

Elissa Gershon, State Bar No. 169741  
[elissa.gershon@disabilityrightsca.org](mailto:elissa.gershon@disabilityrightsca.org)  
Elizabeth Zirker, State Bar No. 233487  
[elizabeth.zirker@disabilityrightsca.org](mailto:elizabeth.zirker@disabilityrightsca.org)  
Kim Swain, State Bar No. 100340  
[kim.swain@disabilityrightsca.org](mailto:kim.swain@disabilityrightsca.org)  
DISABILITY RIGHTS CALIFORNIA  
1330 Broadway, Suite 500  
Oakland, CA 94612  
Telephone: 510.267.1200  
Facsimile: 510.267.1201

Attorneys for Plaintiffs

[Complete list of counsel on following pages]

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF CALIFORNIA

ESTHER DARLING; RONALD BELL by  
his guardian ad litem Rozene Dilworth;  
GILDA GARCIA; WENDY HELFRICH by  
her guardian ad litem Dennis Arnett; JESSIE  
JONES; RAIF NASYROV by his guardian  
ad litem Sofiya Nasyrova; ALLIE JO  
WOODARD, by her guardian ad litem  
Linda Gaspard-Berry; individually and on  
behalf of all others similarly situated,

Plaintiffs,

vs.

TOBY DOUGLAS, Director of the  
Department of Health Care Services, State  
of California, DEPARTMENT OF  
HEALTH CARE SERVICES,

Defendants.

**Case No.: C09-03798 SBA**

**CLASS ACTION**

**PLAINTIFFS' REPLY TO DEFENDANTS'  
OPPOSITION TO PLAINTIFFS' NOTICE OF  
MOTION AND MOTION FOR  
PRELIMINARY INJUNCTION**

**Hearing Date:** July 26, 2011

**Time:** 1:00 p.m.

**Judge:** Hon. Sandra B. Armstrong

**Address:** 1301 Clay Street

Oakland, CA 94612

**Courtroom:** 1, 4<sup>th</sup> Floor

1 Kenneth A. Kuwayti, State Bar No. 145384  
2 [Kkuwayti@mofo.com](mailto:Kkuwayti@mofo.com)  
3 Benjamin A. Petersen, State Bar No. 267120  
4 [Bpetersen@mofo.com](mailto:Bpetersen@mofo.com)  
5 Morrison & Foerster LLP  
6 755 Page Mill Road  
7 Palo Alto, California 94304-1018  
8 Telephone: 650.813.5600  
9 Facsimile: 650.494.0792

6 Eric Carlson, State Bar No. 141538  
7 [Ecarlson@nslc.org](mailto:Ecarlson@nslc.org)  
8 NATIONAL SENIOR CITIZENS LAW CENTER  
9 3435 Wilshire Boulevard, Suite 2860  
10 Los Angeles, CA 90010  
11 Telephone: 213.674.2813  
12 Facsimile: 213.639.0934

10 Kenneth W. Zeller, *Pro Hac Vice*  
11 [kzeller@aar.org](mailto:kzeller@aar.org)  
12 Kelly Bagby, *Pro Hac Vice*  
13 [kbagby@aar.org](mailto:kbagby@aar.org)  
14 AARP FOUNDATION LITIGATION  
15 601 E Street N.W.  
16 Washington, D.C. 20049  
17 Telephone: 202.434.2060  
18 Facsimile: 202.434.6424

Anna Rich, State Bar No. 230195  
[arich@nslc.org](mailto:arich@nslc.org)  
Kevin Prindiville, State Bar No. 235835  
[kprindiville@nslc.org](mailto:kprindiville@nslc.org)  
NATIONAL SENIOR CITIZENS LAW  
CENTER  
1330 Broadway, Suite 525  
Oakland, California 94612  
Telephone: 510.663.1055  
Facsimile: 510.663.1051

Barbara Jones, State Bar No. 88448  
[bjones@aar.org](mailto:bjones@aar.org)  
AARP FOUNDATION LITIGATION  
200 So. Los Robles, Suite 400  
Pasadena, California 91101  
Telephone: 626.585.2628  
Facsimile: 626.583.8538

Sarah Somers, State Bar No. 170118  
[somers@healthlaw.org](mailto:somers@healthlaw.org)  
Martha Jane Perkins, State Bar No. 104784  
[perkins@healthlaw.org](mailto:perkins@healthlaw.org)  
NATIONAL HEALTH LAW PROGRAM  
101 East Weaver Street, Suite G-7  
Carrboro, North Carolina 27510  
Telephone: 919.968.6308  
Facsimile: 919.968.8855

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1 **I. FACTUAL UPDATE**

2 Three significant events have taken place since Plaintiffs' opening brief was filed. First, on July  
3 1, 2011, CMS approved the State's request for a State Plan Amendment (SPA) to eliminate ADHC as an  
4 optional Medi-Cal benefit, with an effective date of September 1, 2011. Supplemental Decl. of Lydia  
5 Missaelides ("Missaelides Supp. Decl.") Ex. A. It is now clear that, without an injunction, ADHC will be  
6 eliminated as an optional Medi-Cal benefit within 35 days of the hearing on this motion. CMS was  
7 careful to state in its approval letter that: "This action does not in any way address the State's independent  
8 obligations under the Americans with Disabilities Act or the Supreme Court's *Olmstead* decision." *Id.*

9 Second, on June 15, 2011, the Legislature passed AB 96 which would require DHCS to submit,  
10 on or before September 1, 2011, an application to CMS to implement the "Keeping Adults Free from  
11 Institutions" ("KAFI") program. Assem. Bill No. 96 (2011-2012 Reg. Sess.); Missaelides Supp. Decl.  
12 Ex. E. AB 96 would require the KAFI program to utilize licensed adult day health centers to provide a  
13 well-defined scope of specified services for Medi-Cal beneficiaries who have been assessed to be at  
14 significant risk of institutionalization. *Id.* At the request of the Governor's office, AB 96 has not been  
15 presented to the Governor for signature. Missaelides Supp. Decl. ¶ 7. Thus, Defendants have not  
16 applied to CMS to implement the KAFI program.

17 Third, on June 30, 2011, the Governor signed California's 2011-2012 budget. Sen. Bill No. 87  
18 (2011-2012 Reg. Sess.) Missaelides Supp. Decl. Ex. D. SB 87 appropriates an augmentation of \$60  
19 million, in addition to the Governor's previously budgeted \$25 million contained in his May, 2011  
20 revision to the budget, "to transition current beneficiaries of the Adult Day Health Care program to other  
21 appropriate services." *Id.* The Governor authorized a total of \$85 million but he deleted Provision 13,  
22 which was the Legislature's prior budget language authorizing and directing the Administration to create  
23 a new KAFI waiver program. *See*, [ECF No. 245-7] Missaelides Decl. Ex. G at PL00886. In his veto  
24 message, the Governor specified the following uses for the \$85 million: (1) to transition current ADHC  
25 beneficiaries to other appropriate services, and (2) "to work with the Legislature to assess the needs of  
26 the population to determine to what extent additional services are needed during and after the  
27 transition," including "seeking federal waiver services and developing alternative funding arrangements  
28 to preserve services at ADHC centers." Missaelides Supp. Decl. Ex. D.

1 **II. DEFENDANTS' FAIL TO REFUTE PLAINTIFFS' EVIDENCE**

2 **A. Defendants' Transition Planning is A "Bridge to Nowhere"**

3 Defendants' belabored attempts to justify their transition planning efforts and identification of  
4 alternative services for the 35,000-37,000 ADHC recipients who will need them in a matter of weeks fail  
5 to provide any assurances that would counter Plaintiffs' claims of inadequacy. *See, e.g.*, [ECF No. 274]  
6 Ogle Decl. ¶¶ 6-23. Defendants' planning efforts are "embryonic," according to Plaintiffs' expert, Dr.  
7 Leslie Hendrickson, who has 25 years of experience administering and consulting on Medicaid  
8 programs. In his opinion, Defendants have proffered "little documentation ... to show they have an  
9 understanding of how many persons need what services and where and how the services can be obtained  
10 by September 1." Declaration of Leslie Hendrickson, Ph.D. ("Hendrickson Decl.") ¶ 32.

11 According to Dr. Hendrickson, Defendants:

12 should conduct the necessary planning and analysis...that would enable them to: (1) identify  
13 recipients who need alternative, replacement services and where these individuals reside;  
14 (2) evaluate the availability of services, including the location and capacity of providers and  
15 whether such services fit recipients' needs; and (3) identify and plan for gaps in services in  
16 order to avoid worsening physical and mental conditions and unnecessary use of hospitals,  
17 other health care providers, and nursing homes.  
18 *Id.* ¶ 13.

19 Defendants' purported assessment process — which thus far ignores more than 75% of the  
20 ADHC population-- is a mere first step. Defendants' Opposition ("Opp.") 3:16-19. The logic of  
21 reviewing the IPCs of only the 4 and 5 day per week recipients is unclear and supported by no evidence  
22 that individuals who attend ADHC for fewer days have the same or lesser needs. In any case,  
23 Defendants' response to the needs they identify in recipients' IPCs — a laundry list of categories of  
24 programs that "might" offer some case management or services — is wholly inadequate to ensure the  
25 real, not "theoretical" availability of those services to meet the needs of ADHC recipients. *See*,  
26 Supplemental Decl. of Kathleen Wilber ("Wilber Supp. Decl.") ¶¶ 6-9. For example:

27 Managed Care and TCM: Defendants now cite managed care case management or Targeted Case  
28 Management (TCM) as a "key available resource." Opp. 4:4. However, case management, even if  
available, does not provide services; rather it is intended to link individuals to needed resources.  
Hendrickson Decl. ¶¶ 26-28; Decl. of Marty Lynch ("Lynch Decl.") ¶¶ 12, 19. Without services to be  
linked to, case management is of little value. *Id.* Moreover, TCM is simply a potential funding source,

1 not a service provider. Hendrickson Decl. ¶¶ 26-27.

2 Defendants' portrayal of managed care as a panacea is equally inaccurate. Lynch Decl. ¶¶ 12-  
 3 19; Hendrickson Decl. ¶ 28; Missaelides Supp. Decl. ¶ 21. For instance, with respect to Plaintiff  
 4 Darling, Defendants foist the responsibility for her care onto her managed care plan and her physician,  
 5 despite the fact that her ADHC provider confirmed that her managed care plan would be inadequate to  
 6 meet either her direct service or case management needs. Supplemental Decl. of Dawn Myers Purkey  
 7 ("Myers Purkey Supp. Decl.") ¶¶ 15-16. Half of California's counties do not have a Medi-Cal managed  
 8 care option at all, and in those that do, significant long term care and disability care services (such as  
 9 IHSS, ADHC, MSSP, HCBS Waiver services, and, for most plans, nursing facilities) are "carved out,"  
 10 which means that managed care plans do not offer or fund them, and, they generally lack expertise to  
 11 provide case management of these long term care and disability services. Lynch Decl. ¶¶ 13, 17-18.

12 IHSS: Defendants also continue to refer to IHSS, completely ignoring Plaintiffs' ample evidence  
 13 that IHSS is not a substitute for the skilled care at ADHC. Mot. 7:27-8:26; Hendrickson Decl. ¶ 53.  
 14 Defendants fail to identify an IHSS substitute for ADHC recipients who already receive the statutory  
 15 maximum. For example, while Defendants acknowledge that Plaintiff Helfrich is not eligible to receive  
 16 more IHSS (Opp. 5:10-12), they fail to reveal that the only other program that offers IHSS-type  
 17 attendant care is the Nursing Facility Waiver, which has a waitlist of approximately 700 people and an  
 18 estimated wait time of 19 months. Wilber Supp. Decl. ¶ 7.

19 IHSS recipients already received a 3.6% cut in February, 2011, and the current budget contains a  
 20 "trigger" that could impose an additional 20% cut in January, 2012. [ECF No. 269] Carroll Decl. ¶ 4;  
 21 CAL. WELF. AND INST. CODE § 12301.07(a)(1). Moreover, 60% of ADHC recipients receive IHSS  
 22 services from a family member, 70% of whom say they cannot provide any additional care. Missaelides  
 23 Supp. Decl. ¶ 15. In Napa County, preliminary assessments by the IHSS program show that 50% of the  
 24 ADHC recipients will not be eligible for any increased IHSS upon the termination of ADHC. The  
 25 average increase for the remaining 50% is 2.5 hours per month. Supplemental Decl. of Celine Regalia  
 26 ("Regalia Supp. Decl.") ¶ 9. Defendants do not explain how this meager increase can substitute for the  
 27 comprehensive services provided at ADHC.

28 Medication Management: Defendants repeatedly mischaracterize the availability and criticality

1 of “medication management,” which they blithely claim can “unquestionably” be provided through  
 2 IHSS. Opp. 5:12-17; Carroll Decl. ¶ 4; [ECF No. 270] Ferreria Decl. ¶ 8; *see* Pl. Obj. to Def. Evid.  
 3 IHSS can only provide assistance with self-administration of medication and “paramedical services”  
 4 under limited circumstances (CAL. MAN. OF POL. & PROC. §§ 30-780 (7), (9)) but cannot substitute for  
 5 the skilled medication management provided at ADHC, which includes monitoring medications for side  
 6 effects, assessing the effectiveness of types and dosages of medications, coordinating with physicians,  
 7 and instructing participants and family members on proper medication administration. *See*, [ECF No.  
 8 244] McCloud Decl. ¶¶ 46-49; [ECF No. 233] Dick-Muehlke Decl. ¶¶ 14-19, 22, 29-31; [ECF No. 254]  
 9 Steinke Decl. ¶¶ 14, 21; [ECF No.251] Puckett Decl. ¶ 47; [ECF No. 252] Regalia Decl. ¶ 25;  
 10 Hendrickson Decl. ¶ 49. Defendants completely ignore the skilled services, such as monitoring and  
 11 medication management that ADHC uniquely provides to Plaintiffs Darling and Garcia, which are  
 12 critical to their ability to remain living independently. “If [Ms. Garcia] loses her daily monitoring and  
 13 interventions at the ADHC center, she loses her independence, her friends, her medical monitoring and  
 14 will inevitably experience a downward spiral.” Steinke Decl. ¶ 27; ¶ 28 (Re: Darling).

15 Lack of Services: Many of the categories of programs identified by Defendants are simply  
 16 irrelevant to the ADHC population, such as the children’s waiver or the closed IHO waiver. [ECF No.  
 17 276] Owen Decl. ¶¶ 7, 10. Defendants also cite to services which have significant barriers to their  
 18 availability to ADHC recipients by the September 1, 2011 deadline, such as programs under  
 19 development (*Id.* ¶ 11); or those with waitlists, like the Nursing Facility Waiver (Wilber Supp. Decl.  
 20 ¶ 7); or those with enrollment caps and/or geographic limitations, such as MSSP, the Assisted Living  
 21 Waiver, and PACE (Owen Decl. ¶¶ 8, 9, 12). *See*, Wilber Supp. Decl. ¶¶ 6-8.

22 Inadequate Transition Process: While other programs may “potentially be appropriate as  
 23 replacement services...Defendants have not indicated that they have taken any of the steps necessary to  
 24 transition ADHC participants to actual alternative services by September 1, 2011.” Wilber Supp.  
 25 Decl.¶ 9. An ADHC provider in Los Angeles contacted the resources in the Community Services  
 26 Resource Guide supplied by Defendants “in anticipation of the transition”. Supplemental Decl. of Nina  
 27 Nolcox (“Nolcox Supp. Decl.”) ¶¶ 10- 16. She found that most programs were not appropriate or  
 28 available; her staff were placed on lengthy holds, left messages that were not returned, and were referred

1 back to ADHC to serve their clients. *Id.* “If this Resource Guide constitutes the transition plan for the  
2 L.A. area, then discharge from ADHC truly is a bridge to nowhere....” Nolcox Supp. Decl. ¶ 16.

3 Defendants have failed to rebut Plaintiffs’ evidence that replacement services are not available  
4 and that Plaintiffs remain at risk of institutionalization without ADHC. *See*, Plaintiffs’ Motion for  
5 Preliminary Injunction (“Mot.”) Sections II.D, E and G. Moreover, Defendants’ portrayal of the  
6 Plaintiffs is inaccurate and misleading and their suggestion that Plaintiffs do not really need ADHC or  
7 the services they receive there is insulting. Defendants’ declarant admits that she did not personally  
8 review Plaintiffs’ records, thereby relying on hearsay in her declaration; the records reviewed were  
9 incomplete; and the declarant apparently did not review any of the declarations submitted by Plaintiffs,  
10 or speak with ADHC providers or family members. Ferreria Decl. ¶ 13. The numerous inaccurate and  
11 irrelevant statements about Plaintiffs are more fully addressed in the supplemental declarations of Celine  
12 Regalia, Dawn Myers Purkey, Nina Nolcox, Tracy McCloud, and Peter Behr.

13 **B. Eliminating ADHC will Result in Nursing Facility Placements and Cost the State**  
14 **More Money than it Saves**

15 Defendants do not rebut the claim that elimination of ADHC as a Medicaid optional benefit will  
16 cost the State more than it saves.<sup>1</sup> They offer only one factually unsupported declaration which states  
17 that by zeroing out the ADHC line item in the State budget, California will save \$170 million in  
18 estimated ADHC costs in 2011-2012.<sup>2</sup> [ECF No. 278] Watkins Decl. ¶ 13; *See also* Pl. Obj. to Evid.

19 Plaintiffs’ expert, Dr. Hendrickson, who recently prepared for the State a 300-page analysis of  
20 long-term care services and financing in California, concludes that Mr. Watkins’ statement is simply  
21 wrong. Dr. Hendrickson has conducted an analysis showing that if just 6,800 ADHC recipients are  
22 placed in nursing facilities, and others receive no services, any savings from the elimination of ADHC  
23

24 <sup>1</sup> While Defendants attack the Lewin Report as biased and unreliable (Opp. 8:20-9:9), Plaintiffs’ experts vouch for the Lewin  
25 Group’s objectivity, and Dr. Hendrickson states that “Lewin is correct in basing its analysis on costs that were actually paid  
rather than making speculative assumptions that some costs should not have been paid.” Hendrickson Decl. ¶¶ 37-39; Wilber  
Supp. Decl. ¶ 5.

26 <sup>2</sup> Defendants’ attempts to characterize the ADHC program as fraudulent simply distract from the legal, personal, and fiscal  
27 issues in this case. Opp. 8:20-9:9. Defendants’ fraud allegations rely on a study which uses an undersized sample and  
28 subjective determinations of fraud and error. Missaelides Supp. Decl. ¶ 18. Most egregiously, the study failed to account for  
the way that ADHC services are delivered compared to physician or pharmacy services. *Id.* “For instance, if a participant  
was found not to meet medical necessity, each day of attendance was counted as a separate error. Consequently, the same  
error was compounded by multiple numbers of days of service.” *Id.* Thus, Defendants’ fraud, error, and cost figures must be  
given little weight given their study’s grossly flawed methodology.

1 will evaporate. Hendrickson Decl. ¶¶ 41-56. Moreover, since the State has budgeted only \$85 million  
 2 for transition and provision of alternative services, if only 2,728 ADHC recipients require nursing  
 3 facility placement, the State will exceed its budgeted amount to serve this population. *Id.* ¶¶ 57-59.

4 Defendants cite just one article from 1994 to justify their contention that ADHC recipients will  
 5 not be institutionalized. [ECF No. 273] Muchmore Decl. ¶ 5. However, “[t]here are now numerous  
 6 articles and research emphasizing and supporting the importance of ADHC as a community-care service  
 7 that helps keep people out of institutions, reduces caregiver stress and burden, and has a positive effect  
 8 on reducing mortality. There are also a number of articles that support the cost effectiveness of ADHC  
 9 and other community-based services.” Wilber Supp. Decl. ¶ 4. ADHC providers estimate that upon  
 10 ADHC elimination, 11% of recipients will be discharged to a nursing facility immediately, an additional  
 11 12.3% within the first 30 days and another 10.9% within two months. Missaelides Supp. Decl. Ex. G.  
 12 Defendants concede that an 18% nursing facility placement rate is a valid estimate (Muchmore Decl.  
 13 ¶ 7), and the experience of one ADHC center that closed shows a likely 25% nursing facility placement  
 14 rate. Hendrickson Decl. ¶ 51; [ECF No. 241] Houghton Decl. ¶¶ 13-15, 24. Even if ADHC recipients  
 15 are not immediately placed in nursing homes, they “will suffer avoidable health consequences from the  
 16 lack of consistent and appropriate skilled care and monitoring” leading to eventual hospitalization and  
 17 nursing facility placement. Steinke Decl. ¶ 31, 21-23; [ECF No. 238] Gardner Decl. ¶ 31 (Without  
 18 ADHC, there is a “serious risk that these adults no longer will be able to live in their own homes or with  
 19 their families and will instead require a more restrictive setting at a higher and [more] costly level of  
 20 care and, in some cases, require expensive psychiatric hospitalization.”)

21 Significantly, while declarant Jim Watkins lists the many cuts to Medi-Cal services contained in  
 22 AB 97, including a 10% rate cut to nursing facilities (Watkins Decl. ¶ 8), Defendants fail to disclose that  
 23 in the final budget enacted on June 30, 2011 the 10% rate cut to nursing facilities will be restored next  
 24 year, costing the State \$155 million. Hendrickson Decl. ¶ 45. In addition, in contrast to community-  
 25 based Medi-Cal services, nursing facilities will receive a rate increase. *Id.* Thus, the State’s argument  
 26 that enjoining elimination of ADHC will “require painful reductions to other essential programs” (Opp.  
 27 17:15), is disingenuous. If nursing facilities were to receive the same rate and service cuts that  
 28 community-based Medi-Cal services have endured, the additional savings could be used to fund the

1 ADHC program or adequate and appropriate alternatives.

2 **III. PLAINTIFFS' CLAIMS ARE RIPE**

3 Defendants mistakenly characterize the gravamen of Plaintiffs' claims as an issue of "timing"  
4 and argue that because their transition plan has not yet been implemented, Plaintiffs' claims are  
5 premature. Opp. 10:5. Plaintiffs' experts, ADHC providers, and Defendants' own witnesses show,  
6 however, that the services identified by Defendants are largely unavailable and inadequate, and that  
7 Defendants have no means by which Plaintiffs and Class Members will be able to access replacement  
8 services by September 1. *See supra* Section II.A.

9 There is a timing issue as well. Defendants have no ability to ensure that in a matter of weeks,  
10 they can implement an effective transition plan that will prevent harm to thousands of ADHC recipients  
11 who will precipitously lose the services they rely on to remain safe and healthy, and in their homes.  
12 Harm to ADHC recipients is already occurring, as ADHC centers close. *See* Missaelides Supp. Decl.  
13 ¶ 8. "What is conspicuously absent in the Defendants' declarations is any discussion of groups of  
14 current ADHC recipients who have in fact been successfully transitioned to alternative community  
15 services identified by defendants." Hendrickson Decl. ¶ 34; Houghton Decl. ¶¶ 12, 13-20.

16 **IV. DEFENDANTS' ACTIONS PLACE PLAINTIFFS AND CLASS MEMBERS AT RISK**  
17 **OF INSTITUTIONALIZATION IN VIOLATION OF THE ADA**

18 **A. Defendants' Actions Constitute Discrimination Under the ADA**

19 Despite their decision to discontinue Medi-Cal funding for ADHC, Defendants remain obligated  
20 under the ADA to take adequate steps to prevent unnecessary institutionalization when they eliminate  
21 funding for a program expressly intended for that purpose. *See* CAL. HEALTH & SAFETY CODE § 1570.2.  
22 Defendants' "failure to prevent unnecessary gaps in service ... improperly discriminate[s] against  
23 persons with disabilities by limiting their ability to maintain their social and economic independence and  
24 depriving them of a real choice between home and institutional care." *Ball v. Rodgers*, No. 00-CV-67,  
25 2009 WL 1395423, at \*5 (D. Ariz. April 24, 2009).<sup>3</sup>

26  
27 <sup>3</sup> "[L]imitations on the availability of [Medicaid] funds may be relevant to the fundamental alteration defense, but those  
28 limitations are not pertinent to the question whether plaintiffs have met their burden of demonstrating a prima facie violation  
of the integration regulation." *Townsend v. Quasim*, 328 F.3d 511, 518, fn. 1 (9th Cir.2003).

1 In a recently-issued technical assistance guide from the United States Department of Justice  
2 (DOJ), the DOJ stated that in making budget cuts:

3 ...public entities have a duty to take all reasonable steps to avoid placing individuals at  
4 risk of institutionalization. For example, public entities may be required to make  
5 exceptions to the service reductions or to provide alternative services to individuals who  
6 would be forced into institutions as a result of the cuts. If providing alternative services,  
7 public entities must ensure that those services are actually available and that individuals  
8 can actually secure them to avoid institutionalization.

9 DOJ ADA/*Olmstead* Technical Assistance Guide, Gershon Decl., Ex. B Question 9.

10 Defendants mischaracterize Plaintiffs' prayers for relief as an unreasonable demand to maintain  
11 "the exact same level of benefits" (Opp. 12:3), citing to a footnote in the Supreme Court's *Olmstead*  
12 decision for the proposition that the ADA does not impose a specific standard of care or certain level of  
13 benefits to individuals with disabilities. Opp. 12:10-16. Defendants miss the point. In the *Olmstead*  
14 footnote, the majority merely responds to the dissent's complaint that its holding will interfere with  
15 states' discretion in their administration of public services and clarifies that "[s]tates must adhere to the  
16 ADA's nondiscrimination requirement with regard to the services they in fact provide." *Olmstead v.*  
17 *L.C.*, 527 U.S. 581, 603, fn. 14, 119 S.Ct. 2176 (1999).

18 Here, Defendants take pains to prove that they "in fact provide" services that ADHC recipients  
19 may receive to replace ADHC; thus, their actions are subject to scrutiny under the ADA. Opp. 3:23-  
20 4:17. Moreover, Defendants have not eliminated ADHC entirely as a program. Even as they have  
21 chosen to eliminate Medi-Cal funding for ADHC, ADHC programs could continue to be licensed and  
22 operational. In addition, the underlying services which make up the ADHC program are services which  
23 the state continues to offer, both in the community and in nursing facilities. The issue at hand is thus  
24 whether or not Plaintiffs and Class Members will have adequate access to those services in the  
25 community versus in institutions.<sup>4</sup> As in *Townsend*, "the precise issue is not whether the state must  
26 provide the long term care services sought by Mr. Townsend and the class members — the state is  
27 already providing these services — but in what location these services will be provided." *Townsend*,

28 <sup>4</sup> Defendants' reliance on *Rodriguez v. City of New York* and *Alexander v. Choate* to support their argument is misplaced for the same reason. *Rodriguez* involved the Second Circuit's refusal to order New York to provide safety monitoring, a service it did not offer to anyone. *Rodriguez v. City of New York*, 197 F.3d 611 (2d Cir. 1999). The *Townsend* Court distinguished *Rodriguez* stating, "[W]here the issue is the location of services, not whether services will be provided, *Olmstead* controls." *Townsend* at 328 F. 3d 517. *Choate* is not an ADA case and did not involve termination of services intended to prevent institutionalization. *Alexander v. Choate*, 469 U.S. 287 (1985).

1 328 F.3d at 517. Plaintiffs have demonstrated that Defendants’ actions will increase the likelihood that  
 2 they will enter institutions to receive those services. *See* Mot. Sections II.G and III.B.; *see also*  
 3 Hendrickson Decl. ¶ 49; Steinke Decl. ¶¶ 31, 21-23; Gardner Decl. ¶ 31.

4 Thus, the issue here is not whether Defendants must maintain a certain standard of care, but  
 5 rather, whether Defendants have met their burden of ensuring more than a “theoretical” availability” of  
 6 alternative services when defunding ADHC services. *Brantley v. Maxwell-Jolly*, 656 F. Supp. 2d 1161,  
 7 1175 (N.D. Cal. 2009). They have not done so and are thus culpable under the ADA.

8 **B. Defendants Cannot Support their Fundamental Alteration Defense.**

9 Defendants’ defense is premised on the State’s fiscal situation and the bald assertion that a  
 10 challenge to their discontinuation of funding for ADHC “necessarily would constitute a fundamental  
 11 alteration of the State’s Medi-Cal program.” *Opp.* 17:12-13. Defendants claim that the requested relief  
 12 would result in cutbacks to other Medicaid programs, and that they would be forced to operate ADHC as  
 13 a state-only benefit without federal matching funds. *Opp.* 13:6-10. Neither assertion is true.

14 The fact that a state has a “fiscal problem, by itself, does not lead to the automatic conclusion  
 15 that [a proposed modification] will result in a fundamental alteration.” *Fisher v. Oklahoma Health Care*  
 16 *Authority*, 335 F. 3d 1175, 1182-83 (10th Cir. 2003). That Defendants have spared nursing facilities  
 17 from the 10% rate cut imposed on many other Medi-Cal providers — at a State cost of \$155 million--  
 18 and bestowed on them a rate increase in the face of massive cutbacks to community-based Medi-Cal  
 19 services belies their argument that elimination of ADHC is necessary for their fisc. *See supra* Section  
 20 II.B. This Court has already rejected Defendants’ argument that “they have no obligation to maintain  
 21 the same level of services as before, and are thus entitled to cut services at will to accommodate the  
 22 State’s budgetary constraints.” *Cota v. Maxwell-Jolly*, 688 F. Supp. 2d 980, 994-995 (N.D. Cal. 2010).

23 Defendants’ actions will in fact cost more than they will save, according to Dr. Hendrickson,  
 24 who concludes that the \$85 million allocated by the State is insufficient to pay for alternative services  
 25 that will be used by ADHC recipients. Hendrickson Decl. ¶ 62. If just 2,700 individuals go to nursing  
 26 facilities, the State will use up the entire \$85 million. *Id.* ¶¶ 58-59. He also finds that if just 6,800  
 27 ADHC recipients go into nursing homes then Defendants will spend more than the \$211 million of State  
 28 dollars that it would have cost to continue ADHC, without funding any services for the remaining

1 individuals. *Id.* ¶ 61. Dr. Hendrickson’s findings are entirely consistent with the Lewin Report, which  
 2 projected a net cost to the State of \$51.6 million in the first year of elimination, and significantly higher  
 3 costs in subsequent years. [ECF No. 228-2] Auerbach Decl., Ex. B at 3.

4 Budgetary shortages alone do not create a fundamental alteration defense according to the DOJ:

5 Budgetary shortages are not, in and of themselves, evidence that...relief [to Plaintiffs]  
 6 would constitute a fundamental alteration. Even in times of budgetary constraints, public  
 7 entities can often reasonably modify their programs by re-allocating funding from expensive  
 8 segregated settings to cost-effective integrated settings. Whether the public entity has  
 9 sought additional federal resources available to support the provision of services in  
 10 integrated settings for the particular group or individual requesting the modification – such  
 11 as Medicaid– is also relevant to a budgetary defense. DOJ ADA/*Olmstead* Technical  
 12 Assistance Guide, Gershon Decl. Ex. B Question 14.

13 Defendants have chosen to eliminate ADHC as an optional Medi-Cal service, a decision with  
 14 fiscal and human consequences. Defendants’ failure to make different choices, however, cannot be used  
 15 to justify their fundamental alteration defense. As the Centers for Medicare and Medicaid Services  
 16 (CMS) has made clear:

17 If other laws (*e.g.* ADA) require the state to serve more people, the State may do so using non-  
 18 Medicaid funds or may request an increase in the number of people permitted under the HCBS  
 19 waiver. Whether the State chooses to avail itself of possible Federal funding is a matter of the  
 20 State’s discretion. Failure to seek or secure Federal Medicaid funding does not generally relieve  
 21 the State of an obligation that might be derived from other legislative sources (beyond Medicaid,  
 22 such as the ADA.) CMS *Olmstead* Update No: 4, Gershon Decl., Ex. A at 4.

23 Here, for example, Defendants could request that CMS extend the date for elimination of ADHC  
 24 to allow for an orderly transition to a new KAFI program and/or other appropriate long-term care  
 25 services. In fact, CMS has indicated that it would consider such an extension, which would enable the  
 26 State to continue receiving federal funds in the interim. Gershon Decl. Ex. D. This appears to be  
 27 contemplated by the Governor’s veto message, in which he allocated \$85 million for transition and  
 28 assessment, including seeking federal waiver approval and development of alternative funding  
 arrangements to avoid shutdown of ADHC centers. Hendrickson Decl. Ex. H. The State has many  
 options in delivering services to people with disabilities and has discretion to choose among these,  
 without fundamentally altering the nature of its program. *Fisher*, 335 F.3d at 1183. It does not have the  
 discretion to choose an option that violates the ADA.

**C. Plaintiffs’ Demonstrated Risk of Institutionalization is Sufficient to State an  
*Olmstead* Claim**

1 Defendants attempt to create a new standard for stating an *Olmstead* claim—one that has already  
 2 been rejected by this Court and is inconsistent with the only appellate court to rule on this issue,  
 3 numerous district courts, and the DOJ. This Court has already rejected Defendants’ assertion that to  
 4 establish an *Olmstead* claim, Plaintiffs would have to show that they had “no choice” but to receive  
 5 services in an institutional setting, holding that a risk of institutionalization is sufficient. *Brantley*, 656  
 6 F. Supp. 2d at 1170. This Court’s holding is consistent with the Tenth Circuit, which held that  
 7 “*Olmstead* does not imply that disabled persons who, by reason of a change in state policy, stand  
 8 imperiled with segregation, may not bring a challenge to that state policy under the ADA’s integration  
 9 regulation without first submitting to institutionalization.” *Fisher*, 335 F.3d at 1182.<sup>5</sup>

10 Significantly, the DOJ has affirmed that “persons at serious risk of institutionalization or  
 11 segregation” are covered by the ADA’s integration mandate and *Olmstead*. DOJ ADA/*Olmstead*  
 12 Technical Assistance Guide, Gershon Decl. Ex. B Question 6. The DOJ explains:

13 [A] plaintiff could show sufficient risk of institutionalization to make out an *Olmstead*  
 14 violation if a public entity’s failure to provide community services *or its cut to such*  
 15 *services* will likely cause a decline in health, safety, or welfare that would lead to the  
 individual’s eventual placement in an institution. *Id.*

16 Plaintiffs and Class Members have provided an abundance of evidence, unrefuted by Defendants,  
 17 that without ADHC or adequate and appropriate services in place when they lose ADHC on September  
 18 1, 2011, they are at serious risk of imminent or eventual institutional placement. *See*, Mot. Section II.E  
 19 and G; *see also, supra*, Section II.B.

## 20 **V. DEFENDANTS ARE IN VIOLATION OF FEDERAL STATUTORY AND CONSTITUTIONAL DUE PROCESS REQUIREMENTS**

21 Defendants assert that the elimination of the ADHC benefit as an optional Medi-Cal benefit does  
 22 not afford due process rights to ADHC participants. However, Defendants mischaracterize the holdings

23 <sup>5</sup> Numerous district courts have held that a similar standard applies. *See, V.L. v. Wagner*, 669 F. Supp. 2d 1106, 1109 (N.D.  
 24 Cal. 2009) (“serious risk” sufficient to state an *Olmstead* claim); *Makin ex rel. Russell v. Hawaii*, 114 F. Supp. 2d 1017,  
 1034-35 (D. Haw. 1999) (denying summary judgment to defendant because statute “could potentially force Plaintiffs into  
 25 institutions”); *Ball v. Rodgers*, 2009 WL 1395423, at \*5 (Defendants’ “failure to provide Plaintiffs with the necessary  
 26 services threatened Plaintiffs with institutionalization.”); *Marlo M. ex rel. Parris v. Cansler*, 679 F. Supp. 2d 635, 638  
 (E.D.N.C. 2010) (entering preliminary injunction based on “substantial risk of institutionalization”); *G. v. Hawaii*, 676 F.  
 27 Supp. 2d 1046, 1057 (D. Haw. 2009) (reduction in services may violate *Olmstead* when it “will likely force beneficiaries  
 from an integrated environment into institutional care”); *Mental Disability Law Clinic v. Hogan*, Civ. No. CV 06-6320, 2008  
 28 WL 4104460, at \*15 (E.D.N.Y. Aug. 28, 2008) (“[E]ven the risk of unjustified segregation may be sufficient under  
*Olmstead*”); *Nelson v. Milwaukee Cty*, No. 04 C 0193, 2006 WL 290510, at \*7 (E.D. Wis. Feb. 7, 2006) (plaintiffs stated  
 cognizable integration claim by alleging that inadequate compensation of providers “substantially increase[s] the probability”  
 that older residents will end up in “less integrated settings”).

1 in both cases they cite in support of this argument. In *Rosen v. Goetz*, the court held that due process  
2 was not violated where the Defendants “will grant hearings to affected beneficiaries so long as they raise  
3 a valid factual dispute about their continued eligibility for coverage, as opposed to a mere challenge to  
4 the change in law or policy.” 410 F.3d 919, 926 (6th Cir. 2005). In *M.R. v. Dreyfus*, the limitation on  
5 the hearing requirement arose from the practical consideration that, *absent some factual dispute* about an  
6 individual's right to benefits, a hearing would serve little, if any purpose. 767 F. Supp. 2d 1149, 1166  
7 (W.D. Wash. Feb. 9, 2011), appeal docketed March 17, 2011, Case No. 11-35026.

8 In *Rosen*, the Plaintiffs argued that they were entitled to a hearing when the State proposed to  
9 eliminate one Medicaid program and a beneficiary claimed continued eligibility under another program,  
10 even if the beneficiary failed to allege a “valid factual dispute” about her eligibility for this other form of  
11 Medicaid coverage. *Rosen*, 410 F.3d at 927. Unlike *Rosen*, here, there will be instances of valid factual  
12 disputes, which will give rise to hearing rights, despite the fact that there has been a change in law.

13 For instance, Defendants acknowledge that there will be individual factual disputes over whether  
14 services provided through Defendants’ “short-term” program will be adequate, which could be  
15 addressed at a hearing. *See, e.g.*, Ogle Decl. ¶ 15 (“DHCS will request that the ADHC centers notify the  
16 state if there are participants for whom they cannot secure access to services.”); ¶ 22 (“If an ADHC  
17 participant cannot be transitioned in a timely manner to another program or service, the participant may  
18 receive services in the short-term transitional program authorized by AB 97.”)

19 In addition to hearing rights to determine if transition services are adequate, Plaintiffs have due  
20 process hearing rights regarding whether or not they continue to be entitled to the underlying skilled  
21 nursing services, personal care services, and other Medi-Cal services for which they qualify, and which  
22 they have received in a “bundled” fashion through the ADHC program. Elimination of the ADHC  
23 optional benefit summarily reduces access to these underlying services, which could be challenged at a  
24 hearing. *See, e.g.*, Ogle Decl. ¶ 21 (“beneficiary currently receiving physical therapy at an ADHC center  
25 will be able to receive physical therapy from another Medi-Cal provider, so long as the beneficiary  
26 meets the medical necessity criteria for receiving that benefit.”)

27 Defendants admit that they will not issue legally adequate notice. Ogle Decl. ¶ 9. Sending  
28 participants notice of the elimination, which will contain a phone number to call with questions, does not

1 meet Constitutional or statutory requirements.

2 **VI. DEFENDANTS CONFLATE ARTICLE III STANDING REQUIREMENTS WITH**  
 3 **PLAINTIFFS' *OLMSTEAD* CLAIM**

4 There can be no question that ADHC recipients whose current benefits are slated to be  
 5 eliminated in less than two months' time have standing under Article III of the Constitution to claim  
 6 injury as a result of that elimination. *See, Indep. Living Ctr. of S. Cal., Inc. v. Shewry*, 543 F.3d 1050,  
 7 1065 (9th Cir. 2008), *cert. granted in part on other grounds sub nom, Maxwell-Jolly v. Indep. Living*  
 8 *Ctr. of S. Cal.*, 131 S.Ct. 992 (U.S. Jan. 18, 2011) (Medi-Cal beneficiaries have Article III standing to  
 9 challenge cuts to medical services); *Harris v. Bd. of Supervisors, Los Angeles County*, 366 F.3d 754,  
 10 761-62 (9th Cir. 2004) (likelihood of harm to indigent plaintiffs due to threatened closure and reduction  
 11 of county hospitals was not too speculative.)<sup>6</sup>

12 Defendants argue that because DHCS' transition plans are not final and other case management  
 13 services are allegedly available (Opp. 20:22-21:5), Plaintiffs cannot show a causal connection between  
 14 the planned elimination of ADHC and impending harm. Here, the chain of causation is clear, and  
 15 Defendants cite no authority that Plaintiffs fail to meet Article III's causality test. The fact that some  
 16 alternative services "may" be available does not undermine Plaintiffs' standing to bring their claims.  
 17 *See, Harris*, 366 F.3d at 763 (plaintiffs challenging closure of public hospital met Article III causation  
 18 requirement despite existence of alternative, inadequate facilities.)

19 In contrast to *M.R. v. Dreyfus*, where a reassessment and exceptions process existed that would  
 20 have allowed the plaintiffs to recover lost services, yet they failed to contact their case managers to  
 21 attempt to correct gaps in care, here Plaintiffs' skilled ADHC providers are fully aware of the impending  
 22 cuts, are exploring feasible options, and yet Plaintiffs and others similarly situated remain at risk of  
 23 imminent harm. *Cf. 767 F. Supp. 2d* at 1153, 1163-64. Plaintiffs have standing under Article III.

24  
 25  
 26 <sup>6</sup> To the extent that Defendants argue that Plaintiffs' allegations of physical or mental deterioration must be "so certain and  
 27 precipitous that they would imminently have no alternative but to submit to, and become qualified for, institutional care"  
 28 (Opp. 20:18-21), Defendants improperly conflate the constitutional requirements for standing (*see Lujan v. Defenders of*  
*Wildlife*, 504 U.S. 555, 560 (2009) (must show an injury that is "actual or imminent")) with the merits questions of likelihood  
 of institutionalization and irreparable harm (addressed in Section IV above, and Section VII.A below, respectively.) *Cf.*  
*Hodgers-Durgin v. de la Vina*, 199 F.3d 1037, 1041-44 (9th Cir. 1999) *en banc* (finding Article III standing, but not  
 sufficient likelihood of irreparable harm, where traffic stop occurred once over ten years).

1 **VII. PLAINTIFFS MEET THE ADDITIONAL WINTER STANDARDS FOR GRANTING OF**  
 2 **A PRELIMINARY INJUNCTION**

3 **A. Plaintiffs have Shown a Likelihood of Irreparable, Imminent Harm**

4 For the third time, Defendants argue that Plaintiffs' impending loss of ADHC services does not  
 5 entail sufficiently likely irreparable harm to support issuance of a preliminary injunction. This position  
 6 is no more persuasive now that the state has chosen to eliminate Medi-Cal funding for the entire ADHC  
 7 program than it was in the face of prior planned reductions in ADHC services. *See, Cota* 668 F. Supp.  
 8 2d 997; *Brantley*, 656 F. Supp. 2d at 1176-77.

9 A preliminary injunction is, of course, "unavailable absent a showing of irreparable injury."  
 10 *Hodgers-Durgin*, 199 F.3d at 1042. Defendants do not acknowledge either this Court's prior holdings or  
 11 supporting Ninth Circuit precedent establishing that "the reduction or elimination of public medical  
 12 benefits is sufficient to establish irreparable harm to those likely to be affected by the program cuts."  
 13 *Cota* 668 F. Supp. 2d 997; *Brantley*, 656 F. Supp. 2d at 1176-77; *see also, e.g., Beno v. Shalala*, 30 F.3d  
 14 1057, 1063-64, n.10 (9th Cir. 1994). As the Court explained in *Brantley* **Error! Bookmark not defined.**,  
 15 "[g]iven the tenuousness and complexities of [Plaintiffs'] conditions, an interruption in their care, even  
 16 if temporary, will have serious consequences for Plaintiffs." 654 F. Supp. 2d at 1176-77.

17 In essence, Defendants characterize any threatened injury to Plaintiffs as "speculative" until  
 18 physical or mental deterioration, hospitalization or other institutionalization actually occurred,  
 19 effectively foreclosing the option of preliminary injunctive relief altogether. With this motion scheduled  
 20 to be heard just over 30 days before implementation of AB 97, with ADHC providers increasingly  
 21 closing in the face cuts, and without an adequate transition plan, Plaintiffs have more than sufficiently  
 22 shown that they are likely to suffer irreparable harm in the absence of an injunction.

23 **B. The Balance of Equities and the Public Interest Support a Preliminary Injunction**

24 Defendants' recitation of theoretically available replacement services is "illusory." Wilber Supp.  
 25 Decl. ¶ 8. Moreover, although "the State has declared its intention to assist plaintiffs in locating"  
 26 alternative services (Opp. 23:7), their inadequate efforts virtually ensure that Plaintiffs and Class  
 27 Members will lose needed medical services in a matter of weeks. Hendrickson Decl. ¶ 32; Wilber Supp.  
 28 Decl. ¶ 9. Plaintiffs' analysis of the balance of equities and public interest is sound. *See, Mot.* 25:1-9.

In addition, as discussed *supra* Section IV, Defendants have not shown that enjoining

1 elimination of ADHC would compel cutbacks to “other essential Medicaid programs.” Opp. 23:18. As  
 2 elimination will actually cost more than it saves, an injunction would protect the State’s fisc, as well as  
 3 prevent harm to thousands of Californians. Plaintiffs agree with Defendants that it is in the public  
 4 interest “to make necessary health care services available to a vulnerable population and to efficiently  
 5 and responsibly manage public funds.” Opp. 24:6-8. An injunction would meet both of these aims.

### 6 **VIII. PLAINTIFFS’ REQUESTED INJUNCTION IS PROPER**

7 Contrary to Defendants’ claims, the claims of Plaintiffs mirror those of the putative class as a  
 8 whole. All Plaintiffs and Class Members have: been determined by Defendants to meet medical  
 9 necessity criteria for ADHC; are Medicaid recipients; have been determined by Defendants to face the  
 10 risk of institutionalization, hospitalization, and/or mental or physical deterioration without ADHC  
 11 services; and will be subjected to the termination of ADHC services as a result of the same statutory  
 12 changes, and Defendants’ implementation of these changes. The Court can issue classwide relief despite  
 13 the fact that plans for Plaintiffs and Class Members necessarily must be specific to individual needs.  
 14 *See*, Hendrickson Decl. ¶¶ 13-23; [ECF No. 257] Wilber Decl. ¶¶ 21-22.

15 Defendants argue that the proposed order gives the Court an “unprecedented level of judicial  
 16 oversight over the DHCS’ transition assistance efforts.” Opp. 25:16. However, this Court has already  
 17 enjoined Defendants from making cuts to ADHC services until they can ensure that appropriate  
 18 alternative Medi-Cal services are provided. *Brantley*, 656 F. Supp. 2d 1161, 1178. The claim that the  
 19 proposed injunction is impermissibly vague is baseless; consistent with the Governor’s veto message,  
 20 there are many ways Defendants can implement the injunction, and they have the ability to do so.

### 21 **IX. CONCLUSION**

22 Plaintiffs respectfully request that this Court issue a preliminary injunction ordering Defendants  
 23 not to cease providing ADHC unless and until they ensure that adequate, appropriate, and uninterrupted  
 24 replacement services are in place to prevent unnecessary institutionalization.

25 Date: July 12, 2011

Respectfully submitted,

DISABILITY RIGHTS CALIFORNIA

27 By: /s/

28 Elissa Gershon  
 Attorneys for Plaintiffs