UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

ADRIANA PARRALES, JANET CRAMER, SALLY GILLEY, JOSEPHINE HOLLISTER, and JAMES McGRIFF,

Plaintiffs,

v. Case No.

ELIZABETH DUDEK,
In her Official Capacity as Secretary for the Florida Agency for Health Care Administration,

Defendant.
_____/

COMPLAINT FOR
DECLARATORY AND INJUNCTIVE RELIEF

PRELIMINARY STATEMENT

1. This is an action seeking declaratory and injunctive relief on behalf of five Plaintiffs who are adults with disabilities enrolled in Florida's Home and Community-Based Services (HCBS) Waiver portion of Florida's Long-Term Care Managed Care Program (LTC Program). The LTC Program is administered through private managed care organizations (MCOs) under contract with the State's single Medicaid agency, Agency for Health Care Administration (AHCA). (Hereafter, the portion of the LTC Program providing HCBS will be referred to as the "LTC Waiver"). Defendant Elizabeth Dudek is being sued in her official capacity as Secretary of AHCA.

2. The LTC Waiver targets a distinct population, the aged and disabled, in order to provide community-based services and supports in lieu of nursing facility costs which would otherwise be reimbursable by Florida's Medicaid Program. MCOs for the LTC Waiver provide home and community-based services under contract with AHCA. MCOs are responsible for providing Plaintiffs with case management, assessments, and adequate provider networks, while also making decisions on approval or denial of services. AHCA is required to oversee MCOs to assure compliance with both federal and state law and with their contract.

3. The main purpose of a HCBS Waiver is to provide adequate services to enrollees that avoid unnecessary institutionalization. AHCA's contract with MCOs fails to set out sufficient requirements to ensure that the purpose of the LTC Waiver is achieved. As a result, Plaintiffs have not received services commensurate with their level of need and within the full scope of services and supports available under the LTC Waiver.

4. Plaintiffs have been harmed by AHCA's failure to establish adequate requirements that MCOs provide an array of services that address the total home care needs for Plaintiffs to remain healthy and safe in the community. They remain at risk of unnecessary institutionalization until such time as sufficient requirements and enforcement are in place.

5. The criteria that AHCA has referenced in its contract with MCOs are so voluminous, confusing, and irrelevant that they cannot be effectively applied or

enforced. The thousands of pages of referenced documents are mostly irrelevant to long-term care services and are not capable of being understood by Plaintiffs. Therefore, Plaintiffs have not been informed participants in the care planning process and cannot meaningfully challenge MCO decisions.

6. Plaintiffs have also been harmed by AHCA's voluminous, confusing, and irrelevant criteria, which have denied them meaningful access to the benefits of the LTC Waiver.

7. AHCA's actions violate Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. § 12132.

JURISDICTION AND VENUE

8. This Court has original jurisdiction over the subject matter of this action pursuant to 28 U.S.C. §§ 1331 & 1343(a)(3) & (4). Plaintiffs' claims for declaratory and injunctive relief are authorized under 28 U.S.C. §§ 2201-02.

9. Venue lies in the Northern District of Florida pursuant to 28 U.S.C. § 1391(b) and Local Rule 3.1(A), and in the Tallahassee Division, because Defendant, in her official capacity as AHCA Secretary, officially resides there.

PLAINTIFFS

10. Plaintiff ADRIANA PARRALES is a 28 year-old woman who has been diagnosed with a rare genetic disorder, neurofibromatosis type 2, and is currently non-ambulatory and ventilator-dependent. Ms. Parrales resides in her home in Miami, Florida, wishes to continue to reside there, and could continue to do so with appropriate services. She is enrolled in the LTC Waiver and cannot

remain safely in the community without adequate and reliable home and community-based services. Under the current system, AHCA has not ensured that she is provided with an array of services sufficient to provide for her health, safety and welfare in the community. She has not been an informed participant in her care planning process, and she continues to be at risk of unnecessary institutionalization each time her service authorizations expire or she requires additional supports.

11. Plaintiff JANET CRAMER is an 80 year-old woman who has suffered paralysis from her chest down due to a series of spinal cord injuries. She lives at home in Stuart, Florida, with her husband, who is 84 years old and unable to assist with her physical care. Ms. Cramer wishes to continue to reside at home, and could continue to reside there with appropriate services. She was enrolled in the LTC Waiver and cannot remain safely in the community without adequate and reliable home and community-based services. Under the current system, AHCA has not ensured that she is provided with an array of services sufficient to provide for her health, safety and welfare in the community. She has not been an informed participant in her care planning process, and she continues to be at risk of unnecessary institutionalization each time her service authorizations expire or she requires additional supports.

12. Plaintiff SALLY GILLEY is a 45 year-old woman who has been a paraplegic since 2003. She also IS diagnosed with Multiple Sclerosis and other medical conditions that have resulted in a colostomy, urostomy, G-tube and

suprapubic catheter. She resides in a home in St. Petersburg, Florida, with her aunt and minor son, wishes to continue to reside there, and could continue to do so with appropriate services. She is enrolled in the LTC Waiver and cannot remain safely in the community without adequate and reliable home and community-based services. Under the current system, AHCA has not ensured that she is provided with an array of services sufficient to provide for her health, safety and welfare in the community. She has not been an informed participant in her care planning process, and she continues to be at risk of unnecessary institutionalization each time her service authorizations expire or she requires additional supports.

13. Plaintiff JOSEPHINE HOLLISTER is a 90 year-old woman with physical and orthopedic impairments. Ms. Hollister resides in her own home in Polk County, Florida. She wishes to remain there and could continue to do so with appropriate services. She is enrolled in the LTC Waiver and cannot remain safely in the community without adequate and reliable home and community-based services. Under the current system, AHCA has not ensured that she is provided with an array of services sufficient to provide for her health, safety and welfare in the community. She has not been an informed participant in her care planning process, and she continues to be at risk of unnecessary institutionalization each time her service authorizations expire or she requires additional supports.

14. Plaintiff JAMES McGRIFF is a 46 year-old man who is legally blind and diabetic, and his ability to perform basic daily tasks was adversely affected by

a stroke he had in 2003. He lives in an apartment in Palm Harbor, Florida, with his fiancé, who is 56 years old and is herself a person with a physical disability. Mr. McGriff wishes to continue to reside at his apartment and could continue to do so with appropriate services. He is enrolled in the LTC Waiver and cannot remain safely in the community without adequate and reliable home and community-based services. Under the current system, AHCA has not ensured that he is provided with an array of services sufficient to provide for his health, safety and welfare in the community. He has not been an informed participant in his care planning process, and he continues to be at risk of unnecessary institutionalization each time his service authorizations expire or he requires additional supports.

DEFENDANT

15. Defendant ELIZABETH DUDEK is sued in her official capacity as AHCA's Secretary. AHCA is Florida's single state Medicaid agency and is responsible for the administration of Florida's Medicaid program. At all times relevant to this action, Defendant has acted under color of state law.

THE AMERICANS WITH DISABILITIES ACT

16. Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132.

17. Under Title II's implementing regulations, a "public entity, in providing any aid, benefit or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of a disability (i) deny a qualified individual with a disability the opportunity to participate in or benefit from the aid, benefit or service." 28 C.F.R. §35.130(b)(1). This provision has been interpreted to require meaningful access to the benefits that the public entity offers.

18. Title II implementing regulations also provide that a public entity shall administer its services, programs and activities in "the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d).

19. These regulations also provide: "A public entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration: (i) [t]hat have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability; [or] (ii) [t]hat have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities...." 28 C.F.R. § 35.130(b)(3).

20. These regulations further provide that public entities "shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would

fundamentally alter the nature of the service, program, or activity." 28 C.F.R. §35.130(b)(7).

21. States' obligations under the ADA are independent from the requirements of the Medicaid Act, and the ADA may require states to provide services beyond what a state currently provides under Medicaid.

22. The federal regulations for Medicaid MCOs provide that a state "must ensure" that each MCO complies with applicable Federal and State laws, and specifically lists Title II of the ADA. 42 C.F.R. §438.100(d).

LTC PROGRAM

23. Medicaid is a cooperative, jointly-funded program between the federal and state governments that provides medical assistance, rehabilitation and other services to low-income families and elderly persons and individuals with disabilities. 42 U.S.C. § 1396a. While states are not required to participate in the Medicaid Program, if a state elects to participate it is required to comply with applicable federal and regulatory requirements.

24. On the federal level, Medicaid is administered by the Centers for Medicare and Medicaid Services (CMS), an agency within the United States Department of Health and Human Services.

a. CMS is responsible for review, approval and oversight of the "State Plan" submitted by Florida for its Medicaid program. "State Plan Medicaid" encompasses the Medicaid services that are offered by the State to all eligible Medicaid recipients. State Plan Medicaid

must include certain mandatory services listed in the Medicaid Act, but states can also choose among a list of optional services.

b. CMS also is responsible for review and approval of a state's applications for programs that offer HCBS to individuals who would otherwise be eligible for institutional care. 42 U.S.C. § 1396n(c). Unlike State Plan Medicaid, these HCBS programs are allowed to "waive" certain Medicaid Act provisions.

25. In 2011, the Florida Legislature made substantial changes to the delivery of Medicaid. Most Medicaid enrollees are now required to participate in a MCO which provides for authorization and delivery of Medicaid services and supports in exchange for a capitated rate. (A capitated rate means that the MCO is paid a set fee per patient regardless of treatment required.) MCOs are either a health maintenance organization or a provider service network. Both operate under an extensive contract with AHCA to provide Medicaid services to their enrollees.

26. The managed care portion of Florida's Medicaid program is known as Statewide Medicaid Managed Care (SMMC). SMMC is divided into two different programs: (1) Managed Medical Assistance, which encompasses most of the State Plan Medicaid services, and (2) the LTC Program, which encompasses long-term care services, including both skilled nursing facilities (a mandatory service previously covered under the State Plan Medicaid program),

and the LTC Waiver, which provides HCBS that allow the recipient to prevent or delay institutionalization.

27. All LTC Waiver enrollees already receive the equivalent of State Plan Medicaid services through either Managed Medical Assistance or fee-for-service Medicaid. State Plan determines services to be offered to all Medicaid recipients and provides only limited home health services to adults over age 21. State Plan Medicaid services do not provide sufficient services to meet the home care needs of individuals with disabilities who would otherwise require an institutional level of care.

28. The LTC Program required two waivers from CMS: one under 1915(b) of the Social Security Act for Managed Care and the other under 1915(c) of the Act for the provision of HCBS for long-term care (the LTC Waiver). ACHA's applications summarize the manner in which programs are to operate, including a description of covered services and any limitations that apply to those services. Once approved, the application's provisions are binding on ACHA.

29. Florida's approved §1915(c) LTC Waiver Application, *inter alia*, sets forth the requirement that MCOs ensure that enrollees receive services that are necessary to maintain their health, safety, and welfare and to remain in a community setting.

30. The 1915(c) LTC Waiver application describes coverage through an array of services and supports that exceed the limits provided by the Medicaid State Plan, to achieve the Waiver's goals to prevent unnecessary

institutionalization of eligible recipients. The §1915(c) LTC Waiver application also requires that all direct service providers are responsible for encouraging independence, inclusion, and integration into the community.

31. AHCA requires the MCOs for both Managed Medical Assistance and Long-Term Care to operate under contract with AHCA. This contract is the primary document setting forth the responsibilities of the MCOs in their delivery of long-term care services to enrollees under the LTC Waiver.

32. Every MCO contract contains the same "core provisions" as set forth in a Model Contract. In addition to the core contract provisions, there also are separate Model Contract Attachments for Long-Term Care MCOs and Managed Medical Assistance MCOs. (The core contract provisions and the attachments for Long-Term Care are referred to here as the "LTC Model Contract.")

33. AHCA, as the single state agency for administration of Medicaid, has oversight of MCOs, both to assure compliance with federal and state law and the LTC Model Contract. As such, AHCA remains accountable for the operation of the LTC Program and cannot evade federal requirements by deferring this responsibility to other entities.

34. Consistent with federal Medicaid regulations and pursuant to the LTC Model Contract, AHCA is responsible for:

Pursuant to the Model Contract, AHCA is responsible for, among other things,:

a. ~~A~~dministration of contracts, monitoring MCO performance, and providing oversight of all MCO operation.

b. Imposing liquidated damages, sanctions or corrective actions for violations or non-compliance with the contract.

c. Promulgating coverage requirements applicable to MCOs through handbooks, fee schedules and the State Plan.

35. Across the state, there are seven MCOs for the LTC Program: United Healthcare, Sunshine Health, Molina, Amerigroup, American Eldercare, Coventry, and Humana.

36. Under the Medicaid Act and supporting regulations, the required method for assessing an enrollee's needs for services is though a written person-centered service plan, known as a "care plan."

37. Case managers, employed by the MCOs, are responsible for facilitation the assessment and development of the care plan, which is the primary written document reflecting the total care needs of the individual and the services and supports that have been authorized to address those needs.

38. The MCO is responsible for reviewing the case plan and determining whether to approve or deny services, and, if approved, the amount, duration and scope of those services.

39. An individual enrolled in the LTC Program may have one MCO for the Program and a different MCO for Managed Medical Assistance. Under the LTC Model Contract, the LTC case manager is responsible for coordinating all home health services, even where those services might otherwise be considered to be the responsibility of the Managed Medical Assistance MCO.

DEFICIENCIES IN THE OPERATION OF THE LTC WAIVER

40. In the LTC Model Contract, AHCA fails to set out sufficient requirements to ensure that the purpose of a HCBS waiver program is achieved: that enrollees receive an array of services that are adequate to prevent or delay unnecessary institutionalization.

41. The LTC Model Contract provides a generalized list of documents that LTC MCOs are directed to comply with in the provision of HCBS. The list includes the Florida Medicaid State Plan, Handbooks, Medicaid fee schedules, and "applicable federal waivers." Most of the documents referenced in the LTC Model Contract are irrelevant to long-term care needs. The referenced material, which encompasses thousands of pages, is so voluminous and confusing that it cannot be explained to enrollees or effectively applied or enforced.

42. AHCA has not proposed or promulgated as a rule a Coverage and Limitations Handbook for the LTC Waiver Program. The Aged and Disabled Adult Coverage and Limitations Handbook, which applied to one of the Waiver programs that was merged into the LTC Waiver, was repealed by AHCA on August 28, 2014. Therefore, decisions on the critical care needs of Plaintiffs are based on only the generalized, complex documents referenced in the Contract.

43. AHCA's failure to provide adequate requirements for the provision of long-term home care has resulted in a system that produces arbitrary and inconsistent results, leaving all Plaintiffs at risk of unnecessary institutionalization

whenever they change MCOs, need increased services, or need service reauthorizations.

a. AHCA has failed to ensure that each participating MCO is using a standardized, person-centered assessment and planning instruments capable of producing similar assessment results from MCO to MCO.

b. AHCA has failed to ensure that MCOs adequately take into account a caregiver's need to work, sleep, or take care of dependents, or the caregiver's physical or mental limitations.

c. AHCA has allowed MCOs to authorize services based on internal "task-based assessments" where the amount of minutes typically required to assist with activities of daily living or housekeeping chores are added together, with no consideration of other critical long-term care needs, like community involvement or supervision.

d. AHCA has permitted MCOs, when reducing or eliminating services, to rely exclusively on the Medicaid State Plan or State Plan Handbooks, which were never intended to apply to HCBS waiver programs.

44. Lacking sufficient requirements to ensure authorization of an array of services that are adequate to prevent or delay unnecessary institutionalization, case managers cannot inform, and Plaintiffs cannot know, how services will be quantified or combined to meet their long-term care needs. As such, the care

planning process fails to provide necessary information and support to ensure that the enrollee directs the process, to the maximum extent possible, and is enabled to make informed choices and decisions. Any assessment of needs that is developed without informed participation by the enrollee cannot ensure that services will be adequate to prevent unnecessary institutionalization.

a. AHCA has authorized care plan templates for use by MCOs that do not adequately reflect the availability or limitations of the Plaintiffs' natural (unpaid) supports, the Plaintiffs' access to the greater community, or any strategies to address unmet goals or outcomes.

b. AHCA has authorized care plan templates for use by MCOs that fail to explain, in understandable language, the necessary information to ensure informed consent by Plaintiffs.

c. Care plans are not being provided to Plaintiffs, or are inappropriately presented, or are insufficiently explained. If Plaintiffs receive a care plan, the Plaintiffs are often asked to sign this vital document without an opportunity to review it in advance. In addition, Plaintiffs are not provided with written notice explaining their right to challenge any part of the care plan.

d. Case managers are failing to tell Plaintiffs about the full scope of available LTC Waiver services and supports or are telling them that services are not available without ever submitting a request on the Plaintiff's behalf.

e. Because the case managers are employed by the MCOs they have an inherent conflict of interest between loyalty to their employer, which benefits financially when a service array is below the capitated rate, and to Plaintiffs, who may need additional or expensive services to prevent unnecessary institutionalization.

45. AHCA has failed to adequately monitor or correct MCOs to ensure Plaintiffs are provided home and community-based services sufficient to prevent risk of unnecessary institutionalization.

a. AHCA has failed to ensure that the MCOs offer services in the most integrated setting possible with the greatest opportunity for community and workforce participation.

b. AHCA has failed to utilize sanctions against MCOs for inadequate authorization of services.

c. AHCA has failed to ensure that each MCO is engaging in the person-centered planning process to address the enrollee's needs and preferences.

d. AHCA has failed to ensure enhanced monitoring of reduction of services.

PLAINTIFFS' ALLEGATIONS

Adriana Parrales

46. Ms. Parrales is a twenty-eight year-old Medicaid recipient residing in Miami-Dade County, Florida, with her mother and sole caregiver, Rita Parrales.

47. Ms. Parrales has a genetic condition known as neurofibromitosis Type 2, which results in painful tumors growing on her spine, brain and other areas. In 2007, Ms. Parrales lost her hearing after surgery on a brain tumor. She has been confined to a wheelchair since April 2013. Since Ms. Parrales was hospitalized in October 2014, she has been confined to her bed and on a ventilator 24 hours/day. She has other medical problems related to this status, including a tracheotomy, a G-tube, and insertion of a PIC line for intermittent intravenous access.

48. Since becoming ventilator-dependent, Ms. Parrales requires twenty-four hours a day of skilled caregivers who can monitor and attend to her medical needs. This includes intermittent and unpredictable needs for suctioning her tracheal tube, administering medication through an IV to a PIC line, G-tube feedings, and injection of an anti-coagulant. Ms. Parrales cannot be left at home alone or unattended by a skilled caregiver at any time.

49. Ms. Parrales also requires total assistance with her activities of daily living, as well as other tasks that enable her to remain living independently in her home and community.

50. From 2008 until December 1, 2013, Ms. Parrales was enrolled in the Aged and Disabled Adult Medicaid Waiver program and received 67 hours per week of in-home care. With this level of care, Ms. Parrales' mother was able to work outside the home as a nurse.

51. On December 1, 2013, Ms. Parrales was transitioned from the Aged and Disabled Adult Waiver to the LTC Waiver. Since her enrollment in the LTC Waiver, she has been subjected to arbitrary decisions concerning her total health care needs and was not authorized sufficient services to keep her healthy and safe in the community:

a. Ms. Parrales was initially assigned to United Healthcare as her LTC Waiver MCO. By letter dated December 26, 2013, United Healthcare informed Ms. Parrales that in-home care services would be reduced to 7 hours per week despite no improvement in her condition or changes in her circumstances. Ms. Parrales appealed this decision, but before the appeal was finalized, she was allowed to change her MCO provider to Amerigroup. Amerigroup authorized 30 hours per week of Companion care when her enrollment began on February 1, 2014.

b. Ms. Parrales was hospitalized from October 2014 until January 8, 2015. During this hospitalization, she became ventilator-dependent. Despite her need for 24-hour skilled in-home nursing care, Amerigroup only authorized one hour a day on weekdays of nursing care and no respiratory therapy. From Ms. Parrales' discharge from the hospital until March 27, 2015, Ms. Parrales' mother provided 23 to 24 hours a day of skilled in-home care that was necessary to prevent serious harm or death in the community setting and to avoid

unnecessary institutionalization. During this time, Ms. Parrales' mother was unable to sleep for more than an hour or two at a time. She had to ask neighbors to run errands and bring groceries. There were times when she wore sanitary pads because she could not leave Ms. Parrales long enough to go to the bathroom.

c. Despite repeated authorizations for Physical Therapy services, those service requests were ignored and when finally authorized, the services were not provided in sufficient quantity or provided only intermittently.

d. Through the intervention of an attorney, Amerigroup began providing 16 hours a day of skilled nursing services and respiratory therapy on March 27, 2015.

52. Even when services have been authorized, the authorization periods have been for short-term time frames, despite her clear need for continuing in-home care services.

a. At the end of each authorization period, Ms. Parrales faces denial, reduction or termination of services because the same system for authorization of home and community-based services that resulted in severely inadequate services continues in place without correction.

b. The most current care plan for Ms. Parrales has limited the authorization for nursing to 60 days, for physical therapy to 6 weeks and for occupational therapy to 4 weeks.

c. Ms. Parrales has experienced gaps in physical therapy and occupational therapy services when authorizations expire and there are delays in documentation, due to this inadequate service authorization process. Each time gaps in services occur, her condition deteriorates and her pain increases.

53. Since Ms. Parrales enrolled in the LTC Waiver, she has not been an informed participant in the care planning process, resulting in a denial of meaningful access to the benefits of the LTC Waiver Program:

a. Case managers have failed to provide necessary information and support to allow Ms. Parrales or her designee to make informed choices.

b. Neither the case manager from United Healthcare nor the case manager from Amerigroup explained the justification for determining the array of long-term care services available through the LTC Waiver, how to request and document the need for these services, or how to challenge an inadequate care plan.

c. The care planning process has failed to reflect the availability and limitations of Ms. Parrales' sole caregiver.

d. When Ms. Parrales and her mother met with the case manager for Amerigroup before Ms. Parrales was discharged from the hospital, they requested in-home skilled nursing and respiratory therapy. The case manager stated that she had spoken with her supervisors, and respiratory therapy would not be offered, nor would nursing services be offered beyond one hour per day on weekdays. Ms. Parrales did not receive a written denial of these services.

e. Ms. Parrales was not provided a copy of her care plan by Amerigroup until January 2015. Even then, the case manager had already checked off "approved" for each service before asking for a signature.

54. Ms. Parrales is eligible for nursing facility services under the Medicaid program. Because Ms. Parrales is immune-compromised, however, living in a home setting with appropriate services is far safer than living in a hospital, nursing facility, or other segregated setting. Her overall health, physically and mentally, is better. Also, while living at home and with the support and encouragement of her mother, Ms. Parrales has managed her genetic condition and even graduated from college as an English major, with a 4.0 grade point average. She would like to pursue a graduate degree in criminology.

55. Ms. Parrales has lived safely in the community for twenty-eight years with appropriate services and can continue to do so with adequate home and community-based services. Now Ms. Parrales is at risk of being forced into a

hospital or nursing facility because the same system for authorization of home and community-based services that resulted in severely inadequate services continues in place without correction. Once the current service authorizations expire, Ms. Parrales is faced with a process that provides inadequate program requirements to prevent or delay institutionalization; assessments that do not take into account her total needs; and a dysfunctional care planning process.

56. In addition, the criteria that AHCA has referenced in its contract with MCOs are so voluminous, confusing, and irrelevant that they cannot be effectively explained, applied or enforced and have denied Ms. Parrales meaningful access to the benefits of the LTC Waiver.

Sally Gilley

57. Plaintiff Sally Gilley is a 45 year old woman whose legs became paralyzed in 2003 after surgeries for hip replacements. She was diagnosed with Multiple Sclerosis in June of 2004. Since that time, her condition has deteriorated and she is now confined to her bed. She has been in and out of nursing homes and hospitals with more surgeries, ulcerating and infected wounds, urinary tract and ostomy infections, gastroenteritis, immune deficiency and other medical conditions. She now has a G-tube for all medication and for nutritional supplementation, a colostomy, urostomy and a suprapubic catheter.

58. Since May 2014, Ms. Gilley has been living with her aunt, Catherine Jones, who has been her sole caregiver. Ms. Gilley also has a minor child who

lives in the home with her and her aunt. Ms. Jones has Ms. Gilley's Durable Power of Attorney for healthcare and other decisions.

59. Ms. Jones does not have any formal medical or health care training, although she has devoted much time and effort into educating herself about medical issues to advocate and voluntarily care for her niece. Despite the lack of formal training, Ms. Jones has been left with the primary responsibility for the complex health care needs of Ms. Gilley, including skilled care, like wound care, ostomy care, infectious disease monitoring, G-tube feedings, and medication administration, as well as physical care for activities of daily living.

60. On or about February 1, 2014, Ms. Gilley was enrolled in Molina for the LTC Waiver. Since her enrollment in the LTC Waiver, she has been subjected to arbitrary decisions concerning her total health care needs and was not authorized sufficient services to keep her healthy and safe in the community. She has experienced arbitrary denials in long-term care services, long delays in the provision of services or supports, and many gaps in services even when authorized:

a. Since April of 2014, Ms. Gilley and her physicians have made numerous requests for Physical Therapy to alleviate severe contractures and pain, strengthen her upper extremities and torso, increase range of motion and improve internal organ function. For over a year, Ms. Gilley did not receive either approval of services or any written denial of Physical Therapy services. The case manager

orally informed Ms. Jones that Molina would not approve Physical Therapy for anyone who would not be able to walk again. Ms. Gilley has had surgery to relieve severe contractions in her legs and is now being assessed for contractions that have developed in her shoulder. Ms. Gilley finally was authorized for a Physical Therapy assessment on June 11, 2015, through the intervention of an attorney, but Physical Therapy visits have yet to be finalized.

b. Requests for a custom motorized wheelchair were initiated on February 12, 2014, while Ms. Gilley was in the hospital to prepare for her eventual discharge on May 2, 2014. She did not receive the wheelchair until February 27, 2015.

c. A bariatric bed was ordered for Ms. Gilley on May 20, 2014, due to an extensive history of chronic decubitus ulcers on her legs, feet, buttocks, back and sacrum. An appropriate bed was not delivered until August 6, 2014, but with the proviso that Ms. Jones sign a rental agreement on behalf of Ms. Gilley to pay for the equipment if Molina defaulted.

d. Ms. Gilley requires the use of a portable Hoyer lift for transfers. A lift was provided when Ms. Gilley came home on May 2, 2014. When the bariatric bed was delivered on August 6, 2014, the Hoyer lift was removed. Ms. Gilley did not receive another Hoyer lift until January 2, 2015.

e. Ms. Gilley also has been unable to get appropriate care for her urostomy and suprapubic catheter. It took months for Molina to provide a silicon catheter rather than latex, which had caused an allergic reaction, resulting in trips to the hospital for a catheter change and repeated infections.

f. For six months, Molina also refused to provide Ms. Gilley with urostomy bags that have a bacteria barrier, necessary due to repeated Urinary Tract Infections, which also result in re-infection of chronic wounds. Through the intervention of an attorney, these were finally authorized in July of 2015.

g. Ms. Gilley has required skilled in-home nursing services to attend to infected wounds caused by skin breakdown or surgical incisions. She also requires nursing care to change her catheter and treat the frequent infections at the catheter insertion point. Skilled in-home nursing care has been delayed, denied, terminated, and not provided in adequate amounts to protect Ms. Gilley's health and safety.

    i. Since May 2014, Ms. Gilley and her physicians made repeated requests for skilled in-home nursing services that were ignored, without written denials.

    ii. Ms. Gilley's caregiver has provided wound care without the assistance of a skilled nursing provider for months at a time.

iii. Nursing services also have been terminated by Molina without advanced written notice.

61. Since Ms. Gilley enrolled in the LTC Waiver, she has not been an informed participant in the care planning process, resulting in a denial of meaningful access to the benefits of the LTC Waiver:

a. Case managers have failed to provide necessary information and support to allow Ms. Gilley or her designee to make informed choices.

b. Case managers did not explain the justification for determining the array of long-term care services available through the LTC Waiver, how to request and document the need for these services, or how to challenge an inadequate care plan.

c. The care planning process has failed to reflect the availability and limitations of Ms. Gilley's sole caregiver.

d. The case manager would read portions of the care plan out loud, then ask Ms. Gilley to sign. Ms. Jones requested that she and Ms. Gilley be provided with a written copy of the care plan in advance of the case manager's visit, to be able to read through the document beforehand. This request was not granted.

e. Ms. Gilley was not provided a written notice with her care plan advising her that she had a right to request a hearing if she believed that services were insufficient to meet her needs.

f. Ms. Gilley was told that requests for services were to be made through the case manager, but she was not told about any particular timeline or process for the request, the meaning of the different service categories, or how to document the need for requests. When Ms. Jones requested to know the status of service requests, she was repeatedly told that the case manager was working on the request months after the original request had been made.

62. Ms. Gilley has lived safely in the community with appropriate services and can continue to do so with adequate home and community-based services. Due to her compromised immune system, remaining in the home is a healthier option than living in an institutional setting. She wants to continue to remain in a community setting.

63. Through the intervention of an attorney, Ms. Gilley has been able to avoid repossession of her bariatric bed and has finally been authorized to receive many of the services or supplies that have been long delayed or denied, including skilled nursing. However, Ms. Gilley continues to be at risk of being forced into a hospital or nursing facility because the same system for authorization of home and community-based services that resulted in severely inadequate services continues. Once the current service authorizations expire, Ms. Gilley is faced with a process that provides inadequate program requirements to prevent or delay institutionalization, assessments that do not take into account her total needs, and a dysfunctional care planning process.

64. In addition, the criteria that AHCA has referenced in its contract with MCOs are so voluminous, confusing, and irrelevant that they cannot be effectively explained, applied or enforced and have denied Ms. Gilley meaningful access to the benefits of the LTC Waiver.

Janet Cramer

65. Janet Cramer is an 80 year-old woman who is paralyzed from her chest down due to spinal cord injuries caused by a series of accidents and surgeries. She requires total assistance with all activities of daily living, care throughout the night to prevent bedsores and infections, administration of medications and nebulizer treatments to prevent respiratory compromise.

66. Ms. Cramer lives at home with her husband, who is 84 years old and is unable to assist with her physical care. Elizabeth Ernst, Ms. Cramer's daughter, a nurse practitioner living in New York, has come to Florida on numerous occasions to provide care for her mother when MCOs have denied or delayed adequate home health care through the LTC Waiver.

67. On September 1, 2014, Ms. Cramer enrolled in the LTC Waiver Program, with Sunshine Health as her MCO. Since her enrollment in the LTC Waiver, she has been subjected to arbitrary decisions concerning her total health care needs and was not authorized sufficient services to keep her healthy and safe in the community:

a. While at a rehabilitation facility recovering from surgery, Ms. Cramer's physician wrote a prescription requesting that on

discharge, she receive 24 hour aide care, intermittent skilled nursing care as needed, as well as physical, speech and occupational therapy evaluation and treatment. Prescriptions were also written at that time for home care supplies, including diapers, which were not provided.

b. Ms. Cramer was discharged on September 8, 2014, but it was not until September 22, 2014, that Sunshine Health issued a denial of the request for 24 hour coverage, authorizing only 3 hours a day of personal care services, with no skilled in-home nursing service or therapies.

c. Multiple prescriptions for therapy services and supplies were written by Ms. Cramer's physicians, but were ignored with no written denial.

d. After Ms. Cramer was injured on October 1, 2014, while being transported to a doctor's appointment, Sunshine Health authorized 24 hour personal care. On November 10, 2014, Sunshine Health issued a notice reducing personal care services from 24 to 12 hours a day, despite physician orders. Ms. Cramer appealed this reduction in services and a fair hearing was requested on November 20, 2014, but Sunshine Health reduced coverage on November 22 despite the request that 24-hour care be reinstated. Reinstatement did not happen until December 10, 2015, resulting in Ms. Cramer having to pay out-of-pocket for adequate home health care in the interim to

protect her health and safety and avoid unnecessary institutionalization. This was reimbursed by Sunshine Health with the intervention of an attorney.

e. While the fair hearing request was pending, Ms. Cramer enrolled in a different LTC Waiver MCO, American Eldercare, on May 1, 2015. The case manager for American Eldercare orally notified Ms. Ernst on April 27, 2015, that personal care services would be reduced to 5 hours a day, effective April 30. Because of the intervention of an attorney, Ms. Cramer's services have not yet been reduced.

f. The LTC Waiver is responsible for providing transportation to and from Medicaid Waiver services. Ms. Cramer scheduled all transportation through Sunshine Health, who contracts with particular transportation providers. Ms. Cramer's scheduled transportation failed to arrive at least ten times, was late at least ten times, and did not arrive with equipment appropriate to transport someone in a wheelchair, resulting in serious injuries to Ms. Cramer. Ms. Cramer's efforts to secure transportation after changing to American Eldercare have also been met with repeated delays, rescheduling, and vehicles inappropriate to meet her needs. Lack of transportation has effectively trapped her in her home.

68. Since Ms. Cramer has enrolled in the LTC Waiver, she has not been an informed participant in the care planning process, resulting in a denial of meaningful access to the benefits of the LTC Waiver Program:

a. Case managers have failed to provide necessary information and support to allow Ms. Cramer or her designee to make informed choices.

b. The case managers from Sunshine Health and American Eldercare have not explained the justification for determining the array of available long-term care services, how to request and document the need for these services, or how to challenge an inadequate care plan.

c. The care planning process has failed to reflect the availability and limitations of Ms. Cramer's sole caregiver.

d. Ms. Cramer has not been provided copies of most care plans, and was not given written notice of how to challenge the care plan.

69. Ms. Cramer is capable of living safely in her own home and wishes to remain at home. Her physicians believe that remaining in the home and community is better for her health and recovery.

70. Ms. Cramer continues to be at risk of being unnecessarily forced into a hospital or nursing facility because the same system for authorization of home and community-based services that resulted in severely inadequate services continues in place without correction. Once the current service

authorizations expire, Ms. Cramer is faced with a process that provides inadequate program requirements to prevent of delay institutionalization; assessments that do not take into account her total needs, and a dysfunctional care planning process.

71. In addition, the criteria that AHCA has referenced in its contract with MCOs are so voluminous, confusing, and irrelevant that they cannot be effectively explained, applied or enforced and have denied Ms. Cramer meaningful access to the benefits of the LTC Waiver.

Josephine Hollister

72. Ms. Hollister is a 90 year-old woman with physical and orthopedic impairments as well as signs of dementia. Ms. Hollister requires total assistance with her activities of daily living and cannot live independently without adequate in-home care services.

73. Ms. Hollister resides in her own home in Polk County, Florida.

74. Ms. Hollister has a professional guardian appointed for her through the Florida courts. All actions taken on her behalf have been through her guardian.

75. In 2013, Ms. Hollister was placed in a nursing home after breaking her leg. Conditions and Ms. Hollister's treatment at the nursing home were very poor and her guardian believed she would do better in a community setting.

76. On September 1, 2014, Ms. Hollister enrolled in the LTC Waiver Program, with Sunshine Health as the MCO. Since her enrollment in the LTC

Waiver, she has been subjected to arbitrary decisions concerning her long-term care needs and was not authorized sufficient services to keep her healthy and safe in the community:

a. When Ms. Hollister transitioned from a nursing home to her own home, she was approved for less than five hours a day of in-home care services. In order to ensure adequate care, Ms. Hollister's guardian personally performed direct care to her ward, utilized her ward's estate to pay for services, and utilized charities to pay her utilities.

b. Ms. Hollister's guardian contacted Sunshine Health on September 9, 2014, and informed them that the authorized services were insufficient to ensure her health and safety in the community.

c. Ms. Hollister received a notice dated September 25, 2014, maintaining that Sunshine Health's authorization of in-home care was sufficient partially due to the fact that Ms. Hollister's guardian was already providing care. Ms. Hollister's guardian has no legal obligation to provide direct healthcare services to Ms. Hollister.

d. Ms. Hollister's guardian again requested increased in-home care services on October 8, 2014, the first time that a case manager met with her to discuss the care needs of Ms. Hollister. Sunshine Health did not authorize any additional services as a result of this request.

e. Ms. Hollister then filed an internal appeal with Sunshine Health on October 10 and received an acknowledgement of that hearing request on October 17, 2014. However, Ms. Hollister never received any further response from Sunshine Health.

f. On October 27, 2014, Ms. Hollister sent a letter to Sunshine Health again requesting additional in-home care and requesting the guidelines used by the MCO to make healthcare decisions.

g. Due to her problems with Sunshine Health, on December 1, 2014, Ms. Hollister changed her enrollment to United Healthcare as her LTC Waiver MCO.

h. On December 3, 2014, a case manager for United Healthcare met with Ms. Hollister and her guardian, discussed Ms. Hollister's needs and performed physical and cognitive assessments. Ms. Hollister never saw or received a copy of the assessments but renewed her request for 168 hours per week of in-home care services from United Healthcare.

i. United Healthcare denied the request on December 15, 2014, but did approve in-home care services at a higher weekly amount than Sunshine Healthcare. Specifically, United Healthcare approved 53 hours a week of mixed in-home care services including personal care, homemaker, and companion services. The notice explained the denial of the full requested amount by listing the number of

minutes per week that were approved for individual activities of daily living (*e.g.*, bathing, toileting, meals) without explaining how those totals were arrived at or the medical justification for their use. There was no recognition of the need for services in between the estimated time needed to attend to activities of daily living or homemaking chores.

j. Ms. Hollister sent a letter to the AHCA Beneficiary Assistance Program on January 16, 2015, requesting a reconsideration of her services. Ms. Hollister never received a response to that request from AHCA.

k. On February 17, Ms. Hollister, was again visited by her United Healthcare case manager. Ms. Hollister and her guardian reiterated the need for 168 hours of in-home care per week. The case manager did not discuss the availability of any other LTC Waiver services..

l. Ms. Hollister requested a fair hearing with her January 16th letter to the AHCA Beneficiary Program, but it was not acted upon. A new request was sent on June 4, 2015, and the fair hearing process is ongoing. Ms. Hollister's guardian is still providing in-home care services through the dwindling funds remaining in her estate in order to fill the deficit left by Ms. Hollister's inadequate LTC Waiver services.

77. Since Ms. Hollister has enrolled in the LTC Waiver, she and her guardian have not been informed participants in the care planning process, resulting in a denial of meaningful access to the benefits of the LTC Waiver Program:

a. Ms. Hollister did not receive a handbook for her coverage from Sunshine Health until the end of September 2014 and was never consulted regarding available services and supports before her initial service approval.

b. When Ms. Hollister's guardian informed Sunshine Health that the authorized services were critically low, she was told that she would be able to meet with her case manager on September 17, 2014. On that date, the Sunshine Health case manager failed to appear for their meeting. Ms. Hollister's guardian immediately contacted Sunshine Health, re-asserting that her approved services were inadequate, and was told that the organization's case managers were unavailable and that she should wait until early October to speak with her case manager and should not pursue an appeal until she had met with her case manager.

c. On October 8, 2014, Ms. Hollister's guardian had her first meeting with Ms. Hollister's case manager for Sunshine Health. The case manager indicated she was only authorized to approve 25 hours

weekly because this was the standard at Sunshine Health for in-home care services.

d. On October 27, 2014, Ms. Hollister wrote to Sunshine Health stating: "I requested guidelines for the waiver program on Oct. 15th and was told to look at my Welcome Package. The Welcome package does not tell me the guideline you use to make healthcare decisions."

e. Ms. Hollister's case manager did not explain the available services, or the requirements to receive them. She was not given the timelines for service delivery or appeals of the care plan. The case manager did not explain how Ms. Hollister could best document her needs for additional services.

78. Ms. Hollister is capable of living safely in her own home and wishes to remain at home. Her physicians and her guardian believe that remaining in her home and community is better for her health and continued well-being.

79. Regardless of the outcome of her fair hearing appeal, Ms. Hollister continues to be faced with a process that provides inadequate program requirements to prevent or delay institutionalization, assessments that do not take into account her total needs, and a dysfunctional care planning process.

80. In addition, the criteria that AHCA has referenced in its contract with MCOs are so voluminous, confusing, and irrelevant that they cannot be effectively

explained, applied or enforced and have denied Ms. Hollister meaningful access to the benefits of the LTC Waiver.

James McGriff

81. Mr. McGriff is forty-six years old and resides in Pinellas County, Florida. Mr. McGriff resides with Donna Reed, who has his Durable Power of Attorney, and is his fiancé and sole caregiver.

82. Mr. McGriff is legally blind, insulin dependent due to type II diabetes, and on oxygen for COPD. Mr. McGriff also suffers from additional chronic medical conditions.

83. In July 2011, Mr. McGriff had a stroke that impaired his speech, cognition, and mobility. Mr. McGriff has trouble concentrating, short-term memory problems, and difficulty making decisions. He requires supervision and assistance with medications and other healthcare needs, including use of an oxygen tank and a CPAP machine. He uses a cane to walk, but his gait is unsteady and he requires physical assistance to prevent falls.

84. In addition, Mr. McGriff requires assistance with his activities of daily living, as well as other tasks that enable him to remain living independently in his apartment and community. These tasks include help with bathing, grooming, housekeeping, preparing meals, eating, transportation, and shopping.

85. Ms. Reed is a person with a disability due to spinal and joint diseases that severely limit her physical functioning. Her disabilities and medical problems prevent her from providing the level of assistance required by Mr.

McGriff. Due to inadequate services from the LTC Waiver sufficient to protect Mr. McGriff's health and safety, Ms. Reed has been left with the primary responsibility to provide a level of care that Ms. Reed is not physically capable of providing.

86. From 2011 until 2014, Mr. McGriff was enrolled in the Aged and Disabled Adult Home and Community Based Services Medicaid Waiver program. Mr. McGriff received in-home care services for 18 hours per week, 56 meals per month, incontinence briefs and other consumable medical supplies, and transportation services from his direct care providers. With this level of care, Mr. McGriff was able to remain living independently in his apartment and community.

87. Mr. McGriff was transitioned from the Aged and Disabled Adult Waiver to the Long-Term Care Waiver Program on February 1, 2014.

88. Since Mr. McGriff's enrollment in the LTC Waiver, he has been subjected to arbitrary decisions concerning his total health care needs and the previous array of services that kept him healthy and safe in the community have been terminated or reduced:

a. On or about March 2015, the United Healthcare case manager and supervisor orally informed Mr. McGriff that his home delivered meals benefit would end. On April 20th, 2015, United Healthcare sent him a Notice of Action that the meals would be terminated as not medically necessary "for reason(s) checked below." Nothing was checked.

b. United Healthcare has arbitrarily limited transportation to one day per month, preventing Mr. McGriff from being able to access Medicaid services or participate in the community.

c. Mr. McGriff, through Ms. Reed, verbally requested transportation once per week for Mr. McGriff's care plan services, such as blind training services and adult day health care. The United Healthcare case manager and supervisor verbally denied the request as not being cost effective.

d. Mr. McGriff needs a companion to arrange for transportation and accompany him to the medical appointments and other places. United Healthcare's LTC Functional Assessment, and his case manager, referred to these services as "escort services," without explaining the availability of companion services. Unfortunately, while companion are covered LTC Waiver services, "escort service" are not.

e. Mr. McGriff's request for "escort services" was denied by Notice of Action dated May 7th, 2015, and then another letter dated June 12th, 2015, as "not a covered benefit."

f. Mr. McGriff has experienced interruptions in his in-home care provided through United Healthcare. One of his providers was arrested and only later removed after multiple requests by Mr. McGriff were made to replace him. United Healthcare failed to

replace this provider and as a result, Mr. McGriff did not have coverage for this service from February 27, 2014, until June 2015, and only after intervention of an attorney.

g. Mr. McGriff previously received antibacterial soap and latex gloves through his plan of care to prevent the spread of a chronic medical condition while he participates in community-based services and when receiving assistance from Ms. Reed or his direct care staff. Mr. McGriff was authorized to receive one box of latex gloves per month but has not received a box of gloves since May 2015, with no written notification from United Healthcare.

h. On or around February 2014, Mr. McGriff also stopped receiving antibacterial soap. United Healthcare did not provide any written or verbal notice that the benefit was terminated. Mr. McGriff later requested antibacterial soap, which was denied by letter dated April 20, 2015, as not being a covered benefit. In another letter dated April 20, 2015, United Healthcare incorrectly claimed § 409.98, Fla. Stat., and service definitions found in Florida AHCA Statewide Model LTC Contract governed the denial.

i. A renewed request by Mr. McGriff for gloves and antibacterial soap resulted in a written denial on June 12, 2015, with the statement that “skin care items” were not covered. The case manager never referred to a handbook or other standards while discussing the

service with Mr. McGriff and Ms. Reed and failed to inform him that there is a $15 per month over-the-counter benefit available in United Healthcare's plan.

89. Since Mr. McGriff enrolled in the LTC Waiver, he has not been an informed participant in the care planning process, resulting in a denial of meaningful access to long-term care services:

a. Case managers have failed to provide necessary information and support to allow Mr. McGriff to make informed choices.

b. During his transition into the LTC Waiver, United Healthcare failed to provide Mr. McGriff with the member Handbook until requested by Ms. Reed after services had been reduced and terminated.

c. The availability of a companion benefit was not thoroughly explained to Mr. McGriff. As a result, he was unable to request the needed benefit. Instead, Mr. McGriff requested escort services, which were denied.

d. The case manager originally told Mr. McGriff that transportation was for emergency medical purposes only. As a result, he was unable to access the true benefit until he learned of it in May 2015 (after requesting the member Handbook) and even then was denied his request to recoup and access the unused non-medical transportation from previous months.

e. Although Mr. McGriff is blind, the case manager had Mr. McGriff sign the care plan on a computer screen, did not read the plan to him and would not allow Ms. Reed to read it.

f. The United Healthcare case manager failed to explain the justification for determining the array of available LTC Waiver services, how to request and document the need for these services, or how to challenge an inadequate care plan.

g. The care planning process has failed to reflect the availability and limitations of Mr. McGriff's fiancé and sole caregiver, Ms. Reed.

h. When Mr. McGriff and Ms. Reed met with the United Healthcare case manager in February 2014, Mr. McGriff requested to continue with all of the services that Mr. McGriff was receiving prior to switching to United Healthcare. The case manager did not have Mr. McGriff's case plan and did not know which benefits he was receiving. Mr. McGriff did not receive a written denial of these services.

i. Mr. McGriff was not provided a copy of his care plan by United Healthcare until on or around April 2015, but it was inaccessible to Mr. McGriff due to his visual impairment.

90. Mr. McGriff is appealing United Healthcare's denials. Mr. McGriff's burden to prove entitlement will be based on vague and voluminous Contract,

Medicaid handbook and State Plan provisions being incorrectly applied to service authorizations.

91. Since Mr. McGriff's stroke, Mr. McGriff has lived safely in the community for four years, and with appropriate services he can continue to do so.

92. Mr. McGriff, Ms. Reed, and Mr. McGriff's doctor agree that living in a home setting with appropriate services is far more beneficial than living in a hospital, nursing facility, or other segregated setting.

93. Regardless of the outcome of his fair hearing appeal, Mr. McGriff continues to be faced with a process that provides inadequate program requirements to prevent or delay institutionalization, assessments that do not take into account his total needs, and a dysfunctional care planning process.

94. In addition, the criteria that AHCA has referenced in its contract with MCOs are so voluminous, confusing, and irrelevant that they cannot be effectively explained, applied or enforced and have denied Mr. McGriff meaningful access to the benefits of the LTC Waiver.

CLAIM FOR RELIEF

Title II of the Americans with Disabilities Act

95. Plaintiffs reallege and incorporate herein by reference each and every allegation and paragraph set forth previously.

96. The Plaintiffs are "qualified individuals with a disability" within the meaning of the ADA in that they: (1) have physical impairments that substantially limit one or more of their major life activities; and (2) meet the essential eligibility

requirements for home and community-based services under Florida's Medicaid program.

97. AHCA is a public entity within the meaning of the ADA. AHCA is the single point of accountability for Florida's Medicaid program.

98. AHCA has failed to establish or enforce adequate requirements that MCOs provide an array of services that address the total long-term care needs for Plaintiffs to remain healthy and safe in the community. Plaintiffs remain at risk of unnecessary institutionalization until such time as sufficient requirements and enforcement are in place.

99. The criteria that AHCA has referenced in its contract with MCOs are so voluminous, confusing, and irrelevant that they cannot be effectively explained, applied or enforced and have denied Plaintiffs meaningful access to the benefits of the LTC Waiver.

100. Defendant has discriminated against the Plaintiffs by failing to provide reasonable accommodations to programs and services that would permit them to live safely in the community.

101. AHCA has utilized criteria and methods of administration that subject the Plaintiffs to discrimination on the basis of disability, including risk of unnecessary institutionalization.

102. Defendant's actions violate Title II of the ADA, 42 U.S.C. § 12132.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully request that this Court:

A. Declare that AHCA's failure to establish and enforce adequate standards and criteria for the authorization and delivery of home and community-based services in the LTC Waiver has and continues to leave the Plaintiffs at risk of unnecessary institutionalization, in violation of the Americans with Disabilities Act.

B. Declare that AHCA's voluminous, confusing, and irrelevant criteria for the provision of home and community-based services through the LTC Waiver has and continues to result in a denial of meaningful access to LTC Waiver services to the Plaintiffs, in violation of the Americans with Disabilities Act .

C. Enter a preliminary and permanent injunction ordering Defendant to:

i. Establish requirements for authorization of an array of services and supports that are sufficient to allow LTC Waiver Plaintiffs to avoid unnecessary institutionalization; and

ii. Develop and implement a plan to ensure that Plaintiffs understand and are able to access all available services and supports within the scope of the LTC Waiver;

D. Award Plaintiffs their reasonable attorneys' fees and costs; and

E. Grant such other relief as this Court deems just and proper.

Dated: August 27, 2015.

Respectfully submitted,

/S/
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