

**IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF ILLINOIS  
EASTERN DIVISION**

STANLEY LIGAS, et al.,	)	
	)	
Plaintiffs,	)	No. 05 C 4331
	)	
v.	)	Judge Sharon Johnson Coleman
	)	
JULIE HAMOS, et al.,	)	
	)	
Defendants.	)	

**PLAINTIFFS' AND INTERVENORS' JOINT MOTION  
TO ENFORCE THE CONSENT DECREE**

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## I. INTRODUCTION

Defendants are failing to provide *Ligas* Class Members and Beneficiaries the resources and services they are guaranteed by the Consent Decree. Individuals with developmental disabilities who have relied upon the promise of resources and services under the Consent Decree are instead suffering enormous hardships, including social isolation, a dearth of meaningful activities, a lack of progress towards their goals, loss of independence and adaptive skills, and, in many instances, anxiety and depression. Class Members risk re-institutionalization if the current situation continues.<sup>1</sup>

The root cause of the Consent Decree violations is the State's inadequate reimbursement rates for providers of services. These rates have been frozen since March 2008, while costs have continually increased. Providers are unable to pay their direct care staff – the employees who provide the critical hands-on care of people with developmental disabilities – a competitive wage. This has led to high turnover of direct care staff and vacant positions. Inexperienced, over-taxed, and insufficient staff have resulted in the deprivation of essential services. The severe harm suffered by Class Members and Beneficiaries is amply documented in the current Monitor's last two annual reports and the numerous declarations attached to this memorandum.

For the second year in a row, the Monitor has found Defendants out of compliance with the resource and service requirements of the Decree. For three years prior to the finding of non-compliance, the previous Monitor warned of a growing crisis.

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<sup>1</sup> There are essentially two groups of people protected by the Consent Decree: (1) *Ligas* Class Members (also referred to as Plaintiffs), who are individuals with developmental disabilities living at home or in intermediate care facilities for the developmentally disabled ("ICF-DDs") who wish to live in community integrated living arrangements ("CILAs") or other community settings, and those who have already moved under the Consent Decree; and (2) Beneficiaries (also referred to as Intervenors), who are individuals with developmental disabilities living in ICF-DDs who wish to remain in those facilities.

Defendants have failed, however, to correct the systemic problem in their service delivery system or to provide any explanation of how providers can maintain essential services in the face of rising costs and stagnant reimbursement rates.

As demonstrated below, Defendants have failed to comply with their obligations under Paragraphs 4, 13, and 14 of the Consent Decree. Plaintiffs and Intervenors respectfully request that the Court require the Defendants to bring themselves into compliance with the Decree so that Class Members and Beneficiaries can receive the services promised by the Decree.

## **II. BACKGROUND AND CASE HISTORY**

Historically, most services for people with developmental disabilities were provided through large state-operated institutions. These institutions were highly restrictive, isolating residents from their families and communities. In the 1960s, motivated by and using strategies from the Civil Rights Movement, people with developmental disabilities and their families started advocating for the right to receive services outside of institutions and to be integrated into their communities.

In 1990, Congress passed the Americans with Disabilities Act (ADA), 42 U.S.C. 12101 *et seq.*, “to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities.” 42 U.S.C. § 12101(b)(1). To implement the ADA’s Title II, the Attorney General promulgated the regulation often referred to as the “integration mandate” requiring that a “public entity shall administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.” 28 CFR § 35.30(d).

The seminal case interpreting the ADA's integration mandate is *Olmstead v. L.C.*, 527 U.S. 581 (1999), which found that "unjustified isolation ... is properly regarded as discrimination on the basis of disability" and affirmed the ADA's mandate that states must offer people with disabilities services in the most integrated setting.<sup>2</sup>

By 2005, the year that the *Ligas* case was filed, most states had made substantial progress towards serving people with developmental disabilities in small community settings. Illinois severely lagged behind those states. Illinois ranked 49th out of all states and the District of Columbia in serving people with developmental disabilities in small community settings.

### ***The Ligas Litigation***

It was against this backdrop that the *Ligas* case was filed. Stanley Ligas had lived for over a decade in a 96-bed ICF-DD, a drab, crowded building that had once been a nursing home. He shared a bedroom with a roommate assigned by the facility, had no privacy, and had little contact with the outside community. Mr. Ligas spent most of his days in a sheltered workshop, which, like the ICF-DD, served only people with developmental disabilities. He was not able to make even basic choices, such as what time to get up or when to eat.

Mr. Ligas desperately wanted to move to an apartment or house -- a setting where he could live and work in the community and be closer to his family. His service

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<sup>2</sup> In 1981, Congress established the Home and Community-Based Care Waiver Program to allow states to provide Medicaid services to people in the community as an alternative to institutionalization. Section 1915(c) of the Social Security Act (SSA), 42 U.S.C. § 1396n. This change gives states flexibility in providing Medicaid services so long as the programs meet several requirements, including that the average annual cost cannot exceed that of institutional placement. The Social Security Act was subsequently amended to require states to comply with the ADA's integration mandate. *See Steimel v. Wernert*, 823 F.3d 902, 906–07 (7th Cir. 2016) (explaining the Medicaid Waiver system).

providers agreed that he could handle and benefit from community placement, but the State refused (despite that such a placement would cost the State no more than his existing placement). Instead, the State required Mr. Ligas, and thousands like him, to be institutionalized as a condition of receiving the long-term care services to which he is entitled under Medicaid law.

This case was filed as a class action on July 28, 2005, bringing claims for violations of the ADA; Section 504 of the Rehabilitation Act, 29 U.S.C. § 794(a); and Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396v. Plaintiffs were people who, like Mr. Ligas, lived in private ICF-DDs but sought to move into the community, and people who lived in their family homes and were at risk of being institutionalized.

On April 10, 2010, the Court granted limited intervention to those representing the interests of people with developmental disabilities choosing to remain in ICF-DDs. On June 15, 2011, following a Fairness Hearing, the Court certified the class and approved the Consent Decree, which had been negotiated and agreed to by the State, the Plaintiffs, and the Intervenors.

### **III. THE STATE'S BREACHES OF THE DECREE**

#### **A. The Terms of the Consent Decree at Issue**

The Consent Decree requires the State to provide services in community settings to those who want them, while also requiring the State to provide adequate resources to meet the needs of those who choose to remain in ICF-DDs. The Decree is not merely a numbers game; it requires the State to do more than move the specified number of individuals each year into community settings. The Decree requires adequate resources to ensure the delivery of appropriate services in both CILAs and ICF-DDs. Without

adequate resources, the Decree's promise of the services needed to achieve a full, safe, and integrated life cannot be fulfilled. Individuals are left segregated in their environment and at risk of returning to a more restrictive setting.

To begin, the Consent Decree's definition of "community based settings" makes explicit the robust nature of the support to which individuals are entitled:

[T]he most integrated residential setting appropriate for an Individual where the setting is designed to promote independence in daily living, community integration, and economic self-sufficiency and enables the Individual to interact with non-disabled persons to the fullest extent possible.

Decree, Paragraph 3(e).

Section IV of the Decree sets forth the requirements for the developmental disability services system. Paragraph 4 sets forth the State's obligations for "Development of Resource Capacity." This includes, in relevant part:

Defendants shall implement sufficient measures to ensure the availability of services, supports and other resources *of sufficient quality, scope and variety* to meet their obligations to such Individuals under the Decree and the Implementation Plan consistent with such choices.

*Resources necessary to meet the needs* of Individuals with Developmental Disabilities who choose to receive services in ICFs-DD shall be made available and such resources will not be affected by Defendants' fulfillment of their obligations under the Decree ...

Decree, Paragraph 4 (emphasis added).

Paragraph 5 requires Defendants, when submitting budgets, to "request sufficient funds necessary to develop and maintain the services, supports and structures described in the Decree" but also specifies that the terms of the Decree are not contingent on a budget. In other words, the lack of a budget, or the lack of money, is not a defense to violations of the Decree.

Section VII of the Consent Decree sets forth the obligations to provide for Transition Plan Services. These include the services that Defendants must provide to class members during the transition process from institutions to community placements, as well as—the issue here—the services that Defendants must provide once the class members are in community placements:

The process for developing a Transition Service Plan shall focus on the Class Member's personal vision, preferences, strengths and needs in home, community and work environments and shall reflect the value of supporting the Class Member with relationships, productive work, participation in community life, and personal decision-making.

Decree, Paragraph 13.

All services and supports in the Transition Service Plan must be integrated into the community to the maximum extent possible, consistent with the choices of the Class Member and the Class Member's legal guardian.

Decree, Paragraph 14.

Sections VIII and IX provide the benchmarks for transitions. These sections reaffirm that each individual's community-based setting must be consistent with his or her Transition Service Plan. Decree, Paragraphs 17-22. Paragraph 4's requirement of adequate resources and the requirements of Paragraphs 13 and 14 to provide appropriate services are independent of the benchmark numbers set forth in Paragraphs 17- 22.

**B. The Funding of CILA and ICF-DD Services**

The State of Illinois, through a combination of state and federal money, pays private organizations to provide CILA and ICF-DD services. Approximately 11,000 Illinois residents with developmental disabilities living in CILAs and 5,000 living in private ICF-DDs are impacted by the Decree.

State reimbursement rates for these service providers have been frozen since 2008. The report of economist Elizabeth T. Powers details how the rates have remained stagnant, but – even worse – their value has actually declined. Ex. 1. In other words, it has become more expensive to operate these services, but the State has not reimbursed providers for these higher costs. From 2002 to present, the actual costs of operating ICF-DDs and CILAs have increased by 36% and the labor/employment costs (such as insurance and other employer expenses) have similarly increased by 39%. *Id.* at ¶ 29. Adjusting for these increases, the reimbursement from the State has declined in value by 23% for CILA providers and 33% for ICF-DD providers. *Id.* at ¶¶ 32-36.

Illinois continually ranks among the lowest of all states in the resources it provides for developmental disability services. Ex. 2, Carmody Dec. at ¶¶ 6-7. Even compared to our neighboring states in the Midwest, Illinois is at the very bottom of the barrel, spending 34% of the average per capita of all the other Great Lakes states. Illinois spends less than half of what Michigan (the next lowest state) spends per capita on home and community based services. *Id.* at 8. Likewise, Illinois spends only 55.5% of the average per capita spending of neighboring states on ICF-DD services. *Id.* at 9-10. In Exhibit 2 the Chief Executive Officer of the Institute on Public Policy for People with Disabilities, Kathy Carmody, overviews Illinois's developmental disability system and analyzes the impact of the staffing crisis.

The gap between the cost of operating CILA and ICF services and the reimbursement paid by the State has grown steadily over the last decade. The provider declarations attached show that the deficit for these services now averages \$761,258 annually per provider, ranging from \$50,000 to almost \$3,000,000 (note that the size of

the providers varies considerably).<sup>3</sup> The average deficit per person served by these providers is \$6,230 (ranging from \$234 to \$18,846 per person served).

Because of the increasing gap between the cost of providing necessary services and the woefully inadequate reimbursement provided by the State, providers have been forced to take drastic measures to reduce costs. These measures include: decreasing staff to resident ratios; cutting services; eliminating specialized staff such as medical and therapeutic personnel; requiring increased overtime; and having supervisors assist with direct care. *See* Ex. A, Ray Graham, at ¶¶ 7-16; Ex. B, Cornerstone at ¶¶ 6, 11; Ex. C, Clearbrook, at ¶¶ 9, 13; Ex. D, Sertoma, at ¶¶ 6-8; Ex. E, El Valor at ¶ 7; Ex. F, Glenkirk at ¶ 7; Ex. G, Avenues at ¶ 8; Ex. H, ACHH at ¶ 9; Ex. I, New Star at ¶¶ 7-8; Ex. J, EP!C at ¶¶ 9, 11; Ex. K, AID at ¶¶ 7-9; Ex. L, Little City at ¶ 7; Ex. M, Envision at ¶ 6.

One of these cost saving measures has been to keep wages for direct care staff (“direct support professionals” or “DSPs”) low, commensurate with the State’s reimbursement rates, frozen since 2008. Many providers have also taken measures to further reduce labor-related costs, such as cutting employee benefits. For example, AID eliminated cost of living increases, decreased retirement contributions, increased

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<sup>3</sup> Ex. A, Ray Graham, at ¶ 7 (in 2015, costs of CILA services exceeded state funding by \$715,000, or \$5,800 per resident, and \$1.047 million, or \$10,475 per ICF-DD resident); Ex. B, Cornerstone at ¶ 6 (2015: \$277,000, or \$1,375 per person served; 2016: \$50,000, or \$234 per person); Ex. C, Clearbrook, at ¶ 8(2015: \$1.25M, or \$3687 per person served); Ex. D, Sertoma, at ¶ 6 (2016, \$198,000, or \$3,422 per person served); Ex. E, El Valor at ¶ 6 (describing but not specifying an annual deficit); Ex. F, Glenkirk at ¶ 6 (2016: \$2,213 per person served); Ex. G, Avenues at ¶ 8 (2016: \$241,000); Ex. H, ACHH at ¶ 8 (2015, nearly 3 million, or \$18,846 per person served); Ex. I, New Star at ¶ 6 (2016: 417,840, or \$8,890 per person served); Ex. J, EP!C at ¶ 8 (2015: \$955,000); Ex. K, AID at ¶ 6 (2015: \$500,000; or \$2,500 per person served); Ex. L, Little City at ¶ 6 (2016: \$2.6M for all programs, or \$10,000 per person served (not included in cumulative averages because not specified for CILA services). *See also* Ex. M, Envision at ¶ 12 (“All of Envision’s CILA program’s ... are operating at a loss.”).

employee contributions and co-pays on health insurance, and reduced holidays and paid time off. Ex. K, AID at ¶ 9. *See also* Ex. A, Ray Graham, at ¶ 20; Ex. J, EP!C at ¶ 11.

Even with those sacrifices, the cost reduction measures have not been enough. *See, e.g.*, Ex. B, Cornerstone at ¶ 11 (“Despite Cornerstone’s best efforts and its increase in fundraising events and donor outreach, it is impossible for the agency to make up for the State’s failure to adequately fund services for people with developmental disabilities”); Ex. D, Sertoma, at ¶ 6 (“Sertoma is only able to sustain these programs due to excess revenue it produces from other program services and fundraising activities which now are inadequate to supplement the low rates the State reimburses for these services.”); Ex. F, Glenkirk at ¶ 7 (“These drastic measures were crucial in keeping our CILA program afloat, but these cuts have not been enough.”); Ex. J, EP!C at ¶¶ 9, 11 (“despite its best efforts, EP!C has been unable to close the gap . . . Unless State funding is increased, EP!C’s reserves will be exhausted in the next few years and EP!C will be forced to close its doors.”); Ex. L, Little City at ¶ 15 (“Even with reductions of staff and services to our residents, our financial situation is increasingly uncertain.”); One provider described, “[u]nable to continue to bear such an extraordinary loss [\$277,000 in 2015], Cornerstone enacted severe cost control measures and in FY16, Cornerstone’s costs still exceeded revenues from the state by an average of \$234 per individual served, a total of \$50,000. Controlling costs comes at a great human cost.” Ex. B at ¶ 6.

### **C. The Staffing Crisis**

In both CILAs and ICF-DDs, DSPs provide the day-to-day care. This includes everything from medication management and feeding to the most intimate levels of care, such as assisting with the toilet and showers. *See, e.g.* Ex. N (declaration of former DSP

Riley Rummel). But the work of DSPs is not simply to care for their residents, but also to assist them in building independence and to support community integration through the Service Plans mandated by the Consent Decree. CILAs and ICF-DDs cannot operate without these staff to provide care, support, and companionship to their residents.

As of the last state-wide survey two years ago, the average starting pay for DSPs was \$9.36 per hour. *See* Ex. 2, Carmody Dec. at ¶ 15.<sup>4</sup> Since that survey, however, Chicago and Cook County have increased minimum wage requirements, forcing some providers to increase pay to more than \$10.00 per hour without a corresponding increase in state reimbursement. *See* Ex. 3, Stover Dec. at ¶ 10.<sup>5</sup> The low wages mean that DSPs make less for this demanding work than they could make working in fast food restaurants or for retailers like Wal-Mart. *Id.* Many applicants for DSP positions withdraw from the hiring process based on the pay alone. *See, e.g.,* Ex. A, Ray Graham at 21 (“It is taking us on average 168 days to hire a new DSP. I know that this is attributable to low DSP pay because many applicants, once they learn the amount they will get paid, do not continue to pursue a DSP position at RGA.”) Ex. C, Clearbrook at 22 (“In 2015 alone, 186 candidates withdrew from the employment process once they learned the pay that Clearbrook offered.”). Attached as Exhibit N is the declaration of Riley Rummel, a dedicated DSP for six years who was forced to leave the job she loved because she could

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<sup>4</sup> The Declarants show DSP pay ranging from \$8.75 to \$12.05 per hour. Ex. A, Ray Graham, at ¶ 21 (average pay is \$10.72 per hour); Ex. B, Cornerstone at ¶ 8 (starting rate of \$8.75); Ex. C, Clearbrook, at ¶ 21 (\$10 per hour); Ex. D, Sertoma, at ¶ 8 (average starting rate is \$9.75 per hour); Ex. E, El Valor at ¶ 11 (\$10.50 per hour); Ex. F, Glenkirk at ¶ 10 (\$9.50 to \$10.00 per hour); Ex. G, Avenues at ¶ 9 (starting wage is \$10.20 per hour); Ex. H, ACHH at ¶ 12 (starting wage of \$10.00 per hour); Ex. J, EP!C at ¶ 13 (\$8.50 per hour base rate); Ex. L, Little City at ¶ 8 (\$10.00 per hour); Ex. M, Envision at ¶ 7 (\$12.05 per hour).

<sup>5</sup> Exhibit 3 is the Declaration of Janet Stover, the President and CEO of the Illinois Association of Rehabilitation Facilities.

not support herself on the low wages. *See also*, Ex. 1, Powers Dec. (expert declaration explaining the labor market issues).

As a result, DSP turnover rates are now at unprecedented highs.<sup>6</sup> The declarations show turnover rates ranging from 24% to 62% with a median rate from these providers of 36%.<sup>7</sup> Some of the declarations include DSP vacancy rates, while others explain the difficulty of filling the positions when the wages are lower than the labor market in their communities. *See, e.g.*, Ex. A, Ray Graham, at ¶ 22 (vacancy rate of 30% in 2015); Ex. C, Clearbrook at ¶ 22 (currently has 35 open positions); Ex. I, New Star at ¶ 10 (currently has 21 vacancies, which equates to one per household); Ex. H, ACHH at ¶ 12 (“we have a difficult time filling these positions” and are “constantly short-staffed”); Ex. J, EP!C at ¶¶ 13-14 (currently has 73 open positions, which is one-third of all DSPs); Ex. F, Glenkirk at ¶ 11 (currently has 24 vacant DSP positions, which will generally take between 60-90 days to fill); Ex. M, Envision at ¶ 8 (33 vacant DSP positions as of March 2, 2017).

The turnover rates demonstrated by the Declarations are consistent with larger statewide surveys. In 2015, the Institute on Public Policy surveyed 36 providers across the state who provide CILA and ICF-DD services for 3,600 people with developmental disabilities. Ex. 2, Carmody Dec. at ¶ 19. The average DSP turnover rate was found to be

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<sup>6</sup> The causal relationship between rates and turnover is established by Dr. Powers’ expert report, attached here as Exhibit 1. It is also discussed by a number of the provider declarations. Ex. J, EP!C at ¶¶ 13-14 (“based on exit interviews... we know that 90% have left for higher paying jobs” and describing the availability of higher paying jobs in the area); Ex. K, AID at ¶ 11 (based on interview responses, employee surveys, and exit interviews). *See also* Ex. A, Ray Graham, at ¶ 21; Ex. B, Cornerstone at ¶ 9; Ex. C, Clearbrook at ¶¶ 21-22; Ex. D, Sertoma at ¶ 10; Ex. G, Avenues at ¶¶ 12-13; Ex. F, Glenkirk at ¶ 11; Ex. L, Little City at ¶¶ 8-10.

<sup>7</sup> Ex. A, Ray Graham, at ¶ 21 (in 2015, turnover rate of 54.6%); Ex. B, Cornerstone at ¶ 7 (describing a “record setting” turnover rate of 39% in 2016); Ex. C, Clearbrook at ¶ 21 (current rate is 49%, a “drastic increase” over 2008); Ex. D, Sertoma at ¶ 9 (37.73%); Ex. F, Glenkirk at ¶ 8 (35%); Ex. G, Avenues ( 24%); Ex. H, ACHH at ¶ 12 (25%); Ex. I, New Star at ¶ 9 (31%); Ex. J, EP!C at ¶ 12 (55%); Ex. K, AID at ¶ 10 (28%); Ex. L, Little City at ¶ 9 (62%); Ex. M, Envision at ¶ 8 (31%).

30.3%; in other words, nearly one-third of all DSPs leave every year. *Id.* Another survey of 51 providers who serve more than 5,300 people with developmental disabilities statewide found that for 91% of responding providers, the DSP turnover is having a significant to extreme impact on the daily lives of the people they serve. *Id.* at ¶ 25.

Economist Elizabeth T. Powers has substantial experience studying the economics of Illinois’s developmental disability system. Her report in this case concludes that a “rigorous study of DSP workers in Illinois finds that compensation has a causal effect on turnover.” Ex.1 at ¶ 7(a). In fact, the studies of direct care workers find that compensation is not only causally connected to turnover, but it is also an important factor in observed turnover. *Id.*

Powers goes on to find that a 25% increase in compensation to DSP workers in ICF-DDs and CILAs would reduce turnover by one-third. *Id.* at ¶ 7(b). In reaching this conclusion, Powers finds, among other things, that DSP turnover in Illinois has increased by 43% in ICF-DDs and 31% in CILAs between 2001 and 2016. *Id.* She concludes that these problems will only grow if the rates are not adjusted. *Id.* at ¶ 72. While increasing rates may not be the only way to combat the staffing crisis, Powers finds that “increasing compensation is one of the most feasible and expeditious methods of reducing DSP turnover.” *Id.* at ¶ 74.

**D. The Inadequate Reimbursement Rates Causing the Staffing Crisis Have Led to Serious Violations of the Decree**

**1. The Monitor’s Findings of Non-Compliance**

For the second year in a row, the Monitor has found that Defendants are in violation of Paragraph 4 of the Decree. Monitor’s Fifth Annual Report (“the Report”), dated January 20, 2017, Doc. No. 646 at 30. The State has failed “to ensure the

availability of services, supports and other resources of sufficient quality, scope and variety to meet their obligations to such Individuals under the Decree.” It has also failed to provide the “[r]esources necessary to meet the needs” of the beneficiaries of the Decree. *See id.* at 12, 30. The “obligations” at issue are the provision of services as required by Paragraph 4 itself as well as by Paragraphs 13 and 14, which set forth the requirements of the Transition Service Plans.

The Report notes that “[t]here has been a great deal of discussion at all levels during the past year without improvement of this situation.” Report, Doc. No. 646 at 4. In fact, the Monitor notes that the Department of Human Services has provided no indication of how it will address the shortage of DSPs resulting from stagnant and low reimbursement rates. *Id.* at 13. The Report details that the “inadequate funding” has led to an “unprecedented staffing crisis,” i.e., high turnover and vacancy rates among DSPs, which have impeded the provision of services and, consequently, community integration and person-centered services. *Id.* at 14-24. Further, the Report finds that in Fiscal Year 2017, “this situation is worsening as new CILA development is being delayed due to lack of availability of DSPs willing to accept current wages and that some existing small CILAs are at risk of either closing or being consolidated into larger homes due to staff turnover rates up to 70%.” *Id.* at 5.

**2. The Monitor Has Raised The Lack of Adequate Funding As a Serious Concern In Every Annual Report Since 2012.**

These are not new issues. Dating back to the very first annual report on compliance in 2012, the initial Monitor, Tony Records, was concerned that, if left unaddressed, the problems in the State’s service delivery system would lead to violations of the Decree. Then—as now—the Monitor found that the lack of adequate funding was

interfering with providers' ability to provide services required under the Consent Decree. *See* Dckt. No. 565 at 12 (First Annual Report); *see also* Ex. 4, Declaration of Tony Records, at ¶¶ 6-7. By the second year, the "stagnant reimbursement rates were having the affect that [he] feared: increased DSP turnover and difficulty filling DSP positions resulting in increased risk to the health and safety of individuals with developmental disabilities, reduced attention to individual service plans, and decreased community employment and community recreational activities." *See* Ex. 4 at ¶ 8.

Lack of adequate funding has been discussed in each of the Monitors' annual reports, as have the increasing efforts to get the State to remedy the problem. Docket No. 565 at 12 (2012), No. 583 at 8, 13-14 (2013); No. 583 at 14 (2014). *See also* Ex. 4 at ¶¶ 8-15. Mr. Records describes, in salient part, his efforts in 2014-2015:

The larger 7 to 8 person settings were an effort by providers to reduce costs in light of Illinois' stagnant rates by having more individuals served by fewer staff. However, families and providers were reporting to me that the DSP staffing crisis and increased resident to staff ratios prevented individuals with developmental disabilities from obtaining the services specified in their individual service plans and from obtaining community employment and engaging in other community activities. These worsening conditions caused me to declare that "[t]he time has come to obtain clarity and direction on the issue of rates for services in Illinois." I recommended that the State retain an independent contractor to evaluate rates for CILAs and ICF-DDs and that a report should be submitted by September 30, 2015 containing a full analysis of the rates and recommendations for a new rate structure.

*Id.* at ¶ 11; *see also* Second Annual Report, Doc. No. 283 at 14-15, 26-27.

The State did not act on Mr. Records' recommendation. As a result, conditions worsened and in the 2016 Annual Report (following Mr. Records' retirement), Ms. Cohn found the State out of compliance. The State again took no actions to remedy this noncompliance. In fact, the Governor vetoed legislation that would have increased reimbursement rates to providers so that they could increase

DSP wages. Ex. 2, Stover Dec. at ¶ 23. In the 2017 Annual Report, the Monitor again finds the State out of compliance.

### **3. The Monitor's Findings Are Supported by the Declarations From Providers**

A community-based setting is one that promotes “independence in daily living, community integration, and economic self-sufficiency and enables the Individual to interact with non-disabled persons to the fullest extent possible.” Decree, ¶ 3(e). To this end, the services provided under the Transition Service Plans “must be integrated into the community to the maximum extent possible” and focus on working on individualized goals to support the Class Members “with relationships, productive work, participation in community life, and personal decision-making.” *Id.* at ¶¶ 13-14.

Attached hereto as Exhibits A – M are declarations from providers of CILA and ICF-DD services for more than 1800 Class Members and Beneficiaries. These providers detail how their own services have been reduced and impaired, causing harm to their residents -- *Ligas* Class Members and Beneficiaries. The significance of these public statements cannot be overstated. The providers are putting their organizational reputations and relationships with the State on the line because the State's failure to meet its obligations under the Consent Decree inhibits community integration and places their residents at risk.

As the declarations detail, the providers do not have the staff necessary to implement person-centered services and community integration, resulting in considerable harm to thousands of Class Members and Beneficiaries. Residents are increasingly isolated in their homes without sufficient staff to accompany them out in the community or work with them on individual goals. They are losing skills and independence, as well

as quality of life. There are disturbing increases in mental health symptoms (such as anxiety and depression), maladaptive behaviors, accidents, medication errors and medical problems. *See, e.g.*, Ex. C, Clearbrook at ¶¶ 12-19 (explaining in detail the scope and consequence of the current services limitations); Ex. E, El Valor at ¶¶ 8-14 (describing decreased outings and individualized care resulting in increased behavioral problems, falls, self-injuries, and “elopements,” with corresponding increases in reliance on police and emergency rooms).

The profound impact of this staffing crisis on *Ligas* Class Members and Beneficiaries is set forth in each of the declarations. Taking just one example, the declaration from Ray Graham (one of Illinois’s largest providers) explains how it can take months for a DSP and a person with a severe disability to learn how to communicate and interact, as well as build the trust and level of comfort necessary for the DSP to successfully provide the services needed. Ex. A, Ray Graham, at ¶¶ 23-24. Disruptions due to staffing changes or vacancies increase mistakes with specialized diets and feeding techniques, which can cause choking, for example. *Id.* They cause mistakes in medication administration. *Id.* They cause high levels of stress, frustration and fear which, in turn, lead to regression, depression, and aggression among residents. *Id.* *See also*, Ex. C, Clearbrook at ¶¶ 25-26 (describing that it takes 4-6 months for a DSP to build the knowledge and rapport necessary to do the job, but many DSPs now leave within 6 months, which causes tangible harms to residents); Ex. E, El Valor at ¶ 13 (describing increased anxiety and self-injurious behavior resulting from staff turnover and vacancies).

***Person-Centered Services Required by the Ligas Transition Plans Are Lost***

One large provider of both ICF-DD and CILA services states: “Without adequate funding and the level of staff needed, the person-centered plan risks becoming just another piece of paper in the individual’s file, as opposed to a true plan that is followed. Fulfilling the individual plans for each person requires quality and consistent staff ... The high turnover we are currently suffering due to insufficient State funding makes it nearly impossible for the staff to gain the knowledge and understanding necessary to implement the person-centered plans.” Ex A, Ray Graham at ¶ 29.

Each one of these providers similarly confirms that the staffing shortages are compromising the person-centered services that are at the heart of the Consent Decree. Ex. B, Cornerstone at ¶ 13 (“Ligas class members are not being served in accordance with their Transition Service Plans and are not being integrated into the community to the maximum extent possible.”); Ex. C, Clearbrook, at ¶ 27 (“The constant turnover of our staff and our inability to hire sufficient staff ... makes it impossible to implement these individual plans.”); Ex. D, Sertoma, at ¶¶ 7, 13-15 (“our ability to implement individual’s services plans ... has been severely diminished by the State’s low funding”); Ex. E, El Valor at ¶ 14 (“The service plans for our residents become less individualized and tend to more ‘cookie-cutter’ plans”); Ex. F, Glenkirk at ¶ 16 (contrary to *Ligas* service plans, residents now have to live in 6-8 person homes and it is impossible for individual choices and preferences to be met); Ex. G, Avenues at ¶ 15 (“Person-centered planning has been hardest hit by inadequate State funding ... *Ligas* class members are seeing their integration into the community diminished because of the lack of State funding and services set forth in their Transition Service Plans are not being implemented as quickly

as desired.”); Ex. J, EP!C at ¶ 16 (residents—many of whom cannot communicate verbally—have specialized diets, feeding programs, medications, and physical and behavioral challenges, which make it “extremely difficult” for the new and inexperienced staff to provide the individualized care and support required in the services plans); Ex. K, AID at ¶ 15 (“The turnover ... is causing the person-centered plans not to be implemented timely and services not provided on a consistent basis.”); Ex. L, Little City ¶ 11 (“we are extremely limited in our ability to meet person centered planning”); Ex. M, Envision at ¶ 11 (“As rates stay stagnant, Envision’s ability to provide person-centered planning for CILA residents has declined.”).<sup>8</sup>

### ***Community Integration Cannot Be Achieved***

Community integration cannot be provided without adequate staff. As a result, Class Members in CILAs are spending an “unprecedented” amount of time at home. Ex. B, Cornerstone at ¶ 14 (60% decrease in outings as a direct result of the staffing problems.). Similarly, one large provider describes that ICF-DD residents are now only getting out of the facility twice a month. Ex. A, Ray Graham, at ¶ 18. For all these providers, the staffing shortages inhibit community integration. Ex. C, Clearbrook at ¶ 14 (outings in the community have been significantly reduced for both ICF-DD and CILA residents); Ex. E, El Valor at ¶ 8 (describing reduced outings); Ex. F, Glenkirk at ¶ 15

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<sup>8</sup> Transition Plans frequently specify the need for smaller settings, such as 3-4 person CILAs. The provider declarations explain that the availability of these small settings is decreasing and individuals are not being housed consistent with the Service Plans. *See also* Ex. 4, Stover Dec. at ¶ 8. DHS Secretary Dimas recently testified about this issue as well: “The average -- I mean, our most common CILA size is an eight-person CILA ... I think an eight-person CILA is too big for people with severe medical needs, or people with, you know, challenging behaviors. And I think there’s – there’s good national evidence that suggests they could function better and more safely in a smaller environment.” Ex. 5, Transcript of Joint State House-Senate Human Services Committee Hearing, December 13, 2016 (excerpt), at pg. 52.

(“While we are meeting the basic needs of our residents ... residents are not being integrated into the community to the maximum extent possible”); Ex. H, ACHH at ¶¶ 13-16.; Ex. I, New Star at ¶ 12 (“Our residents find themselves less integrated in the community as a result”); Ex. J, EP!C at ¶ 15 (“we do not have sufficient staff to be able to safely take residents on outings” and describing a 40% reduction in the use of its transport vehicles from June 2015 to June 2016); Ex. K, AID at ¶ 16 (describing that community activities are cancelled weekly); Ex. M, Envision at ¶ 11 (“[d]ue to insufficient funding, Envision is unable to facilitate residents’ community integration”).

A former-DSP explains that it is extremely challenging for a DSP—even one as experienced as she was—to take four to five residents into the community. Ex. N, Rummel Dec. at ¶ 12. Until a DSP has several months of experience, they are hesitant to take residents out in the community. *Id.* New staff members simply do not have the skill, experience or comfort necessary to manage multiple individuals outside of the house. *Id.*

The Institute for Public Policy conducted two surveys in 2016 to determine the impact of the staffing crisis on individuals living in ICF-DDs and CILAs. The first survey looked at staffing and activities over a weekend in January 2016. That survey covered 5,200 individuals and found that 1,200 of them could not leave their homes over the entire weekend due to inadequate staff. Ex. 2, Carmody Dec. at ¶¶ 21, 22. The second survey was conducted in August 2016 and covered over 5,300 individuals living in ICF-DDs and CILAs in Illinois. It similarly found that over a summer weekend in August, 1,150 individuals could not leave their homes due to inadequate staff. *Id.* at ¶¶ 23-25.

***Individual Goals and Independence Are Sacrificed***

With the staffing shortages, the providers must focus on keeping their residents safe instead of building independence. Ex. A, Ray Graham, at ¶ 9 (“Often capital needs must be prioritized with a focus on safety.”); Ex. C, Clearbrook, at ¶ 14 (“When one DSP is responsible for five or more [individuals], the DSP’s time is consumed just meeting all the individuals’ needs and making sure they are safe.”); Ex. D, Sertoma, at ¶ 13; Ex. E, El Valor at ¶ 8 (“The individual goals and activities of our residents cannot be pursued because our reduced staff must focus on simply keeping our residents safe.”); Ex. K, AID at ¶ 15 (“the focus becomes just on doing what is absolutely necessary to keep residents safe. Work on individual skills to enhance independence and quality of life gets put aside.”).

“Another impact of insufficient and inexperienced staff is that less time is devoted to implementing each resident’s individual goals and to maintaining skills or learning new ones ... All of this impairs the ability of our residents to become more independent. It also makes our homes more restrictive environments.” Ex. E, El Valor at ¶ 14. *See also* Ex. A, Ray Graham, at ¶ 17; Ex. C, Clearbrook at ¶ 16. One very simple example is that it takes a DSP less time to change residents’ clothes for them than it does to provide the necessary support to allow residents to dress themselves. The same holds true for nearly every function, especially in houses with increased ratios of residents to staff. The impact of these short-cuts, however, is severe: “an increase in ... anxiety, stress, and depression. Residents have missed the individual attention of staff, which has led to skill regression and increased feelings of worthlessness ...” Ex. L, Little City at ¶ 12; Ex. J, EP!C at ¶ 15

(“The result of not following the person-centered plans is that residents become depressed as they lose skills they once had ...”). *See also* Ex. N, Rummel Dec. at ¶ 9.

### ***Health and Wellbeing Is At Risk***

Providers have reduced medical staff, such as nurses and physical, occupational, and speech therapists. Ex. A, Ray Graham, at ¶ 12, 19; Ex. I, New Star at ¶ 7; Ex. J, EP!C at ¶ 11. As a result, “for example, some residents who had been able to feed themselves ... have lost their ability to do so.” Ex. J, EP!C at ¶ 16. Several of the providers describe increased medication problems because of the staffing reductions. Ex. E, El Valor at ¶ 8; Ex. J, EP!C at ¶ 16. One describes that CILA residents are regularly missing appointments, including medical appointments. Ex. M, Envision at ¶ 11.

With the decrease in individualized care and more time restricted to the house, behavioral and emotional problems are increasing, resulting in related incidents of self-harm and injury to others. *See, e.g.* Ex. A, Ray Graham, at ¶ 13; Ex. C, Clearbrook at ¶ 18; Ex. E, El Valor at ¶¶ 9, 12; Ex. H, ACHH at ¶¶ 18-20. Several providers describe residents hitting, biting, pulling hair, and throwing objects because they feel neglected and ignored, with one resident gouging her own eyes. Ex. E at 12; *see also* Ex. H, ACHH at ¶¶ 18-19; Ex. J, EP!C at ¶ 17; Ex. K, AID at ¶¶ 15-16.

Ms. Rummel, the former DSP, describes the relationship between a DSP and their residents and stress caused by turnover. *See also* Ex. N, Rummel Dec. at ¶¶ 9-10. She observed the impact of the staff turnover on her residents, including that they would become more aggressive, hit, bite, and scream; some hitting their heads into the wall in distress. *Id.* ¶ 10.

*Admissions Are Being Restricted*

The providers state that they cannot expand CILA and ICF-DD services. Several admit that they are no longer able to care for higher need residents. Ex. A, Ray Graham, at ¶ 14 (“Limited resources have forced RGA to become extremely cautious when considering people for admission”); Ex. C, Clearbrook at 19 (“Clearbrook is now far more selective in the individuals [] that it will accept ... Clearbrook will no longer accept individuals with more intensive medical ... or behavioral needs.”); Ex. D, Sertoma, at ¶14 (“We are now in a position that we are not considering individuals with mental health and/or serious behavioral issues for residence because we know that we will not have the resources to properly serve them.”), ¶ 12 (“we are considering closing one of our homes serving individuals with the most severe disabilities”); Ex. J, EP!C at ¶ 24 (“EP!C cannot provide adequate care for more individuals with intensive behavioral or medical needs and has declined to admit such individuals”).

The Declaration from Ray Graham describes that they have gone as far as discharging residents with significant needs:

RGA has had to discharge four people with very significant behavioral and mental health records. The discharges were a direct result of insufficient State funding. These individuals are now residing in an SODC or other more restrictive environment. It would cost the State far less money to increase the rates it pays RGA so that RGA can properly care for these more complex individuals, rather than the State paying for these residents to live in an SODC.

Ex. A, Ray Graham, at ¶ 14.

***Providers Foresee Reductions and Closures***

If the State does not make a change soon to help stabilize the delivery of services, increasing numbers of Class Members and Beneficiaries will be harmed and the system itself may deteriorate beyond repair.

Despite everything that we have been forced to let go, Glenkirk is at a critical point in its history. Without an increase in the amount that Illinois pays for its CILA rates, Glenkirk will be force to continue to eliminate services by closing CILA sites.

Ex. F, Glenkirk at ¶ 7.

Despite its best efforts, EP!C has been unable to close the gap .... EP!C's reserves will be exhausted in the next few years and EP!C will be forced to close its doors. ... many [of its residents] will have to go to more restrictive environments such as nursing homes and state operated centers.

Ex. J, EP!C at ¶ 9.

Because any further cost saving measures would jeopardize the safety of their residents, providers will need to start downsizing their operations if the State does not soon provide additional resources through increased reimbursements. Ex. A, Ray Graham, at ¶ 11. *See also* Ex. D, Sertoma at ¶¶ 12, 17 (“Even with the compromises outlined above – increased CILA size, fewer community activities, imposition of charges for services that we want to provide to residents free of charge --, we are uncertain that we will be able to maintain the *status quo*. Sertoma is now forced to further increase occupancy rates in our CILAs to 8 or even to close CILAs.”); Ex. B at ¶ 18 (plans to expand CILA to serve 18 new residents were cancelled because they could not recruit sufficient staff); Ex. C, Clearbrook at ¶ 11 (“We cannot cut additional costs without putting the health and welfare of our residents at risk.”); Ex. E, El Valor at ¶ 7 (“El Valor cannot cut additional costs without seriously affecting the health and welfare of our

residents.”); Ex. G, Avenues at ¶ 16 (“As costs continue to increase without any improvement in State funding, Avenues will have no choice but to reduce our overall residential capacity or close programs before being forced to provide less than adequate levels of daily support.”). Ex. J, EP!C at ¶ 10 (“EP!C cannot cut additional costs without seriously affecting the health and welfare of our residents.”); Ex. M, Envision at ¶ 13 (“Envision has closed CILAS over the past two years and is planning to close additional CILAS within the next year.”).

If providers are forced to close operations, many residents will have to leave CILAs and IFC-DDs to live in more restrictive settings, such as SODCs, which cost three times more than a CILA or ICF-DD. Ex. A, Ray Graham, at ¶ 10; Ex. B, Cornerstone at ¶ 10. “These centers cost Illinois taxpayers \$265,266 per resident compared to \$54,517 for a CILA, or a staggering difference of \$210,749 – nearly four times more per person – than the best practice community living options. And, while expensive, sadly, the facilities offer none of the richness of community living. Most states have eliminated or significantly downsized such centers, while Illinois continues to heavily invest in them at the expense of the community system.” Ex. B, Cornerstone at ¶ 17.

Many of the provider declarations have been submitted by professionals who have devoted decades to helping individuals with developmental disabilities in Illinois. *See, e.g.*, Ex. C, Clearbrook at ¶ 28 (Carl LaMell, 38 years); Ex. H, ACHH at ¶ 21 (Ron Messner, 35 years); Ex. K, AID at ¶ 20 (Lynn O’Shea, 33 years); Ex. J, EP!C at ¶ 28 (Kim Cornwell, 27 years); Ex. A, Ray Graham at ¶ 37 (Kim Zoeller, 22 years). Each states that they have never before seen a crisis in Illinois like exists today in providing services to individuals with developmental disabilities. *Id.* Each attributes this

unprecedented crisis to the inadequate funding by the State. Each states, based on their long experience, that the solution is a substantial increase in the reimbursement rates which have been frozen since March 2008. Carl LaMell—the recently retired CEO of Clearbrook, one off Illinois’s largest and most respected providers—summarized the current situation as follows:

Illinois has reached a crisis in providing services to individuals with developmental disabilities. The current funding situation is like nothing I have seen in all of my 38 years devoted to serving individuals with intellectual and developmental disabilities in Illinois. Illinois is simply not providing sufficient funding to permit providers to adequately care for their residents. Residents are not being served in the least restrictive environment and they are not able to pursue their individual treatment plans and goals. Skill attainment is being delayed if not abandoned altogether. Residents are being subjected unnecessarily to emotional distress as a result of staff shortages and turnover directly attributable to insufficient State funding. Absent a substantial increase in funding to make up for eight years of stagnant rates, this situation will continue and will, in fact, worsen.

Ex. C, Clearbrook at ¶ 28.

#### **4. Declarations from Families Also Support the Monitor’s Findings of Non-Compliance**

Attached as Exhibits O to T are declarations of families who rely on CILAs and ICF-DDs to provide long-term care for their loved ones. These narratives vividly illustrate what the systemic evidence proves – that people with developmental disabilities are being harmed and segregated as a result of insufficient services, in violation of the *Ligas* Consent Decree. Plaintiffs highlight three of those declarations here.

##### ***The Richter Declaration***

Gina Richter’s daughter, “Lisa” who is 32 years-old, lives in a CILA. Lisa has cerebral palsy, fetal alcohol syndrome, Tourette’s syndrome, rheumatoid arthritis, seizure disorder, and bipolar disorder. Until about two years ago, Lisa was enjoying activities in

the community, socializing with disabled and nondisabled people, and developing new skills, all with the support of the CILA staff. She received excellent care and was stable. That has changed over the last two years. Lisa relies on DSP staff for very intimate levels of care. The constant change in this staff has substantially increased her anxiety in demonstrable ways. She throws things and screams at staff. Lisa now calls her mother 12-15 times a day, most frequently in distress about the staff. Her psychiatrist has increased her medications twice since April 2016 and states that he will not decrease the medications again until the staffing at the CILA is stabilized

The frequent turnover has also impacted Lisa's physical wellbeing, as the inconsistent staff cannot appropriately monitor her condition. The results have included a 10-day hospitalization followed by a month in a nursing home in 2015. More recently, Lisa had an eye infection that no one noticed until her eye had swollen shut. The turnover also impacts her medication administration.

Previously, Lisa was out in the community about three times a week. Now, she gets out no more than once a week. It is now common for Lisa to be confined to the CILA for entire weekends, which she spends alone in her room. Lisa's weekly library trip to choose audio books has been eliminated for the past nine months. This reduction in outings has impaired her skill development, and increased her stress, anxiety and frustration.

An important part of person-centered services is to work on individualized goals, such as Lisa's desire to balance her own checkbook and fold her laundry. Due to lack of staff, neither of these goals has been pursued for almost a year.

Ms. Richter's declaration is attached as Exhibit O.

*The Goldstein Declaration*

Candice Goldstein's son, "Michael" is 26 years-old and lives in a CILA.

Michael has autism and is non-verbal. It takes several weeks for a new DSP to learn how to work with him and to understand his needs. Over the last two years, the rate of turnover has increased and Michael frequently has to start these relationships over as soon as they get established.

Michael craves time out in the community, but requires close supervision to prevent his darting into traffic or pica behaviors— persistent eating for non-nutritional purposes, including of non-food substances—which in the past have resulted in hospitalizations. Because of these very serious safety concerns, high rates of DSP turnover mean that Michael's community outings have been significantly reduced; new staff lack the necessary understanding of his behaviors to safely take him into the community. Michael is also fearful of leaving the CILA with DSPs who are strangers to him. He now spends most of his weekends alone in his room, resulting in the loss of social skills.

Michael is losing other self-care skills too. For example, because the new and inexperienced staff don't understand him or don't have enough time, they put him in a diaper instead of providing him the supports he needs to use the toilet himself.

Over the last two years, Michael is increasingly acting out and engaging in socially inappropriate behaviors. His psychiatrist has advised that he needs more activity to occupy him and help with his anxiety. Instead, Michael is spending more and more time isolated in his room.

Ms. Goldstein's declaration is attached as Exhibit P.

### *The Pasquarella Declaration*

Susan Pasquarella's two daughters, Nicole and Angela, live in a CILA. They both have Fragile X Syndrome (FXS), a genetic condition that causes intellectual disability, behavioral and learning challenges, and various physical characteristics. Because of frequent turnover in their CILA in recent years, Nicole and Angela are not receiving the care or services that they require.

Their eight-person house is typically staffed with only one DSP, which means that they cannot engage in individualized activities or work on personal goals. Angela, for example, loves to swim and feels good in the water. But due to limited staffing, she no longer is able to go swimming. Nicole's service plan includes working with a job coach to pursue vocational opportunities which cannot happen with current staffing. Nicole and Angela rarely leave the house. This means that they have very limited opportunities to work on social skills or get the exercise they need. Both Nicole and Angela have gained weight due to the lack of exercise and activity.

Angela needs help with hygiene that she is not receiving. She does not shower often enough and frequently wears dirty clothes. CILA staff is also supposed to help her track her menstrual cycle but is not. Because of ongoing accidents relating to her menstrual cycle, her mother has had to place her on birth control to help her regulate it, something she did not want to do.

For both Angela and Nicole, the inconsistent and low staffing has resulted in increased anxiety, agitation, and behavioral problems. They have both had their medications increased as a result. Their mother would like the medications to be reduced again, but it will not happen until the staffing and community opportunities improve.

Angela and Nicole have “regressed socially and developmentally. This regression, along with the lack of community activities, means Angela and Nicole’s lives are more and more restricted, contrary to their desires and their service plans.”

Ms. Pasquarella’s declaration is attached as Exhibit Q.

**IV. THIS COURT SHOULD FIND DEFENDANTS OUT OF COMPLIANCE AND ENFORCE THE CONSENT DECREE**

The *Ligas* Consent Decree is an enforceable Order of this Court. *See Frew v. Hawkins*, 540 U.S. 431, 437-38 (2004). It meets the standard set forth by the Supreme Court for federal enforcement: it “is a federal-court order that springs from a federal dispute and furthers the objectives of federal law.” *Id.* at 438 *citing Local No. 93, Int’l Ass’n of Firefighters, AFL-CIO C.L.C. v. City of Cleveland*, 478 U.S. 501, 525 (1986). “The decree reflects a choice among various ways that a State could implement the Medicaid Act. As a result, enforcing the decree vindicates an agreement that the state officials reached to comply with federal law.” *Frew*, 540 U.S. at 439.

**A. The Federal Principles That Underlie the *Ligas* Consent Decree.**

Under *Olmstead v. L.C.*, 527 U.S. 581 (1999), and its progeny in the Seventh Circuit, Illinois must offer services to people with developmental disabilities in the most integrated setting appropriate to each individual’s needs. The State’s failure to provide resources adequate to allow people to be truly integrated in their communities is a violation of federal law, as well as of the *Ligas* Consent Decree.

The Supreme Court in *Olmstead* noted that “Congress explicitly identified unjustified ‘segregation’ of persons with disabilities as a ‘for[m] of discrimination’” and that “confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic

independence, educational advancement, and cultural enrichment.” 527 U.S. at 600. As a condition of receiving needed services, “persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice.” *Id.*

The Seventh Circuit has repeatedly and vigorously upheld the right of people with disabilities to community integration, starting not long after the *Olmstead* decision. *See Bruggeman ex rel. Bruggeman v. Blagojevich*, 324 F.3d 906, 911-12 (7th Cir. 2003) (finding that the purpose of the integration mandate “is to prevent the isolation or segregation of the disabled” and therefore reversing denial of ADA claim for individual who sought services outside the family home, which would be less restrictive than living at home with aging parents); *Radeszewski v. Maram*, 383 F.3d 599, 611 (7<sup>th</sup> Cir. 2004) (where state denied young man with complex disabilities intensive home nursing services, offering him only institutional placement, the Court reversed summary judgment in the state’s favor, holding that the ADA’s “integration mandate may well require the State to make reasonable modifications to the form of existing services in order to adapt them to community-integrated settings.”).

Most recently, and analogous to this case, in *Steimel v. Wernert*, 823 F.3d 902 (7th Cir. 2016), the Court of Appeals considered whether Indiana was administering its home- and community-based services inconsistently with the integration mandate of the ADA. In reversing the district court’s grant of summary judgment to the State of Indiana, the Court held that the ADA’s integration mandate can be violated where a state’s policies

have the effect of segregating people with disabilities in their homes or putting them at serious risk of institutionalization.

The *Steimel* plaintiffs were people with developmental disabilities who were moved by the state from a program that had no funding cap to one with a low funding cap. Under the uncapped program, plaintiffs had been able to enjoy many community activities and participate in integrated day services. They were able to spend about 40 hours per week involved in community services. Under the new, capped program, their community activities plummeted to 10-12 hours per week, fewer than two hours per day. *Id.* at 908. Plaintiffs were isolated in their homes.

The Court of Appeals found that the *Olmstead* analysis should apply. 823 F.3d at 910. The mandate “bars unjustified segregation of persons with disabilities, wherever it takes place.” *Id.* at 912. The Court held that “the integration mandate is implicated where the state’s policies have *either* (1) segregated persons with disabilities within their homes, *or* (2) put them at serious risk of institutionalization.” *Id.* at 914 (emphasis added).

The integration mandate regulation has “maximalist language” demanding the “most integrated setting appropriate.” *Id.* at 912. In turn, the “most integrated setting” is a setting that enables people with disabilities to interact with non-disabled people to the fullest extent possible and offers choice of community activities, when and with whom the disabled person wants. *Id.* at 911. Meeting the integration mandate may therefore require the provision of additional services: “so long as any additional services do not cause a fundamental alteration in the state program, the state may be required to provide them; budget cuts can violate the integration mandate.” *Id.*

Here, as in *Steimel*, the *Ligas* Class Members and Beneficiaries are being unnecessarily segregated. While they may live in houses that are located in the community, they cannot take advantage of community life due to staff shortages. They are being increasingly isolated and restricted, contrary to the Decree and their service plans, because they do not have the staff support needed to get out into the community nor—just as detrimentally—to develop and maintain skills that allow for integration. The *Ligas* Class Members' and Beneficiaries' homes, both CILAs and ICF-DDs, have become more restrictive environments due to inadequate funding by the State.

Additionally, as shown in the supporting declarations, many providers are on the brink of collapse. If some providers collapse, other providers will not be able to absorb the residents, as the declarations show that virtually no providers are able to significantly expand their services. The only option for displaced people will be institutions. Thus, the *Ligas* Class Members who currently live in the community in CILAs are very much at risk of re-institutionalization, and those awaiting community placements face the same lack of resources necessary to their successful community integration. Likewise, *Ligas* Beneficiaries living in ICF-DDs are at risk of being placed in SODCs.

Defendants cannot defend violations of Paragraphs 4, 13, and 14, by arguing they have met the numerical requirements of Paragraphs 17-22. As held in *Steimel*, the ADA's integration mandate is not met simply by having individuals reside in the community. It is the services that allow for integration, and therefore the services that are required to meet the ADA's integration mandate. *Steimel*, 823 F.3d at 912. The requirements of the Consent Decree, which are intended to vindicate the Class Members' rights under the

ADA, are not met simply by moving them into homes in the community without providing for the service necessary to achieve integration into the community.

As the Monitor has found and as is documented in the attached declarations, the State's failure to provide adequate resources has resulted in Class Members and Beneficiaries not receiving the services they need. Their homes, whether ICF-DDs or CILAs, have become more restrictive environments in violation of both the Decree and the ADA.

**B. This Court's Authority to Enforce the Consent Decree**

"[F]ederal courts are not reduced to approving consent decrees and hoping for compliance. Once entered, a consent decree may be enforced." *Frew*, 540 U.S. at 440. *See also Shakman v. City of Chicago*, 426 F.3d 925, 931 (7th Cir. 2005); *Jones-El v. Berge*, 374 F.3d 541, 545 (7th Cir. 2004). "Against a state that violates a valid federal court decree the court has the power to issue any order necessary to enforce the decree, including an order to pay." *Wisconsin Hospital Ass'n. v. Reivitz*, 820 F. 2d 863, 868 (7th Cir. 1987).

The State claims that the budget crisis is the basis for its non-compliance, but the State has made no efforts – financial or otherwise – to help providers deal with the DSP crisis. It is the State's responsibility under Medicaid to serve people with developmental disabilities. This responsibility cannot be met by delegating it to private providers and then depriving those providers of the funds necessary to meet the needs of people with disabilities.

Even in the current budget situation, the State is not free to abandon the Decree it voluntarily entered and dispense with compliance, especially where a budget non-contingency term was part of the bargain the State entered. Decree ¶ 5.

Having entered into the consent decree rather than bringing the dispute to trial, [Defendant] cannot now evade an integral portion of that decree . . . Such a result would impugn the integrity of the court and allow the [Defendant] to avoid [its] bargained-for obligations – while retaining the benefits of concessions it obtained on other issues during the negotiations.

*Wilder v. Bernstein*, 153 F.R.D. 524, 529 (S.D.N.Y. 1994) (internal quotation omitted).

The Court has discretion to fashion an appropriate remedy to bring the State into compliance through a supplemental order for injunctive relief or contempt proceedings.

*Reivitz*, 820 F.2d at 868 (“Whether one calls such an order [to enforce the decree] one of civil contempt or, as we would prefer out of comity to characterize it, an equitable supplement to the consent decree, it is within the power of the federal court to make.”).

*See also South Suburban Housing Ctr. v. Berry*, 186 F.3d 851, 854 (7th Cir. 1999)

(recognizing that a district court has “broad discretion to fashion an award” for civil contempt sanctions in action to enforce consent decree pertaining to alleged unfair real estate practices); *Duran v. Elrod*, 713 F.2d 292, 297 (7th Cir. 1983) (stating that the district court has broad discretionary power in shaping remedy to enforce consent decree in jail conditions case). Here, Plaintiffs and Intervenors seek a supplemental order requiring Defendants to immediately take affirmative steps to facilitate the delivery of necessary services required under the Decree.

The recent case of *O.B. v. Norwood*, 838 F.3d 837 (7<sup>th</sup> Cir. 2016), upheld injunctive relief ordered by the district court to protect rights of people with disabilities to receive needed services in integrated settings. The case involved a class of children who

were approved by Illinois' Department of Healthcare and Family Services (HFS) to receive nursing services in the home through the State's Medicaid plan. Without the nursing services to treat their medical needs, the class members would likely need to live in institutions.

The parents of the class members had been unable to hire sufficient numbers of nurses to provide the care needed and which HFS had approved, leaving their right to receive the services ephemeral rather than real. O.B. had a lengthy hospitalization, necessitated only by the fact his parents could not find enough nurses to fill the approved hours. The district court issued a preliminary injunction requiring HFS to take immediate steps to obtain for class members the nursing services that HFS had approved.

The Seventh Circuit rejected the State's argument that, because of the nursing shortage, there was nothing it could do to resolve the situation. The State had to *at least* try recruiting the nurses to provide these services. *Id.* at 841-42. Without the court order requiring the State to "take affirmative steps" the Court found that "there is no indication that HFS will (unless compelled by the courts) lift a finger to find nursing for children in O.B.'s situation." 838 F.3d at 841-42. The Court closed its discussion by noting "a final oddity in HFS's appeal" – that the cost of O.B.'s unnecessary hospitalization was four times the cost of home nursing.

Here, as in *O.B.*, Class Members and Beneficiaries are being denied necessary care with grave consequences, including a dearth of community integration opportunities, loss of skills, and risks to health and safety. And, also like *O.B.*, Class Members and Beneficiaries are faced with enduring dangerous and unsatisfactory conditions in the community or submitting themselves to a significantly more restrictive and more costly

institution. Indeed, if the Class Members and Beneficiaries presented themselves at state-operated developmental centers tomorrow morning, the State would be required to serve them at a rate far greater than the current providers need to adequately serve them.

Another example of a district court providing injunctive relief to enforce the rights of people to live in the community is *Rolland v. Cellucci*, 198 F. Supp. 2d 25, 46 (D. Mass. 2002) *aff'd sub nom. Rolland v. Romney*, 318 F.3d 42 (1st Cir. 2003). This was a class action challenging limitations on access to community placements for nursing home residents, which resulted in people who could be served in the community being confined to nursing homes. *See Voss v. Rolland*, 592 F.3d 242, 247 (1st Cir. 2010) (discussing case history). The consent decree required the state to place many class members in the community and provide specialized services. *Id.* The state satisfied its community-placement and diversion obligations, but “largely failed to provide specialized services to about 800 class members who remained in nursing homes.” *Id.* at 247 (internal citation omitted).

On a non-compliance motion, the district court ordered injunctive relief: “although the court is obviously reluctant to redesign the entire structure of service delivery, there are five specific changes which must be made in order to remedy Defendants’ noncompliance.” *Rolland*, 198 F.Supp.2d at 46. The order required that the defendants: establish and implement an active treatment program for nursing facility residents who needed specialized services; ensure a single case manager and single treatment plan for each class member; develop a measuring device for evaluating compliance with the federal active treatment mandate; and train staff accordingly. *Id.*

In another case, *Juan F. v. Weicker*, 37 F.3d 874, 878-79 (2d Cir. 1994), the Second Circuit upheld a trial court order issuing injunctive relief requiring a foster care agency's compliance with the existing terms of a consent decree in the face of impending budget cuts. The decree in *Weicker* required the defendant to achieve a reduction in caseworker caseloads by a given date. *Id.* at 877. When "steep" budget cuts of more than \$8 million threatened the agency's ability to comply, the *Weicker* plaintiffs sought and obtained injunctive relief setting a timetable for caseworker hiring that would ensure compliance with the caseload reduction deadlines already set forth in the decree. *Id.* at 877-78. The Second Circuit held that the relief granted by the district court was fully within its discretionary authority. *Id.* at 879.

### **CONCLUSION**

The Monitor has found for two consecutive years that the State has failed to comply with its obligations under Paragraph 4 of the Decree to provide adequate resources to ensure that Class Members and Beneficiaries receive required services. The declarations submitted herewith support those findings and amply demonstrate that Class Members and Beneficiaries of the Decree are not receiving the services mandated by the Decree, particularly those in Paragraphs 13 and 14, as a result of inadequate resources. The resulting harm has been amply documented.

Wherefore, as a result of Defendants' violations of the Consent Decree and the harm caused by those violations, Plaintiffs and Intervenors respectfully request the Court make the following findings and enter an Order to enforce the Consent Decree as follows:

1. Defendants are out of compliance with the following provisions of the Consent Decree:
  - a. Paragraph 4's requirement that "Defendants shall implement sufficient measures to ensure the availability of services, supports and other resources of sufficient quality, scope and variety to meet their obligations ... under the Decree ..." including the services required by Paragraphs 13 and 14;
  - b. Paragraph 4's requirement that the Defendants provide the "[r]esources necessary to meet the needs of Individuals with Developmental Disabilities who choose to receive services in ICFs-DD;"
  - c. Paragraph 14's requirement that "[a]ll services and supports in the Transition Service Plan must be integrated into the community to the maximum extent possible, consistent with the choices of the Class Member and the Class Member's legal guardian."
  - d. That such non-compliance and the resulting denial of services violates the integration mandate of the Americans with Disabilities Act.
2. Defendants shall bring themselves into compliance with all provisions of the *Ligas* Consent Decree including:
  - a. Paragraph 4's requirement that "Defendants shall implement sufficient measures to ensure the availability of services, supports and other resources of sufficient quality, scope and variety to meet their obligations ... under the Decree..." including the services required by Paragraphs 13 and 14; and
  - b. Paragraph 4's requirement that the Defendants provide the "[r]esources necessary to meet the needs of Individuals with Developmental Disabilities who choose to receive services in ICFs-DD."

- c. Paragraph 14's requirement that "[a]ll services and supports in the Transition Service Plan must be integrated into the community to the maximum extent possible, consistent with the choices of the Class Member and the Class Member's legal guardian."
3. Defendants shall increase the rates for CILA and ICF-DD services and take other measures sufficient to insure that the State's contracted providers are able to provide services of the quality and scope required by the Consent Decree.
4. Within 30 days, Defendants shall submit a detailed plan to fulfill the above-requirements. The plan shall include but not be limited to affirmative steps that Defendants will take within 90 days in a good faith effort to achieve compliance. The plan, once approved, shall be incorporated into the Implementation Plan and the Consent Decree.
5. Monitor, Plaintiffs, and Intervenors shall have twenty-one days after Defendants submit a plan to submit comments to the Court and Defendants regarding the Defendants' plan.
6. Within 60 days of the Court's approval of a compliance plan, and continuing every 30 days thereafter, Defendants shall provide Plaintiffs, Intervenors and the Monitor a report describing their progress implementing the plan, including what specific steps have been taken by Defendants to assure the provision of resources and services to people with developmental disabilities in CILAs and ICF-DDs as required by the Consent Decree and this Order.
7. Award such other relief as the Court may deem just and proper.

RESPECTFULLY SUBMITTED,

/s/ Amanda Antholt

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