ROBERT D. NEWMAN, SBN 86534
KIMBERLY LEWIS, SBN 144879
RICHARD A. ROTHSCHILD, SBN 067356
WESTERN CENTER ON LAW
AND POVERTY
3701 Wilshire Boulevard, Suite 208
Los Angeles, California 90010
Telephone: (213) 487-7211
Facsimile: (213) 487-0242

KIRK A. HORNBECK, SBN 241708
MATTHEW BENEDETTO, SBN 252379
HELLER EHRMAN LLP
333 S. Hope Street, 39th Floor
Los Angeles, California 90071-3043
Telephone: (213) 689-0200
Facsimile: (213) 614-1868

Attorneys for Plaintiffs
[Additional Counsel Listed on Next Page]

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

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)

PLAINTIFFS' PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW RE MOTION FOR PRELIMINARY INJUNCTION

The Hon. A. Howard Matz
Courtroom: 14

MARK D. ROSENBAUM, SBN 59940
MELINDA BIRD, SBN 102236
AMERICAN CIVIL LIBERTIES UNION
OF SOUTHERN CALIFORNIA
1616 Beverly Boulevard
Los Angeles, California 90026
Telephone: (213) 977-9500
Facsimile: (213) 250-3919

MARILYN HOLLE, SBN 61530
PROTECTION & ADVOCACY, INC.
3580 Wilshire Boulevard, Suite 902
Los Angeles, California 90010
Telephone: (213) 427-8747
Facsimile: (213) 427-8767

JOHN O'TOOLE, SBN 62327
PATRICK GARDNER, SBN 208119
LEECIA WELCH, SBN 208741
NATIONAL CENTER FOR YOUTH LAW
405 14th Street, 15th Floor
Oakland, California 94612
Telephone: (510) 835-8098
Facsimile: (510) 835-8099

IRA BURNIM (*pro hac vice*)
ALISON BARKOFF (*pro hac vice*)
BAZELON CENTER FOR
MENTAL HEALTH LAW
1101 Fifteenth Street, NW, Suite 1212
Washington, DC 20006
Telephone: (202) 467-5730
Facsimile: (202) 223-0409

Additional Counsel listed on caption page

PROCEDURAL HISTORY

1. Currently before the Court is Plaintiffs' motion for a preliminary injunction. Plaintiffs' motion, like their previous motion, is based on the Medicaid Act, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act. In their motion, Plaintiffs seek a mandatory preliminary injunction to require State Defendants – Sandra Shewry, current Director of the California Department of Health Care Services (DHCS) and John Wagner, current Director of the Department of Social Services (DSS) – to provide wraparound services and therapeutic foster care (TFC) to members of the class for whom these services are medically necessary. Plaintiffs' Memorandum of Points and Authorities in Support of Motion for Preliminary Injunction (Feb. 2, 2008) (Pls. Mem. of P&A), at 1.

2. On March 14, 2006, the Court granted an earlier motion for preliminary injunction seeking similar relief. *Katie A. v. Bonta*, 433 F. Supp. 2d 1065 (C.D. Cal. 2006). The Court's order was based on the Medicaid Act, and the Court did not decide Plaintiffs' claim under the Americans with Disabilities Act. *Id.* at 1069 n.5, 1078 at n.17. That order was appealed, and the U.S. Court of Appeals for the Ninth Circuit reversed and remanded the order. *Katie A. ex rel Ludin v. Los Angeles County*, 481 F.3d 1150 (9th Cir. 2007). With respect to Plaintiffs' Medicaid claim, the Ninth Circuit directed this Court to address three discrete issues on remand. *Katie A.*, 481 F.3d at 1163.

3. According to the Ninth Circuit's decision, this Court should first address whether each component of wraparound services and TFC falls under the categories of services listed in 42 U.S.C. § 1396d(a). *Katie A.*, 481 F.3d at 1163. The Court should next address whether Defendants have effectively provided each mandated component service. *Id.* If they have not, the Court should decide "whether the State should be required to provide the required services in another manner which will render such services effective, or proceed directly to wraparound and TFC." *Id*.

/ / /

FINDINGS OF FACT

State Defendants

4. The term "Defendants," when used herein, refers to Ms. Shewry, DHCS' current Director, and Mr. Wagner, DSS' current Director. DHCS, which was previously known as the California Department of Health Services, is the state agency responsible for supervising the administration and operation of the Medi-Cal program. *Katie A.*, 481 F.3d at 1152; *Emily Q. v. Bonta*, 208 F. Supp. 1078, 1088 (C.D. Cal. 2001).

5. DHCS has entered into an interagency contract so that the California Department of Mental Health (DMH) has assumed responsibility for supervising the administration of mental health services to Medi-Cal recipients and other indigent persons. *Emily Q.*, 208 F. Supp. 2d at 1089. On a county level, the Mental Health Plans (MHPs) are responsible for providing mental health services to Medi-Cal recipients. *Id.*

6. DSS is the state agency with supervisory responsibility over the administration of foster care and child welfare services in California. Welf. & Inst. Code § 10600; *see also Katie A.*, 481 F.3d at 1152 n.2. DSS plays a significant role in determining whether class members receive needed mental health services. *Katie A.*, 481 F.3d at 1163 and n.22 (DSS "has the power to affect foster care children's receipt of mental health services" and acts "in active concert with DHS with regard to the class members' receipt of health care through MediCal"; internal quotations omitted).

Plaintiff Class

7. As this Court previously found, "[a]t stake in this lawsuit is the health of thousands of children in California who are already in, or are likely soon to wind up in, foster care." *Katie A.*, 433 F. Supp. 2d at 1069.

8. There are approximately 78,000 children in child welfare-supervised foster care in California. Needell, *et al*., *Child Welfare Supervised Foster Care*

Highlights from CWS/CMS, Further Newman Declaration (Decl.), Exhibit (Exh.) 168 at 1061; Freitas Decl., 544-45 at ¶ 7, Exh. 3 at 618. Thousands of additional children receive child welfare services in their own homes. In Los Angeles County alone, 23,000 children were in out-of home (foster) care, while another 17,000 children were receiving child welfare services from the County's Department of Children and Family Services (DCFS) but had not been removed from their homes. Findings of Fact and Conclusions of Law re Settlement Agreement between Plaintiffs and County dated November 20, 2006 (Findings) at ¶¶ 17, 23, 52.

9. Approximately 50 to 80 percent of children in or at risk of foster care placement require mental health services. *See, e.g.*, California Little Hoover Commission, *Young Hearts and Minds: Making a Commitment to Children's Mental Health* (Oct. 2001) (Young Hearts), Exh. 101 at 134; California Mental Health Planning Council, *California Mental Health Master Plan: A Vision for California* (March 2003), Exh. 132 at 946. According to Defendants' own expert, Dr. John Landsverk, the research literature "suggests that between one-half and three-fourths of the children entering foster care exhibit behavior or social competency problems that warrant mental health care" and "[t]here is also evidence that this high rate of need may be anticipated as well for children who are served by child welfare while remaining in their biological homes." Landsverk Decl., 391-92 at ¶ 4; *accord* California Health and Human Services, Exh. 133 at 963-64 (study finding that 84% of a sample of 213 foster children had developmental, emotional, and/or behavioral problems).

10. By definition, the Plaintiff class consists of children who require mental health treatment. The certified class is children in California who (a) are in foster care or at imminent risk of foster care placement; and (b) have a mental illness or condition that has been documented or, had an assessment already been conducted, would have been documented; and (c) who need individualized mental health services, including but not limited to professionally acceptable assessments, behavioral support and case management services, family support, crisis support,

therapeutic foster care and other necessary services in the home or in a home-like setting, to treat or ameliorate their illness or condition. Order dated June 18, 2003, at 21-22.

11. Plaintiffs are substantially limited in major life activities, such as caring for themselves, interacting with others and learning. *See, e.g.*, Smith Decl., 30-34 at ¶¶ 4, 8, 11, 12; Truesdale Decl., 48-51 at ¶¶ 3, 4, 7-10; Frakes Decl, at ¶ 8.[1]

12. Almost 100 percent of class members in foster care are eligible for Medicaid. Hatekayama Deposition (Depo.) at 47:18-48:4.[2] In addition, a large number of children at risk of foster care placement are eligible for Medicaid under the other mandatory Medicaid categories listed in 42 U.S.C. § 1396a(a)(10)(A)(i), including Social Security Income (SSI) recipients and children in families with limited income. *Accord Emily Q.*, 208 F. Supp. 2d at 1088 ("States are required to provide Medicaid coverage to all individuals and groups designated in 42 U.S.C. § 1396a(a)(10)(A)(i). These groups include low income families with children, as described in Section 1931 of the Social Security Act.").

13. The Plaintiff class has "'complex needs'" and "'are particularly vulnerable.'" *Katie A.*, 433 F. Supp. 2d at 1068 (quoting *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 23-24 (D.Mass. 2006)). The medical needs of the Plaintiff class "'frequently extend across a spectrum of service providers and state agencies.'" *Katie A.*, 433 F.Supp.2dd at 1068 (quoting *Rosie D.*, 410 F. Supp. 2d at 23-24). Three critical state agencies are DHCS, DMH and DSS.

14. Members of the Plaintiff class are caught up in a system that "has been widely acknowledged to be failing." *Katie A.*, 433 F. Supp. 2d at 1069. In past years, California has ranked last among the 50 states on average Medicaid

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[1] Plaintiffs have submitted some declarations and exhibits in support of this motion that had been filed in support of the prior preliminary injunction. Those earlier declarations generally did not include Bates Stamp numbers for citation purposes.

[2] Children in foster care receiving federal assistance under Title IV-E of the Social Security Act are eligible for Medicaid. 42 U.S.C. § 1396a(a)(10)(A)(i)(I); *see also Katie A.*, 481 F.3d at 1154 n.9.

expenditures on foster children. 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. California's Little Hoover Commission has found that "[m]ore than 50,000 children in the foster care system who may need mental health services do not get them." *Young Hearts*, Exh. 101 at 87. A DMH official admits that they "are unable to provide adequate services to all foster children." Neilsen Depo. at 112:12-113:9. An official with Los Angeles County likewise admits that only a fraction of foster children in the County who need mental health services are getting them. Hatekayama Depo. at 125:19-126:15, 160:10-162:14.

15. Thousands of foster children in California, including members of the Plaintiff class, have been placed in group homes. Further Newman Decl., Exh. 168 at 1061 (estimating almost 6500 children in foster care in group homes). A significant percentage of these foster children, perhaps more than 50%, are in high level group homes, namely Rate Classification Level (RCL) facilities of 12 and above.[3] *See 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). As of November 2005, Los Angeles County alone had 1,832 foster children in group homes, with more than half of them in RCL 12 facilities and above. Findings at ¶ 38. Thousands more foster children in California are placed outside the state. DSS, *Child Welfare Services/Case Management System: Total Children in Supervised Out of Home Placements by Placement - June 2003*, Exh. 112 at 444 (estimating 2900 foster children placed out of state).

16. The "delivery of treatment" is not "the primary purpose of group homes

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[3] 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.

for foster children." Barthels Depo. (Vol. 1) at 81:3-22. Defendants' own expert reports that the "benefit of care in group and institutional settings is not well substantiated and may even be deleterious due to close association with deviant peers, the risk of contagion, loss of contact with family and peers, and other factors." Landsverk Decl., 391-92 at ¶ 4, Exh. 2 at 420. A top state DMH official agrees that that residential care is not an "evidence-based" practice. Neilsen Depo. at 187:9-18. To the contrary, "the evidence is negative, mixed, or shows no effect for institutionally-based interventions – in hospital, residential or group home settings." California Institute of Mental Health Report, Exh. 104 at 361; *see also* Bruns Decl., at ¶ 15 ("near absence of outcome data" to support residential treatment and psychiatric hospitalization). "Children in group care almost certainly … 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." 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"). Group homes can also be dangerous. *See, e.g.*, Centobie Decl., at ¶ 8 (Kayla beaten by older girls in a residential placement); Supplemental (Supp.) Beckman Decl., 9 at ¶ 14 (Cherise placed in a group home that is a "known recruiting grounds for pimps"); Worth Decl., 26-27 at ¶¶ 26-27 (Christine's behaviors got worse, not better, when placed in a group home, as she "has learned all kinds of bad behavior from other kids in the group homes," such as how to cut her wrists).

17. Foster children with significant mental health needs, including members of Plaintiff class, often experience multiple placements and placement disruptions because they are not provided with the mental health services they need. *See, e.g.*, Rauso Decl., 72-73 at ¶¶ 18-19 (group of 43 foster children averaged nearly seven placements per child in less than three years); Worth Decl., 22-26 at ¶¶ 16-20 and 25 (Since being placed in foster care in 2004, Christine has been in more

than eight placements and is currently living in an RCL: 12 group home three hours away from her home); Centobie Decl., at ¶¶ 1, 2, 8 (In 18 months in Merced County's foster care system, Kayla was shunted through 9 different residential placements and 11 psychiatric hospitalizations); *see also* Magnatta Decl., at ¶¶ 1, 4, 23; Frakes Decl., at ¶¶ 2, 3, 5, 10-23; Brumbach Decl., at ¶¶ 4, 12, 17, 21. DSS has 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." DSS, *Reexamination of the Role of Group Care in a Family-Based System of Care*, Exh. 103 at 263 and 281. In the twelve-month period ending March 31, 2007, 44% of the children in foster care in California had experienced three or more placements during their current episode and 14.3% of them had experienced six or more placements. Freitas Decl., 544-45 at ¶ 7, Exh. 3 at 619. 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; *accord* Beckman Supp. Decl., 9 at ¶ 16 (shuttling Cherise in and out of seven or more placements, including foster homes, group homes and psychiatric hospitals "has aggravated her feelings of depression, abandonment and uncertainty about the future"); 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").

18. Many foster children, including members of Plaintiff class, eventually end up in the delinquency system because a lack of appropriate mental health services. *See, e.g., Children with Behavioral Problems: High Incidence of Failed Placements*, Exh. 127 at 762; 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; Centobie Decl., at ¶¶ 6, 8, 15, 17, 22, 33, 37 (Despite history and diagnosis of

serious mental disorders, Kayla's mother was told by the local child welfare agency that "the only way Kayla would get the services she needed was through the probation department," and Kayla ended up in jail).

Definition of Wraparound Services and TFC

19. Wraparound services are defined in Welfare and Institutions Code § 18251(d) as "community-based intervention services that emphasize the strengths of the child and family and includes the delivery of coordinated, highly individualized unconditional services to address the needs and achieve positive outcomes in their lives." Providers of wraparound care services: (a) engage in a unique assessment and treatment planning process that is characterized by the formation of a child, family, and multi-agency treatment, (b) marshal community and natural supports through intensive case management, and (c) make available an array of therapeutic interventions, which may include behavioral support services, crisis planning and intervention, parent coaching and education, mobile therapy, and medication monitoring. *Katie A.*, 481 F.3d at 1153 n.5; *Katie A.*, 433 F. Supp. 2d at 1071-72; McCabe Decl., Ex. D, Appendix A (Appendix A); Supp. Bruns Decl., 212 at ¶ 16; Supp. Friedman Decl., 318 at ¶ 10; Supp. Huffine Decl., 382 at ¶ 10.

20. Wraparound services are comprised of the following nine component services and activities: engagement of the child and family; immediate crisis stabilization; strength and needs assessment; wraparound service plan development; wraparound service plan implementation; ongoing crisis and safety planning; tracking and adapting the wraparound service plan; and transition. *Katie A.*, 481 F.3d at 1153; *Katie A.*, 433 F. Supp. 2d at 1072; Appendix A; Supp. Bruns Dec., 212 at ¶ 16; Supp. Friedman Decl., 318 at ¶ 10; Supp. Huffine Decl., 382 at ¶ 10.

21. TFC is an intensive, individualized mental health service provided to a child in a family setting, utilizing specially trained and intensely supervised foster parents. Therapeutic foster programs (a) place a child singly, or at most in pairs, with a foster parent who is carefully selected, trained, and supervised and matched with the child's needs; (b) create, through a team approach, an individualized

treatment plan that builds on the child's strengths; (c) empower the therapeutic foster parent to act as a central agent in implementing the child's treatment plan; (d) provide intensive oversight of the child's treatment, often through daily contact with the foster parent; (e) make available an array of therapeutic interventions to the child, the child's family, and the foster family (interventions may include behavioral support services for the child, crisis planning and intervention, coaching and education for the foster parent and the child's family, mobile therapy for the child and the child's family, and medication monitoring); and (f) enable the child to successfully transition from therapeutic foster care to placement with the child's family or an alternative family by continuing to provide therapeutic interventions. *Katie A.*, 481 F.3d at 1153 n.6; *Katie A.*, 433 F. Supp. 2d at 1072; McCabe Decl., Ex. D, Appendix B (Appendix B); Supp. Friedman Decl., 318 at ¶ 10; Supp. Huffine Decl., 382 at ¶ 12; Second Supp. Chamberlain Decl., 279 at ¶ 11.

22. TFC is comprised of the following seven component services and activities: recruitment and matching; therapeutic foster parent training; development of a treatment plan; tracking and adapting the treatment plan; plan implementation – individual child treatment; plan implementation – family treatment; and transition. *Katie A.*, 481 F.3d at 1153; *Katie A.*, 433 F. Supp. 2d at 1072; Appendix B; Supp. Friedman Decl., 318 at ¶ 10; Supp. Huffine Decl., 382 at ¶ 12; Second Supp. Chamberlain Decl., 279 at ¶ 11.

23. Wraparound services and TFC are mental health services appropriate for children both in and outside of the foster care system. The services are the same regardless of whether the child is involved in the foster care system. Second Supp. Redman Decl., 492-509 at ¶ 22; *accord* Knisley Decl., 654 -55 at ¶ 17.

Evidence of Medicaid Coverage of the Components of Wraparound Services and TFC

24. Plaintiffs have presented persuasive evidence from leading national experts that each component of wraparound services and TFC can be covered under one or more provisions of 42 U.S.C. § 1396d(a) and is already covered by other

states' Medicaid programs. The Court finds both credible and persuasive the declaration of Dr. Redman and her accompanying table, which demonstrate how the activities and services that are the components of wraparound services and TFC in Appendices A and B are available under other states' Medicaid programs. Second Supp. Redman Decl., 482-83 at ¶ 12 and Exh. 7 at 548-618. The declarations of Ms. Knisley, Ms. Koyanagi, and Mr. Westmoreland corroborate that the components of wraparound services and TFC are covered by Medicaid and that the activities that comprise these components have been covered by other states' Medicaid programs with CMS' approval. Westmoreland Decl., 767-71 at ¶¶ 2, 10, 12-14; Knisley Decl., 646-54 at ¶¶ 3, 15, 16; Koyanagi Decl., at ¶¶ 3, 22, 25, 26, 28, 29, 30.

25. "[O]ther states fund wraparound and TFC programs under Medicaid." *Katie A.*, 481 F.3d at 1156; *accord Katie A.*, 433 F. Supp. 2d at 1076-77 (discussing other states' Medicaid programs' coverage of wraparound services, including Arizona, Wisconsin, and Pennsylvania for wraparound services, and 19 states' coverage of TFC); *see also* Second Supp. Redman Decl., 482-83 at ¶ 12 and Exh. 7 at 548-618; Knisley Decl., 653-54 at ¶ 16; Penrod Decl., 414-17 at ¶ 4, 8-13; Koyanagi Decl., at ¶ 22.

Evidence That Wraparound Services and TFC Are Effective Treatments and Are Medically Necessary for Children with Significant Emotional, Behavioral, and Mental Health Needs

26. Wraparound services and TFC are effective treatments for children in the class, including those with serious mental health, emotional, or behavioral needs. *See, e.g.*, Supp. Supp. Friedman Decl., 316-20 at ¶¶ 5, 8-12 (wraparound services and TFC); Supp. Bruns Decl., 209-21 at ¶¶ 7-8, 11-12, 20, 30-31 (same); Supp. Huffine Decl., 380-82 at ¶¶ 5, 8, 9, 11 (same); Chamberlain Decl., at ¶ 3 (TFC); Second Supp. Chamberlain Decl., 279-80 at ¶ 12 (TFC); *Katie A.*, 433 F. Supp. 2d at 1078 (citing Lourie Decl., at ¶¶ 2, 13; Chamberlain Decl., at ¶ 3; Bruns Decl., at ¶ 3; Huffine Decl., at ¶ 7; Friedman Decl., at ¶¶ 4-5, 31).

27. The "gold standard" of efficacy in the mental health field is an

"evidence-based practice" where there have been randomized clinical trials of a treatment. Chamberlain Decl., at ¶ 14; Second Supp. Chamberlain Decl., 282 at ¶ 15; *see also* Friedman Decl., at ¶¶ 19-21; Supp. Friedman Decl., 318-20 at ¶ 11; *accord* Landsverk Decl., 392-93 at ¶ 7. TFC and, more recently, wraparound services are both considered "evidence-based practices." Supp. Friedman Decl., 320 at ¶ 12 (wraparound services and TFC); Supp. Bruns Decl., 215-21 at ¶¶ 20, 30 (same); Supp. Huffine Decl., 381-82 at ¶¶ 9, 11 (same); Second Supp. Chamberlain Decl., 282 at ¶ 15 (TFC).

28. Defendants acknowledge that wraparound and TFC are among the "successful practices and approaches to effectuate child and family well-being." State Defendants' Opposition to Plaintiffs' Motion for Preliminary Injunction (Defs.' Opp.) at 21.

29. The provision of wraparound services and TFC is medically necessary for a large number of children in the class, including those with serious mental health, emotional or behavioral needs. Supp. Friedman Decl., 316-20 at ¶¶ 5, 8-12 (wraparound services and TFC); Supp. Huffine Decl., 380-82 at ¶¶ 5, 8, 9, 11 (same); Supp. Bruns Decl., 209-22 at ¶¶ 7-8, 11-12, 20, 30-31 (same); Chamberlain Decl., at ¶ 3 (TFC); Second Supp. Chamberlain Decl., 279-80 at ¶ 12 (same); *accord Katie A.*, 433 F. Supp. 2d at 1076 (citing Laurie Decl., ¶¶ 2, 13; Chamberlain Decl., ¶ 3; Bruns Decl., ¶ 3; Huffine Decl., ¶ 7; Friedman Decl, ¶¶ 4, 31).

30. Defendants do not dispute Plaintiffs' evidence of medical necessity, as was true when Plaintiffs filed their earlier motion, *Katie A.*, 433 F. Supp. 2d at 1076-77.

Evidence that Defendants Are Not Effectively Providing the Components of Wraparound Services and TFC

31. All of the components of wraparound services and TFC must be provided in a coordinated fashion to be effective and to ensure that class members receive medically necessary services. *See, e.g.,* Supp. Bruns Decl., 209-22 at ¶¶ 8-10, 16, 24, 31, 33 (discussing research showing that "to achieve these positive

outcomes" that are possible from wraparound services and TFC "all of the components. . .must be provided and they must be provided in a coordinated fashion"); Supp. Huffine Decl., 380-88 at ¶¶ 6, 7, 10-12, 15, 21 ("in order to get the results that are possible from wraparound services and therapeutic foster care, these services must be provided as they were designed (that is, with all of the components being provided in a coordinated fashion)" and discussing research supporting that opinion); Supp. Friedman Decl., 316-25 at ¶¶ 6, 7, 10, 14-16, 19 ("[t]here is no evidence to suggest, and no reason to believe, that wraparound services or therapeutic foster care will have the positive outcomes expected without providing all of the components and doing so in a coordinated fashion as they have been designed, developed and researched" and discussing research supporting that opinion); Second Supp. Chamberlain Decl., 279-86 at ¶¶ 9-11, 17, 18, 23 ("To meet the mental health needs of children for whom therapeutic foster care is necessary, all of the components of therapeutic foster care must be provided and they must be provided in a coordinated fashion as they are with MTFC."); *accord* Supp. Kamradt Decl., 368-72 at ¶¶ 3, 8, 9, 11; Supp. Penrod Decl., 414-27 at ¶¶ 4, 6, 7, 19, 22, 26-29; Rauso Decl., 68-70 at ¶¶ 5, 12.; Bhattacharya Decl., 199 at ¶ 9; Berrick Decl., 147-59 at ¶¶ 4, 28, 41; Champion Decl., 163-66 at ¶¶ 10, 17; Further Farr Decl., 147-59 at ¶¶ 2-9.

32. Defendants have not identified any specific component or components of wraparound services or of TFC that they contend are being effectively provided. Nor have Defendants offered evidence that they are effectively providing any specific component or components of wraparound services and TFC.

33. In discovery, Defendants asserted that *none* of the components of wraparound services and TFC are covered under the Medi-Cal program. DHCS' Director has stated in her interrogatory responses that "[n]one of the components of wraparound services set forth in Appendix A" and "[n]one of the components of TFC set forth in Appendix B" are "covered as such by the Medi-Cal program." Further Newman Decl., 833-34 at ¶ 4; Exh. 164 at 874-75. Rita McCabe testified on

behalf of California's DMH at a deposition last October that the Medi-Cal program should not be reimbursing providers for any of the components of wraparound services listed in Appendix A or any of the components of TFC listed in Appendix B. Further Newman Decl., Exh. 167 at 964-1029. In a letter dated February 14, 2008, Defendants' counsel represented that "there is no one to testify" on Defendants' behalf as to whether the Medi-Cal program was effectively providing any of the mandated components of wraparound services and TFC. Supp. Newman Decl., 1104 at ¶ 7, Exh. 176 at 1296 (February 14, 2008 Letter from Karen Ackerson-Brazille).

34. Wraparound services and TFC are available to class members only at the counties' discretion. For example, Alameda County discontinued its successful wraparound program. Berrick Decl., 150-55 at ¶¶ 14-18, 27. For counties that do provide wraparound services, it is undisputed that the counties have complete discretion on the number of wraparound "slots" they wish to provide. Treadwell Depo. at 21:22-22:1, 31:21-25, 102:20-23. 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 or otherwise appropriate. *Id.* at 27:1-28:10, 38:20-39:1.

35. In existing wraparound programs, eligibility is limited to foster children residing in or at risk of being placed in RCL facilities of 10 or above. Grayson Depo. at 38:14-39:16; Treadwell Depo. at 22:7-10. Counties do not provide wraparound services 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.

36. The current availability of wraparound services and TFC falls far short of class members' need for these services. *See, e.g.*, Huffine Decl., at ¶¶ 38-43 (giving a "conservative estimate" that wraparound services are medically necessary for 15-20% of children in California's foster care system); Supp. Huffine Decl., 383 at ¶ 13 (TFC is medically necessary for children in or at risk of placement in group homes, RTCs, or psychiatric hospitals for whom receiving wraparound services in

their own home or in an alternative home is not possible or is insufficient); Chamberlain Decl., at ¶ 24 ("The research shows that MTFC is both appropriate and necessary for many children who are eligible for substitute care (*i.e.*, kids being sent to residential or group homes) because of severe emotional, behavioral, or psychiatric impairments")); Findings at ¶¶ 32 and 39 (more than half the foster children in RCL facilities of 12 and above could be served in family settings). Only about 2,500 children received wraparound services in California in June 2007. Further Newman Decl., Exh. 165 at 916-925. From January through March 2007, 312 children were placed in Intensive Treatment Foster Care (ITFC), the most common form of TFC in California. Further Newman Decl., Exh. 169 at 1062-1074. *See also Katie A.*, 481 F.3d at 1153 and 1156-57 (Ninth Circuit affirmed prior findings of irreparable harm where this Court cited the "undisputed evidence that wraparound and TFC are medically necessary for children with serious mental health needs" and "described the potential for irreparable harm to plaintiffs in the form of unnecessary institutionalization and unmet mental health needs").

37. Plaintiffs have provided persuasive evidence that Defendants are not effectively providing the components of wraparound services and TFC.

Providing Wraparound Services and TFC Will Not Create Significant Additional Costs for California or Compel Cutbacks to Other Medicaid Recipients

38. County after county has found that wraparound services are cheaper than the care now being provided class members. *See, e.g.*, DSS, Foster Care Rates Group Home Facility Listing, Exh. 123 at 610 (monthly payments per child are $5,613 for a RCL 12 facility and $6,371 for a RCL 14 facility); Rauso Decl., 73-74 at ¶20 (preliminary estimates by Los Angeles County indicate wraparound services has saved the County more than $55,000 per child in placement costs alone); SB 163 Wraparound Final Evaluation, Mono County, Exh. 135 and 969 (average child in wraparound program costs less than half the costs of keeping the youth in a RCL 14 facility); Mendocino County's SB 163 Children's Wraparound Services Pilot

Project Final Report, Exh. 163 at 971 (wraparound services about a third less expensive than cost of out of home placement and specialty mental health services); Report to the Legislature on Humboldt County's Wraparound Services Program, Exh. 137 at 974 (cost of serving child with wraparound services almost one-third less expensive than serving a child without wraparound services); Farr Decl., at ¶ 20 (Sacramento County has saved approximately $6 million in foster care funding with wraparound services); *see also* Kamradt Decl., at ¶¶ 16-17 (serving a child through the Wraparound Milwaukee program cost less than half as much as placing the child in a Residential Treatment Center (RTC)).

39. TFC is also cheaper than the care now provided to class members. *See, e.g.,* Champion Decl., 164-65 at ¶ 15 ($2,000 per month to therapeutic foster parents for each child placed in their homes, which is far less than the "alternative high level residential placements with costs beginning at more than $5,600 per month"); Chamberlain Decl., at ¶ 26 (discussing study finding taxpayer savings from MTFC program); Supp. Chamberlain Decl., at ¶ 6 (discussing cost savings from providing TFC to child in lieu of placing in a RTC); Richard P. Barth, *Institutions vs. Foster Home: The Empirical Base for the Second Century of Debate* (2002), Exh. 129 at 792 ("The costs of institutional care far exceed those for foster care or treatment foster care. The difference in monthly cost can be. . .2 to 3 times as high as treatment foster care").

40. Local juvenile detention facilities spend approximately $3,500 to house a child for the average 27-day stay and the California Youth Authority spends $3,100 just to house a child. Young Hearts and Minds, Exh. 101 at 91.

41. The evidence does not support any contention by Defendants that providing wraparound services and TFC would create significant costs that would compel cutbacks to other Medi-Cal recipients.

Evidence that State Defendants Are Unnecessarily Institutionalizing Class Members

42. By failing to provide wraparound services and TFC to class members,

Defendants are unnecessarily institutionalizing individuals with mental disabilities in congregate care, emergency psychiatric wards, psychiatric hospitals and juvenile detention facilities. *See, e.g.*, Supp. Bruns Decl., 209-210 at ¶¶ 8-9; Supp. Friedman Decl., 316 at ¶ 5; Kamradt Decl., at ¶¶ 1, 3, 11-15, 19; Rauso Decl., 71-72 at ¶¶ 14-18; Farr Decl., at ¶¶ 2, 7-13; Findings of Fact and Conclusions of Law re Settlement Agreement between Plaintiffs and County dated November 20, 2006, at ¶¶ 32 and 39 (more than half the foster children in RCL facilities of 12 and above could be served in family settings); *see also* Champion Decl., at ¶¶ 6, 7, 12; Letter dated January 31, 2003, from Bradford R. Luz, Director of Butte County Department of Behavioral Health, Exh. 117 at 579-80; Treadwell Depo. at 126:11-18; Neilsen Depo. at 158:4-159:18; Lourie Decl., at ¶¶ 4-11, 13. Chamberlain Decl., at ¶¶ 1, 2, 13-17; Watrous Decl., at ¶¶ 5-7; Berrick Decl., 157-58 at ¶¶ 34-37; Grealish Decl., at ¶¶ 1-4, 31.

43. There is no evidence that children would object to receiving wraparound services or TFC rather than being institutionalized. Available evidence is to the contrary. *See, e.g.,* Smith Decl., 29-36 at ¶¶ 3, 4, 15 and 17; Further Farr Decl., 119-33 at ¶¶ 12-60.

CONCLUSIONS OF LAW

Plaintiffs Have Met the Standard for a Mandatory Preliminary Injunction

44. Plaintiffs seeking a preliminary injunction 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. *Katie A.*, 481 F.3d at 1156; *Katie A.*, 1069. In cases where plaintiffs seek mandatory preliminary relief, plaintiffs must show that the facts and law clearly favor the moving party. *Katie A.*, 481 F.3d at 1156; *Stanley v. University of Southern California*, 13 F.3d 1313, 1320 (9th Cir. 1994); *Katie A.*, 433 F. Supp. 2d at 1070.

45. Plaintiffs suffer an array of injuries from Defendants' failure to meet their mental health needs, including unnecessary institutionalization, emotional

injuries from multiple failed placements, and abuse in group homes. *See supra* at ¶¶ 13-18. The harms Plaintiffs face are imminent, grave, and irreparable. *Katie A.*, 481 F.3d at 1156. *See Beltran v. Meyers*, 677 F.2d 1317, 1322 (9th Cir. 1982) (irreparable injury occurs when State denies "needed medical care" to Medicaid recipients). Plaintiffs will continue to face these harms without the preliminary injunction. *Katie A.*, 481 F.3d at 1156-57.

46. This Court rejects Defendants' arguments that Plaintiffs have not shown irreparable harm because they waited three years before filing the prior preliminary injunction motion and eight months after the Ninth Circuit's remand to file this new motion for preliminary injunction. As this Court previously found, Plaintiffs "initially focused much of their efforts and limited resources on their claims against Los Angeles County," and these efforts resulted in a "pioneering, albeit still problem-laden, settlement" in which the County agreed to make a number of important commitments for the care of members of the countywide class. *Katie A.*, 433 F. Supp. 2d at 1078. Defendants' argument regarding the timing of this motion is similarly unavailing, given the five months of discovery preceding this motion and Defendants' request for an additional two months to file their opposition. "The unmet mental health needs and harms of unnecessary institutionalization" to the Plaintiff class "are no less grave now" than when this lawsuit was filed. *Id.*

47. This Court also rejects Defendants' argument that Plaintiffs have not been irreparably harmed because they have an adequate remedy through the Medicaid appeals process. As this Court previously found, "exhaustion of state administrative remedies should not be required as a prerequisite to bringing an action pursuant to § 1983." *Katie A.*, 433 F. Supp. 2d at 1078 (citing *Patsy v. Board of Regents of State of Fla.*, 457 U.S. 496, 516, 102 S.Ct. 2557, 73 L.Ed. 2d 172 (1982)).

48. "The public interest is a factor to be strongly considered" in granting a preliminary injunction. *Lopez,* 713 F.2d at 1437. A "government must be

concerned not only with the public fisc but also with the public weal." *Id*. Here, it is in the public interest to ensure that the Plaintiff class, foster children who are both poor and disabled, get the mental health services they need. Providing wraparound services and TFC will also likely save the public money. *See supra* at ¶¶ 38-40.

49. The balance of hardships clearly tips in Plaintiffs' favor.

50. The facts and law in this case clearly favor the Plaintiffs on their Medicaid claim and their ADA claim, as set forth below.

Plaintiffs' Claims under the Medicaid Act

51. As this Court previously ruled, Plaintiffs have a private right of action against Defendants under 42 U.S.C. § 1983 for their violations of the Medicaid Act, including 42 U.S.C. §§ 1396a(a), 1396d(a), and 1396d(r). *Katie A.*, 433 F. Supp. 2d at 1070 (citing *Watson v. Weeks*, 436 F.3d 1152, 1155 (9th Cir. 2006) (noting that "[i]n ruling that § 1396a(a)(10) creates a private right of action enforceable under § 1983, the Ninth Circuit joined five federal circuits that have already held so"; internal quotation marks omitted); *accord Katie A.*, 481 F.3d at 1162.

52. When a state chooses to participate in the Medicaid program, the state must comply with the Medicaid Act and its implementing regulations. *Katie A.*, 481 F.3d at 1154; *Katie A.*, 433 F. Supp. 2d at 1071.

53. The Medicaid Act requires that each state provide for making medical assistance available, including "early and periodic screening, diagnostic, and treatment services ... for individuals who are eligible under the plan and are under the age of 21, " 42 U.S.C. § 1396d(a)(4) (EPSDT).

54. 42 U.S.C. § 1396d(r)(5) defines these services to include "[s]uch other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section 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 plan." Under § 1396d(r)(5), states must cover every type of health care or service necessary for EPSDT corrective or ameliorative purposes that is allowable under § 1396d(a). *Katie A.*, 481 F.3d at

1154, 1158.

55. 42 U.S.C. § 1396d(a) contains a list of 28 categories of care or service. *Katie A.*, 481 F.3d at 1154. The 1396d(a) categories are fairly general. *Katie A.*, 481 F.3d at 1154.

56. A service need not be expressly listed in § 1396d(a) to be covered. *Katie A.*, 483 F.3d at 1158; Second Supp. Redman Decl., 480 at ¶ 8 ; Knisley Decl., 651-52 at ¶ 13; Westmoreland Decl., 773 at ¶ 18.

57. States must provide all of the services listed in § 1396d(a) to eligible children when such services are found to be medically necessary. *Katie A.*, 481 F.3d at 1154; Defs.' Opp. at 5.

58. California is required to provide EPSDT services to eligible children under the age of 21. *Katie A.*, 481 F.3d at 1154.

59. California must provide covered services to class members rather than simply make such services available. *Katie A.*, 481 F.3d at 1162, *citing* 42 U.S.C. § 1396a(a)(43).

Plaintiffs Prevail on the Three Issues Identified by the Ninth Circuit

60. All the components of wraparound services and TFC fall within the 28 categories of services under § 1396d(a). *See, e.g.,* Second Supp. Redman Decl., 478-483 at ¶¶ 5, 11, 12, and Exh. 7 at 548-618; Westmoreland Decl., 767-71 at ¶¶ 2, 10, 12-14; Knisley Decl., 646-54 at ¶¶ 3, 15, 16; Koyanagi Decl., at ¶¶ 3, 22, 25, 26, 28, 29, 30.

61. The category of services known as rehabilitative services covers "other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting)" when those services "are recommended by a physician or other licensed practitioner . . . for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level." 42 U.S.C. § 1396d(a)(13). This includes: diagnosis, assessment, treatment planning and coordinating the delivery of rehabilitative services; crisis services; family psychoeducation to enlist a person's

family in addressing and managing the person's mental illness; peer support and counseling; basic life skills and social skills training and support; medication education and management; and illness and disability management. U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, *A Primer on How to Use Medicaid to Assist Persons Who are Homeless to Access Medical, Behavioral Health and Support* Services (January 2007), at 58-59 (Second Supp. Redman Decl., Exh. 6 at 546-47); Second Supp. Redman Decl., 488-90 at ¶ 19; *accord* Knisley Decl., 651-55 at ¶¶ 13, 16, 17; McCabe Decl., 64-65 at ¶ 9 (coverage under rehabilitative services includes assistance to individuals with "functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, support resources, and medication management").

62. The case management category of services covers "services which will assist individuals eligible . . . in gaining access to needed medical, social, educational, and other services." 42 U.S.C. § 1396n(g)(2). This includes: assessments to determine service needs, which can involve "[g]athering information from other sources such as family members, medical providers, social workers, and educators"; development of a specific care plan with the active participation of the eligible individual and others and that, among other things, "specifies the goals and actions to address" the various services needed by the eligible individual; referral and related activities to help an individual obtain needed services; and monitoring and follow-up activities. P.L. 109-171, § 6052(a)(2) (Feb. 8, 2006), codified at 42 U.S.C. § 1396n(g)(2)(A)(ii); Second Supp. Redman Decl., 484-85 at ¶ 14; Knisley Decl, 656-57 at ¶ 18; *accord* McCabe Decl., 65-67 at ¶¶ 11, 13A (case management services "may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service;" assessments; service plan development and periodic review; linkage and consultation; assistance in accessing services; and crisis planning).

63. 42 U.S.C. § 1396d(a)(9) covers "clinic services furnished by or under

the direction of a physician, without regard to whether the clinic itself is administered by a physician, including such services furnished outside the clinic by clinic personnel to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address."

64. 42 U.S.C. § 1396d(a)(6) covers "any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law."

65. All the components of wraparound services and TFC fall within the §1396d(a) categories of rehabilitative services, §1396d(a)(13), case management services, § 1396d(a)(13), clinic services, § 1396d(a)(9), and/or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law," § 1396d(a)(6). Second Supp. Redman Decl., 481-82 at ¶ 10; Koyanagi Decl., at ¶ 25, 28-30; Knisley Decl., 653 at ¶ 15; Westmoreland Decl., 770 at ¶ 12.

66. With regard to the nine components of wraparound services, the Court finds that these components fall under the following categories of services under § 1396d(a):

A. "Engagement of the child and family" – rehabilitative services and case management services. Koyanagi Decl., at ¶ 28(a); Second Supp. Redman Decl., 491-92 at ¶ 21.

B. "Immediate crisis stabilization" – rehabilitative services. Koyanagi Decl., at ¶ 28(b); Second Supp. Redman Decl., 492-509 at ¶ 22(b)(i).

C. "Strengths and needs assessment" – rehabilitative services and case management services. Koyanagi Decl., at ¶ 28(c); Second Supp. Redman Decl., 483-85 at ¶¶ 13, 14; *see also id.*, 486-91 at ¶¶ 16, 20.

D. "Wraparound team formation" – rehabilitative services and case management services. Koyanagi Decl., at ¶ 28(d); *see also* Second Supp. Redman Decl., 486-91 at ¶¶ 16, 20.

E. "Wraparound plan development" – rehabilitative services and case

management services. Koyanagi Decl., at ¶ 28(e); Second Supp. Redman Decl., 483-509 at ¶¶ 13, 14, 22(a)(i).

F. "Wraparound service plan implementation" – rehabilitative services and, depending on the nature of the services in the plan, possibly other § 1396d(a) categories, including case management services. Koyanagi Decl, at ¶ 28(f).

G. "Ongoing safety and crisis planning" – rehabilitative services and clinic services. Koyanagi Decl., at ¶ 28(g); Second Supp. Redman Decl., 492-509 at ¶ 22(b)(i).

H. "Tracking and adapting the wraparound service plan– rehabilitative services and case management services. Koyanagi Decl., at ¶ 28(h); Second Supp. Redman Decl., 486-91 at ¶¶ 16, 20.

I. "Transition" – rehabilitative services. Koyanagi Decl., at ¶ 28(i); Second Supp. Redman Decl., 510-11 at ¶ 23(b).

67. With regard to the seven components of TFC, the Court finds that these components fall under the following categories of services under § 1396d(a):

A. "Recruiting and matching" – rehabilitative services and case management services, when done on behalf of a particular child.[4] Koyanagi Decl., at ¶ 30(a); Second Supp. Redman Decl., 492-509 at ¶ 22(b)(ii).

B. "Therapeutic foster parent training" – rehabilitative services and case management services, when done on behalf of a particular child.[5] Koyanagi Decl., at ¶ 30(b); Second Supp. Redman Decl., 492-509 at ¶ 22(b)(iii).

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[4] When not done on behalf of a particular child, this component is covered as an administrative expense built into the provider reimbursement rate. Second Supp. Redman Decl., 492-509 at ¶ 22(b)(ii).

[5] When not done on behalf of a particular child, this component is covered as an administrative expense built into the provider reimbursement rate. Second Supp. Redman Decl., 492-509 at ¶ 22(b)(iii).

C. "Development of treatment plan – rehabilitative services and case management services. Koyanagi Decl, at ¶ 30(c); Second Supp. Redman Decl., 492-509 at ¶ 22(a)(i).

D. "Tracking and adapting the treatment plan" – rehabilitative services and case management services. Koyanagi Decl., at ¶ 30(d); Second Supp. Redman Decl., 492-509 at ¶ 22(a)(ii).

E. "Plan implementation – individual child treatment" – rehabilitative services and, depending on the nature of the services in the plan, possibly other § 1396d(a) categories, including case management services. Koyanagi Decl., at ¶ 30(e).

F. "Plan implementation – family treatment" – rehabilitative services and clinic services. Koyanagi Decl., at ¶ 30(f); Second Supp. Redman Decl., 491-92 at ¶ 21.

G. "Transition" – rehabilitative services and case management services. Koyanagi Decl., at ¶ 30(g); Second Supp. Redman Decl., 492-509 at ¶ 22(a)(iii).

68. While Defendants do not expressly concede that any particular component of wraparound services is covered by Medicaid, they state that "[i]f the medical necessity criteria is met and the services are properly described, the service activities under the process called wraparound could be Medicaid covered services under 42 U.S.C. § 1396d(a)(19) and covered pursuant to 42 U.S.C. § 1396d(a)(13) as other diagnostic, screening, preventative and rehabilitative services. Defs.' Opp. at 7; *see also* McCabe Decl., 64 at ¶ 8 (same).

69. Defendants argue that the new case management regulations prohibit coverage of TFC under this category of services.[6] Even if the components of TFC

[6] Recently proposed legislation would, however, put a moratorium until April 9, 2009 on enforcement of the case management regulations as well as the rehabilitative service regulations and other regulations proposed by CMS. *See* H.R. 5613, The Protecting the Medicaid Safety Net Act of 2008.

do not fall within the category of case management services, they fall within other categories of services in § 1396d(a), including rehabilitative services. *See, e.g.*, Koyanagi Decl. at ¶ 28 (stating that TFC "is a mental health service that is commonly billed under the Medicaid Rehabilitation category" and describing how each component can be covered as a rehabilitative service); *accord* Appendix B. *See also supra* at ¶ 65. Moreover, the case management regulations do not prohibit covering the components of TFC – when TFC is provided as a mental health intervention – under a state's Medicaid program. Second Supp. Redman Decl., 492-509 at ¶ 22. The case management regulations "do[] not in any way, compromise a Medicaid recipients' eligibility for medically necessary services . . ., including medically necessary case management (and targeted case management) services that are not used to administer other programs." 72 Fed. Reg. 68077, 68088 (Dec. 4, 2007). When TFC is provided as a mental health intervention, the components of TFC that fall within the definition of case management services are "not used to administer other [non-health care] programs." Second Supp. Redman Decl., 492-509 at ¶ 22.

70. Defendants are not effectively providing the components of wraparound services and TFC to class members. *See supra at* ¶¶ 31-37**.** There is ample evidence that the State does not cover the components of wraparound services and TFC under its Medicaid program. Additionally, the evidence is clear that the State does not consider class members to have an entitlement, under Medicaid or otherwise, to receive the components of wraparound services and TFC or to receive them in a coordinated fashion. The result is that class members are denied medically necessary mental health services.

71. Defendants have not demonstrated that providing the components of wraparound services and TFC in a manner other than the comprehensive and coordinated fashion set forth by Plaintiffs is effective or that an alternative approach would meet the medical needs of class members. Plaintiffs' evidence clearly demonstrates that to be effective, Defendants must provide all of the components of

wraparound services and TFC in a coordinated fashion to class members for whom they are medically necessary. *See supra* at ¶ 31.

72. Plaintiffs have not requested, and Defendants need not provide, wraparound services and TFC as bundled services for billing purposes.

Plaintiffs Have Proven Their ADA and Rehabilitation Act Claims

73. Plaintiffs and members of the class are entitled to relief under Title II of the ADA, § 12102(2), and Section 504 of the Rehabilitation Act, 29 U.S.C. § 794.[7]

74. Class members are persons with disabilities under the ADA. *See* 42 U.S.C. § 12102(2) (disability includes mental impairment that substantially limits one or more major life activities); *see supra* at ¶ ¶ 10-11.

75. Defendants Shewry and Wagner are appropriate defendants under the ADA. *Miranda B. v. Kitzhaber*, 328 F.3d 1181, 1187-89 (9th Cir. 2003).

76. The regulations implementing Title II mandate that public entities 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).

77. 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. *Id.* at 587; *see also ARC of Washington State Inc. v. Braddock*, 427 F.3d 615, 618 (9th Cir. 2005)("states are required to provide care in integrated environments for as many disabled persons as is reasonably feasible, so long as such an environment is appropriate to their mental health needs"). States are required to transfer individuals with disabilities from institutional to integrated community settings if: (1) the individual is appropriate for community placement, (2) the individual does not oppose such a placement, and (3) the community placement could be reasonably accommodated. *Olmstead*, 527 U.S.

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[7] The analysis of the ADA applies equally to Section 504. See *Miranda B. v. Kitzhaber*, 328 F.3d 1181, 1188 (9th Cir. 2003).

at 587, 607.

78. Plaintiffs have proven that wraparound services and TFC will prevent the unnecessary institutionalization of class members. *See supra* at ¶ 42. The Ninth Circuit affirmed this Court's prior finding that Plaintiffs "would face unnecessary institutionalization without the preliminary injunction." *Katie A.*, 481 F.3d at 1156.

79. Plaintiffs have proven that class members' community placement can be reasonably accommodated and that it would not be a fundamental alteration to transfer class members to, or maintain them in, community settings. *See supra* at ¶¶ 38-41.

80. Defendants bear the burden of establishing a fundamental alteration defense. *Townsend v. Quasim*, 328 F.3d 511, 520 (9th Cir. 2003). Defendants fundamental alteration defense is based on two arguments: that wraparound and TFC are not covered by Medicaid and that Plaintiffs seek unreasonably to impose "one approach to delivering mental health service on all children in all counties." Defs.' Opp. at 23, 24-25. However, Plaintiffs have proven that the components of wraparound services and TFC are covered by Medicaid. *See supra* at ¶¶ 65-68. Moreover, Plaintiffs do not seek a "one size fits all" approach and they have never sought to preclude the State or counties from providing services other than wraparound services or TFC to class members. This lawsuit seeks wraparound services and TFC only for those members of the class for whom these services are medically necessary. *See* Pls.' Reply Mem. of P&A, at 2. That does not constitute a fundamental alteration within the meaning of the ADA.

81. Defendants have failed to demonstrate that, 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. *See Olmstead, Townsend v. Quasim*, 328 F.3d 5111 (9th Cir. 2003).

This Court Will Grant Plaintiffs' Preliminary Injunction

82. Plaintiffs have met the standard for the granting of a mandatory

preliminary injunction. *See supra* at ¶¶ 44-50. Accordingly, this Court will grant a preliminary injunction directing Defendants to make wraparound services and TFC available to all class members on a consistent statewide basis through the Medi-Cal program or other means. The Defendants should be given 60 days to develop a plan and another 60 days to provide the actual services. Defendants' counsel shall meet and confer with Plaintiffs' counsel to develop a plan for implementing this preliminary injunction. *See Katie A.*, 433 F. Supp. 2d at 1079. The plan must identify, among other things, the responsibilities of the different State agencies, the need for additional providers, the eligibility criteria for wraparound services and TFC, methods and procedures to inform class members of the availability of these services, and a timeline for accomplishing needed tasks. *Id.* With regard to developing this implementation plan, the parties shall submit joint progress reports to the Court every two weeks. These progress reports shall reflect any issues where the parties have reached agreement on particular issues as of that date (e.g., the eligibility criteria for wraparound services) and any issues where the parties have been unable to reach agreement and so the Court will have to resolve this particular dispute over implementation.

83. The injunction will issue against both Defendants in their official capacities as the current Directors of DHCS and DSS. Concerted action by both Departments is needed to ensure class members receive needed mental health services. *Katie A.*, 481 F.3d at 1162. The actions of the child welfare system heavily influence whether class members receive needed mental health services. *Id.*

84. The Court will not require the posting of a bond. *See People of State of Cal. ex rel. Van De Kamp v. Tahoe Regional Planning Agency,* 766 F.2d 1319, 1325-26 (9th Cir. 1985); *Orantes-Hernandez v. Smith,* 541 F. Supp. 351, 385 n.42 (C.D. Cal. 1982); *accord Katie A.*, 433 F. Supp. 2d at 1079.

85. All of the foregoing constitutes the Court's findings of fact and conclusions of law. To the extent that the factual recitals also constitute legal

conclusions and to the extent that legal conclusions also constitute factual recitals, such recitals, findings and conclusions shall be so construed.

Dated: April __, 2008

A. HOWARD MATZ
U.S. DISTRICT JUDGE

Submitted by,

Robert D. Newman
Attorney for Plaintiffs