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United States Department of Health and Human Services
Secretary Xavier Becerra
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Re: Notice of Proposed Rulemaking by Department of Health and Human Services, "Discrimination on the Basis of Disability in Health and Human Service Programs or Activities," RIN 0945–AA15, Docket ID HHS-OCR-2023-0013-0001

Dear Secretary Becerra:

The undersigned Attorneys General, as the chief legal officers of their States (the "States"), submit the following comments regarding the Department of Health and Human Services' ("DHHS") September 13, 2023 Notice of Proposed Rulemaking, *Discrimination on the Basis of Disability in Health and Human Service Programs or Activities* (the "Proposed Rule").

The Proposed Rule is an attempt by an executive agency to circumvent the democratic process and intrude on state political judgments by enacting regulations that would vastly expand the scope of the Rehabilitation Act.

Through the Proposed Rule, DHHS attempts to trump the judicial and legislative branches by imposing a regime that Congress and the courts have declined to support. DHHS blatantly refused to follow its obligations to consult with states and local governments prior to pursuing action and conduct the required regulatory impact analysis required for each component of its Proposed Rule.

This arbitrary, capricious, and willful disregard of proper process and the roles of the legislative and judicial branches is egregious federal overreach that will cause fiscal damage to states and local governments and real harm to citizens and providers of services.

I. The Proposed Rule Violates Principles of Separation of Powers.

"The question here is not whether something should be done; it is who has the authority to do so."[1] An executive branch administrative agency cannot overrule the judicial branch's authoritative interpretation of law, whether a Court of Appeals or the Supreme Court of the United States. Likewise, an agency cannot override Congress by using regulation to amend a statute. In this Proposed Rule, DHHS tries to do both.

In *Olmstead v. L.C.*, the Supreme Court held in a plurality opinion that "unjustified isolation…is properly regarded as discrimination based on disability."[2] But the Court was careful to recognize the important role the states play in treating individuals with disabilities, and it expressly noted that its holding did not require states to create new programs out of whole cloth.

Justice Kennedy, casting the decisive fifth vote, explained:

> Of course, it is a quite different matter to say that a State without a program in place is required to create one. No State has unlimited resources, and each must make hard decisions on how much to allocate to treatment of diseases and disabilities. If, for example, funds for care and treatment of the mentally ill, including the severely mentally ill, are reduced in order to support programs directed to the treatment and care of other disabilities, the decision may be unfortunate. *The judgment, however, is a political one and not within the reach of the statute*.[3]

Here, the Proposed Rule would remove those political judgments from the hands of the states by *requiring* them to design (or redesign) their systems and programs, for *all* individuals with disabilities, to eliminate "practices that result in…serious risk of institutionalization."[4] The impact is obvious—the Proposed Rule will supplant state legislatures' authority and discretion in appropriating funds by dictating state budgetary decisions. It even acknowledges as much:

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1 *Biden v. Nebraska*, 143 S. Ct. 2355, 2358 (2023).

2 *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 597 (1999).

3 *Olmstead*, 527 U.S. at 612-13 (Kennedy, J., concurring) (emphasis added).

4 Discrimination on the Basis of Disability in Health and Human Services Programs or Activities, 88 Fed. Reg. 63392, 63485-86 (proposed Sept. 14, 2023) (to be codified at 45 C.F.R. § 84) (emphasis added).

> *Service reductions resulting from budget cuts*—even where permitted under Medicaid and other public program rules—*may violate the integration mandate if they create a serious risk of institutionalization* or segregation" or "result in more favorable access to services in segregated settings than in integrated settings."[5]

In addition to overstepping DHHS's authority, the "at risk" standard the rule articulates is incapable of any objective definition.[6] Worse yet, implementation of that standard could actually result in *inappropriate* treatment of individuals with disabilities. As Justice Kennedy noted in *Olmstead*:

> It would be unreasonable, it would be a tragic event, then, were the Americans with Disabilities Act of 1990 (ADA) to be interpreted so that States had some incentive, for fear of litigation, to drive those in need of medical care and treatment out of appropriate care and into settings with too little assistance and supervision.[7]

By explicitly providing "the caveat that we do not here determine their validity,"[8] the *Olmstead* court was careful to preempt any inference of approval of the underlying "integrated setting" and "reasonable modifications" regulations. And no subsequent Supreme Court case has supported the "at risk" theory the Proposed Rule seeks to codify.

Throughout the Proposed Rule, DHHS repeatedly and consistently cites a non-binding guidance document issued by the Department of Justice (DOJ) in June 2011. And while the preamble of the Proposed Rule characterizes its changes as "consistent with cases from the U.S. Supreme Court and lower courts," that simply isn't the case. In September 2023, the United States Court of Appeals for the Fifth Circuit expressly rejected the "at risk" theory presented by the DOJ in its lawsuit against the State of Mississippi (the same interpretation underpinning much of the Proposed Rule). The court explained:

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5 *Id.* (emphasis added).

6 *See United States v. Mississippi*, 82 F.4th 387, 398 (5th Cir. 2023) (describing the "at risk" theory as a "vague and standardless theory [that would] license courts under the ADA to rework an entire state's mental health system").

7 *Olmstead*, 527 U.S. at 592 (Kennedy, J., concurring).

8 *Id*.

> Nothing in the text of Title II, its implementing regulations, or *Olmstead* suggests that *risk of institutionalization*, without actual institutionalization, constitutes actionable discrimination.[9]

The Fifth Circuit further explained that the same DOJ guidance document that the Proposed Rule relies upon and seeks to codify cannot be used to establish an ADA claim, as it was "not intended to be a final agency action, has no legally binding effect, […] may be rescinded or modified in the Department's complete discretion," does "not establish legally enforceable responsibilities beyond what is required by the terms of the applicable statutes, regulations, or binding judicial precedent,"[10] and "never underwent notice and comment under the APA to become a binding regulation."[11]

It has long been established that "[t]he rulemaking power granted to an administrative agency charged with the administration of a federal statute is not the power to make law. Rather, it is 'the power to adopt regulations to carry into effect the will of Congress as expressed by the statute.'"[12] In more than two decades since *Olmstead* was decided, despite multiple updates to the Rehabilitation Act, Congress has *never* modified the Act to incorporate the "integration mandate" or extend the Act to individuals who are "at risk of institutionalization."

The Fifth Circuit has already determined that the regime promoted by the Proposed Rule is not consistent with the statutes, stating that "[c]ourts must follow the language Congress has enacted; we may not enhance the scope of a statute because we think it good policy or an implementation of Congress's unstated will."[13]

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9 *Mississippi*, 82 F.4th at 392 (emphasis in original).

10 U.S. Dep't of Justice, Civil Rights Div., *Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.,* https://www.ada.gov/resources/olmstead-mandate-statement/ (last visited Nov. 6, 2023).

11 *Mississippi*, 82 F.4th at 393.

12 *Ernst & Ernst v. Hochfelder*, 425 U.S. 185, 213 (1976) (quoting *Dixon v. United States*, 381 U.S. 68, 74 (1965)); *see In re JPMorgan Chase Bank*, 799 F.3d 36, 42 ("Where Congress has spoken with specificity, any agency may not promulgate regulations that are 'an attempted addition to the statute of something which is not there,' even if the intent behind the attempted addition is consistent with the intent behind the authorizing statute." (quoting *United States v. Calamaro*, 354 U.S. 351, 358-59 (1957)); *Island Operating Co., Inc. v. Jewell*, No. 6:16-cv-00145, 2016 WL 7436665, at *8 (W.D. La. Dec. 23, 2016) ("[R]egulations cannot expand the scope of the statute itself.").

13 *Mississippi*, 82 F.4th at 393.

Here, adoption of the Proposed Rule would result in an arbitrary and unpredictable regulatory framework, well beyond that set forth in the ADA or Rehabilitation Act, where a state's obligation to comply depends on the federal circuit in which the state sits. The "at risk" theory might be viable outside the Fifth Circuit, but it would not apply in Texas, Louisiana, and Mississippi. Regulations are, by definition, arbitrary and capricious when they cannot be uniformly applied.

II. The Proposed Rule Violates Federalism and Related Regulatory Requirements.

In its haste to impose this mandate, DHHS bypassed requirements to "closely examine the constitutional and statutory authority supporting any action that would limit the policymaking discretion of the States."[14] The Proposed Rule includes a disclaimer that "state law will continue to govern unless displaced under the standard principles of preemption,"[15] but that goes without saying. The question is whether the "federalism implications" acknowledged in the Proposed Rule that have been adequately and appropriately analyzed *before* a rule has been put into place.

DHHS blatantly failed to follow the rule that "to the extent practicable, State and local officials shall be consulted *before any such action is implemented"* and that "agencies shall consult with appropriate State and local officials to determine whether Federal objectives can be attained by other means."[16] DHHS's belief that it is a "necessity to create a Federal benchmark that will provide a uniform level of nondiscrimination protection across the country"[17] shines a spotlight on its disregard of the agency's duty specific to this type of action:

> *Agencies shall*…in determining whether to establish uniform national standards, consult with appropriate State and local officials as to the need for national standards and any alternatives that would limit the scope of national standards or otherwise preserve State prerogatives and authority.[18]

DHHS has not consulted with states in development of this rule—quite the opposite. It attempts to restrain state input to a two-month window for public comment on a 121 page Proposed Rule with a 146 page Regulatory Impact Analysis ("RIA").

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14 Exec. Order No. 13132, 64 Fed. Reg. 43,255, 43,256 (Aug. 10, 1999).

15 Discrimination on the Basis of Disability, 88 Fed. Reg. at 63,493.

16 EO 13132, 64 Fed. Reg. at 43,255 (emphasis added).

17 Discrimination on the Basis of Disability, 88 Fed. Reg. at 63,493.

18 EO 13132, 64 Fed. Reg. at 43,255.

Despite failing to consult with states in advance, it suggests in its questions that *states* should be the ones to explain costs, identify impacted recipients, refine proposed definitions, and analyze "potential federalism implications of the proposed rule and on the proposed rule's effects on State and local governments."[19]

III. The Proposed Rule is an Unfunded Mandate that Fails to Consider Costs and Interferes with State Budget Processes.

The Unfunded Mandates Reform Act (UMRA) specifically states that "[e]ach agency shall, unless otherwise prohibited by law, assess the effects of Federal regulatory actions on State, local, and tribal governments, and the private sector."[20] DHHS attempts to circumvent the requirements of the UMRA by providing a conclusory statement that the Proposed Rule "falls under an exception for regulations that establish or enforce any statutory rights that prohibit discrimination."[21] But here, there is no "statutory right[] that prohibit[s] discrimination" because "[n]othing in the text of Title II, its implementing regulations, or *Olmstead* suggests that *risk of institutionalization*, without actual institutionalization, constitutes actionable discrimination."[22] Instead, DHHS is attempting to create, through regulation, quasi-statutory rights (*e.g.* the "at risk" theory) that would then be enforced by the same regulations by which they were created.

In its RIA, the majority of the cost and benefit analysis relates to "health care providers." The fact that "the proposed rule covers all recipients of HHS funding"—which would include the States—merits only a cursory mention.[23] The Proposed Rule adds burdensome technical accessibility rules for web and mobile applications and content, which requires additional human resources and systems updates, but the RIA asserts that "even the smallest affected entities would be unlikely to face a significant impact."[24] The Proposed Rule requires recipients, including in-home providers, to obtain additional medical equipment for offices and procure additional portable equipment for in-home services. DHHS cannot both claim that there is a nationwide lack of a broad array of services, technology, and durable medical equipment while also stating that there will be a negligible cost to adding this sweeping set of requirements.

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19 Discrimination on the Basis of Disability, 88 Fed. Reg. at 63,494.

20 2 U.S.C.A. § 1531.

21 Discrimination on the Basis of Disability, 88 Fed. Reg. at 63,491.

22 *Mississippi*, 82 F.4th at 393 at 392 (emphasis in original).

23 Discrimination on the Basis of Disability, 88 Fed. Reg. at 63,491.

24 Dep't of Health and Human Services, Office for Civil Rights, Regulatory Impact Analysis, 2 (Sept. 13, 2023).

DHHS also bends over backwards to avoid addressing the costs imposed by the "integrated setting mandate" it proposes. Its financial analysis speaks of podiatrists and child day care providers, hoping that the reader won't notice the glaring omission of *all recipients of DHHS funding* (including small providers of behavioral health and intellectual and developmental disability support services).

The further one reads through the so-called "Regulatory Impact Analysis," the shallower the analysis becomes. Rather than providing an orderly analysis of each proposed change in turn, DHHS rearranged the provisions so that it provides substantive analysis for only four sets of its proposed changes. DHHS's proposed change to the "most integrated setting" definition receives only a cursory mention on the last few pages, with no fiscal impact analysis whatsoever. In fact, an "extensive list of provisions" merited only a combined three pages of assertions about what DHHS "believes" to be the case (the term "analysis" cannot be reasonably used to describe the commentary provided).

The Proposed Rule claims:

> Because the costs of the proposed rule are small relative to the revenue of recipients, including covered small entities, and because even the smallest affected entities would be unlikely to face a significant impact, we propose to certify that the proposed rule will not have a significant economic impact on a substantial number of small entities.[25]

This conclusion fails to recognize that the Proposed Rule would require every provider accepting Medicaid to "administer programs and activities" in the newly expanded "most integrated setting."[26] This rule would be financially devastating to providers.

Not only does this rule require the state to create programs that the Supreme Court said was not required, this rule flies in the face of the fundamental alterations concept under the ADA and Rehabilitation Act. A state cannot be required to fundamentally alter the nature of its services, programs, or activities, and relevant to this are the resources available to the state, the cost of the modifications, and the other obligations held by the State.[27] Claiming that the Proposed Rule "is not unlimited"[28] does not make it so,

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25 Discrimination on the Basis of Disability, 88 Fed. Reg. 63,491.

26 Discrimination on the Basis of Disability, 88 Fed. Reg. 63,506.

27 *Olmstead*, 527 U.S. at 603-04.

28 Discrimination on the Basis of Disability, 88 Fed. Reg. 63,487.

especially considering the theories and remedies the Department of Justice has pursued in ADA and Rehabilitation Act cases against the states.[29] In plain language, the rule requires programs and activities to be offered in all settings regardless of the nature of the program and activity, and without regard to the capabilities or expertise of the individual provider.

DHHS cannot shift the burden of justifying its mandates onto the recipients of the action. The lack of clarity and detail as to the costs that this rule will impose upon states is an egregious lack of compliance with DHHS's obligation to provide an RIA and assess all costs and benefits of available regulatory alternatives.[30]

IV. The Proposed Rule is Inconsistent with Medicaid Rules and Federal Funding.

As noted above, the Proposed Rule requires creation of new programs through unfunded mandates, which places the full burden of implementation on states and providers without acknowledging the role of federal funding mechanisms in creating systems of care that this rule is attempting to address.

The current Medicaid system *favors institutional and medical-model care.* [31] Since its inception, Medicaid has paid for intermediate care, skilled care, and all other types of care but through a medical model, not through a community-based model. To their credit in 1981, DHHS created the mechanism for certain waivers to be applied so that services could be provided in other settings—this was primarily done to address community integration and the cost of institutional care. These waivers have been in place for close to forty years, but in order to take advantage of a waiver, states have to go through a lengthy and cumbersome application process.[32] Most waivers require demonstration of

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[29] *See Mississippi*, 82 F.4th at 390-91 (explaining the scope of the district court's remedial order).

[30] *See* Regulatory Flexibility Act, 5 U.S.C. §§ 601-612; Unfunded Mandates Reform Act of 1995, 2 U.S.C.A. § 1501; Exec. Order No. 12866, 58 Fed. Reg. 51,735 (Sept. 30, 1993) as amended by Exec. Order No. 14094, 88 Fed. Reg. 21,879 (Apr. 6, 2023); Exec. Order No. 13563, 76 Fed. Reg. 3,821 (Jan. 18, 2011); Exec. Order No. 13,132, 64 Fed. Reg. 43,255 (Aug. 4, 1999).

[31] *Steimel v. Wernert*, 823 F.3d 902, 906 (7th Cir. 2016).

[32] The Proposed Rule creates inconsistency between federal rules by undermining the existing Medicaid rules that allow states to design HCBS waivers that have caps. It simultaneously asserts that CMS would not be required to assess compliance with Section 504 when approving Medicaid proposals, but that states would be liable if their Medicaid programs are later seen as providing insufficient coverage of community services.

cost-neutrality (for the federal payment source), meaning that providing the services in community does not cost more than care in an institutional setting would. And despite cost neutrality and community integration positives, the federal government has not seen fit to incorporate these services into standard Medicaid and requires states to "prove" the value of these waivers every few years through a laborious approval and renewal processes.

The proposed rule will cripple states unless the federal government fully examines a way to revisit its foundation for reimbursement based upon institutional care. Congress has refrained from adding these requirements to statute, and the Supreme Court has stated that "a State may not be forced to create a community-treatment program where none exists.[33] This rule turns both of those concepts on their head by adding community care without funding and by creating programs where none were previously required.

DHHS's Proposed Rule flies in the face of Supreme Court precedent in *Olmstead*, will be impossible to implement at programmatic level, and is an unfunded mandate with ruinous implementation costs imposed on state budgets. This activist attempt to undermine State sovereignty through an administrative rulemaking process while openly refusing to follow the requirements of a legitimate regulatory process should not be allowed.

Sincerely,

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33 *Olmstead* 527 U.S. 612–13.

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