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UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA/WESTERN DIVISION

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

Plaintiffs,

v.

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

Defendants.

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

[CLASS ACTION]

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

Date: October 3, 2005
Time: 9:00 a.m.
Courtroom: 14

I. INTRODUCTORY STATEMENT

Each day thousands of foster children in California are needlessly confined in locked hospital wards and other institutional facilities or are needlessly placed in large group homes. Yet these children could remain in their own homes and communities if only they were provided the full range of mental health services to which they are entitled under federal law. A battery of experts who have submitted declarations in support of this motion, as well as the Surgeon General and the state's respected Little Hoover Commission, all agree that foster children must have available the full range of treatment services. For foster children, the full range of treatment services includes wraparound services and therapeutic foster care ("TFC") as they are "among the most effective integrated community-based interventions for children with emotional, behavioral, and mental health disorders." Bruns Declaration ("Decl."), at ¶ 3. Indeed, California's leading mental health research institute has identified wraparound services and TFC as the "[o]nly two intervention models [that] have demonstrated effectiveness in the treatment of foster children."[1]

Yet California's Medicaid program, known as Medi-Cal, does not cover either wraparound or TFC. For many children, the absence of these services has resulted in the unnecessary and preventable decline in their mental health. To give just one example, a court-appointed expert recommended wraparound services and TFC for "Charlie," an emotionally disturbed eight-year old subjected to prenatal drug exposure and early parental abuse, so that this boy could eventually be placed with his loving and committed grandmother. Burgess Decl., at ¶¶ 3-5. However, because wraparound services and TFC were not available in his county, this young class member only deteriorated in foster care, "bounc[ing] from placement to placement for the next four years," each more restrictive and costly, only to end up in

[1] California Institute for Mental Health, *Evidence-Based Practices in Mental Health Services for Foster Youth* (March 2002) ("CIMH Report"), Exhibit ("Exh.") 104 at 323, 328-30.

Metropolitan State Hospital, which even state officials describe as the "end of the line." Lowe Decl., at ¶¶ 8-11; Deposition ("Depo.") of Teri Barthels (Volume ("Vol.") I) at 117:5-24.

To prevent similar tragedies from occurring, plaintiffs are moving for a preliminary injunction compelling the California Departments of Health Services, Social Services and Mental Health to make wraparound services and TFC available to all class members on a consistent statewide basis through the Medi-Cal program or other means. These State Defendants should be given 30 days to develop a plan and another 30 days thereafter to provide the actual services.

Plaintiffs are likely to succeed on the merits of their claims under the Early and Periodic Screening, Diagnosis and Treatment provisions of the Medicaid Act because wraparound services and TFC are medically necessary to correct or ameliorate the mental health conditions of many class members. In fact, the Medicaid programs in several other states already provide both wraparound and TFC to eligible children and youth under age 21. Why not California? Plaintiffs are also likely to succeed on the merits of their claims under the Americans with Disabilities Act ("ADA"). Without consistent access to these Medicaid covered services, class members face needless institutionalization in costly and restrictive group homes and hospitals, in violation of the integration mandate of the ADA, which requires that a state provide services such as Medicaid in the most integrated setting appropriate to an individual's needs.

The balance of hardships tips sharply in favor of the plaintiff children. Each day that passes marks another day lost for class members whose conditions steadily worsen without access to wraparound and TFC – services that experts say can turn around a child's negative trajectory and produce virtual miracles. A preliminary injunction directing the state to implement these two much needed services will give these children hope.

II. STATEMENT OF FACTS

A. The Majority of Foster Children Have Significant Mental Health Needs.

As of July 1, 2004, 85,268 children were in child welfare-supervised foster care in California.[2] California's Little Hoover Commission, a "watchdog" agency created by the state legislature, has stated that nearly 70% of children in foster care system in California will experience a mental health problem.[3] The California Health and Human Services ("CHHS") Agency has given even higher estimates of the prevalence of mental illness among foster children, citing one study which found that 84% of a sample of 213 foster children had developmental, emotional, and/or behavioral problems.[4]

The California Institute for Mental Health ("CIMH") has summarized the reasons why foster children are at risk: first, their entry into the child welfare system resulted from a family breakdown due to abuse, neglect, or both; second, the children suffer disruptions in their relationships when they are separated from family, friends and teachers to enter foster care; third, children who suffer the chronic stresses of living in poverty are over-represented in the child welfare system; and fourth, the "foster care experience itself may actually exacerbate emotional and behavioral problems" since multiple placements are common and the length of placement is often indeterminate.[5]

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[2] B. Needell, *et al*., 1998-2004 July 1 Caseload Children in Child Welfare Supervised Foster Care by Placement Type in California, Exh. 106 at 393-94.

[3] *Young Hearts & Minds: Making a Commitment to Children's Mental Health* (October 2001) (hereafter "*Young Hearts*"), Exh. 101 at 134.

[4] CHHS Foster Care Slide Presentation, Exh. 133 at 963-64. *See also Code Blue: Health Services for Children in Foster Care* (December 1998), Exh. 113 at 449 (50 to 60% of foster children in California have "moderate to severe mental health problems"); California Mental Health Planning Council, *California Mental Health Master Plan: A Vision for California* (March 2003), Exh. 132 at 946 (depending on the study, the estimated percentage of children entering the foster care system with significant mental health problems ranges from 35 to 85%).

[5] CIMH Report, Exh. 104 at 336.

B. <u>The Medi-Cal Program Has Failed to Meet the Mental Health Needs of Many Foster Children.</u>

Nearly all foster children are eligible to receive medical services, including mental health services, from Medi-Cal, California's Medicaid program.[6] Medicaid is a joint federal and state program designed to provide medical and remedial services to low-income people. 42 U.S.C §1396 *et seq*. The Department of Health Services ("DHS") is the single state agency responsible for supervising the administration and operation of the Medi-Cal program. *Emily Q.*, 208 F.Supp. 2d at 1088. DHS has, however, entered into an interagency contract so that the Department of Mental Health ("DMH") has assumed responsibility for supervising the administration of mental health services to Medi-Cal recipients and other indigent persons. *Id.* at 1089. On a county level, the Mental Health Plans ("MHPs") are responsible for providing mental health services to Medi-Cal recipients. *Id.*

In past years California has ranked last among the 50 states on average Medicaid expenditures on foster children.[7] The Little Hoover Commission has warned that "[m]ore than 50,000 children in the foster care who may need mental health services do not get them."[8] A DMH official confirms that "we are unable to provide adequate services to all foster children." Neilsen Depo. at 112:18- 113:9. An official with Los Angeles County likewise admits that only 14% of the foster children in that County are receiving mental health services whereas "research tells

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[6] *Emily Q. v. Bontá*, 208 F. Supp. 2d 1078, 1088 (C.D. Cal. 2001); Hatekayama Depo. at 47:18-48:4 ("almost 100 percent" of children in foster care are "eligible for Medicaid services"). Foster children are automatically eligible for Medicaid if they receive Title IV-E foster care assistance. 42 U.S.C. § 1396a(a)(10)(A)(i)(I). Other foster care children can still qualify for Medicaid through one of the other mandatory eligibility categories, such as receiving supplemental security income [*id.* at § 1396a(A)(10)(A)(i)(II)], or one of the optional categories, such as being "medically needy" [*id.* at § 1396a(A)(10)(A)(ii].

[7] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Health Conditions, Utilization and Expenditures of Children in Foster Care* (September 2000), Exh. 121 at 595 and 600.

[8] *Young Hearts*, Exh. 101 at 87*; see also* Little Hoover Commission, *Still in Our Hands: A Review of Efforts to Reform Foster Care in California* (February 2003) (hereafter *"Still in Our Hands"*), Exh. 9 at 50.

us . . . that between 40 and 80 percent of the kids in foster care would need mental health services." Hatekayama Depo. at 125:19-126:15, 160:10-162:14.

Because foster children have no source of medical care besides Medi-Cal, they also suffer from the Medi-Cal program's overall problems in meeting the mental health needs of poor children: "limits on services – including limits on who can be served and when they can be served"; "[s]hort term treatment goals are given a higher priority than services to address long-term outcomes"; and "funding rules do not create incentives that encourage counties to provide children the most cost-effective treatment."[9]

The experiences of many class members unfortunately reflect these broader problems in the foster care and mental health systems. One mother describes in excruciatingly painful detail the experiences of her 15-year old daughter, Kayla. Centobie Decl., at ¶¶ 1-39. In eighteen months in Merced County's foster care system, Kayla was shunted through 9 different residential placements and 11 psychiatric hospitalizations, including a group home in Redding, which was six hours away from her mother. *Id.* at ¶¶ 1, 2 and 8. Rather then helping Kayla, each new placement contributed to her distress: in one she was beaten by older girls and in another she ran away and was raped while she wandered the streets. *Id*., at ¶¶ 8, 13. She continually attempted suicide and cut her arms with a knife and a razor. *Id.* at ¶¶ 6, 8, 15 and 22. Despite this history and a diagnosis of severe depression and other serious mental disorders, the local child welfare agency eventually told Ms. Centobie that "there was nothing they could do for" her daughter and that "the only way Kayla would get the services she needed was through the probation department." *Id.*, at ¶¶ 6, 8, 15, 17, 22, 33. Kayla is now in jail. *Id*., at ¶ 37.

Kayla's story is all too typical. Approximately 9,000 foster children are placed in group homes.[10] A significant percentage of these foster children, perhaps more

[9] *Young Hearts*, Exh. 101 at 96.

[10] DSS, *Reexamination of the Role of Group Care in a Family-Based System of Care*

(Footnote continued)

than 50%, are in high level group homes, namely Rate Classification Level ("RCL") facilities of 12 and above.[11] As of February 2004, Los Angeles County alone had 2,160 foster children in group homes, including 405 children under age 12 and a "shocking" 122 children ages 8 and below.[12] Another 2900 foster children in California are placed outside the state.[13]

By all accounts, the "delivery of treatment" is not "the primary purpose of group homes for foster children." Barthels Depo. (Vol. I) at 81:3-22. A top State DMH official admits that residential care is not an "evidence-based" practice with the exception of TFC. Neilsen Depo. at 187: 9-18. On the contrary, "the evidence is negative, mixed, or shows no effect for institutionally-based interventions – in hospital, residential or group home settings"[14] "Children in group care almost certainly also experience fewer interpersonal experiences that support their well-being, including the chance to develop [a] close relationship with a significant individual who will make a lasting, legal commitment to them."[15]

Like Kayla, foster children with high-level mental health needs often experience multiple placements and placement disruptions because they are not provided with the services they desperately need.[16] The Department of Social Services ("DSS"), which is responsible for administering the foster care system, has

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(June 2001)(60% of 15,000), Exh. 103 at 276 and 279.

[11] S*ee Katie A.* Advisory Panel, *Third Panel Report to the Court* (hereafter "*Third Panel Report),* Exh. 140 at 998 (nearly 60% of foster children in Los Angeles County in RCL facilities are in RCL facilities of 12 and above). Group homes in California are classified into RCLs of 1-14, using a point system designed to reflect the level of care and services they provide. DSS, *Reexamination of the Role of Group Care in a Family-Based System of Care*, Exh. 103 at 282.

[12] *Third Panel Report*, Exh. 140 at 998-1000.

[13] DSS, *Child Welfare Services/Case Management System: Total Children in Supervised Out of Home Placements by Placement - June 2003*, Exh. 112 at 444.

[14] CIMH Report, Exh. 104 at 361; *see also* Bruns Decl., at ¶ 15 ("near absence of outcome data" to support residential treatment and psychiatric hospitalization).

[15] Richard P. Barth, *Institutions vs. Foster Homes: The Empirical Base for the Second Century of Debate* (2002), Exh. 129 at 791; *see also* Farr Decl., at ¶ 22 ("severe risks associated with residential treatment").

[16] *See, e.g.*, Magnatta Decl., at ¶¶ 1, 4, 23 ("Dusty"); Frakes Decl., at ¶¶ 2, 3, 5, 10-23 ("Preston"); Brumbach Decl., at ¶¶ 4, 12, 17, 21 ("Chris" and "Ana").

acknowledged that "many children have been caught in a revolving door of inappropriate placements," adding that the "typical child in group care has experienced an average of five different placements before being put in a group setting."[17] DMH has also begun to document how foster children have experienced multiple group home placements and repeated hospitalizations.[18]

Multiple placements can subject foster children to the "trauma of repeated abandonment," so that they "come to expect they will fail and often give up trying to succeed." Burgess Decl., at ¶¶ 8, 13. The declarations submitted in support of this motion describe both this pattern and its tragic consequences.[19] When children do not receive appropriate mental health services at home, crises and hospitalization are inevitable, as many declarants attest.[20] Kayla's story also points to the problem of out-of-county placements, where distance makes obtaining necessary mental health services and reunification with family even more difficult.[21]

Kayla's eventual involvement in the delinquency system is all too common. The Children's Services Inspector General for Los Angeles County has warned that a "disproportionate number of Juvenile Court actions are presently being filed based upon the failure of relative placements resulting from a child's behavioral

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[17] DSS, *Reexamination of the Role of Group Care in a Family-Based System of Care*, Exh. 103 at 263 and 281.

[18] DMH has recently conducted a series of Qualitative Focused Reviews of the services provided to class members in *Emily Q. v. Bontá*. *See, e.g.*, San Bernardino Review, cases 5, 7, 8, Exh. E to Bird Decl. at 1605-06, 1609-12; Yolo County Review, case 4, Exh. D to Bird Decl. at 1572-73.

[19] *See* Dembrowsky Decl., at ¶ 12 (for child who went through 15 placements in three years, the "only constants in Bobby's life since entering foster care has been that his mental disabilities will cause him to act out and he will be moved to another placement to repeat the cycle somewhere else"); Hardy Decl., at ¶¶ 28-29 (twelve-year old girl finally placed with grandmother after 19 failed placements).

[20] *See, e.g.*, Beckman Decl., at ¶¶ 6, 9; Brumbach Decl., at ¶ 9, Lowe Decl., at ¶ 2. *See also* examples of foster children with multiple hospitalizations in DMH San Bernardino Review, cases 5, 7, 8, 10, Exh. E to Bird Decl. at 1605-06, 1609-12, 1615-16. Yolo Review, case 1, Exh. D to Bird Decl. at 1565-66.

[21] The Special Master in *Emily Q.* found that "children placed out of county, particularly those who are dependents and in the custody of the state's child welfare system, have significant difficulties accessing mental health services." Second Quarterly Report, Exh. C to Bird Decl. at 1529.

problems."[22] San Diego County estimated that 200 children were placed in juvenile justice system to obtain mental health services just in fiscal year 2001.[23] Thus, the Little Hoover Commission found that some "children in California have needs beyond the capacity of existing treatment programs" and are "sent to out-of-state programs"; others "end up in the juvenile justice system . . . on the streets, or cycling through inappropriate programs."[24]

C. Through Wraparound, Foster Children Can Avoid Group Homes and Multiple Placements.

In brief, wraparound "is a process which focuses on helping people apply their strengths to overcome their needs." Lourie Decl., at ¶ 12. A panel of nationwide experts has agreed that the core elements of wraparound services are that they be "family-driven, team-based, collaborative, community-based, culturally competent, individualized, strength based, natural support focused unconditional and outcome based." Bruns Decl., at ¶¶ 22 and 33.[25] DSS has given much the same description of the core elements of wraparound.[26]

DMH has identified wraparound as one of the measures that has "been working to improve services/supports to our foster care populations and their families."[27] DSS officials believe that wraparound programs have enabled foster children to live at home or in a home-like setting. Grayson Depo. at 46:20-47:5.

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[22] *Children with Behavioral Problems: High Incidence of Failed Placements*, Exh. 127 at 762.

[23] GAO, *Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services"* (April 2003), Exh. 131 at 863.

[24] *Young Hearts*, Exh. 101 at 139.

[25] *See also* CIMH Report, Exh. 104 at 345 (giving similar description of wraparound). Explanations of these terms, such as "strength based" and culturally competent" can be found in "Wraparound Principles." Bruns Decl.., at ¶ 33 and Exh. 2 at 1716-23; see also Dennis Decl., at ¶ 19.

[26] DSS' All-County Information Notice No. I-28-99 (April 7, 1999), Exh. 5 at 7.

[27] DMH, "Talking Points, Responses to Little Hoover Commission Report," Exh. 102 at 255-59. *See also* DMH *Chapter 26.5 1997 Out-Of-Home Care Report*, Exh. 111 at 430 (wraparound services are among the "intensive efforts [that] are critical to the successful treatment of youth" with severe emotional disturbances and "help to minimize the need for future" out-of-home care and institutional care).

Wraparound is one of the few mental health interventions for which there is "strong" evidence of efficacy, with significant expert support and many scholarly articles describing its benefits.[28] For example, in one of the first programs, Wraparound Milwaukee, the level of dysfunction and impairment significantly decreased for children and youth during their enrollment according to three nationally accepted research instruments on child behavior. Kamradt Decl., at ¶ 15. One wraparound provider in Sacramento County has attained the following results with children whom the County itself describes as the "most challenging to the system of care": the percentage of children living in RCL facilities of 12 and above has declined from 45% at the time of admission to 11% at time of discharge; 89% are attending school four or five days a week; and 74% of the children are discharged to family settings. Farr Decl., at ¶¶ 7-8, 15.[29]

Statistics do not tell the whole story. With wraparound services, one teenage boy in Alameda County progressed from living in a foster home, wetting his bed, fighting and having difficulties in school to living again with his mother and planning to attend a local community college followed by a four-year school. Charles-Heathers Decl., at ¶ 18. A fifteen-year old boy in Sacramento County who was severely depressed, recovering from "a self-abuse incident that required surgery," and enrolled in a school for severely emotionally disturbed children made such incredible improvements with wraparound services that he transferred to a large

[28] CIMH Report, Exh. 104 at 344 and 360; Bruns Decl., at ¶¶ 21-29; Friedman Decl., at ¶¶ 19-29.

[29] Sacramento County compiled additional data on the outcomes after discharge of children who Child Protective Services ("CPS") had referred for wraparound services versus children who CPS had referred for the usual services. Farr Decl., at ¶¶ 14, 19. The County found that: 52% of the children in wraparound services were no longer in CPS versus 29% of the control group; only 9% of wraparound youth were still in CPS and living in RCL of 12 and above versus 25% of the control group; and 6% of the wraparound youth had been transferred to probation versus 15% of the control group. *Id*., at ¶ 19.

mainstream school where he was an honor roll student and captain of a championship bowling team, and subsequently became a student at a local community college. Farr Decl., at ¶ 13. These stories are typical of the result of quality wraparound services.[30]

D. Fewer Than Half of California's Counties Even Offer Wraparound, and Even These Fail To Serve All Those In Need.

Despite its remarkable effectiveness, wraparound has been implemented in California in fewer than half the state's counties and only through two pilot programs initiated by DSS. One is a state-only funded program created by Senate Bill No. ("SB") 163, while the other is a special foster care demonstration program with the federal government known as the IV-E waiver. Treadwell Depo. at 15:17-17:15.[31] Each of the state's 58 counties can choose whether it wants to provide wraparound services to foster children through these pilot programs. Grayson Depo. at 107:24-108. As of February 2004, only 24 out of 58 counties in California provide wraparound, including five counties that participate through the Title IV-E waiver. Treadwell Depo. at 15:20-23, 17:13-18:5, 69:20-87:17. For more than a year, admissions to the Title IV-E wraparound have been frozen.[32]

It is bad enough that wraparound services essentially are "an elective service to be offered at the discretion of each county." Burgess Decl., at ¶ 11. To make matters worse, eligibility for wraparound services is limited to foster children who are

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[30] *See., e.g*., Dennis Decl., at ¶ 21 (with wraparound services, older teenager who had been suicidal and struggling with substance abuse and who had a borderline personality disorder went on to graduate from college and receive a Masters of Social Work).

[31] Funding for the two programs is quite different: SB 163 -- 40% from the state and 60% from the counties; Title IV-E waiver -- 50% from the federal government with approximately 20% from the state and 30% from the counties. Treadwell Depo. at 44:10-45:18. There are, however, more limitations on the Title IV-E waiver programs in that a county must divide children into an experimental and control groups, must measure certain outcomes, and must attempt to be "cost neutral." *Id.* at 103:12-106:12, 108:21-109:1. Children in the control group are precluded from receiving wraparound services. *Id*. at 35:19-22; *see also* Hardy Decl., at ¶¶ 10-13 (foster child with unmet mental health needs not given wraparound services because he was in the control group); Magnatta Decl., at ¶¶ 14-15 (same).

[32] Notice from Patricia Aguiar, Exh. 108 at 407-08 (no new children as of June 29, 2004).

currently residing in or at risk of being placed in RCL facilities of 10 or above for the SB 163 counties and RCL facilities of 12 or above for the Title IV-E waiver counties. Grayson Depo. at 38:14-39:16; Treadwell Depo. at 22:7-10.

Moreover, there is no requirement that a county provide wraparound services to all children in the target population for whom these services would be medically necessary, helpful or otherwise appropriate. Treadwell Depo. at 27:1-28:10, 38:20-39:1. On the contrary, counties have complete discretion on the number of wraparound "slots" they wish to provide. *Id.* at 21:22-22:1, 31:21-25, 102:20-23. Hence, the DSS official who is responsible for all of California's wraparound programs admitted that the participating counties were not even providing wraparound to all children in the target population for whom such services would be appropriate. *Id*. at 9:1-10:25, 13:3-13, 40:15-20.

The 24 participating counties combined had the capacity to provide wraparound services to just slightly more than 1500 children as of February 2004. *Id*. at 69:20-87:17. Declarations in support of this motion document the great need for and limited access to wraparound around the state.[33] DMH itself recently concluded that providing only 30 wraparound slots in a county with more than 6000 clients under age 21 was "insufficient given the number of potential eligibles."[34]

Los Angeles County is a case in point. Long after entering into the settlement agreement in this case, this County only had the capacity to provide wraparound services to 466 children and their families and, as a consequence, "many class members that need Wraparound support cannot access it," and the "quality of

[33] *See, e.g.*, Crary Decl., at ¶¶ 3-10 ("Wraparound services would accelerate. . . return home" of a boy, age 16, and would transition the return to a "less restrictive setting" for three other children, ages 5, 7 and 8, but such services have been denied because all these children receive federal foster care funds); Waxler Decl., at ¶¶ 3-5 ("In January 2005, the court ordered Wraparound services for James, and his social worker referred James to Wraparound," but, as of June 2005, Los Angeles County had still not provided such services to this 17-year old boy in foster care).

[34] San Bernardino Review, Exh. E to Bird Decl. at 1588-89, 1592.

Wraparound services is not adequate to meet the needs" of the County-wide class.[35] One County official has testified that Los Angeles County should have "1500 or more slots in wraparound" given the need. Hatekayama Depo. at 142:21-143:5. DSS has given even higher estimates, stating that Los Angeles County should expand capacity to "address the needs of the more than 3,000 children who are eligible" for the Title IV-E wraparound program.[36]

E. Medi-Cal Policies Significantly Limit Access to Wraparound.

DHS and DMH have not taken any steps to ensure that wraparound is available to all foster children on Medi-Cal, and have erected multiple barriers to its use. DMH officials state that their agency unquestionably does not provide a wraparound program. Neilsen Depo. at 143:13-15. While Medi-Cal can cover some components of wraparound, agency staff did not know precisely what could be covered or whether these components include all services that a child may need.[37] One indication that wraparound is not covered is the absence of a billing code for providers to claim Medi-Cal reimbursement. Health procedure billing codes in use across the nation include "Community Wraparound Services,"[38] but these codes are not covered by the Medi-Cal program. Barthels Depo. (Vol. II) at 82:11-83:24.

In the counties which have chosen to offer wraparound services, providers can attempt to bill portions of their services to Medi-Cal, but they do so at the risk of not being paid "even though these services are medically necessary and appropriate for the children." Charles-Heathers Decl., at ¶ 25. Auditors recently issued 19 disallowances to Lincoln Child Center, which will cost that wraparound provider hundreds of thousands of dollars. *Id*., at ¶ 24. As this provider explained, the

[35] *Third Panel Report*, Exh. 140 at 984 and 1025.
[36] Letter dated March 28, 2003, from Sylvia Pizzini, Exh. 107 at 397.
[37] Barthels Depo. (Vol. I) at 82:14-18, 88:15-89:3, (Vol. II) at 14:11-18, 96:20-97:10, 106:22-107:7, 119:6-120:4, 124:3-12, 124:23-125:21, 126:6-11.
[38] The primary coding system for health insurance billing is called Health Care Procedures Coding System ("HCPCS"). Barthels Depo. (Vol. II) at 35:1-36:20. HCPCS has a number of codes whereby mental health providers can bill for wraparound services, such as H2021 and H2022.

auditors "did not appreciate the acuity of the mental health needs of our children" or "the importance of starting with a high level of services and then reducing the level of services to ensure that the child does not experience another failure." *Id.* Aside from the risks, billing Medi-Cal for the components of wraparound on a piecemeal basis is quite difficult. DMH has permitted each county to set its own claims policies, procedures, contracts and practices regarding the extent of Medi-Cal reimbursement for different components of wraparound services. Barthels Depo. (Vol. II) at 28:6-29:7. This creates an administrative nightmare for providers which attempt to serve children in different counties. Watrous Decl., at ¶¶ 11-15. It also means that the availability of federal Medicaid reimbursement differs markedly from county to county.[39] In turn, the state's failure to maximize federal matching funds also prevents service expansion.[40]

F. Therapeutic Foster Care Is Another Medically Necessary Mental Health Service for Many Foster Children.

Therapeutic foster care ("TFC")[41] has been described as a "service for children with serious behavioral and emotional needs who cannot be cared for in their own homes." Friedman Decl, at ¶ 25. Like wraparound services, TFC "is a flexible intervention approach that emphasizes building upon positive family strengths, and provides crisis intervention, family counseling, assistance with child management and skills to enhance family functioning, and provides access to other community support programs." *Id*.

By all accounts, TFC is one of the very few mental health interventions for which there is a strong evidence of its effectiveness. *Id.*, at ¶ 26; Neilsen Depo. at

[39] For example, one wraparound provider in Alameda County, Lincoln Child Center, bills less than 40% of all costs to Medi-Cal program, whereas another provider in Sacramento County, River Oaks, bills approximately 65% of all costs to the Medi-Cal program. Charles-Heathers Decl., at ¶ 20; *see also* Burgess Decl., at ¶ 10.

[40] *Katie A.* Advisory Panel, Fifth Panel Report to the Court (hereafter "*Fifth Panel Report*"), Exh. 141 at 1047-48.

[41] TFC is also called treatment foster care or specialized foster care.

187:9-18; CIMH Report, Exh. 104 at 323, 346-48. Based upon the results of a number of studies,[42] the Surgeon General found that youth in TFC "showed more improvements in behavior and lower rates of reinstitutionalization, and the costs were lower than those in other settings."[43] The Executive Director of the Oregon Social Learning Center likewise states that a children's mental health system that does not include TFC "is incomplete and inadequate because intense mental health interventions, provided in home-like settings are necessary for many children with serious behavioral or mental health needs." Chamberlain Decl., at ¶¶ 1, 3.[44] TFC is the best and sometimes only appropriate option for many class members who cannot function in large congregate facilities such as group homes, often because they do not have the skills to interact with peers, especially those who also have mental health and behavior problems.[45]

G. Therapeutic Foster Care Is Not Available on a Consistent Statewide Basis When Children Need It.

As with wraparound, the Medi-Cal program does not cover a service known as TFC. Barthels Depo. (Vol. I) at 100:4-12. Although there are standardized national codes for billing TFC on a daily basis (S5145) and monthly basis (S5146),[46] the Medi-Cal program does not include either code. Barthels Depo. (Vol. II) at 81:24-82:9. The Medi-Cal program also does not cover many components of TFC. *Id.* at 133:9-21, 135:11-17, 136:6-13, 137:2-12, 140:11-18, 142:24-143:10.

[42] Chamberlain Decl., at ¶¶ 1, 3 (one form of TFC, know as multi-systemic therapeutic foster care or "MTFC", has been the subject of extensive evaluation, including eight randomized experimental clinical trials, and, based on research and program evaluation); Watrous Decl., at ¶¶ 5-6 (new MTFC program in San Diego County documented a nearly 200% decrease in aggregate negative behaviors).
[43] *Mental Health*, *A Report of the Surgeon General*, Exh. 105 at 391.
[44] *See also* Grealish Decl., at ¶ 34 (TFC is "a necessary component of a children's mental health system"); Friedman Decl., at ¶ 30 (TFC is "widely thought of as essential to any modern children's mental health system").
[45] *See, e.g.*, Dennis Decl, at ¶ 5; Dembrowsky Decl., at ¶ 16.
[46] Redman Decl., at ¶¶ 19, 20 and Exh. 3 thereto at 2591 and 2595.

DSS does offer a service called Intensive Treatment Foster Care ("ITFC)," which is an alternative placement option for children who might otherwise go into "high-end group care." Dupay Depo. at 35:15-25. By state statute, ITFC programs are required to provide a wide range of services to "emotionally disturbed children in certified family homes," including "individualized needs and services plans, "education and mental health services, " and "therapeutic after-school programs." Welf. & Inst. Code § 18358.15(a)(1)-(5). However, the state officials most knowledgeable about the ITFC programs did not know what services are actually available or whether those services differ from those in other forms of foster care.[47]

Approximately 20 counties have received state approval to have ITFC programs. Dupay Depo. at 18:25-19:4. However, only 500 children up to age 19 were served through ITFC during the quarter October -December 2002.[48] Several factors have kept ITFC participation low. The regulations regarding the ITFC program are so restrictive that few providers are willing to participate. Hatekayama Depo. at 93:20-94:15 (no LA providers were interested in ITFC). In addition, the State reimburses ITFC at a rate which is significantly lower than the rates for comparable group home care in RCLs of 14 or 12.[49]

[47] Markell Depo. at 13:21-14:21 (appearing on DHS' behalf pursuant to Fed. R.C.P 30(b)(6)); *see also* Dupay Depo. at 20:22-21:1, 23:8-16, 24:20-23 (The state only reimburses for "board and care services," which pays for food, clothing, utilities, and housing.). These state officials also do not know whether the participating counties limit the number of children who can enroll in their ITFC program. Markell Depo. at 20:14-18; Dupay Depo. at 29:16-30:5.

[48] DSS, *Intensive Treatment Foster Care Program: Quarterly Statistical Report*, Exh. 134 at 966.

[49] Dupay Depo. at 26:16-22. The maximum ITFC rate of $4476 per month is also significantly less than the $5613 per month for a RCL 12 group home and $6371 for a RCL 14 group home facility. *Compare*, DSS, *Intensive Treatment Foster Care Programs, Authorized Rates* (August 5, 2005), Exh. 122 at 602-03; *with* DSS, *Foster Care Rates Group Home Facility Listing* (August 5, 2005), Exh. 123 at 604 and 610.

ARGUMENT

III. PLAINTIFFS CAN MAKE THE REQUISITE SHOWING FOR ISSUANCE OF A PRELIMINARY INJUNCTION.

To obtain a preliminary injunction, plaintiffs usually must show either (1) a combination of probable success on the merits and the possibility of irreparable injury, or (2) that serious questions are raised and the balance of hardships tips sharply in their favor. *Rodde v. Bontá*, 357 F.3d 988, 994 (9th Cir. 2004). "These two alternatives represent extremes of a single continuum, rather than two separate tests. . . ." *Clear Channel Outdoor Inc. v. City of Los Angeles*, 340 F.3d 810, 813 (9th Cir. 2003) (internal citation and quotation marks omitted). As a result, "the greater the relative hardship to [the party seeking the preliminary injunction,] the less probability of success" must be established by the party. *Id*. (citation omitted).

However, in cases where plaintiffs seek mandatory preliminary relief, they must show that "the facts and law clearly favor the moving party." *Anderson v. United States*, 612 F.2d 1112, 1114 (9th Cir. 1979). Although mandatory preliminary injunctions are disfavored, courts have granted such relief in appropriate circumstances. *See, e.g., Dahl v. HEM Pharm. Corp.*, 7 F.3d 1399, 1401-03 (9th Cir. 1993)(drug company enjoined to provide experimental new medication to patients with chronic fatigue syndrome); *Cupolo v. Bay Area Rapid Transit*, 5 F. Supp. 2d 1078, 1080-86 (N.D. Cal 1997)(BART ordered to improve and repairs its elevators to make them accessible to individuals with mobility disabilities).

No matter what standard applies in the instant case, plaintiffs have made the requisite showing for issuance of the requested preliminary injunction.

IV. THE FACTS AND LAW CLEARLY FAVOR PLAINTIFFS ON THEIR CLAIMS UNDER THE MEDICAID ACT.

The Medi-Cal program does not cover either wraparound services or TFC as such. As a result of these huge gaps in Medi-Cal coverage, many class members

with serious mental health needs do not receive the services necessary to treat or ameliorate their conditions. DHS' Director is violating the Medicaid Act.

A. Wraparound Services and TFC Are Medically Necessary.

Although a state's participation in the Medicaid program is wholly voluntary, participating states, like California, obligate themselves to "comply with the requirements imposed both by the Medicaid Act (Act) and by regulations promulgated by the Secretary of Health and Human Services." *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990). Federal law requires states to cover certain mandatory services. 42 U.S.C. §1396d(a)(1). Among the mandatory services is "early and periodic screening, diagnostic and treatment" or EPSDT, for children under the age of 21. 42 U.S.C. § 1396d(r)(1), 42 C.F.R. § 441.56(b). When EPSDT was added to the Medicaid Act in 1967, "'Congress intended to require States to take aggressive steps to screen, diagnose and treat children with health problems.'" *Stanton v. Bond*, 504 F.2d 1246, 1249 (7th Cir. 1974)(italics and citation omitted).

Under federal requirements for EPSDT programs, Medi-Cal must screen eligible children "to determine the existence of certain physical or mental illnesses or conditions." 42 U.S.C. §1396d(r)(1)(A)(ii). Medi-Cal must then provide these eligible children with vision, dental and hearing services and "[s]uch other necessary health care, diagnostic services, treatment, and other measures described in . . .[42 U.S.C. § 1396d(a)] . . . to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State's plan." 42 U.S.C. § 1396d(r)(2)-(5).

Prior to 1989, state EPSDT programs were only required to pay for medically necessary treatment for hearing, vision, and dental problems. *Cf. Rosie D v. Swift*, 310 F.3d 230, 232 (1st Cir. 2002). With the amendments in 1989, states are required "to provide Medicaid coverage for any service 'identified as medically necessary through the EPSDT program.'" *Id.*

The Medicaid Act does not itself define when a medical service is "necessary." The Supreme Court in *Doe v. Bolton*, 410 U.S. 179, 93 S. Ct. 739, 35 L.Ed.2d 201 (1973), wrote that a determination of necessity "is a professional judgment that . . . may be exercised in the light of all 'factors—physical, emotional, psychological, familial, and the women's age—relevant to the well being of the patient.' " The Court went on to say that this formulation of the term "allows the attending physician the room he needs to make his best medical judgment." *Id.*

The lower courts have also held that a broad interpretation of the term "medical necessity" is required to carry out the remedial goals of the Medicaid program. *See, e.g., Weaver v. Reagen*, 886 F.2d 194, 197-200 (8th Cir. 1989) (Missouri ordered to fund AZT treatment for Medicaid recipients with AIDS whose doctors had determined that the treatment was medically necessary); *Visser v. Taylor*, 756 F. Supp. 501, 504-08 (D. Kan. 1990) (Kansas' Medicaid program ordered to cover the prescription drug Clozapine when a doctor had determined that it was the last remaining therapy appropriate for his patient).

Both wraparound services and TFC are medically necessary for many members of the plaintiff class. Dr. Ira Lourie has been a practicing psychiatrist for over 30 years with a specialty in children and adolescents and is the former Director of the Child and Adolescent Service System Program at the National Institute of Mental Health. Lourie Decl., at ¶¶ 1, 4, 5. Based on his many years of studying children's mental health interventions, Dr. Lourie states that "wraparound services are medically necessary for children with serious mental health needs." *Id.* at ¶ 2. Dr. Lourie explains that the "necessary treatment for an illness or impairment includes both therapeutic and rehabilitative components" and "wraparound programs enable children with behavioral, psychiatric, or emotional impairments to function as well and as normally as possible in as unrestrictive a setting as possible." *Id.* at ¶¶ 12-13. Similarly, Dr. Patricia Chamberlain states that TFC is "necessary for many children with serious behavioral or mental health needs" as "most foster children with

the most serious and chronic emotional or behavioral impairments often can best have their needs met in therapeutic foster homes." Chamberlain Decl., at ¶¶ 1, 3. Here, many other declarants have attested to the medical necessity of wraparound and/or TFC for class members because these services would correct or ameliorate the child's mental health conditions.[50]

According to three nationally accepted research instruments – the Child Adolescent Functional Assessment Scale ("CAFAS"), the Child Behavior Checklist, and the Youth Self Report – the level of dysfunction and impairment significantly decreased for children and youth during their enrollment in Wraparound Milwaukee. Kamradt Decl., at ¶ 15; *see also* Farr Decl., at ¶ 8 (for youth enrolled in Wraparound Sacramento, "[o]verall levels of behavioral dysfunction, as assessed by clinical measures, significantly decreased from admission to discharge."). MTFC, in turn, "is widely accepted as an evidence-based practice for controlling and allaying delinquency and anti-social behavior caused by psychological, behavioral or emotional impairments." Chamberlain Decl., at ¶¶ 1, 3, 16. In short, wraparound services and TFC are medically necessary for members of the plaintiff class.

B. Wraparound and TFC Are Mandated Services for EPSDT Beneficiaries.

The Medicaid Act lists specific categories of services that must be covered under EPSDT when needed to correct or ameliorate physical and mental conditions. 42 U.S.C. § 1396d(a). The Health Care Financing Administration ("HCFA")[51] State

[50] *See, e.g.*, Bruns Decl., at ¶ 2 (TFC, wraparound and "a small number of other mental health interventions" are generally cited "among the most effective integrated community-based interventions for children with emotional, behavioral, and mental health disorders"); Huffine Decl., at ¶ 30 ("Wraparound services are medically necessary for some children with emotional and behavioral challenges"); Nace Decl., at ¶ 18 (wraparound services are "medically necessary, behavioral health rehabilitative and treatment services . . . ."); and Friedman Decl., at ¶ 31 (Both wraparound and TFC "are necessary for some children with serious emotional disturbance, many of whom are in the foster care system.").

[51] HCFA has since changed its name to the Centers for Medicare and Medicaid Services ("CMS").

Medicaid Manual advises states that they must provide "any service which [they] are permitted to cover under Medicaid" so long as it meets the EPSDT medical necessity definition. State Medicaid Manual, §5110 (April 1990). Thus, the state *must* provide a medically necessary service "whether or not such services are covered" for adults [42 U.S.C. §1396d(r)(5)], so long as the state *could* elect to include the service in its Medicaid plan if it chose to do so. *See, e.g.*, *Mitchell v. Johnston*, 701 F.2d 337, 340-42, 346-52 (5th Cir. 1983)(coverage of several different dental services); *Chisholm v. Hood*, 110 F. Supp. 2d 499, 505-08 (E.D. La. 2000)(coverage of occupational, speech, and audiological services). As one high ranking DHS official admitted, "[s]tates must provide all needed services whether the service is covered by the state's state plan or whether the provider type is normally enrolled in the Medicaid program."[52]

"Typically, the state's obligation to provide comprehensive community-based services arises under the EPSDT mandate, as the services typically fit within Medicaid categories." Koyanagi Decl., at ¶ 25. Rehabilitation services are one such mandatory EPSDT service. 42 U.S.C. § 1396d(a)(13). Rehabilitative services are broadly defined as "any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law." 42 C.F.R. § 440.130(d). The federal regulation specifically refers to mental health services: the goal is the "maximum reduction of physical or mental disability and restoration of the individual to his best possible functional level." *Id.* (emphasis added).

Another mandatory EPSDT service is case management, which consists of services to "assist individuals under the [Medicaid] plan in gaining access to needed medical, social, educational, and other services." 42 U.S.C. §§ 1396d(a)(19), 1396n(g)(2). A third mandated EPSDT service are personal care services; they are

[52] E-mail message from Stan Rosenstein (February 23, 2003), Exh. 125 at 698.

offered to individuals who are not residing in hospitals or other institutions when "(A) authorized for the individual by a physician in accordance with a plan of treatment. . .; (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or other location." 42 U.S.C. § 1396d(a)(24); *see also* 42 C.F.R. § 440.167.

The Court is invited to pay close attention to the Declaration of Chris Koyanagi as this nationwide expert on the Medicaid funding of children's mental health services describes in detail how all the components of wraparound services and TFC are covered under different mandatory Medicaid categories, such as rehabilitation services or case management services.[53] Koyanagi Decl., at ¶¶ 27-30. Ms. Koyanagi has not only been a policy analyst in the mental health and disability fields for more than 30 years, most recently as the Policy Director for the Judge David L. Bazelon Center for Mental Health Law, but she also was the primary author of the last comprehensive survey of funding for children's mental health services under Medicaid. *Id*. at ¶¶ 1-22 and Exhs. 1 and 2 thereto at 2119-77.

C. Other State EPSDT Programs Cover Wraparound and TFC.

Ms. Koyanagi's analysis is borne out by the fact that several states' Medicaid programs already cover wraparound services and nearly half of the states' Medicaid programs cover TFC. *Id*. at ¶¶ 3, 27, 29. Some states use Medicaid to fund wraparound and TFC per se, as a bundled package of services. *Id*., at ¶¶ 27, 29. Nebraska, for instance, has covered wraparound per se, defining it as "intensive home-based services as well as resources and community supports tailored to the

[53] While Medicaid covers wraparound and TFC as mental health services, it may not cover all the expenses when the wraparound team or TFC program goes beyond providing mental health services. For example, if school-related services, such as a tutor, are recommended for a child, the school system will pay for that service, not Medicaid. Koyanagi Decl., at ¶ 31; *see also* Penrod Decl., at ¶ 19. By the same token, Medicaid will not cover the purchase of goods and/or services needed to support the child and their family though a crisis, such as clothes or a refrigerator. Koyanagi Decl., at ¶ 31; *see also* Penrod Decl., at ¶ 19. These non-Medicaid covered services are, however, not the central or core components of either wraparound or TFC as mental health services. Koyanagi Decl., at ¶ 31.

unique needs, strengths and priorities of the individual family." *Id.* at ¶ 27. Other states, such as Arizona, cover all of the components of wraparound and TFC as a mental health services but allow for separate billing of these components. *Id.* at ¶¶ 27, 29; *see also* Redman Decl, at ¶¶ 3,4, 10, 18, 22-24, 27-31, and Exhs. 2 and 4 thereto; Penrod Decl., at ¶¶ 3, 19. It is, however, highly preferable for providers to bill for wraparound services and TFC as a bundled package of services. Koyanagi Decl., at ¶ 29.

That other state Medicaid programs provide wraparound services and TFC demonstrates conclusively that these are medically necessary services covered by Medicaid. Under the EPSDT mandate, California could unquestionably cover both these services and should be required to do so for members of the class.[54]

V. THE FACTS AND LAW CLEARLY FAVOR PLAINTIFFS ON THEIR CLAIMS UNDER THE ADA AND THE REHABILITATION ACT.

Apart from the Medicaid Act, plaintiffs are also entitled to relief under Title II of the ADA and Section 504 of the Rehabilitation Act.[55] The ADA defines a disability as: (A) a physical or mental impairment that substantially limits one or more major life activities, (B) a record of such an impairment, or (C) being regarded as having such an impairment. 42 U.S.C. § 12102(2).

Virtually all members of the plaintiff class qualify as persons with disabilities under the ADA. By definition, the class consists of children in foster care or at imminent risk of foster care placement who "have a mental illness or condition that has been documented or, had an assessment already been conducted, would have been documented," and who "need individualized mental health services. . . in the home or in a home-like setting, to treat or ameliorate their illness or condition."

[54] The State Defendants have themselves presented evidence that Medicaid covers TFC and at least components of wraparound. *See* Duckett Decl., at ¶¶ 4, 5.

[55] Plaintiffs' analysis of the ADA applies equally to Section 504, which prohibits discrimination on the basis of disability by recipients of federal funds. 29 U.S.C. § 794, 28 C.F.R. § 41.51(d). *See Miranda B. v. Kitzhaber*, 328 F.3d 1181, 1188 (9th Cir. 2003)(Title II incorporates Section 504's rights, remedies and procedures).

Order dated June 18, 2003, at 21-22. These children are substantially limited in major life activities, such as caring for themselves, interacting with others and learning. *See, e.g.*, Frakes Decl., at ¶ 8 (foster child was "often suicidal," "was constantly yelling" and "was verbally assaultive to other children").

Each state agency in this lawsuit, DHS and DSS, is a "public entity" under the ADA: any state or local government, or department, agency or other instrumentality of state or local government. 42 U.S.C. § 12115(1). State officials sued in their official capacities for injunctive and declaratory relief, such as the current Directors of DHS and DSS, are appropriate defendants for purposes of claims under Title II of the ADA and Section 504. *Miranda B.*, 328 F.3d at 1187-89.

Title II of the ADA prohibits public entities from discriminating against individuals on the basis of disability in their programs, services, and activities. 42 U.S.C. § 12102(2)(A). The implementing regulations of the Department of Justice provide that public entities shall administer their services to individuals with disabilities in the "most integrated setting appropriate" to their needs [28 C.F.R. § 35.130(d)], which means "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." 28 C.F.R. pt. 35, App. A, p. 543 (2004).

In *Olmstead v. L.C.*, 527 U.S. 581, 119 S.Ct. 2176, 144 L.Ed.2d 540 (1999), the Supreme Court held that the ADA prohibits unnecessary institutionalization of individuals with disabilities.[56] *Id.* at 587. By failing to provide wraparound services and TFC to class members who need and want these services, DHS and DSS are guilty of the unnecessary institutionalization of individuals with mental disabilities in congregate care facilities, emergency psychiatric wards, state psychiatric hospitals

[56] The Supreme Court's conclusion that unnecessary institutionalization of individuals with disabilities is a form of discrimination under the ADA applies equally to Section 504. *See, e.g., Radaszewski ex rel. Radaszewski v. Maram*, 383 F.3d 599, 607 (7th Cir. 2004); *Frederick L. v. Department of Pub. Welfare of Pennsylvania*, 364 F.3d 487, 491-92 (3rd Cir. 2004).

and juvenile detention facilities. DSS readily acknowledges that "the current group system often minimizes the importance of family connections" and that the payment system to the group homes gives them an "incentive to keep their beds full and to sometimes take more difficult children than the program can adequately serve."[57] State officials also admit that wraparound services have allowed children to live with parents or relatives when they otherwise might not have been able to live with their family members. *See, e.g.*, Treadwell Depo. at 126:11-18 (DSS official); Neilsen Depo. at 158:4-159:18 (DMH official). Meanwhile, the Surgeon General has described TFC as "the least restrictive form of out-of-home therapeutic placements for children with severe mental disorders."[58]

The *Olmstead* Court held that the ADA requires states to transfer individuals with disabilities from institutional to community settings if: (1) the individual is appropriate for the community, (2) the individual does not oppose community placement, and (3) the community placement could be reasonably accommodated. 527 U.S. at 587, 607. As will be demonstrated below, plaintiffs easily satisfy all three requirements of this integration mandate.

A. <u>Class Members Are Appropriate for Community Placement.</u>

When Congress enacted the ADA, it found that "historically, society has tended to isolate and segregate individuals with disabilities," discrimination "persists in such critical areas as. . . institutionalization," and "individuals with disabilities continually encounter various forms of discrimination, including,. . . failure to make modifications to existing facilities and practices. . . ." 42 U.S.C. §§ 12101(a)(2), (3) and (5). Citing these findings, the *Olmstead* Court declared that:

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[57] DSS, *Reexamination of the Role of Group Care in a Family-Based System of Care*, Exh. 103 at 283-84; *see also Policies, Procedure, and Practices Affecting the Education of Children Residing in Group Homes* (2002), Exh. 128 at 787 (recent studies in Los Angeles County suggest that residential placements are influenced more by fiscal considerations than by the child's needs).

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

> Recognition that unjustified institutional isolation of persons with disabilities is a form of discrimination reflects two evident judgments. First, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life. . .Second, 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 600-01. The high court, however, cautioned that individuals must be able to benefit from community settings. *Id*. at 601.

There is no question that class members can be appropriately served with wraparound services and TFC at home or in a community setting. For the past ten years, Wraparound Milwaukee has been providing wraparound services to thousands of children and adolescents with severe emotional and psychological disorders who have been removed from foster homes and placed in residential treatment centers (which are quite similar to RCL facilities of 10 and above). Kamradt Decl., at ¶¶ 1, 3, 11-15, 19 . Wraparound Milwaukee has been able to return more than 80% of these children to their homes or communities *Id*., at ¶ 12. Thereafter, these children have normally resumed their education, be it at public or an alternative school, some have later attended either college or trade school, and others successfully obtained work upon turning age 18. *Id*.

Closer to home, Butte County halved the number of group placements by providing intensive services, including wraparound services, to children in the severe to very severe functional impairment range.[59] Kern County also was successful in decreasing psychiatric hospitalizations and in treating children and youth in less

[59] Letter dated January 31, 2003, from Bradford R. Luz, Director of Butte County Department of Behavioral Health, Exh. 117 at 579-80.

restrictive settings when it significantly increased intensified community-based wraparound services.[60] Thus, one nationwide expert correctly concluded that "wraparound programs enable children with behavioral, psychiatric, or emotional impairments to function as well and as normally as possible in as unrestrictive a setting as possible." Lourie Decl, at ¶¶ 4-11 and 13.

The results with TFC programs are just as encouraging. The oft evaluated and heavily praised MTFC program in Oregon found that children and adolescents leaving the state hospital "were placed in the community more quickly and, upon follow-up had fewer behavioral problems" when they received MTFC. Chamberlain Decl., at ¶ ¶ 1, 2, 13-17. Similarly, a new MTFC program in San Diego County achieved a decrease in mental health symptoms and negative behaviors, number of residential placement transfers and educational placement changes with its initial group of youths who had been in high level group home or at risk of being discharged to a higher level of care. Watrous Decl., at ¶¶ 5-7. One nationwide expert who has worked with thousands of children with complex mental health needs reports that TFC "has not only permitted countless number of children to live in their communities, but also has ensured that many of these children grow up to lead relatively normal lives without any support or intervention." Grealish Decl., at ¶¶ 1-4, 31; *see also* Dennis Decl., at ¶ 5 (most children who need TFC would otherwise be placed in residential treatment centers or psychiatric hospitals).

The case at bar does not concern mental health professionals' assessments as to whether particular class members can be appropriately served in community settings with wraparound services or TFC. The more fundamental problem is that these intensive mental health services are not available at all in many counties in California

[60] Letter dated May 11, 2001, from Diane Koditek, Director of Kern County DMH, Exh. 116 at 577-78. *See also* Farr Decl, at ¶¶ 2, 7-13 (Sacramento County wraparound providers have reduced the number of youths with serious mental health needs living in RCL facilities of 12 and above from 45% at the time of admission to 11% at the time of discharge, and has discharged 74% of these children to family settings).

and are only available on a limited basis in other counties. *See, e.g.*, Burgess Decl., at ¶¶ 4, 5 (psychologist recommended that foster child be transitioned to a small foster home in the community with wraparound services, but San Bernardino County could find no local provider to provide such services). It is difficult for mental health professionals to recommend a course of treatment for class members when neither the state nor the counties will pay for this treatment.

B. Class Members Do Not Oppose Community Placement.

The Court in *Olmstead* observed that the integration mandate does not require a state to provide community-based services to individuals who are opposed to being transferred from an institutional setting to the community. 527 U.S. at 587. The Court reasoned that there is no "federal requirement that community-based treatment be imposed on patients who do not desire it." *Id*. at 602.

Plaintiffs have no interest in overriding any class member's objection to being released from an institution to live in a community setting. It is, however, difficult to imagine that many foster children would prefer living in a group home[61] or, even worse, a state hospital if they could receive the necessary mental health services at home or in another community setting. Hence, one such class member complains to his grandmother that the conditions at Metropolitan State Hospital are "terrible" and that he is "living in hell"since it "is dirty, he "has fleabites all over" and he "is afraid of being injured by other, larger boys there." Lowe Decl., at ¶¶ 12, 13.

Plaintiffs merely want to give the option to class members (or, in many instances, their parents, foster parents, or others responsible for their care) as to whether these foster children with intense mental health needs can receive wraparound services or TFC and thereby remain at home or in a home-like setting.

[61] The living conditions in group homes can be brutal. *See, e.g.*, Lowe Decl, at ¶ 7 (her grandson has called "on many occasions sobbing, telling me how depressed and scared he was after being physically assaulted and sexually victimized by staff or peers"); Hardy Decl., at ¶¶ 22 and 35 (older children in group homes had sexually molested two of her grandchildren).

To give just one illustration, Cherise M. is a foster child in Alameda County who since entering group home care "has received a "variety of mental health services," including psychotropic medications, group therapy five times per week, individual therapy once a week, and therapeutic behavioral services. Beckman Decl., at ¶¶ 2, 3 and 9. Her CASA bemoans the fact that "there were no attempts to provide" this 13-year old girl with "similarly intensive services," such as TFC or wraparound, "to avoid placing her in an institution, in the first place." *Id*., at ¶¶ 2 and 9.

C. It Would Not be a Fundamental Alteration to Transfer Class Members Into, or Maintain Them in, Community Settings.

Title II of the ADA requires that public entities make reasonable modifications to rules, policies and practices when necessary to avoid discrimination based on disability. 42 U.S.C. § 12132; 28 C.F.R. § 35.130(b)(7). A modification is not reasonable if the public entity can demonstrate that it would fundamentally alter the nature of the program, service or activity in question. 28 C.F.R. § 35.130(b)(7). This has been referred to as the "fundamental alteration defense." *Olmstead*, 527 U.S. at 603-04. "Though clearly relevant, budgetary constraints alone are insufficient to establish a fundamental alteration defense." *Pennsylvania Protection and Advocacy, Inc. v. Pennsylvania Dept. of Public Welfare*, 402 F.3d 374, 380 (3rd Cir. 2005).

In *Olmstead* the Court was concerned to avoid situations where relief for a particular plaintiff would prove inequitable given the state's responsibilities to serve other individuals with disabilities. 527 U.S. at 604. For example, a plaintiff could not use the filing of an ADA lawsuit to jump to the top of a waiting list if a state was able to "demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated." *Id*. at 605-06. Hence, the Supreme Court held that public entities must administer their services to individuals with disabilities in the most integrated setting appropriate to their needs unless, taking into account the

cost of providing the services, the needs of others with disabilities, and the resources available to the state, it would be a fundamental alteration to furnish community services to the plaintiffs. *Id.* at 587, 607.

The Ninth Circuit further clarified the meaning of the fundamental alteration defense in *Townsend v. Quasim*, 328 F.3d 511(9th Cir. 2003). The *Townsend* court observed that "*Olmstead* and the integration regulation would be effectively gutted" if a state could not be required to provide community-based services simply because the state has currently chosen to provide those services only in an institution. *Id*. As the Ninth Circuit elaborated, "*Olmstead* did not regard the transfer of services to a community setting, without more, as a *fundamental* alteration." *Id*. at 519 (italics in original); *see also Radaszewski ex rel. Radaszewski v. Maram,* 383 F.3d 599 (plaintiffs need not prove that the services they wish to receive in a community setting "already exist in exactly the same form in the institutional setting").

The *Townsend* court ruled that the state would be able to show a fundamental alteration *only* if it could prove that: (1) extending community services to medically needy Medicaid recipients would create greater expenses for the Medicaid program because individuals who would have refused costly nursing home care would now exercise a newly available entitlement to receive community-based services, *and* (2) those expenses would be significant enough to compel cuts in services to other Medicaid recipients. 328 F.3d at 520. Because the record lacked sufficient information for the court to make these determinations, it remanded for consideration of the fundamental alteration defense in light of its holding. *Id*.

Neither of the concerns identified in *Townsend* is present in the instant case. First, unlike the *Townsend* plaintiffs, who sought to require the state to provide them with a new Medicaid service to which they were not currently entitled, plaintiffs in this case only seek mental health services that the state is already obligated to provide them through the Medicaid program – wraparound services and TFC. Defendants cannot credibly argue that complying with the Medicaid Act will require them to cut

services to other Medicaid recipients. The cost of meeting current Medicaid obligations to plaintiffs is not a cost that may be balanced against the needs of other individuals as part of the fundamental alteration defense.

Second, in further contrast to *Townsend*, there is little, if any, risk that providing the services plaintiffs seek would create significant additional costs for the Medi-Cal program and possibly compel cutbacks to other Medi-Cal recipients. To the contrary, the monthly costs of placing a foster 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."[62] Last year the monthly costs of all services from Wraparound Milwaukee, including the costs of foster care or group care, mental health services, and social or other support services, were approximately $3,900 per child, whereas the monthly costs of all services for children in residential treatment centers were approximately $8,000 to $10,000 per child. Kamradt Decl., at ¶¶ 16-17. Meanwhile, MTFC produced the largest costs saving to taxpayers of all the juvenile justice programs evaluated by the Washington State Public Policy Group and the benefit-to-cost ratio for MTFC was "$43.70 for every dollar spent." Chamberlain Decl., at ¶ 26. Sacramento County has saved approximately $6 million in foster care funding with wraparound services. Farr Decl. at ¶ 20. Several other counties have likewise saved monies with their wraparound programs (*see* pages 33-34 *infra*).

In short, the cost concerns in *Townsend* do not exist in this case. Defendants are unable to prove the fundamental alteration defense, and plaintiffs are likely to prevail on their ADA claims.

VI. THE BALANCE OF HARDSHIPS TIPS SHARPLY IN FAVOR OF THE PLAINTIFF CLASS.

As demonstrated above, plaintiffs are likely to prevail on both their Medicaid and ADA claims. The balance of hardships also tips sharply in plaintiffs' favor.

[62] Richard P. Barth, *Institutions vs. Foster Homes: The Empirical Base for the Second Century of Debate* (2002), Exh. 129 at 792.

Generally, in Medicaid cases, "[t]he nature of [plaintiffs] claim – a claim against the state for medical services – makes it impossible to say that any remedy at law could compensate them." *McMillan v. McCrimon,* 807 F. Supp. 475, 479 (C.D. Ill. 1992). In particular, irreparable injury is shown where a State denies "needed medical care" to Medicaid recipients. *Beltran v. Meyers,* 677 F.2d 1317, 1322 (9th Cir. 1982). The Supreme Court has stated that "[t]o allow a serious illness to be untreated until it requires emergency hospitalization is to subject the sufferer to the danger of a substantial and irrevocable deterioration in his health." *Memorial Hosp. v. Maricopa County,* 415 U.S. 250, 94 S.Ct. 1076, 39 L.Ed.2d 306 (1974). "The denial of medical care is all the more cruel in this context, falling as it does on indigent who are often without the means to obtain alternative treatment." *Id.*

Dusty is a class member in Humboldt County, a "smart young man who is capable of going to college and making something of his life, if given wraparound or therapeutic foster services." Magnatta Decl, at ¶¶ 1, 4, 23. When, however, Dusty did not receive the wraparound services he "desperately needed," this 15-year old boy was eventually removed from the home of a caring foster parent and placed in a high-level group home in another county. *Id*. at ¶¶ 17, 19-22. As a Butte County official warned, the "consequences of youth needing mental health services and not receiving them are great."[63] Six youths completed suicides in that county alone during one year.[64]

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

[64] *Id.*; *see also* Bialik Decl., at ¶¶ 3, 4, 14, 16, 20 and 21(foster youth who "enjoys reading, math, and sports" and "wants to go to college" became "increasingly depressed and desperate" when Contra Costa County refused to move him into a foster home with therapeutic foster care and so he is "currently detained in Juvenile Hall"); Frakes Decl., at ¶¶ 2, 3, 5, 10-23 (class member who has a "quick wit," "is very good at arts and crafts," and was at least "fully capable" at one time "of 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).

This lawsuit presents the classic "win-win situation." Not only will plaintiffs benefit from the granting of the preliminary injunction, but so will the State Defendants. For many class members with their intense mental health needs, the alternatives to wraparound services and TFC will be placement in a group home or other congregate care setting. Others will end up in locked Community Treatment Facilities, the State Hospital or juvenile hall.

The State's monthly payments per child are $5613 for a RCL 12 facility and $6371 for a RCL 14 facility.[65] On top of these expenses, the costs of providing mental health services are approximately $120 per day for a child in an RCL facility of 12 and approximately $160 per day for a child in an RCL facility of 14. Hatekayama Depo. at 137:17-24. One county official estimated that the costs of group home placement was "approximately $100,000 per youth per year" and that did not include "the non-public school costs, the medication costs, or the mental health costs usually associated with group home placements."[66] Even worse, Community Treatment Facilities can cost $9,000 to $20,000 per month per child.[67]

Although the costs vary, county after county has found that wraparound services and TFC are cheaper than group home care. For example, it costs Mono County approximately $167,800 per year to keep one youth in a RCL 14 facility, while the average child in the wraparound program costs $4638 per month (or $56,196 per year).[68] In Mendocino County, the monthly cost of out of home placement and specialty mental health services averaged $9495 per child, whereas providing wraparound services averaged $6065 per child.[69] For Humboldt County,

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[65] DSS, *Foster Care Rates Group Home Facility Listing*, Exh. 123 at 610.
[66] Letter dated July 13, 2000, from Michael W. Clarke, Assistant Director of Butte County Department of Behavioral Health, Exh. 118 at 581-82.
[67] DMH, *Status of the Implementation of the Community Treatment Facilities* (April 2001), Exh. 110 at 417. If a foster child ends ups in the delinquency system, incarceration alone can cost more than $3,000 per month. *Young Hearts*, Exh. 101 at 91.
[68] SB 163 Wraparound Final Evaluation, Mono County, Exh. 135 at 969.
[69] Mendocino County's SB 163 Children's Wraparound Services Pilot Project Final Report, Exh. 136 at 971.

the average monthly cost was $3334 for a child without wraparound services versus $2438 for a child with wraparound services.[70]

Plaintiffs nonetheless recognize that for some foster children wraparound services and TFC may be more expensive in the short term than the existing alternatives.[71] The Ninth Circuit has, however, stated that:

> [T]he physical and emotional suffering shown by plaintiffs in the record before us is far more compelling than the possibility of some administrative inconvenience or monetary loss to the government. . . Faced with such a conflict between the financial concerns and preventable human suffering, we have little difficulty concluding that the balance of hardships tips decidedly in plaintiffs' favor.

Lopez v. Heckler, 713 F.2d 1432, 1437 (9th Cir. 1983), *rev'd in part on other grounds*, *Heckler v. Lopez*, 463 U.S. 1328, 104 S.Ct. 10, 77 L.Ed. 2d 143 (1983). In *Lopez*, 713 F.2d at 1436-37, the Ninth Circuit refused to stay a preliminary injunction even thought it cost the federal government more than $20 million per month in 1980, a figure that would be much higher in current dollars. In *Rodde*, 357 F.3d at 999, the Ninth Circuit affirmed a preliminary injunction despite Los Angeles County's estimates that it would be losing $58 million annually. Thus, even assuming *arguendo* that the State Defendants might lose some money if the preliminary injunction is granted, such financial losses still pale by comparison to the preventable

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[70] Report to the Legislature on Humboldt County's Wraparound Services Program, Exh. 137 at 974.

[71] State Defendants can be expected to point to DSS' findings that the costs were greater for children in the experimental group (wraparound services) than children in the control group (regular services) in the Title IV-E counties. But the efforts to compare these two groups were fraught with problems. Schroeder Decl., at ¶¶ 9-16, 21-23. One such problem was that DSS only looked at the amount of federal monies being spent and so did not try to measure any savings in Title XIX, Medi-Cal, county and state-only juvenile justice funds, education, Short-Doyle Medi-Cal, California Youth Authority or any other funding sources. *Id.*, at ¶ 21.

human suffering that class members will endure if the preliminary injunction is denied. The Court should grant such provisional relief.

VII. THE PUBLIC INTEREST FAVORS THE GRANT OF AN INJUNCTION

"The public interest is a factor to be strongly considered" in granting a preliminary injunction to assure that Medicaid recipients receive essential medical services. *Lopez,* 713 F.2d at 1437. The Ninth Circuit has cautioned that the "government must be concerned not only with the public fisc but also with the public weal," adding that "[o]ur society as a whole suffers when we neglect the poor, the hungry, the disabled, or when we deprive them of their rights or privileges. . . ." *Id.* Here, it is in the public interest to protect the legal rights of the plaintiff class, foster children who are both poor and disabled.

VIII. PLAINTIFFS SHOULD NOT BE REQUIRED TO POST A BOND

This Court has the discretion to issue a preliminary injunction without requiring plaintiffs to post bond. *People of State of Cal. ex rel. Van De Kamp v. Tahoe Regional Planning Agency,* 766 F.2d 1319 (9th Cir. 1985), *Lowe v. Monrovia,* 775 F.2d 998 (9th Cir. 1985). Exercise of that discretion is particularly appropriate where an action is brought by a class of indigent plaintiffs. *Orantes-Hernandez v. Smith,* 541 F. Supp. 351, 385 n. 42 (C.D. Cal. 1982). No bond should be required in this case brought by a class of indigent plaintiffs.

IX. CONCLUSION

For all the foregoing reasons, the Court should issue a preliminary injunction enjoining the State Defendants to provide wraparound and TFC to class members for whom these services are medically necessary.

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Respectfully submitted,

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