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12 UNITED STATES DISTRICT COURT
13 CENTRAL DISTRICT OF CALIFORNIA
14

15 **KATIE A.**, by and through her next
friend Michael Ludin; **MARY B.**, by and
16 through her next friend Robert Jacobs;
JANET C., by and through her next
17 friend Dolores Johnson; **HENRY D.**, by
and through his next friend Gillian
18 Brown; AND **GARY E.**, by and through
his next friend Michael Ludin;
19 individually and on behalf of others
similarly situated,

20 Plaintiffs,

21 v.

22 **DIANA BONTÁ**, Director of California
Department of Health Services; **LOS**
23 **ANGELES COUNTY; LOS ANGELES**
COUNTY DEPARTMENT OF
24 **CHILDREN AND FAMILY**
SERVICES; ANITA BOCK, Director of
25 the Los Angeles County Department of
Children and Family Services; **RITA**
26 **SAENZ**, Director of the California
Department of Social Services, and
27 **DOES 1 through 100, inclusive,**

28 Defendants.

Case No.: CV-02-05662 AHM (SHx)

**PLAINTIFFS' MEMORANDUM
OF POINTS AND AUTHORITIES
IN SUPPORT OF MOTION FOR
PRELIMINARY INJUNCTION**

Date: February 4, 2008
Time: 10:00 a.m.
Courtroom: 14

The Hon. A. Howard Matz

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INTRODUCTION

1
2 “[A]t stake in this lawsuit is the health of thousands of children who are
3 already in, or are likely soon to wind up, in foster care.” *Katie A. v. Bontá*, 433 F.
4 Supp.2d 1065, 1068 (C.D. Cal. 2006). These “mentally-troubled youngsters” are
5 caught up in a foster care system that “has been widely acknowledged to be failing.”
6 *Id.* at 1069. This Court granted Plaintiffs’ prior motion for a preliminary injunction
7 which would have required State Defendants to provide two intensive community-
8 based mental health services — wraparound services and therapeutic foster care
9 (“TFC”) — to members of the statewide class. *Id.* at 1078-79. In March 2007, the
10 Ninth Circuit vacated the preliminary injunction. *Katie A. ex rel Ludin v. Los*
11 *Angeles County*, 481 F.3d 1150, 1162 (9th Cir. 2007). Significantly, the Court of
12 Appeals rejected almost all of State Defendants’ “contentions of error regarding the
13 factual findings and legal standard relied on by the district court.” *Id.* at 1152-62.

14 Plaintiffs *Katie A., et al.*, now move for another preliminary injunction. The
15 Ninth Circuit remanded this case as to three discrete issues regarding Plaintiffs’
16 claims under the Medicaid Act. As set forth below, the facts and law clearly favor
17 Plaintiffs on those three issues, as well as their additional claims under the
18 Americans with Disabilities Act (“ADA”) and Section 504 of the Rehabilitation Act.

19 This Court previously ruled that the balance of hardships tipped in Plaintiffs’
20 favor, finding that the “unmet mental health needs” of members of the statewide
21 class and “the harms of unnecessary institutionalization are no less grave now than
22 three years ago.” *Katie A.*, 433 F.Supp.2d at 1077-78. The Ninth Circuit did not
23 disturb those findings. *Katie A.*, 481 F.3d at 1156-57. Those findings of irreparable
24 harm are just as true today. Moreover, preliminary estimates by Los Angeles
25 County indicate that it has saved more than \$55,000 per child just in placement costs
26 from providing wraparound services instead of group home care. *See* Rauso
27 Declaration (“Decl.”), at ¶ 20. Thus, the Court should again enjoin State Defendants
28 – Sandra Shewry, Director of the California Department of Health Care Services

1 (“DHCS”), and John Wagner, Director of the California Department of Social
2 Services (“DSS”) – to provide wraparound services and TFC to class members.

3 **STATEMENT OF FACTS**

4 **A. Foster Children in California Still Are in Desperate Need of**
5 **Wraparound Services and TFC.**

6 As of July 1, 2006, 78,278 children were in child welfare-supervised foster
7 care in California.¹ Thousands of additional children receive child welfare services
8 in their own homes.² Plaintiffs will not repeat here the lengthy discussion in earlier
9 briefing about how: a significant percentage of children in or at risk of foster care
10 placement have mental health needs; the Medi-Cal program does not meet the
11 mental health needs of most members of the statewide class; wraparound services
12 and TFC are proven effective treatments for these children; and wraparound services
13 and TFC are not available to most class members. *See* Plaintiffs’ Memorandum of
14 Points and Authorities in Support of Preliminary Injunction at 1-16.³ There has
15 been little improvement since Plaintiffs filed their earlier motion.

16 For several years, Tara Beckman has been the Court Appointed Special
17 Advocate (“CASA”) for Cherise M., who is now age fifteen and still a dependent of
18 Alameda County. Beckman Supplemental Declaration (“Supp. Decl.”), at ¶¶ 2-4.
19 Since Ms. Beckman gave a declaration in support of Plaintiffs’ earlier motion,
20 Cherise has moved in and out of seven more placements, including foster homes,

21 ¹ B. Needell, *et al.*, *Child Welfare Supervised Foster Care Highlights from*
22 *CWS/CMS*, Further Newman Decl., Exhibit (“Exh.”) 168 at 1061.

23 ² In Los Angeles County alone, 23,000 children were in out-of-home (“foster”)
24 care, while another 17,000 children were receiving child welfare services from the
25 County’s Department of Children and Family Services (“DCFS”) but had not been
26 removed from their homes. Findings of Fact and Conclusions of Law re Settlement
27 Agreement between Plaintiffs and County dated November 20, 2006 (“Findings”) at
28 ¶¶ 17, 23, 52.

³ For the Court’s convenience, Plaintiffs will be delivering to chambers copies of the
earlier briefs and the most important declarations, exhibits and deposition excerpts
filed in support of the prior motion.

1 group homes, and psychiatric hospitals. *Id.* at ¶¶ 3, 8-14. In Ms. Beckman’s
2 opinion, the “haphazard nature” of Cherise’s placements reveals that the county
3 “does not have a treatment plan” for her and shuttling Cherise among those
4 placements “has aggravated her feelings of depression, abandonment and
5 uncertainty about the future.” *Id.* at ¶ 16. Most recently, Cherise was placed in a
6 group home that is “known recruiting ground for pimps.” *Id.* at ¶ 14. Besides
7 offering “very few services” to Cherise, this group home does not monitor whether
8 she is going to school and did not contact the authorities when she ran away for two
9 days. *Id.* Because no other group home in Alameda County is reportedly willing to
10 take Cherise, Ms. Beckman feels that she has “no other choice” but to ask that
11 Cherise now be moved out-of-county for her own safety. *Id.* at ¶ 15. Ms. Beckman
12 considers this “the hardest decision I have had to make” in “working with Cherise”
13 as “she needs a loving, nurturing therapeutic home, not another residential group
14 home far away from the few people and places she knows.” *Id.* A trained
15 Therapeutic Behavioral Specialist, Ms. Beckman worries that if Cherise never
16 receives TFC or wraparound services, “she will likely never be able [to] overcome
17 her mental health problems” and “may remain institutionalized for the rest of her
18 childhood.” *Id.* at ¶¶ 2, 19.

19 Tragically, Cherise is not alone in experiencing multiple placements and often
20 ending up in group homes. *See, e.g.*, Rauso Decl., at ¶¶ 18-19 (group of 43 foster
21 children averaged nearly seven placements per child in less than three years);
22 Further Farr Decl., at ¶¶ 50-51 (“ Matt shuffled between three foster homes, one
23 shelter and two group homes” becoming “more and more downcast”). A recent
24 report from the Center for Social Services Research shows 6,478 children in child
25 welfare-supervised foster care in group homes. Further Newman Decl., Exh. 168 at
26 1061. As of November 2005, 1,832 foster children in Los Angeles County were in
27 group homes and more than half of them were in high level group homes, Rate
28

1 Classification Level (“RCL”) facilities of 12 or above.⁴ Findings at ¶ 38.

2 The evidence continues to mount that both wraparound services and TFC are
3 effective treatments for children with mental health needs. *See, e.g.*, Supp. Bruns
4 Decl., at ¶ 20; Second Supp. Chamberlain Decl., at ¶ 14; Rauso Decl., at ¶¶ 14-20.
5 Of course, these research studies do not provide the whole story. With the benefit of
6 wraparound services, one teenaged girl in foster care who had a history of seven
7 prior placements, including two stays in juvenile hall, was able to live with her
8 stepfather, quit taking drugs and alcohol, and was finishing high school with top
9 grades. Further Farr Decl., at ¶¶ 22- 27. Another wraparound program helped a
10 fifteen-year old boy, who “had lived in foster care or group homes all his life,” to
11 transition to living with a foster family and to plan on living with this family when
12 he starts working or goes to college. Bhattacharyya Decl., at ¶¶ 20-24; *see also*
13 Further Kamradt Decl., at ¶¶ 12-34 (recounting experiences of other children).

14 Nevertheless, only about 2,500 children received wraparound services in
15 California in June 2007. Further Newman Decl., Exh. 165 at 0916-0925; *see also*
16 Sommers Decl., at ¶¶ 3, 10 (wraparound services recommended, but never provided,
17 to foster child who now is in a restrictive group home). From January through
18 March 2007, 312 children were placed in Intensive Treatment Foster Care (“ITFC”),
19 the most common form of TFC in California. Further Newman Decl., Exh. 169 at
20 1062-1074. Both wraparound services and TFC continue to be available to class
21 members only at the counties’ discretion. Alameda County, for instance, has

22
23 ⁴ Group homes in California are classified into RCLs of 1-14, using a point system
24 designed to reflect the level of care and services they provide. DSS, *Reexamination*
25 *of the Role of Group Care in a Family-Based System of Care*, Exh. 103 at 282. Data
26 from the California Department of Mental Health (“DMH”) indicates that
27 approximately 9,000 children were placed in RCL facilities of 12 and above, or
28 locked facilities for the treatment of mental health needs in 2005-06. Further
Newman Decl., Exh. 170 at 1089-1090. Children in the delinquency system are also
placed in RCL facilities, and foster children often go in and out of the delinquency

1 discontinued its successful wraparound program. Berrick Decl., at ¶¶ 14-18, 27.

2 Monterey County has a policy to “wrap one kid at a time” in a family. Worth
3 Decl., at ¶ 14. This policy has proven particularly tragic for Kelly Worth and her
4 family. Ms. Worth was the “victim of frequent and serious domestic violence when
5 [her] two younger children were small.” *Id.* at ¶ 3. As a consequence, both
6 Thomas, age 10, and Christine, age 12, have been diagnosed with Post-Traumatic
7 Stress Disorder and other mental disorders, and both children have exhibited many
8 of the same serious emotional and behavioral problems. *Id.* at ¶¶ 3, 4, 6. Ms. Worth
9 eventually obtained wraparound services from the county for Thomas. *Id.* at ¶ 5, 6.
10 “Unlike Thomas’ teachers, the wraparound team did not give up on Thomas.” *Id.* at
11 ¶ 10. The result has been that Thomas graduated from wraparound last summer, is
12 living at home, and attending school full-time. *Id.* at ¶ 13. Meanwhile, Ms. Worth
13 voluntarily placed Christine in the foster care system in 2004 because “[i]t seemed
14 like the only way that Christine could receive intensive mental health treatment.”
15 *Id.* at ¶¶ 14, 15. Since then, Christine has been in more than eight placements and is
16 currently living in an RCL 12 group home three hours away from her home. *Id.* at
17 ¶¶ 16-20, 25. “Christine’s behaviors have gotten worse, not better,” as she “has
18 learned all kinds of bad behavior from other kids in the group homes,” such as how
19 to cut her wrists, and has been charged with two misdemeanors. *Id.* at ¶¶ 26-27.

20 **B. The Preliminary Injunction Was Vacated on Narrow Grounds.**

21 The Ninth Circuit’s opinion allows Plaintiffs the opportunity to file another
22 preliminary injunction motion. *Katie A.*, 481 F.3d at 1162. The Ninth Circuit held,
23 *inter alia*, that: (1) this Court did not err in stating that “Defendants do not dispute
24 that currently they are not providing” wraparound services and TFC, “as such, to
25 members of the plaintiff class” [*id.* at 1155-56]; (2) “[e]vidence in the record
26 supports the court’s findings” that “other states fund wraparound and TFC programs
27

28 system.

1 under Medicaid” [*id.* at 1156]; (3) this Court “correctly applied” the applicable tests
2 for granting a mandatory preliminary injunction [*id.*]; and (4) “the court
3 appropriately allowed defendants an opportunity jointly to develop the remedial plan
4 needed to implement the injunction” [*id.* at 1157].

5 The Ninth Circuit affirmed that the state’s obligations under the EPSDT
6 provisions of the Medicaid Act are “extremely broad” [*id.* at 1154], and that the
7 state must “provide services to class members, rather than simply make such
8 services available” [*id.* at 1158-59]. Pursuant to 42 U.S.C. § 1396a(a)(43)(C),⁵ a
9 state must “see that the services are provided when screening reveals that they are
10 medically necessary for a child” and, even if a state delegates the responsibility to
11 provide treatment to other entities, “the ultimate responsibility to ensure treatment
12 remains with the state.” *Katie A.*, 481 F.3d at 1158.

13 At one point the Ninth Circuit referred to what this Court had “described as
14 plaintiffs’ undisputed evidence that wraparound and TFC are medically necessary
15 for children with serious medical needs.” *Id.* at 1153. The appellate court found no
16 fault with this finding. Nor did the Ninth Circuit reject this Court’s determination
17 that wraparound services and TFC “are mental health ‘services,’ rather than simply
18 processes, approaches, or philosophies.” *Id.* at 1158.

19 According to the Ninth Circuit, the one error by this Court was that “it did not
20 explore the possibility that the State might only have an obligation to fund the
21 component services of wraparound and TFC, rather than to offer the coordinated
22 complex of services in a single package.” *Id.* at 1158. This Court mistakenly
23 “assumed that if each component of a given type of care falls within the State’s
24 EPSDT obligations, this necessarily implies that that form of care itself must be
25 *funded* and provided by the State as a single package.” *Id.* at 1161 (*italics added*).
26 The Ninth Circuit gave directions that on remand the “district court should first
27

28 ⁵ Hereafter, all statutory citations are to Title 42 of the United States Code unless

1 make separate determination as to (1) whether each component service of
2 wraparound and TFC falls under a provision of § 1396d(a), and (2) whether
3 defendants have effectively provided each mandated component service. . . .” *Id.* at
4 1163. Next, this Court should determine “whether the State should be required to
5 provide the required services in another manner which will render such services
6 effective, or proceed directly to wraparound and TFC.” *Id.*

7 ARGUMENT

8 I. The Facts and Law Clearly Favor Plaintiffs’ Medicaid Claim.

9 Plaintiffs seeking mandatory preliminary relief must show that the facts and
10 law clearly favor the moving party. *Katie A.*, 481 F.3d at 1156. The facts and law
11 clearly favor Plaintiffs on all three issues this Court was instructed to address.

12 A. Each Component of Wraparound Services and TFC Falls under 13 One or More Provisions of 42 U.S.C. § 1396d(a).

14 “Under § 1396d(r)(5), states must ‘cover every type of health care or service
15 necessary for EPSDT corrective or ameliorative purposes that is allowable under 42
16 U.S.C. § 1396d(a).’” *Katie A.*, 481 F.3d at 1154 (citing *S.D. ex rel Dickson v. Hood*,
17 391 F.3d 581, 590 (5th Cir. 2004), and other cases). Thus, the state must provide a
18 medically necessary service “whether or not such services are covered under the
19 State plan” [§1396d(r)(5)], so long as the state could elect to include the service in
20 its Medicaid plan. *See, e.g., Mitchell v. Johnston*, 701 F.2d 337, 340-42, 346-52 (5th
21 Cir. 1983) (dental services); *Rosie D. v. Romney*, 410 F.Supp.2d 18, 30 (D. Mass
22 2006) (comprehensive assessments of children’s clinical needs, ongoing case
23 management and monitoring, and in-home behavioral support services).

24 Pursuant to the Ninth Circuit’s directions, this Court should first decide
25 whether each component of wraparound services and TFC falls under the 28
26 categories of services listed in § 1396d(a). *Katie A.*, 481 F.3d at 1163. The
27 activities that comprise the components of wraparound services and TFC fall within

28 indicated otherwise.

1 § 1396d(a)'s coverage of – and qualify as – rehabilitative services, case
2 management services or other types of “remedial care.” Second Supp. Redman
3 Decl., at ¶ 10; *accord*, Koyanagi Decl., at ¶¶ 25, 28-30.

4 With regard to rehabilitative services, the Medicaid Act broadly covers “other
5 diagnostic, screening, preventive, and rehabilitative services, including any medical
6 or remedial services (provided in a facility, a home, or other setting)” when those
7 services “are recommended by a physician or other licensed practitioner . . . for the
8 maximum reduction of physical or mental disability and restoration of an individual
9 to the best possible functional level.” § 1396d(a)(13); *see also* 42 C.F.R. §
10 440.130(d) (goal of rehabilitative services is “maximum reduction of physical or
11 *mental* disability” (italics added)). Guidance from the Centers for Medicare and
12 Medicaid Services (“CMS”) includes the following examples of rehabilitative
13 services: diagnosis, assessment, treatment planning and coordinating the delivery of
14 rehabilitative services; crisis services; family psychoeducation to enlist a person’s
15 family in addressing and managing the person’s mental illness; peer support and
16 counseling; basic life skills and social skills training and support; medication
17 education and management; and illness and disability management. Second Supp.
18 Redman Decl., Exh. 6 at 0546-0547.

19 Case management services consist of services to “assist individuals under the
20 [Medicaid] plan in gaining access to needed medical, social, educational, and other
21 services.” §§ 1396d(a)(19), 1396n(g)(2)(A)(i). With the Deficit Reduction Act of
22 2005 (“DRA”), Congress clarified that case management services include:
23 assessments to determine service needs, which can involve “[g]athering information
24 from other sources such as family members, medical providers, social workers, and
25 educators”; development of a specific care plan that, among other things, “specifies
26 the goals and actions to address” the various services needed by the eligible
27 individual; referral and related activities to help an individual obtain needed
28 services; and monitoring and follow-up activities. P.L. 109-171, § 6052(a)(2) (Feb.

1 8, 2006), codified at § 1396n(g)(2)(A)(ii).

2 As to other types of remedial care, § 1396d(a)(6) generally covers “medical
3 care, or any other type of remedial care recognized under State law, furnished by
4 licensed practitioners within the scope of their practice as defined by State law.”

5 All the components of wraparound services and TFC fall within the 28
6 categories of services under § 1396d(a). This Court might begin with the first
7 component of wraparound services – engagement of the child and family in the
8 process of planning the child’s mental health services. CMS has itself stated that
9 rehabilitative services include “[f]amily psychosocial education in order to enlist a
10 person’s family in addressing and managing the person’s mental illness” [Second
11 Supp. Redman Decl., Exh. 6 at 0546], and “family treatment planning” is defined as
12 the “active involvement of family members in the planning and input of setting
13 goals and treatment.” *Id.*, Exh. 10 at 0639.⁶ The second component of wraparound
14 services is immediate crisis stabilization; CMS has stated that rehabilitative services
15 include crisis services. *Id.*, Exh. 6 at 0546. Some of the other components of
16 wraparound services on Appendix A are strength and needs assessment, wraparound
17 service plan development, wraparound service plan implementation, and tracking
18 and adapting the wraparound service plan. Congress has clarified that case
19 management services include assessments to determine service needs, care plan
20 development, referral and related activities to help an individual obtain needed
21 services, and monitoring and follow-up activities. § 1396n(g)(2)(A)(ii); *see also*
22 Second Supp. Redman Decl., Exh. 6 at 0546 (rehabilitative services include
23 diagnosis, assessment, treatment planning and coordinating the delivery of services).

24
25 ⁶ The Interim Final Case Management Services Rules similarly state that contacts
26 with an eligible individual’s family that are directly related to the identification of
27 the individual’s needs, identifying needs and supports to assist the individual in
28 obtaining services, providing case managers with feedback, and alerting case
managers to changes in the individual’s needs are all covered activities. 42 C.F.R. §
440.169(e), 72 Fed. Reg. 68077, 68092 (Dec. 4, 2007).

1 Declarations from several leading national experts prove that each component
2 of wraparound services and TFC can be covered under one or more provisions of §
3 1396d(a) and is already covered by other states' Medicaid programs. Dr. Linda
4 Redman, former Deputy Director of Arizona's Medicaid Program, has helped
5 several states to develop a wide array of community-based services covered by
6 Medicaid. Second Supp. Redman Decl., at ¶¶ 1-2. Based upon her review of
7 approximately twelve states' Medicaid documents and conversations with staff in
8 those states, Dr. Redman has created a table demonstrating how the activities and
9 services described under all the components of wraparound services and TFC in
10 Appendices A and B are available under other states' Medicaid programs. *Id.* at ¶
11 12 and Exh. 7 at 0548-0618. In Dr. Redman's expert opinion, the fact that the
12 components of wraparound services and TFC are covered by the other states'
13 Medicaid programs and that those states are currently being reimbursed by CMS
14 constitutes "strong evidence" that the components of wraparound services and TFC
15 on Appendices A and B "are covered by Medicaid." *Id.* at ¶ 11.

16 Plaintiffs have also submitted declarations from Tim Westmoreland and
17 Martha Knisley. Mr. Westmoreland is the former Director of CMS' Center for
18 Medicaid and State Operations, where he was responsible for the administration and
19 operation of the entire Medicaid program. Westmoreland Decl., at ¶¶ 4-5. In that
20 position, he developed regulations and administrative guidance on coverage of
21 Medicaid services and reviewed states' proposals for covering services using
22 Medicaid through the State Plan Amendment process. *Id.* Ms. Knisley was Director
23 of the Departments of Mental Health in both the District of Columbia and in Ohio
24 and Deputy Secretary for Mental Health in Pennsylvania. Knisley Decl., at ¶¶ 1, 6.
25 Now a consultant, she has assisted more than a dozen states in designing, gaining
26 CMS approval and implementing Medicaid-funded community-based services for
27 adults and children with mental health needs. *Id.* at ¶¶ 2, 7. Mr. Westmoreland and
28 Ms. Knisley both opine that the components of wraparound services and TFC are

1 covered by Medicaid and that the activities that comprise these components have
2 been covered by other states' Medicaid programs with CMS' approval.
3 Westmoreland Decl., at ¶¶ 2, 10, 12-14 and 21 (discussing approval of other states'
4 coverage of the components during his tenure and thereafter); Knisley Decl., at ¶¶ 3,
5 12, 13, 16 (describing District of Columbia's coverage of the components).

6 Finally, this Court should reread the earlier declaration of Chris Koyanagi,
7 who has thirty years' experience with public financing of mental health services.
8 Koyanagi Decl., at ¶¶ 2-8. Based on a 50-state survey, she discussed other states'
9 coverage of the components of wraparound services and TFC and the provisions of
10 § 1396d(a) under which states have covered these components. *Id.* at ¶¶ 22, 26-30.

11 According to State Defendants, none of the components of wraparound
12 services and TFC are covered by the Medicaid Act in part because they are not
13 "independently recognized" under § 1396d(a). Further Newman Decl., at ¶ 4, Exh.
14 164 at 0871-0915. State Defendants are merely rehashing their earlier unsuccessful
15 argument that a service must be expressly mentioned in the Medicaid Act to be
16 covered. As the Ninth Circuit made clear, § 1396d(a) "contains a list of 28
17 categories of care" and "these categories are fairly general." *Katie A.*, 481 F.3d at
18 1154. This Court need look no farther than Therapeutic Behavioral Services
19 ("TBS"), a Medicaid covered mental health service not expressly mentioned in §
20 1396d(a). *Emily Q. v. Bontá*, 208 F.Supp.2d 1078 (C.D. Cal. 2001).⁷

21 In opposition to this motion, State Defendants can be expected to rely on the
22 August 16, 2006 letter from Gail Arden of CMS to Stan Rosenstein of DHCS.⁸

24 ⁷ See also *Pediatric Specialty Care, Inc., v. Arkansas Dept. of Human Servs.*, 293
25 F.3d 472, 480 (8th Cir. 2002) (early intervention day treatment services); *Chisholm*
26 *v. Hood*, 133 F.Supp.2d 894, 897-99 (E.D. La. 2001) (behavioral and psychological
services).

27 ⁸ Invoking the work product privilege, State Defendants have strenuously resisted
28 discovery as to their written and oral communications with CMS officials, both
before and after Ms. Arden's August 16 letter. Further Newman Decl., at ¶¶ 5-9.

1 Further Newman Decl., at ¶ 4, Exh. 164 at 0876-0903. Their reliance on this letter
2 is misplaced. On close inspection, Ms. Arden allows for the possibility that nearly
3 all the components of wraparound services could be covered either in whole or in
4 part under Medicaid. Second Supp. Redman Decl., at ¶ 16, Exh. 4 at 0533-0534.
5 Yet State Defendants have made no attempts to explore those possibilities.

6 A “careful reading of Ms. Arden’s letter reveals that most of her concerns
7 about coverage of the components” of wraparound services and TFC “are based on
8 CMS needing more information from California.” Second Supp. Redman Decl., at ¶
9 18, Exh. 4 at 0532-0535. States typically provide such detailed information to CMS
10 as part of the process for review and approval of State Medicaid Plan Amendments,
11 and state plan amendment documents contain, for example, a description of both
12 covered and excluded services, provider qualifications and reimbursement
13 methodologies.” *Id.*; *accord*, Knisley Decl., at ¶ 4 (“much of Ms. Arden’s letter . . .
14 is a reflection of the fact that California did not submit a formal State Plan
15 Amendment to CMS”).

16 Ms. Arden’s August 2006 letter also expressed concerns that some
17 components of wraparound services and TFC may not be for the exclusive benefit of
18 the Medicaid-eligible child and therefore are not covered. Second Supp. Redman
19 Decl., at ¶ 21, Exh. 4 at 0532, 0535-0536. While Medicaid does not cover services
20 provided to non-Medicaid family members “for their sole benefit,” Medicaid does
21 cover services provided to family members that “are for the benefit of the Medicaid-
22 eligible child.” *Id.*, at ¶ 21; *accord* Westmoreland Decl., at ¶ 19. Examples of these
23 covered services are family counseling, family involvement in the child’s treatment
24 planning, and family psychoeducation. Second Supp. Redman Decl., at ¶ 21, Exh.
25 10 at 0639-0640;⁹ *accord*, Knisley Decl., at ¶ 27 (discussing covered services to
26

27 Plaintiff’s motion to compel as to these written communications is currently pending
28 before Magistrate Judge Hillman. *Id.*

⁹ See also CMS’ Interim Final Case Management Services Rules, 72 Fed. Reg. at

1 families in the District of Columbia). As Dr. Redman explains, all the references to
2 family participation and/or treatment in Appendices A and B are to services that
3 include families but benefit the Medicaid-eligible child and thus can be covered
4 under Medicaid. Second Supp. Redman Decl., at ¶ 21.

5 Citing the case management provisions of the DRA, Ms. Arden raises further
6 concerns as to whether one component of wraparound services and most
7 components of TFC contain activities that are the responsibility of the child welfare
8 or foster care systems. Second Supp. Redman Decl., at ¶ 22. Dr. Redman shows
9 that these concerns also are unwarranted. Whereas the child welfare and foster care
10 systems are responsible for case management of social services and for placement
11 activities related to providing a home and family for a child, the behavioral health
12 system is responsible for case management of the child's behavioral health
13 conditions and services. Second Supp. Redman Decl., at ¶ 22. Neither the DRA nor
14 other directives from CMS prohibit coverage for "this type of behavioral health case
15 management just because a Medicaid-eligible child is involved in the child welfare
16 or foster care systems." *Id.* Indeed, CMS' interim final rules on case management
17 services state that "a Medicaid eligible child with a mental disorder receiving child
18 protective services may also qualify to receive case management services targeted to
19 children with mental disorders." 72 Fed. Reg. at 68086. Moreover, wraparound
20 services and TFC are mental health services available to children both in and outside
21 of the foster care system; the covered mental health services available to the
22 Medicaid-eligible child are the same regardless of whether the child is involved in

23
24 68092 (contacts with non-eligible individuals are covered case management
25 activities when directly related to identification of the covered individual's needs,
26 identifying needs and supports to assist the individual in obtaining services, and
27 providing feedback to case managers, or alerting case managers to changes in the
28 individual's needs); CMS' Proposed Rehabilitative Services Rules, 72 Fed. Reg. at
45207 (involving parents in the treatment planning process and counseling sessions
for treatment of the child are covered rehabilitative services).

1 the foster care system. Second Supp. Redman Decl., at ¶ 22. In Dr. Redman’s
2 expert opinion, Appendices A and B describe the types of case management
3 activities that are covered under the Medicaid Act, as they do not entail the direct
4 delivery of foster care or child welfare services. *Id.* at ¶ 21; *accord*, Knisley Decl.,
5 at ¶¶ 28-30; Westmoreland Decl., at ¶ 20.

6 Proposed regulations from CMS on rehabilitation services continue prior
7 policy in nearly every respect relevant to this case. *See* 72 Fed. Reg. 452001 (Aug.
8 13, 2007).¹⁰ The one exception is that the proposed rules would prohibit a state’s
9 Medicaid program from paying for TFC as a “package” instead of paying for its
10 component parts. Second Supp. Redman Decl., at ¶ 13. This Court previously
11 found that at least 20 state Medicaid programs cover TFC. *Katie A.*, 433 F.Supp.2d
12 at 1075-76. The proposed regulations, if eventually adopted (which is somewhat
13 questionable),¹¹ would prohibit providers from billing for TFC on a daily rate and
14 would require them to bill separately for each component service. Yet, as Dr.
15 Redman makes clear, this is a billing issue, not a coverage issue. Second Supp.
16 Redman Decl., at ¶ 22, n. 18. Plaintiffs have repeatedly stated that while it is
17 preferable to bill wraparound services and TFC as a single bundled service, it is not
18 required. *Katie A.*, 481 F.3d at 1161 n. 20.

19 CMS’ proposed rules include language prohibiting coverage of services that
20 are “intrinsic elements of programs other than Medicaid,” but also make clear that
21 “medically necessary rehabilitative services” are not intrinsic elements of these
22 other programs. 42 C.F.R. § 441.45(b)(1); 72 Fed. Reg. at 45213. The preamble to
23

24 ¹⁰ The proposed rules, for example, reaffirm coverage for team-based treatment
25 planning that includes the individual’s family and others, education of the covered
26 individual’s family regarding the individual’s disorder and how to manage it, and
comprehensive assessments. *See* Second Supp. Redman Decl., at ¶¶ 13, 21.

27 ¹¹ Just last month, Congress passed a six month moratorium on implementation of
28 the proposed regulations. *See* The Medicare, Medicaid and SCHIP Extension Act of
2007, S. 2499 (Dec. 29, 2007).

1 the proposed rules (not the rules themselves) indicates that “recruitment” and
2 “training” of foster parents, insofar as they are “the responsibility of the foster care
3 system,” are intrinsic elements of foster care and so are not covered by Medicaid.
4 72 Fed. Reg. at 45205. However, as Dr. Redman explains, this language is
5 consistent with Plaintiffs’ claims in this lawsuit.

6 There are two types of TFC recruiting. The first type is recruiting a family to
7 serve as therapeutic foster parents for a specific child for whom TFC has already
8 been determined to be medically necessary. Second Supp. Redman Decl., at ¶ 22.
9 This type of recruiting falls well within the definition of case management services,
10 namely “[r]eferral and related activities to help an individual obtain needed
11 services” and “activities and contacts that are necessary to ensure that the care plan
12 is effectively implemented and adequately addressing the needs of the eligible
13 child.” *Id.* (citing § 1396n(g)(2)(A)(ii)(III) and (IV)). The behavioral health
14 system, not the foster care system, is responsible for case management related to the
15 child’s mental health condition and services. *Id.* Meanwhile, the second type of
16 recruiting is enlisting a family to serve as therapeutic foster parents where the
17 specific child will later be matched with them. *Id.* This type of recruiting is not
18 typically billed as a separate service and is instead factored into the reimbursement
19 rate as an administrative expense for the Medicaid provider agency delivering TFC.
20 *Id.* Many types of administrative expenses are included in the reimbursement rate to
21 providers, such as training and supervision of employees and record-keeping. *Id.*

22 Similarly, there are two types of training for therapeutic foster parents.
23 Training them about the mental health disorder of the specific child for whom they
24 will be caring and on how to manage the child’s disorder is family psychoeducation,
25 which both prior CMS policy and the proposed rules state is a covered rehabilitative
26 service. Second Supp. Redman Decl., at ¶ 22. By comparison, general training on
27 caring for a child with mental health needs is typically not billed as a separate
28 service and is instead factored into the reimbursement rate for the TFC provider

1 agency as an administrative expense. *Id.*

2 In short, Plaintiffs have demonstrated that each component of wraparound
3 services and TFC falls under one or more category of services listed in § 1396d(a).

4 **B. Given Defendants' Position that the Medi-Cal Program Should**
5 **Not Cover Any Component of Wraparound Services or TFC,**
6 **They Cannot Effectively Provide Any Mandated Component.**

7 The second question for this Court to resolve is whether Defendants "have
8 effectively provided each mandated component service." *Katie A.*, 481 F.3d at
9 1163. To resolve this question, Plaintiffs propounded interrogatories to Defendant
10 Shewry as to which components of wraparound services and TFC are currently
11 covered by the Medi-Cal program. Further Newman Decl., at ¶ 4. The responses
12 from DHCS' Director were that "[n]one of the components of wraparound services
13 set forth in Appendix A" and "[n]one of the components of TFC set forth in
14 Appendix B" are "covered as such by the Medi-Cal program." *Id.*, Exh. 164 at
15 0874-0875.

16 The critical phrase in both responses is "as such." There is no dispute that
17 Medi-Cal does not *expressly* cover wraparound services or TFC. On the other hand,
18 Plaintiffs submitted declarations in support of their earlier motion showing that
19 some providers were billing Medi-Cal for some of the activities described under the
20 components of wraparound services and TFC. *See, e.g.*, Farr Decl., at ¶ 24
21 (provider billed 67% of wraparound services to Medi-Cal). Moreover, in opposition
22 to Plaintiffs' earlier motion, State Defendants submitted the Declaration of Rita
23 McCabe, a high ranking DMH official, who allowed for the possibility that six of
24 the nine components of wraparound services and four of the seven TFC components
25 could be covered by Medi-Cal. McCabe Decl., 96-112 at ¶¶ 12-43. The July 2006
26 letter from DMH stated that all the components of wraparound services are currently
27 covered by Medi-Cal. Further Newman Decl., Exh. 163 at 0864-0865. Lastly, the
28 Ninth Circuit found "evidence in the record that Medi-Cal currently reimburses
providers for at least some components of wraparound and TFC." *Katie A.*, 481

1 F.3d at 1158.

2 However, on October 2, 2007, Ms. McCabe appeared on DMH's behalf at a
3 deposition pursuant to Fed. R. Civ. P. 30(b)(6) to testify about, *inter alia*, "which, if
4 any, services and activities" that are described under the nine components of
5 wraparound services in Appendix A and the seven components of TFC in Appendix
6 B "are currently covered by the Medi-Cal program." Further Newman Decl., Exh.
7 167 at 0961-0962. Under Rule 30(b)(6), a "corporate deponent has an affirmative
8 duty to make available 'such number of persons as will' be able 'to give complete,
9 knowledgeable and binding answers' on its behalf." *Reilly v. Natwest Markets*
10 *Group Inc.*, 181 F. 3d 253, 268 (2nd Cir. 1999) (citation omitted). An entity must
11 "prepare its selected deponent to adequately testify not only on matters known by
12 the deponent, but also on subjects that the entity should reasonably know." *Hooker*
13 *v. Norfolk Southern Railway Co.*, 204 F.R.D. 124, 126 (S.D. Ind. 2001).

14 At the deposition, Ms. McCabe testified unequivocally that Medi-Cal should
15 not be reimbursing providers for any of the components of wraparound services in
16 Appendix A or any of the components of TFC in Appendix B. Further Newman
17 Decl., Exh. 167 at 0964-1029. Taking Ms. McCabe at her word, Medi-Cal does not
18 currently cover any component of either wraparound services or TFC.¹² If, as State
19 Defendants insist, Medi-Cal should not be providing any component of wraparound
20 services or TFC, then it would be impossible for State Defendants to provide
21 effectively any mandated component of either mental health service to class

22 **C. To Be Effective, All the Components of Wraparound Services**
23 **and TFC Must Be Provided and Must Be Coordinated.**

24 The last question for this Court to resolve is "whether the State should be
25 required to provide the required services in another manner which will render such

26 ¹² Even if Ms. McCabe was not telling the truth at her deposition and the Medi-Cal
27 program does currently cover at least some components of wraparound services and
28 TFC, all the components of these mental health services must be provided and must
be provided in a coordinated fashion to be effective (*see* pages 17-21 *infra*).

1 services effective, or proceed directly to wraparound and TFC.” *Katie A.*, 481 F.3d
2 at 1163. Plaintiffs do not contend that California must provide wraparound services
3 and TFC as a bundled service under Medi-Cal. *See* page 14 *supra*. Instead,
4 Plaintiffs contend that these services are medically necessary for class members.
5 There is little, if any, dispute on this issue. *Katie A.*, 433 F.Supp.2d at 1076-77.

6 A battery of mental health experts agree that all the components of
7 wraparound services and TFC in Appendices A and B are necessary and that they all
8 must be provided in a coordinated fashion to be effective. *See, e.g.*, Supp. Bruns
9 Decl., at ¶¶ 8-10, 16, 24, 31, 33; Supp. Huffine Decl., at ¶¶ 6, 7, 10-12, 15, 21;
10 Supp. Friedman Decl., at ¶¶ 6, 7, 10, 14-16, 19; Second Supp. Chamberlain Decl.,
11 at ¶¶ 9-11, 17, 18, 23; Supp. Kamradt Decl., at ¶¶ 3, 8, 9, 11; Supp. Penrod Decl., at
12 ¶¶ 4, 6, 7, 19, 22, 26-29; Rauso Decl., at ¶¶ 5, 12.; Bhattacharya Decl., at ¶ 9; Berrick
13 Decl., at ¶¶ 4, 28, 41; Champion Decl., at ¶¶ 10, 17. These experts attest to the need
14 for each component of both wraparound services and TFC. *See, e.g.*, Supp. Farr
15 Decl., at ¶¶ 3-8; Supp. Kamradt Decl., at ¶¶ 4-10; Chamberlain Decl., at ¶ 12.

16 A respected Sacramento wraparound provider, for instance, offers some of the
17 reasons for forming a child and family team (“CFT”) versus intensive case
18 management services, which is the closest alternative to wraparound services. Supp.
19 Farr Decl., at ¶ 3. “[E]ven if a case manager is attentive, engaged and thoughtful,
20 that arrangement is not an adequate substitute for a functioning child and family
21 team.” *Id.* A “good case manager assumes most responsibilities for a child’s mental
22 health services,” which nonetheless creates “dependence by the child and his or her
23 family on a system of formal supports – namely the case manager and the services
24 the case manager can arrange for the child.” *Id.* A CFT ensures participation by
25 the child and family in making and implementing important decisions in the child’s
26 life and thereby actively regaining control over their lives. *Id.*; *see also* Supp.
27 Penrod Decl., at ¶ 23 (CFT “acts as the ‘glue’ to coordinating the implementation of
28 all the components of wraparound services, and the team itself functions as a mode

1 of treatment”); Supp. Bruns Decl., at ¶ 18 (research has found better outcomes
2 through the “provision of services through a treatment team”).

3 The “gold standard” in the mental health field is an “evidence-based practice”
4 where there have been randomized clinical trials of a treatment. Chamberlain Decl.,
5 at ¶ 14; *see also* Friedman Decl., at ¶¶ 19-21. TFC and, more recently, wraparound
6 services are both considered “evidence-based practices.” Supp. Friedman Decl., at
7 ¶¶ 12; Supp. Bruns Decl., at ¶¶ 20, 30; Second Supp. Chamberlain Decl., at ¶ 15.
8 “As a general proposition regarding evidence-based practices, there is no evidence,
9 and no reason to believe, that the intervention will be effective if you vary the
10 method of providing it from the way it was designed, developed and researched.”
11 Supp. Friedman Decl., at ¶ 13; *accord*, Supp. Huffine Decl., at ¶ 14; Second Supp.
12 Chamberlain Decl., at ¶ 16.

13 Studies have borne out the importance of providing all the components of
14 wraparound services and TFC. One study by Dr. Eric Bruns found that “as
15 adherence to wraparound’s core components increased, so did the improvements in
16 outcomes for the children and their families, including better improvements in
17 child’s behavior,” “less restrictive arrangements for the child,” and “increased
18 family perception that their children were making progress.” Supp. Bruns Decl., at
19 ¶ 29. Another study by Dr. Bruns of children with mental health needs in Nevada’s
20 child welfare system found that the “more that the wraparound provider adhered to
21 the core components,” “the better the outcomes would be for children and their
22 families,” such as greater declines in behavior problems, increased functional
23 improvements, less restrictive living arrangements and more placement stability.
24 *Id.*, at ¶ 28.; *see also* Supp. Friedman Decl., at ¶ 18 (multi-site Department of
25 Defense wraparound project did not provide all the components and did not
26 coordinate the components that were provided and, as a result, there were not
27 statistically significant differences between children in the program and those
28 receiving traditional mental health services). In Maryland, researchers found the

1 positive impact on children receiving TFC was likely to be reduced when some TFC
2 programs did not provide intensive training to therapeutic foster parents, did not
3 actively support them in implementing the treatment plan, or did not adequately
4 supervise them. Supp. Bruns Decl., at ¶ 32; *see also* Second Supp. Chamberlain
5 Decl., at ¶ 19 (nationwide study of several TFC programs found significant
6 variations in the components of services and that only MTFC, a TFC program that
7 provides all of the components in a coordinated fashion, proved an effective
8 intervention for children).

9 This Court has remarked that members of the class “have ‘complex needs
10 [and are] particularly vulnerable.’” *Katie A.*, 433 F.Supp.2d at 1068 (*quoting Rosie*
11 *D.*, 410 F.Supp.2d at 33-34). Foster children can be involved in multiple systems,
12 such as child welfare, mental health, probation and others [Rauso Decl., at ¶ 12] and
13 often are receiving care from more than one provider. *See, e.g.*, Supp. Farr Decl., at
14 ¶ 10 (psychiatrist prescribes medications, therapist provides individual or group
15 therapy, third professional provides TBS). It is critical that everyone in a child’s life
16 be working together to meet the child’s needs. Supp. Kamradt Decl., at ¶ 8.

17 Absent coordination of services, one provider might do everything possible to
18 keep the child in the home while another is trying to remove the child. *Id.* at ¶ 9.
19 Without coordination, problems can also arise when providers differ on issues such
20 as treatment strategies, whether the child should remain in public school, or whether
21 the father should play an important role in the child’s life. *Id.*; *see also* Supp.
22 Huffine Decl., at ¶ 19 (“child and family are pulled in a variety of directions by
23 different obligations and approaches and there is a replication of efforts by different
24 child-serving agencies”). Ultimately, “[s]uch disjointed or competing assignments
25 or orders from different providers or systems” can set “the child and family up for
26 failure.” Rauso Decl., at ¶ 12; *see also* Hughes-Malara Decl., at ¶ 14 (“setting up
27 the family to fail” without team’s coordination of services); Supp. Bruns Decl., at ¶
28 27 (effectiveness of wraparound services depends upon providing all the

1 components in a “coordinated fashion,” that is the “services are interrelated and
2 interconnected”); Second Supp. Chamberlain Decl., at ¶ 18 (to be effective TFC
3 “must be provided as an integrated service,” which means that the “components are
4 interrelated and must be coordinated”).

5 To give one example of the need for coordination, providers in Nebraska of
6 multi-systemic therapy (“MST”), a treatment for children with anti-social behavior,
7 originally insisted on providing services independent of the wraparound team but
8 quickly found that the children were not having the expected positive outcomes.
9 Supp. Friedman Decl., at ¶ 18. Once the MST providers were integrated into the
10 wraparound team, Nebraska found that children’s mental health was improving. *Id.*;
11 *accord* Supp. Penrod Decl., at ¶ 24 (Arizona discovered that “the best way” to
12 ensure effective services was to have the CFT work with providers and coordinate
13 the child’s care).

14 “Just as all the people who build a building do not work on their own, so too
15 all the people who help a child with mental health needs cannot operate on their
16 own.” Supp. Kamradt Decl., at ¶ 9. In sum, the facts and law clearly favor
17 Plaintiffs on all three remaining issues regarding their Medicaid claims.

18 **II. The Facts and Law Clearly Favor Plaintiffs on Their Claims under** 19 **the ADA and the Rehabilitation Act.**

20 Apart from the Medicaid Act, Plaintiffs are also entitled to relief under Title
21 II of the ADA, § 12102(2), and Section 504 of the Rehabilitation Act, 29 U.S.C. §
22 794.¹³ The regulations implementing Title II mandate that public entities administer
23 their services to individuals with disabilities in the “most integrated setting
24 appropriate” to their needs [28 C.F.R. § 35.130(d)], which means “a setting that
25 enables individuals with disabilities to interact with non-disabled persons to the
26 fullest extent possible.” 28 C.F.R. pt. 35, App. A, p. 543 (2004).

27 ¹³ Plaintiffs’ analysis of the ADA applies equally to Section 504. *See Miranda B. v.*
28 *Kitzhaber*, 328 F.3d 1181, 1188 (9th Cir. 2003). State officials are appropriate

1 Class members qualify as persons with disabilities under the ADA. *See* 42
2 U.S.C. § 12102(2) (disability includes a mental impairment that substantially limits
3 one or more major life activities). The class consists of children who “have a mental
4 illness or condition” and who “need individualized mental health services. . . .”
5 Order dated June 18, 2003, at 21-22. These children are substantially limited in
6 major life activities, such as caring for themselves, interacting with others and
7 learning. *See, e.g.*, Smith Decl., at ¶¶ 4, 8, 11, 12; Truesdale Decl., at ¶¶ 3, 4, 7-10.

8 In *Olmstead v. L.C.*, 527 U.S. 581, 119 S.Ct. 2176, 144 L.Ed.2d 540 (1999),
9 the Supreme Court held that the ADA prohibits unnecessary institutionalization of
10 individuals with disabilities. *Id.* at 587; *see also ARC of Washington State Inc. v.*
11 *Braddock*, 427 F.3d 615, 618 (9th Cir. 2005)(“states are required to provide care in
12 integrated environments for as many disabled persons as is reasonably feasible, so
13 long as such an environment is appropriate to their mental health needs”). States are
14 required to transfer individuals with disabilities from institutional to community
15 settings if: (1) the individual is appropriate for community placement, (2) the
16 individual does not oppose such a placement, and (3) the community placement
17 could be reasonably accommodated. *Olmstead*, 527 U.S. at 587, 607.¹⁴

18 By failing to provide wraparound services and TFC to class members who
19 need and want these services, State Defendants are unnecessarily institutionalizing
20 individuals with mental disabilities in congregate care, emergency psychiatric
21 wards, psychiatric hospitals and juvenile detention facilities. *See, e.g.*, Findings at
22 ¶¶ 32 and 39 (more than half the foster children in RCL facilities of 12 and above
23 could be served in family settings). A cadre of children’s mental health experts has
24 discussed how wraparound services and TFC prevent unnecessary placement of
25 children in institutional settings. *See, e.g.*, Supp. Bruns Decl., at ¶¶ 8-9; Supp.

26
27 defendants under the ADA. *Id.* at 1187-89.

28 ¹⁴ Plaintiffs addressed in greater detail each of these requirements in their prior
motion for preliminary injunction (a copy of which has been provided to the Court).

1 Friedman Decl., at ¶ 5; Kamradt Decl., at ¶¶ 1, 3, 11-15, 19. Wraparound
2 Milwaukee has been able to return more than 80% of these children to their homes
3 or communities. Kamradt Decl., at ¶ 12. In Los Angeles County, more than 90%
4 (49 of 52) children were no longer in DCFS’ jurisdiction as a result of receiving
5 wraparound services. Rauso Decl., at ¶¶ 14-18. Similarly, Sacramento County has
6 reduced the number of youths with serious mental health needs living in RCL
7 facilities of 12 and above. Farr Decl., at ¶¶ 2, 7-13; *see also* Champion Decl., at ¶¶
8 6, 7, 12 (Santa Clara County wraparound program). Butte County halved the
9 number of group placements by providing intensive services, including wraparound
10 services.¹⁵ Indeed, State officials have admitted that wraparound services have
11 allowed children to live with families and in their own communities instead of in a
12 more restrictive setting. *See, e.g.*, Treadwell Deposition (“Depo.”) at 126:11-18
13 (DSS official); Neilsen Depo. at 158:4-159:18 (DMH official). Thus, one
14 nationwide expert correctly concluded that “wraparound programs enable children
15 with behavioral, psychiatric, ... impairments to function as well and as normally as
16 possible in as unrestrictive a setting as possible.” Lourie Decl., at ¶¶ 4-11, 13.

17 The results with TFC programs are just as encouraging, including the oft-
18 evaluated and heavily praised MTFC program in Oregon. Chamberlain Decl., at ¶¶
19 1, 2, 13-17. TFC programs in San Diego and Alameda Counties have also had
20 success. Watrous Decl., at ¶¶ 5-7; Berrick Decl., at ¶¶ 34-37. An expert who has
21 worked with thousands of children reports that TFC “has not only permitted
22 countless number of children to live in their communities, but also has ensured that
23 many of these children grow up to lead relatively normal lives....” Grealish Decl.,
24 at ¶¶ 1-4, 31. The Surgeon General has described TFC as “the least restrictive form
25 of out-of-home therapeutic placements for children with severe mental disorders.”¹⁶

26
27 ¹⁵ Letter dated January 31, 2003, from Bradford R. Luz, Director of Butte County
28 Department of Behavioral Health, Exh. 117 at 579-80.

¹⁶ *Mental Health: A Report of the Surgeon General* (1999), Exh. 105 at 391.

1 Turning to the second requirement in *Olmstead*, 527 U.S. at 587, Plaintiffs
2 have no interest in overriding any class member’s wishes to remain institutionalized
3 but that is not likely to be the majority view. Hence, one foster child who wanted
4 “desperately” to be placed in a home-like setting recently left her group home and
5 got into a car with a pimp, later stating that she “would rather be a prostitute than
6 live at [the RCL 14 facility].” Smith Decl., at ¶¶ 3, 4, 15 and 17; *see also* Further
7 Farr Decl., at ¶¶ 12-16 (girl wanted “out of shelter”). Plaintiffs merely want to give
8 class members the option of receiving wraparound services or TFC and thereby
9 remaining at home or in a home-like setting.¹⁷

10 Finally, Plaintiffs have shown that the community placements could be
11 reasonably accommodated and that it would not be a fundamental alteration to
12 transfer class members into, or maintain them in, community settings. § 12132; 28
13 C.F.R. § 35.130(b)(7). State Defendants lack a “fundamental alteration defense”
14 here. *Olmstead*, 527 U.S. at 603-04. They cannot demonstrate that, taking into
15 account the cost of providing the services, the needs of others with disabilities, and
16 the resources available to the state, it would be a fundamental alteration to furnish
17 community services to the Plaintiffs. *Id.* at 587, 607; *see also Pennsylvania*
18 *Protection and Advocacy, Inc. v. Pennsylvania Dept. of Public Welfare*, 402 F.3d
19 374, 380 (3rd Cir. 2005) (“though clearly relevant, budgetary constraints alone are
20 insufficient to establish a fundamental alteration defense”).

21 The Ninth Circuit clarified the meaning of the fundamental alteration defense
22 in *Townsend v. Quasim*, 328 F.3d 5111 (9th Cir. 2003). The *Townsend* court
23 observed that “*Olmstead* and the integration regulation would be effectively gutted”
24 if a state could avoid providing community-based services simply because it has
25 chosen to provide those services only in an institution. *Id.* As the Ninth Circuit

26
27 ¹⁷ The living conditions in group homes can be brutal. *See, e.g.*, Lowe Decl, at ¶ 7
28 (child physically assaulted and sexually victimized by staff or peers); Hardy Decl.,
at ¶¶ 22 and 35 (child sexually molested).

1 elaborated, “*Olmstead* did not regard the transfer of services to a community setting,
2 without more, as a *fundamental* alteration.” *Id.* at 519 (italics in original); *see also*
3 *Radaszewski ex rel. Radaszewski v. Maram*, 383 F.3d 599, 611 (7th Cir. 2004)
4 (plaintiffs need not prove that the community-based services “already exist in
5 exactly the same form in the institutional setting”). The *Townsend* court ruled that
6 the state would be able to show a fundamental alteration *only* if it could prove that:
7 (1) extending community services would create greater expenses for the Medicaid
8 program because individuals who would have refused costly nursing home care
9 would now exercise the new entitlement to community-based services, *and* (2) those
10 expenses would compel cuts in services to other Medicaid recipients. 328 F.3d at
11 520. Neither of these concerns is present in the instant case.

12 Unlike the *Townsend* plaintiffs, who sought a new Medicaid service to which
13 they were not currently entitled, Plaintiffs in this case only seek mental health
14 services that the state is already obligated to provide under Medicaid – wraparound
15 services and TFC. State Defendants cannot credibly argue that complying with the
16 Medicaid Act will require them to cut services to other Medicaid recipients.
17 Compare *ARC of Washington State Inc.*, 427 F.3d at 617 (suit challenged cap on a
18 waiver program for community-based services to developmentally disabled
19 individuals where the cap “was expressly contemplated by the Medicaid waiver
20 provisions”). The cost of meeting current Medicaid obligations to Plaintiffs is not a
21 cost that may be balanced against the needs of other individuals as part of the
22 fundamental alteration defense. Furthermore, there is not much, if any, risk that
23 providing wraparound services and TFC would create significant additional costs
24 that would compel cutbacks to other Medi-Cal recipients.¹⁸ *See, e.g., Chamberlain*

25
26 ¹⁸ Richard P. Barth, *Institutions vs. Foster Homes: The Empirical Base for the*
27 *Second Century of Debate* (2002), Exh. 129 at 792 (monthly costs of placing a foster
28 child in institutional care “can be 6 to 10 times as high as foster care and 2 to 3
times as high as treatment foster care”).

1 Decl., at ¶ 26; Champion Decl., at ¶¶ 13-15; Kamradt Decl., at ¶¶ 16-17; Farr
 2 Decl., at ¶ 20. Los Angeles County has estimated a \$3 million savings in placement
 3 costs alone for providing wraparound services instead of group care to just 52
 4 children. Rauso Decl., at ¶ 20.

5 In short, State Defendants are unable to prove the fundamental alteration
 6 defense, and Plaintiffs are likely to prevail on their ADA claims.

7 **III. The Balance of Hardships Tips Sharply in Favor of Plaintiffs.**

8 Generally, in Medicaid cases, “[t]he nature of [plaintiffs’] claim — a claim
 9 against the state for medical services — makes it impossible to say that any remedy
 10 at law could compensate them.” *McMillan v. McCrimon*, 807 F.Supp. 475, 479
 11 (C.D. Ill. 1992). In particular, irreparable injury is shown where a State denies
 12 “needed medical care” to Medicaid recipients. *Beltran v. Meyers*, 677 F.2d 1317,
 13 1322 (9th Cir. 1982). “[T]o allow a serious illness to be untreated until it requires
 14 emergency hospitalization is to subject the sufferer to the danger of a substantial and
 15 irrevocable deterioration in his health.” *Memorial Hosp. v. Maricopa County*, 415
 16 U.S. 250, 261, 94 S.Ct. 1076, 39 L.Ed.2d 306 (1974).

17 As a Butte County official warned, the “consequences of youth needing
 18 mental health services and not receiving them are great.”¹⁹ Six youths committed
 19 suicide in that county alone during one year.²⁰

21 ¹⁹ Letter dated July 13, 2000, from Michael W. Clarke, Assistant Director of Butte
 County Department of Behavioral Health, Exh. 118 at 581-82.

22 ²⁰ *Id.*; see also Bialik Decl., at ¶¶ 3, 4, 14, 16, 20 and 21 (foster youth who “enjoys
 23 reading, math, and sports” and “wants to go to college” became “increasingly
 24 depressed and desperate” when Contra Costa County refused to move him into a
 25 foster home with therapeutic foster care and so he is “currently detained in Juvenile
 26 Hall”); Frakes Decl., at ¶¶ 2, 3, 5, 10-23 (class member who has a “quick wit,” “is
 27 very good at arts and crafts,” and was at least “fully capable” at one time “of
 28 performing at grade level in school,” was unable to receive a majority of the
 wraparound services that the county had promised and so his difficult behaviors
 escalated to the point that his foster mother eventually had to ask for his removal
 from her home).

1 This lawsuit presents the classic “win-win situation.” Not only will Plaintiffs
2 benefit from the granting of the preliminary injunction, but so will the State
3 Defendants. For many class members, the alternatives to wraparound services and
4 TFC will be more expensive placement in a group home, Community Treatment
5 Facilities or juvenile hall.²¹ County after county has found that wraparound services
6 and TFC are cheaper than group home care.²²

7 Perhaps, for some foster children, wraparound services and TFC may be more
8 expensive in the short term than the existing alternatives. Even so, the Ninth Circuit
9 once stated that the “physical and emotional suffering shown by plaintiffs in the
10 record before us is far more compelling than the possibility of some administrative
11 inconvenience or monetary loss to the government.” *Lopez v. Heckler*, 713 F.2d
12 1432, 1437 (9th Cir. 1983), *rev’d in part on other grounds, Heckler v. Lopez*, 463
13 U.S. 1328, 104 S.Ct. 10, 77 L.Ed. 2d 143 (1983). “Faced with such a conflict
14 between the financial concerns and preventable human suffering,” that Court had
15 “little difficulty concluding that the balance of hardships tips decidedly in plaintiffs’
16 favor.” *Id.* (refusing to stay a preliminary injunction costing more than \$20 million
17 per month). In *Rodde v. Bontá*, 357 F.3d 988, 999 (9th Cir. 2004), the Ninth Circuit
18 affirmed a preliminary injunction despite Los Angeles County’s estimates that it
19 would be losing \$58 million annually. Here, even assuming the State might lose
20 some money if relief is granted, such losses still pale by comparison to the

21
22 ²¹ DSS, *Foster Care Rates Group Home Facility Listing*, Exh. 123 at 610 (monthly
23 payments per child are \$5,613 for a RCL 12 facility and \$6,371 for a RCL 14
24 facility); Hatekayama Depo. at 137:17-24; Letter dated July 13, 2000, from Michael
25 W. Clarke, Assistant Director of Butte County Department of Behavioral Health,
26 Exh. 118 at 581-82. DMH, *Status of the Implementation of the Community
27 Treatment Facilities* (April 2001), Exh. 110 at 417. Incarceration alone can cost
28 more than \$3,000 per month. *Young Hearts and Minds*, Exh. 101 at 91.

²² SB 163 Wraparound Final Evaluation, Mono County, Exh. 135 at 969;
Mendocino County’s SB 163 Children’s Wraparound Services Pilot Project Final
Report, Exh. 136 at 971; Berrick Decl., at ¶¶ 29-38 (Alameda County).

1 preventable human suffering that class members will endure if the preliminary
2 injunction is denied.

3 Moreover, “the public interest is a factor to be strongly considered” in
4 granting a preliminary injunction to assure Medicaid recipients essential medical
5 services. *Lopez*, 713 F.2d at 1437. The Ninth Circuit has cautioned that the
6 “government must be concerned not only with the public fisc but also with the
7 public weal,” adding that “[o]ur society as a whole suffers when we neglect the
8 poor, the hungry, the disabled, or when we deprive them of their rights or privileges.
9 . . .” *Id.* Here, it is in the public interest to protect the legal rights of the Plaintiff
10 class, foster children who are both poor and disabled. Thus, Plaintiffs have met all
11 of the requirements for a preliminary injunction.

12 CONCLUSION

13 For the foregoing reasons, Plaintiffs respectfully submit that the Court should
14 grant Plaintiffs’ motion for preliminary injunction. The Court should grant much
15 the same relief as was granted last time. *See Katie A.*, 433 F.Supp.2d at 1078-79.
16 Plaintiffs also urge appointment of a Special Master. *Id.* at 1079 (raising possibility
17 of such appointment). Finally, the Court should exercise its discretion and not
18 require the posting of a bond where, as here, an injunction is sought by a class of
19 indigent plaintiffs. *See People of State of Cal. ex rel. Van De Kamp v. Tahoe*
20 *Regional Planning Agency*, 766 F.2d 1319, 1325-26 (9th Cir. 1985); *Orantes-*
21 *Hernandez v. Smith*, 541 F. Supp. 351, 385 n. 42 (C.D. Cal. 1982).

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