeting the “cost neutrality” objective set by Congress. Since the statute requires that cost effectiveness be demonstrated on a

---

160. *Id.*

161. *See Doe v. Childs*, 136 F.3d 709, 718 (11th Cir. 1998).

162. 42 U.S.C. § 1396(a)(8) (2006).

163. *See discussion supra* Part II.C.

164. 42 U.S.C. § 1396a(22)(D) (2006).

165. *Id.* § 1396a(3)(A).

*per capita* basis, population limits appear to be the most facile and direct way to demonstrate that the state's waiver program is operating cost effectively on a *per capita* basis, without necessarily prohibiting increases.<sup>166</sup> In any case, even if these cost estimates are exceeded by a state, it is not clear that the state can be in any way penalized:

The Secretary may not require as a condition of approval of a waiver under this section under paragraph (2)(D), that the actual total expenditures for home and community-based services under the waiver (and a claim for Federal financial participation in expenditures for the services) cannot exceed the approved estimates for these services. *The Secretary may not deny Federal financial payment* with respect to services under such a waiver on the ground that, in order to comply with paragraph 2(D), a State failed to comply with such a requirement.<sup>167</sup>

If Congress wanted “hard” population limits on the waiver program, it probably would not have *prohibited the Secretary* from limiting federal financial participation in states that exceed these limits. Much more likely than constraining the Secretary from denying funding, Congress would have strictly limited federal financial contribution to states to the specified cap amount. Thus, the reference to the limits, whatever Congress intended by them, does not support the further inference that, despite the statute's plain language, Congress intended these services to be denied indefinitely to eligible beneficiaries.

#### V. THE DEFICIT REDUCTION ACT OF 2005: ADDITIONAL STATUTORY AUTHORITY FOR STATES TO PROVIDE COMMUNITY-BASED SERVICES WITH EXPLICIT POPULATION LIMITS

Congress appears to have tried to address the limited availability of community-based services in the Deficit Reduction Act of 2005

---

166. *Id.* § 1396n(c)(2)(D) (emphasis added).

167. *Id.* § 1396n(c)(6) (emphasis added).

(DRA).<sup>168</sup> Among the many significant changes the DRA made to Medicaid, it authorizes states to offer a new type of community-based services, but with several critical features that distinguish it from the waiver programs authorized under 42 U.S.C. § 1396n(c). The new program, codified at 42 U.S.C. § 1396n(i), permits states to offer community-based services to individuals that do not have medical needs severe enough to meet an institutional level of care, such as nursing home or hospital levels of care.<sup>169</sup> Accordingly, it does away with the “cost neutrality” requirement of 42 U.S.C. § 1396n(c).<sup>170</sup> And while 42 U.S.C. § 1396n(c) authorizes targeting services to individuals with particular conditions, diseases or disabilities (such as individuals with developmental disabilities), the new program does not authorize states to limit services to individuals with particular conditions.<sup>171</sup> Significantly, § 1396n(i) explicitly authorizes states to limit the number of participants in this new waiver program.<sup>172</sup> The conference report to the DRA, in explaining the new community based service provisions, discusses, but did not amend, the pre-existing waiver program, 42 U.S.C. § 1396n(c). In describing the existing 42 U.S.C. § 1396n(c) waiver, it also interjects upon the issue that has been the focus of this article.

Medicaid’s home and community-based services (HCBS) waivers . . . allow states to provide home and community-based services to Medicaid beneficiaries who would otherwise need the level of care provided in a nursing facility, intermediate care facility for persons with mental retardation (ICF-MR) or hospital. . . . As part of the waiver, states may define services that will be offered, target a specific population (e.g., individuals with developmental disabilities) or a specific geographic region,

---

168. Pub. L. No. 109-171, 120 Stat. 4 (2006).

169. *Id.* § 6086.

170. *Id.*

171. See CMS comments to implementing regulations. 73 Fed. Reg. 18,676, 18,691 (Apr. 4, 2008).

172. Pub. L. No. 109-171, § 6086, 120 Stat. 4 (2006).

and limit the number of waiver participants (resulting in a waiting list in many states) (emphasis added).<sup>173</sup>

What effect does the statement in the Conference Report have on the analysis of 42 U.S.C. § 1396n(c) waivers? Very little. First, as a statement in a conference report rather than in the actual statute, the conference language itself does not work a legal effect. Statutory analysis is focused on the language and terms of the *statute*. Generalized statements in legislative history not “anchored” to particular statutory language offer little for a court to consider in the process of interpreting statutes.<sup>174</sup> “While a committee report may ordinarily be used to interpret unclear language contained in a statute, a committee report cannot serve as an independent statutory source having the force and effect of law.”<sup>175</sup> Second, even if the language was viewed as an expression of a generalized statement of “legislative intent” of the waiver statute (irrespective of the actual language it enacted), it is simply too remote in time to be given any consideration. If the conference report had been submitted in reference to the *original* waiver legislation, it perhaps would be suggestive of the then-Congress’s intentions with respect to that program. But coming nearly twenty-five years after the waiver program was enacted, the 2006 Conference Committee was hardly in a better position than anyone else to divine what the then-voting legislators that enacted the waiver program intended when they passed the legislation, even assuming this was the report author’s intent. As often noted, “subsequent legislative history provides an extremely hazardous basis for inferring the meaning of a

---

173. H. REP. NO. 109-362, at 296 (2005) (Conf. Rep.).

174. *Nw. Env'tl. Def. v. Bonneville Power*, 477 F.3d 668, 683 (9th Cir. 2007) (quoting *Shannon v. United States*, 512 U.S. 573, 583 (1994)).

175. *Int'l Bd. of Elec. Workers Local Union No. 474 v. NLRB*, 814 F.2d 697, 712 (D.C. Cir. 1987) (emphasis omitted). “The principle that committee report language has no binding legal effect is grounded in the text of the Constitution and in the structure of separated powers the Constitution created. Article I, section 7, clause 2 of the Constitution is explicit about the manner in which Congress can take legally binding action.” *Bonneville Power*, 477 F.3d at 684; *accord* *Miedema v. Maytag Corp.*, 450 F.3d 1322, 1328 (11th Cir. 2006) (arguing that a statute’s silence coupled with a sentence in a legislative committee report un-tethered to any statutory language does not cause a change in the law).

Congressional enactment.”<sup>176</sup> Third, as the 109th Congress’s “interpretation” of the Medicaid waiver statute, it has no legal significance. Congress enacts statutes, but interpreting statutes is not within its constitutional powers.<sup>177</sup> “Committee report’s statements regarding earlier statutes cannot be ‘authoritative interpretations’ because it is the function of the courts, and not the Legislature to say what an enacted statute means.”<sup>178</sup>

The tools for interpreting the meaning of 42 U.S.C. § 1396n(c)—the statutory language, the Agency’s interpretation of the language, the judicial doctrines used in statutory interpretation, and the relevant legislative history—were fixed long ago. This, and future committee reports do not meaningfully alter the analysis of the statute unless, and until, accompanied by legislation amending the relevant statutory language. Rather than intending a change in the law, or changing the analysis of the original law, the statement in the conference report may be deemed merely as the report author’s recognition of the majority view of the law that clearly follows *Makin*.<sup>179</sup> However, if *Makin* was improperly decided, and its legal conclusions are determined to not withstand authoritative legal analysis, the report does not abate or absolve such errors.

Notwithstanding the lack of legal effect of the language of the Conference Report, does the failure to change the statute after *Makin* reflect “legislative acquiescence” to the position espoused by *Makin*? There is scant basis for such an interpretation, as ascribing intentions

---

176. *Consumer Prod. Safety Comm’n v. GTE Sylvania, Inc.*, 447 U.S. 102, 118 n.13 (1980) (citing *Red Lion Broad. Co. v. FCC*, 395 U.S. 367, 380–81 (1969)); see also *MAMMEN*, *supra* note 150, at 71 (referring to subsequent legislative history as “the least persuasive” form of legislative history).

177. While the power of judicial review may originate as a constitutional doctrine with *Marbury v. Madison*, as a doctrine of jurisprudence of the separate authority of courts and legislatures, it has precedents in both the common law and civil law traditions of Europe. See JOHN CHAPMAN GRAY, *THE NATURE AND SOURCES OF THE LAW* 170–72 (2d ed. 1921).

178. *Grey Panthers Advocacy Comm. v. Sullivan*, 936 F.2d 1284, 1288 (D.C. Cir. 1991) (citing *Pierce v. Underwood*, 487 U.S. 552, 566 (1988)).

179. This view has become so dominant that in the recent case *Brown v. Tenn. Dep’t of Fin. & Admin.*, 561 F.3d 542, 548 n.4 (6th Cir. 2009), the Court of Appeals for the Sixth Circuit dismissed an anticipated challenge to the state’s wait list without deeming it necessary to cite authority. “We acknowledge that enrollment in the waiver program is capped at the number of slots proposed by the state and approved by CMS, and we do not take the Plaintiffs to contend that Tennessee has an unlimited duty to enroll eligible individuals in its HCBS waiver. To the extent that is plaintiffs’ position, we reject it now.” *Id.*

or meaning from Congressional inaction is an inherently unreliable exercise.<sup>180</sup> “[C]ongressional silence lacks persuasive significance . . . . The verdict of quiescent years cannot be invoked to baptize a statutory gloss that is otherwise impermissible . . . . Congressional inaction frequently betokens unawareness, preoccupation, or paralysis . . . .”<sup>181</sup>

From the passage of a new form of community based services in the DRA one may perhaps surmise that Congress wanted to give states the option to expand community based services to populations that do not have access to them under the original waiver program.<sup>182</sup> And although the DRA authorizes wait lists, they are in a significantly different context. These community-based services are not subject to the same inherent limitations found in the 42 U.S.C. § 1396n(c) of cost neutrality, and with eligibility limited to those meeting an institutional level of care. While such a wait list may be authorized under 42 U.S.C. § 1396n(i), that may not be the end of the matter with respect to whether a Medicaid program is compliant with federal law. This point was noted by CMS in its meticulously reasoned preamble to the new rule:

A State electing to use a waiting list must develop policies for establishing and maintaining the list, if it elects to establish a limit to the number of individuals served. . . . [W]e would require the State to assure that its policies are published with opportunity for comment, equitable, and meet all applicable state and federal requirements. Those requirements are not limited to Medicaid provisions such as timely evaluation and right to a fair hearing; civil rights protections such as the State’s compliance with the Americans with Disabilities Act (ADA) and the decisions of the United States Supreme Court in *Olmstead v. L.C.* and, in some

---

180. MAMMEN, *supra* note 150, at 71.

181. *Id.* (quoting *Brown v. Gardner*, 513 U.S. 115, 123 (1994) (internal citations omitted)).

182. Pub. L. No. 109-171, § 6086, 120 Stat. 4 (2006).

cases, other judicial decisions or procedures for court monitoring.<sup>183</sup>

### CONCLUSION

As a consequence of *Makin*, Medicaid waiver services are a judicially-created oddity in the Medicaid program. Up until the new waiver service program of the DRA, which arguably is itself a legacy of *Makin*, Medicaid's community-based waiver program was the only service among a lengthy list of services authorized under the Medicaid program that states can elect to deny to individuals who are qualified and eligible to receive them, as effectively, a "non-entitlement" service. Despite this, the waiver program is among the most popular programs, and by its very definition, cost-effective. As a result, Medicaid recipients are often caught between a service they do not want, and a service they cannot get. This uncomfortable state of affairs disproportionately harms those with disabilities nearly four decades after Congress enacted anti-disability discrimination legislation and called for the integration of the disabled in society.

To say that waiver services must be provided with "reasonable promptness" does not mean that services must be immediate, but is suggestive of an individualized factual inquiry. Reasonable promptness generally means ninety (90) days.<sup>184</sup> Under the statute, it appears that states may set caps, or may not. But if they do, giving effect to the reasonable promptness provision means requiring the caps to be based on reasonable estimates of need for the services in the state, and eliminating the practice of denying services for eligible individuals for undetermined, indefinite periods. Applying the reasonable promptness language would go a long way towards bringing the promise of *Olmstead* to fruition and bringing to an end a multi-generational struggle to curtail the use of health facilities as vehicles for segregating those with disabilities.

---

183. 73 Fed. Reg. 18,676, 18,679 (Apr. 4, 2008).

184. *Doe v. Childs*, 136 F.3d 709 (11th Cir. 1998).

As the American health system moves from an institutional model to a less costly and more consumer-directed focus, *Makin* stands as a stubborn anachronism. It limits consumer choice and perpetuates the discriminatory effects of an institutionalized health care system that Congress has sought to relegate to the past. It is time that *Makin*'s holding be reconsidered.<sup>185</sup>

---

185. Neil Johnson, *Home Care for Seniors Has New Urgency*, MINNEAPOLIS STAR-TRIBUNE, Jan. 6, 2008, <http://www.startribune.com/business/12995121.html>. Ironically Hawaii appears to be one of the few places where *Makin* has no lingering effect, at least with respect to the developmentally disabled. The state is now one of the few that has ended all care for the developmentally disabled in institutions, and only provides community-based services. It is reported to have no one waiting for services under its waiver. See BRAGDON, *supra* note 33, at 5.

## APPENDIX I

The agency must furnish HCFA with sufficient information to support the assurances required by § 441.302. Except as HCFA may otherwise specify for particular waivers, the information must consist of the following, at a minimum:

- (a) A description of the safeguards necessary to protect the health and welfare of recipients. This information must include a copy of the standards established by the State for facilities that are covered by section 1616(e) of the Act.
- (b) A description of the records and information that will be maintained to support financial accountability.
- (c) A description of the agency's plan for the evaluation and reevaluation of recipients, including—(1) A description of who will make these evaluations and how they will be made; (2) A copy of the evaluation instrument to be used; (3) the agency's procedure to ensure the maintenance of written documentation on all evaluations and reevaluations; and (4) the agency's procedure to ensure reevaluations of need at regular intervals.
- (d) A description of the agency's plan for informing eligible recipients of the feasible alternatives available under the waiver and allowing recipients to choose either institutional services or home and community-based services.
- (e) An explanation of how the agency will apply the applicable provisions regarding the post-eligibility treatment of income and resources of those individuals receiving home and community-based services who are eligible under a special income level (included in section 435.217 of this chapter).
- (f) An explanation with supporting documentation satisfactory to HCFA of how the agency estimated the per capita expenditures for services. This information must include but is not limited to the estimated utilization rates and costs for services included in the plan, the number of actual and projected beds in Medicaid

certified SNFs, ICFs, and ICF/MRs by type, and evidence of the need for additional bed capacity in the absence of the waiver.

(1) The annual average per capita expenditure estimate of the cost of home and community-based and other Medicaid services under the waiver must not exceed the annual average per capita expenditures of the cost of services in the absence of a waiver. The estimates are to be based on the following equation:

$$\frac{(A \times B) + (A' \times B') + (C \times D) + (C' \times D') + (H \times I)}{F + H} \leq \frac{(F \times G) + (H \times I) + (F' \times G')}{F + H}$$

where:

A = the estimated annual number of beneficiaries who would receive the level of care provided in an SNF, ICF, or ICF/MR with the waiver.

B = the estimated annual Medicaid expenditure for SNF, ICF, or ICF/MR care per eligible Medicaid user with the waiver.

C = the estimated annual number of beneficiaries who would receive home and community-based services under the waiver.

D = the estimated annual Medicaid expenditure for home and community-based services per eligible Medicaid user.

F = the estimated annual number of beneficiaries who would likely receive the level of care provided in an SNF, ICF, or ICF/MR in the absence of the waiver.

G = the estimated annual Medicaid expenditure per eligible Medicaid user of such institutional care in the absence of the waiver.

H = the estimated annual number of beneficiaries who would receive any of the noninstitutional, long-term care services otherwise provided under the State plan as an alternative to institutional care.

I = the estimated annual Medicaid expenditure per eligible Medicaid user of the noninstitutional services referred to in H.

The symbol “less than/equal to” is intended to mean that the result of the left side of the left side of the equation must be less than or equal to the result of the right side of the equation.

A' = the estimated annual number of beneficiaries referred to in A who would receive any of the acute care services otherwise provided under the State plan.

B' = the estimated annual Medicaid expenditure per eligible Medicaid user of the acute care services referred to in A'.

C' = the estimated annual number of beneficiaries referred to in C who would receive any of the acute care services otherwise provided under the State plan.

D' = the estimated annual Medicaid expenditure per eligible Medicaid user of acute care services referred to in C'.

F' = the estimated annual number of beneficiaries referred to in F who would receive any of the acute care services otherwise provided under the State plan.

G' = the estimated annual Medicaid expenditure per eligible Medicaid user of the acute care services referred to in F'.

(2) For purposes of the equation, acute care services means all services otherwise provided under the State plan that are neither SNF, ICF, or ICF/MR services, nor the noninstitutional, long-term care services referred to in H.

(3) Data on the estimated annual number of beneficiaries and expenditures for those who would otherwise receive an SNF, ICF, or ICF/MR level of care is required for all three types of institutions only if the waiver request provides that each of these groups will be offered home and community-based services. For example, if the request does not include persons who would otherwise receive an ICF/MR level of care, the State is not required to furnish data on that group.

(4) The data must show the estimated annual number of beneficiaries who will be deinstitutionalized from certified SNFs, ICFs and ICF/MRs because they would receive home and community-based services under the waiver, and the estimated annual number of beneficiaries whose admission to such institutions would be diverted or deflected because of the waiver

services. For the latter group, the State's evaluation process required by section 441.303(c) must provide for a more detailed description of their evaluation and screening procedures for recipients to assure that waiver services will be limited to persons who would otherwise receive the level of care provided in an SNF, ICF, or ICF/MR.

(g) Except as HCFA may otherwise specify for particular waivers, the agency must provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-effectiveness. The results of the assessment must be submitted to HCFA at least 90 days prior to the third anniversary of the approved waiver period and cover at least the first 24 months of the waiver.

[50 FR 10027, March 13, 1985; 50 FR 25080, June 17, 1985]