

No. 10-15635

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In The  
**United States Court of Appeals**  
For The Ninth Circuit

HARRY COTA; GILDA GARCIA; ALLIE JO  
WOODWARD, by her guardian ad litem Linda Gaspard-Berry;  
SUMI KONRAI, by her guardian ad litem Casey Konrai;  
RONALD BELL, by his guardian ad litem Rozene Dilworth,  
individually and on behalf of all others similarly situated,

*Plaintiffs-Appellees,*

v.

DAVID MAXWELL-JOLLY, Director of the Department  
of Health Care Services, State of California, and  
DEPARTMENT OF HEALTHCARE SERVICES,

*Defendants-Appellants.*

*On Appeal from the United States District Court for the Northern District of  
California, No. 4:09-cv-03798-SBA – Honorable Sandra Brown Armstrong*

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**ANSWERING BRIEF OF APPELLEES**

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Elissa Gershon  
[elissa.gershon@disabilityrightsca.org](mailto:elissa.gershon@disabilityrightsca.org)  
Elizabeth Zirker  
[elizabeth.zirker@disabilityrightsca.org](mailto:elizabeth.zirker@disabilityrightsca.org)  
DISABILITY RIGHTS CALIFORNIA  
1330 Broadway, Suite 500  
Oakland, CA 94612  
Telephone: (510) 267-1200  
Facsimile: (510) 267-1201  
*Counsel for Plaintiffs-Appellees*

June 21, 2010

*Additional Counsel  
Listed on Inside Cover*

---

Anna Rich  
[arich@nsclc.org](mailto:arich@nsclc.org)  
NATIONAL SENIOR CITIZENS LAW  
CENTER  
1330 Broadway, Suite 525  
Oakland, CA 94612  
Telephone: (510) 663-1055  
Facsimile: (510) 663-1051

Barbara Jones  
[bjones@aarp.org](mailto:bjones@aarp.org)  
AARP FOUNDATION LITIGATION  
200 So. Los Robles, Suite 400  
Pasadena, CA 91101  
Telephone: (626) 585-2628  
Facsimile: (626) 583-8538

Kenneth W. Zeller, *pro hac vice*  
[kzeller@aarp.org](mailto:kzeller@aarp.org)  
AARP FOUNDATION LITIGATION  
601 E Street NW  
Washington, DC 20049  
Telephone: (202) 434-2060  
Facsimile: (202) 434-6424

Sarah Somers  
[somers@healthlaw.org](mailto:somers@healthlaw.org)  
NATIONAL HEALTH LAW PROGRAM  
211 N. Columbia Street  
Chapel Hill, NC 27514  
Telephone: (919) 968 - 6308  
Facsimile: (919) 968-8855

Henry C. Su  
[suh@howrey.com](mailto:suh@howrey.com)  
HOWREY LLP  
1950 University Ave., 4th Floor  
East Palo Alto, CA 94303-2281  
Telephone: (650) 798-3500  
Facsimile: (650) 798-3600

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## I. INTRODUCTION

Plaintiffs-Appellees (“Plaintiffs”) are seniors and people with disabilities whom Defendants-Appellants (“Defendants”) have determined need Adult Day Health Care (“ADHC”) services “to support [them] in the living arrangement of [their] choice and to avoid or delay the use of institutional services” including hospitalization and placement in nursing facilities. CAL. WELF. & INST. CODE § 14525.1(a)(5) (West 2009). Based on Defendants’ determination, Plaintiffs have been authorized to receive ADHC services.

Plaintiffs filed suit in the United States District Court for the Northern District of California on behalf of themselves and putative class members challenging A.B. 5, 4<sup>th</sup> Ex. Sess. (Cal. 2009) (Chapter 5, Statutes of 2009) (“ABx4 5”), which sought to restrict their eligibility for ADHC services for budgetary reasons. They moved for and obtained from the district court a preliminary injunction preventing Defendants’ imposition of an across-the-board, three-day cap on ADHC services, which Defendants did not appeal. *Brantley v. Maxwell-Jolly*, 656 F. Supp. 2d 1161 (N.D. Cal. 2009).

But Defendants have now appealed the district court’s issuance of a second preliminary injunction prohibiting the implementation of new,

restrictive eligibility criteria for ADHC services that would terminate 8,000-15,000 individuals from the program. Contrary to Defendants' mischaracterization of ABx4 5 (AOB 1-2, 7, 17), its new eligibility restrictions do not preserve ADHC services for the most needy individuals. Indeed, the district court rejected this claim as "conclusory," "unsupported" and "unpersuasive." ER000013 n.6; 000017 n.8. Rather, ABx4 5 would terminate and deny ADHC services to extremely vulnerable individuals, without consideration of their risk of institutionalization and the attendant costs to the State.

The district court therefore correctly enjoined the implementation of ABx4 5, finding that Plaintiffs are likely to prevail on their claims of discrimination under the Americans with Disabilities Act (ADA) and the Rehabilitation Act, violations of the Medicaid Act's "comparability" and "reasonable standards" requirements, and due process violations. It also correctly determined that Plaintiffs would suffer irreparable injury in the absence of a preliminary injunction.

## **II. STATEMENT OF JURISDICTION**

Plaintiffs agree with Defendants' Statement of Jurisdiction but note that injunctive relief is also sought under the ADA and Rehabilitation Act.

In response to Defendants' reservation of immunity, Plaintiffs note that this suit seeks only injunctive and declaratory relief, and Director Maxwell-Jolly is sued only in his official capacity. *See Rosie D. v. Swift*, 310 F.3d 230, 237 (1st Cir. 2002).

### **III. STATEMENT OF THE ISSUES**

1. Whether the district court abused its discretion in holding that Plaintiffs had demonstrated a likelihood of success on their claims that ABx4 5 violated the ADA and the Rehabilitation Act, Medicaid's comparability and reasonable standards requirements, and Constitutional and federal due process requirements when it determined that there was ample evidence in the record to support each claim?
2. Whether the district court abused its discretion in concluding that Plaintiffs had shown a likelihood of irreparable injury that supported issuance of a preliminary injunction, when it found that that there was ample evidence in the record to support this claim?

### **IV. STATEMENT OF THE CASE**

Plaintiffs agree with Defendants' Statement of the Case. Regarding Defendants' claim that they had no chance to respond to Plaintiffs' Reply

Brief (AOB 4), however, the district court heard extensive oral argument on the first preliminary injunction on September 9, 2009, including an in-depth examination of the structure and content of the ADHC program, the State's obligations under the ADA, and the effects of reductions in ADHC services on individual named Plaintiffs. Moreover, the district court, in its discretion, may decline to hold oral argument. FED. R. CIV. P. 78(b).

## **V. STATEMENT OF FACTS**

### **A. The ADHC Program and Authorization for Services.**

ADHC is a Medi-Cal funded community-based program for low income seniors and younger disabled adults. CAL. WELF. & INST. CODE § 14521 (West 2009); ER000156-157. ADHC services are provided at community-based centers throughout California. ER000447-448.

Individuals who live at home or in licensed residential care participate from one to five days per week, depending on their assessed needs.

One of the express statutory purposes of the program is to “provide a viable alternative to institutionalization for those elderly persons and adults with disabilities who are capable of living at home with the aid of appropriate health care or rehabilitative and social services.” CAL. HEALTH & SAFETY CODE § 1570.2(b) (West 2009).

In enacting the ADHC program, the California Legislature found:

[T]here exists a pattern of overutilization of long-term institutional care for elderly persons or adults with disabilities, and that there is an urgent need to establish and to continue a community-based system of quality adult day health care which will enable elderly persons or adults with disabilities to maintain maximum independence. . . .

[O]verreliance on [nursing facility care] has proven to be a costly panacea in both financial and human terms, often traumatic, and destructive of continuing family relationships and the capacity for independent living.

CAL. HEALTH & SAFETY CODE § 1570.2 (West 2009).

ADHC centers provide a full range of medical and rehabilitative services for restoring or maintaining optimal capacity for self-care, including: skilled nursing, social work, dietician and nutritionally customized meal services, physical therapy, occupational therapy, speech and language pathology services, mental health services and non-emergency transportation to and from the center. ER000156-157; ER000446; CAL. CODE REGS. tit. 22, § 54309(a) (2009); CAL. WELF. & INST. CODE § 14520, *et seq.* (West 2006); CAL. HEALTH & SAFETY CODE § 1570, *et seq.* (West 2009). ADHC centers are licensed by Defendant DHCS and receive a daily all-inclusive Medi-Cal reimbursement rate of \$76.22 per person. ER000156; ER000445-446. ADHC is an especially effective program because it serves

to enhance and supplement primary care and helps keep seniors and people with disabilities at home and out of institutions. ER000317–318; ER000420; ER000316-317.

Individuals wishing to receive ADHC services must have a physician submit their medical history and physical information, and must participate in a 3-day assessment performed by a multidisciplinary team of clinicians including, at a minimum, a physician, registered nurse, social worker, physical therapist and occupational therapist, at minimum. CAL. CODE REGS. tit. 22, § 54211 (2009); ER000446. The multidisciplinary team designs an Individual Plan of Care (IPC) that includes recommended days of attendance, which is then submitted to the Medi-Cal Field Office along with the Treatment Authorization Request (TAR) for approval by Medi-Cal. ER000156; ER000446.

To receive Medi-Cal approval for funding, the multi-disciplinary team must certify in the IPC that individuals require ADHC services on each day of attendance in order to “avoid emergency department visits, hospitalizations, or other institutionalization.” CAL. WELF. & INST. CODE §§ 14526.1(d)(5) (West 2009). The team must also certify that if ADHC services are not provided, “a high potential exists for the deterioration of the

participant's medical, cognitive, or mental health condition or conditions in a manner likely to result in emergency department visits, hospitalization, or other institutionalization..." CAL. WELF. & INST. CODE §§ 14526.1(d)(4) (West 2009); ER000447.

There are about 328 ADHC centers located in 34 counties in California, serving approximately 37,000 individuals annually. ER000447-448. Over half of ADHC participants are over the age of 75, and 14 percent are over 85. ER000448. The average participant is 75 years old and takes six or more medications per day; more than two-thirds have cardiovascular disease, dementia, and diabetes. *Id.* "While the majority of persons served are elderly, ADHC centers also serve non-elderly adults with chronic disabling mental health, cognitive or physical conditions." *Brantley*, 656 F. Supp. 2d at 1165.

**B. Promulgation of New, Restrictive Eligibility Criteria.**

The district court enjoined the implementation of new, restrictive eligibility requirements contained in ABx4 5, which were to go into effect on or about March 1, 2010. ER000025-26; ER000158. The new eligibility restrictions would have resulted in termination of all ADHC services for an estimated 8,000-15,000 individuals who have been determined to need and

currently receive such services, and denial of eligibility for otherwise qualified future applicants to ADHC. ER000089; ER000450.

As part of the assessment process for ADHC under current eligibility criteria, all participants must show that they require assistance or supervision with at least two of 15 qualifying daily activities which are used as a measure of the person's overall functioning abilities. CAL. WELF. & INST. CODE §§ 14525(b) & 14526.2(d)(2)(A) (West 2009); ER000450-451. ABx4 5 shrinks the list of qualifying activities to only eight: bathing, dressing, self-feeding, toileting, ambulation, transferring, hygiene, and medication management. *Id.*; CAL. WELF. & INST. CODE §§ 14525.1(a)(2) & 14526.2(d)(2)(A) (West 2009). The following seven activities would no longer qualify under ABx4 5: transportation, money management, shopping, meal preparation, laundry, accessing resources, and housework. *Id.* ABx4 5 still requires individuals to demonstrate deficits in two qualifying activities. *Id.*

In addition to shrinking the list of qualifying activities that may be considered in determining eligibility, the new rules under ABx4 5 “effectively create two categories of beneficiaries, depending on whether an individual has” or does not have, certain conditions, including: (1) chronic

mental illness; (2) moderate to severe Alzheimer’s disease; or (3) other “cognitive impairments.” CAL. WELF. & INST. CODE §§ 14525.1(b-c) & 14522.4(a)(11) (West 2009); ER000451. Individuals who have any of these conditions will be required to show a need for “assistance” with two or more of the eight specified activities. CAL. WELF. & INST. CODE §§ 14525.1(a)(3)(B), 14526.2(d)(2)(B), 14522.4(a)(9) (West 2009); ER000451-452.

In contrast, individuals who do not have any of the three conditions listed above must meet a *heightened* level of need in order to qualify for services: that they require “substantial human assistance” (defined as “hands-on” assistance) to perform two or more of the abbreviated list of specified activities. ER000451; CAL. WELF. & INST. CODE §§ 14525.1(a)(3)(A); 14526.2(d)(2)(B); 14522.4(a)(10) (West 2009).<sup>1</sup>

Current participants who cannot show sufficient impairment in the eight remaining activities will be terminated from ADHC without any

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<sup>1</sup> In addition, they must meet a new level of institutional care equivalent — Nursing Facility Level A, which Plaintiffs contend violates the law. CAL. WELF. & INST. CODE § 14525.1(b) (West 2009). However, this new eligibility criteria was not relied on by the district court and therefore is not discussed further here.

reassessment of already established individual risk factors, which include medication mismanagement, self-neglect, fall risk, isolation, and frailty.

ER000447.

**C. New, Restrictive Eligibility Criteria Will Not Measure Actual Need for ADHC Services.**

These new, restrictive eligibility criteria do not measure actual need for ADHC services and will result in termination of individuals who will be placed at risk of institutionalization and who are as needy as those who will be allowed to remain. ER000320. The reasons underlying this conclusion were discussed by the district court and are described below.

**1. Failure to Consider Individualized Assessment of Risk Factors.**

The new, budget-driven eligibility requirements ignore current individualized determinations of risk of medical, cognitive, or mental health deterioration and risk of institutionalization without ADHC services. The district court found that “[s]ignificantly, Defendants make no attempt to explain how these changes are linked to the individual’s circumstances, particular need for ADHC services or their risk of institutionalization.” ER000012. The district court found that although Defendants claim that “[t]hese criteria are especially geared toward determining who is in the

greatest need for services and who meets nursing facility level of care,' they provide no analysis or evidentiary support for this general assertion.”<sup>2</sup>

ER000012-13.

The district found in its first, unappealed, preliminary injunction order that Plaintiffs’ IPCs, based on a “comprehensive assessment by a team of health care professionals — and approved by Medi-Cal,” were “compelling evidence” of Plaintiffs’ need for ADHC services. *Brantley*, 656 F. Supp. 2d at 1173. The new criteria, by contrast, do not allow for consideration of this comprehensive assessment of overall functional limitations, medical conditions, and individual circumstances, nor do they consider already established risk factors. ER000614, ER000619; ER000366; ER000385-386; ER000274, ER000276-277; ER000419; ER000717, ER000719; ER000667-668. Rather, ABx4 5 limits eligibility determinations to a mechanical application of the new, abbreviated list of activities outlined in Section V.B.

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<sup>2</sup> Defendants misuse the term, “medically necessary” when they characterize ABx4 5 as allowing the “most needy” individuals to remain eligible. AOB 1, 2. “Medical necessity” refers to the showing required for Medi-Cal authorization for payment. CAL. WELF. & INST. CODE § 14133.05(a) (West 2009). All approved ADHC participants have met Medi-Cal medical necessity criteria. CAL. WELF. & INST. CODE § 14526.1(d) (West 2009); ER000003.

*supra*. The new criteria do not allow for a determination of who, among those to be terminated, is most at risk of institutionalization without ADHC services or a suitable alternative, as there is no exception process. CAL. WELF. & INST. CODE § 14525.1 (West 2009); ER000450.

**2. Elimination of Qualifying Daily Activities.**

Elimination of seven qualifying activities from consideration for ADHC eligibility will have an arbitrary and disproportionate impact on certain types of individuals who have demonstrated a high need for ADHC services, but whose abilities and areas of need do not happen to match the new criteria. *See, e.g.*, ER000323-324; ER000662, 667-669; ER000857.

For example:

[T]he seemingly arbitrary elimination of essentially half of the qualifying impairments...will result in individuals who previously could show two impairments now only being able to meet one of the requirements. Although these individuals' need for services and risk of institutionalization are the same as before — or the same as individuals who are able to meet the new requirements — they will no longer be allowed access to ADHC services.

ER000012.

Defendants have not, as they contend, eliminated only “domestic chores” as qualifying activities. AOB 17, 19, 23. Rather, they have

eliminated consideration of those activities that require the use of judgment and cognition, which will disproportionately harm:

[i]ndividuals with mental or cognitive disabilities [who] are more likely to be unable to manage their medication, exercise poor judgment, are prone to social isolation, debilitating anxiety, feelings of hopelessness, and depression, and are therefore just as ‘at risk’, despite being more physically capable.

ER000667-668; ER000323-324; ER000857. Such individuals may be physically capable and therefore cannot demonstrate deficits in two of the remaining areas. *Id.* Others may need help with only one activity – often medication management, but such need is particularly critical. *Id.*

**3. Heightened Need Standard for Cognitively Intact Beneficiaries.**

The new eligibility criteria also will not adequately measure the needs of individuals who are cognitively intact but who have very high medical needs. Individuals who have unstable diabetes or other medical conditions prone to sudden shifts in severity are often dependent on ADHC’s medical monitoring, nursing treatments, medication monitoring, therapies, structured environment and social support to maintain stable health. ER000320-322; ER000824; ER000717, ER000719. Medically frail elders may not require hands-on assistance in performing daily care activities because they are

ambulatory and can move their limbs. Such individuals may require stand-by assistance or “spotting” to perform physical tasks such as transferring or toileting, but they will be terminated from ADHC because they cannot meet the new, heightened “substantial human assistance” requirement, despite the fact that they depend on ADHC to maintain stable health and avoid institutionalization.

**4. “At the Center” Requirement.**

Plaintiffs offered ample evidence that in determining eligibility, Defendants allow consideration of only functional activities that take place at the ADHC center, thereby disallowing consideration of daily tasks performed at home such as bathing, dressing, and hygiene. ER000452-453; ER000608; ER000364-365; ER000415; ER000271; ER000388-389; ER000340; ER000715. The practical effect of this requirement is that only five qualifying activities remain for consideration of eligibility under ABx4 5 – self-feeding, toileting, ambulation, transferring, and medication management. Defendants deny in their legal papers that such a requirement exists but they have not provided evidence to that effect, and no State official has disavowed its existence. AOB 28. The court below declined to rule on the “at the center” rule (ER000004, n.2); however, Plaintiffs describe

it here since Defendants have mistakenly claimed that Plaintiffs' evidence relies exclusively on the existence of this requirement. AOB 28; *see infra* Section VIII.B.1.a.(3).

**D. Implementation of New, Restrictive Eligibility Criteria.**

The district court noted that “[d]espite the Byzantine nature of these new requirements, there apparently is no money budgeted to conduct training on the implementation of the new criteria.” ER000005.

Notwithstanding their statement that they created a Power Point presentation (AOB 8), Defendants have failed to provide clarification as to essential definitional and procedural aspects of implementation of the new eligibility requirements, and have declined to offer training to ADHC providers who will be required to conduct assessments and make eligibility determinations. ER000087; ER000609; ER000457-460; ER000718; ER000278; ER000366.

Defendants have informed providers that it is their responsibility to give notice of termination to affected participants, but have not offered or provided any information about pre-termination hearings and continuation of benefits pending a decision challenging a termination. ER000456-458; 869-870.

**E. Plaintiffs and Putative Class Members.**

Plaintiffs Woodard and Garcia represent the “Limitation of Benefits” subclass whose claims were resolved by stipulated court order on May 14, 2010. As the Order challenged herein applied only to the “Termination of Benefits” subclass, represented by Plaintiffs Bell, Cota, and Konrai, Plaintiffs Woodard and Garcia have no claims that are the subject of the present appeal. ER000005.

**1. Ronald Bell.**

Ronald Bell is a 45-year-old-man with diabetes, organic brain syndrome, a seizure disorder, arthritis, hypertension, and hyperlipidemia. ER000390. He is Medi-Cal eligible and has been approved by Medi-Cal to receive three days a week of ADHC services through the Graceful Senescence ADHC Program in Los Angeles, California. *Id.*

Mr. Bell lives with his 78-year-old grandmother, Rozene Dilworth, and Mr. Bell and Ms. Dilworth rely on ADHC to keep him safely at home with her. ER000736-737. Mr. Bell’s most recent Medi-Cal approved IPC authorizes him to receive the following ADHC services three days per week: professional nursing services; personal care; social services; therapeutic activities; physical therapy; occupational therapy; and registered dietician

services. He also receives mental health services, on a one-on-one basis, twice a month and as needed to assist him with coping skills and decrease his depression and social isolation. ER000391-392.

Of the 15 current qualifying activities, Mr. Bell's IPC certifies that he needs *assistance* with accessing resources, housework, laundry, meal preparation, money management, and shopping, and that he is totally *dependent* on others for transportation and medication management.

ER000390. Because the only qualifying activity he meets under ABx4 5's new criteria is assistance with medication management, he will be terminated from ADHC if the new criteria go into effect. ER000392.

According to his grandmother, "if Ronald couldn't go [to] the adult day health center, I would have to care for him almost full time, seven days a week . . . I would be afraid that he would have to move into some place like a nursing home." ER000737-000739; 000668-669.

## **2. Harry Cota.**

Plaintiff Harry Cota is a 60-year-old man with a left-sided hemi paresis, hypertension, insulin dependent diabetes, arthritis, a peptic ulcer, a seizure disorder, muscle spasms, neuropathy, myelopathy, and obstructive sleep apnea. ER000716. He is Medi-Cal eligible, and currently receives

five days a week of ADHC at Lifelong Medical Care ADHC in Oakland, California. *Id.*; ER000829. Mr. Cota lives alone. ER000716.

Mr. Cota depends upon the services of ADHC to remain living independently in the community. ER000831; ER000824. According to Mr. Cota's treating nurse, "Mr. Cota has suffered from multiple disabling conditions for decades. He tolerates excruciating pain, disabling spasticity and weakness and blood sugar abnormalities. He has fought fiercely to maintain his independence...." ER000830.

Mr. Cota's most recent Medi-Cal approved IPC authorizes him to receive the following ADHC services on a daily, weekly, and monthly basis: professional nursing; personal care services; social services; therapeutic activities including social groups, physical therapy, occupational therapy, and pain treatments; and registered dietician counseling services as needed. ER000716-717.

Of the 15 current qualifying activities, Mr. Cota's IPC certifies that he: needs *supervision* with ambulation; *assistance* with accessing resources, housework, meal preparation, shopping, and transportation; and is *dependent* on others for laundry. *Id.* He primarily uses a wheelchair for ambulation, though sometimes uses a walker. *Id.* Because he does not require

“substantial human assistance” (or hands-on assistance) with any of the qualifying factors, he will be terminated from ADHC by ABx4 5. *Id.*

According to his treating physician, “the medical care, skilled regular assessment and monitoring, physical and occupational therapies, and social services offered by Lifelong ADHC helps to reduce hospitalizations and delay or avoid institutionalization of participants in the program, including Mr. Cota.” ER000824.

**3. Sumi Konrai.**

Sumi Konrai is an 87 year-old woman with dementia, hypertension, and a history of depression. ER000273; ER000660. Mrs. Konrai has been attending the Mt. Diablo Center for ADHC in Pleasant Hill, California, for three years. *Id.* She is Medi-Cal eligible and approved by Medi-Cal to receive ADHC services five days per week. *Id.* Mrs. Konrai lives alone in subsidized senior housing; her daughter-in-law provides attendant care for her. Her family relies on ADHC to keep her in her own apartment and avoid institutionalization. ER000660-661. Pursuant to her most current IPC, Mrs. Konrai receives, on a daily, weekly, or monthly basis: professional nursing services; personal care services; assistance with consuming appropriate and adequate nutrition; social services case management; therapeutic activities

including cognitive stimulation activities, physical therapy, and occupational therapy; and registered dietician services to address her poor intake of food and history of failure to thrive. ER000273-274.

As set forth in her most current IPC, of the 15 currently qualifying activities, Mrs. Konrai needs *supervision* with bathing, dressing, and hygiene, and *assistance* with housework. *Id.* She is *dependent* on others for medication and money management, accessing resources, laundry, meal preparation, shopping, and transportation. She can feed herself, but she needs to have her food prepared specially to ensure that she eats properly. *Id.* Because under ABx4 5 the only qualifying activity she obtains at the ADHC center is assistance with medication management, she would be terminated from ADHC if the new criteria were to go into effect. *Id.*

According to Plaintiffs' expert:<sup>3</sup>

Because of her cognitive and physical deficits, she is entirely dependent in many areas critical for independent living which will no longer be considered for ADHC eligibility, such as accessing resources, meal preparation, and money management. Nonetheless, she is at great risk of

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<sup>3</sup> The district court found Plaintiffs' medical experts, Drs. William Gardner and Gary Steinke, to be qualified to render the opinions set forth in their declarations in this case. ER000023-24.

institutional placement without ADHC, because of her lack of judgment, self-neglect, and dementia.

ER 000323-324.

**4. Harm to Other Affected Class Members.**

Approximately 8,000 - 15,000 Class Members would also lose ADHC services and face serious harm as a result, including emergency room visits, hospitalizations, institutionalizations, and even death. ER000089. The district court found that “[g]iven the purpose of [ABx4 5], it is axiomatic that in order to have any significant impact on the State’s budget, the curtailment of ADHC services arguably will be dramatic.” ER000022.

The Class Members who will be discharged from ADHC include current participants with needs as high as or higher than the needs of people who will be not be terminated. ER000616, ER000619; ER000366. ER000272, ER000275-277; ER000884; ER000344; ER000783; ER000322-324; ER000669; ER000379.

According to one ADHC provider: “I am very concerned about all of the participants we will have to discharge...[t]hey face a downward spiral in their health and mental well-being which will lead to increased hospitalizations and eventual nursing facility or other institutional

placements.” ER000619. Another provider states: “I am terribly concerned that Mrs. Konrai as well as the 48 other individuals [we] will have to discharge, face serious consequences to their health... including hospitalizations and institutionalization.” ER000280.

For example, putative Class Members Fred Palmer and Ron Smith both have psychiatric disabilities and, of the narrowed list of qualifying daily activities under ABx4 5, they require only assistance with medication management at the ADHC center. ER000341-342; ER000615. Without ADHC, they are at high risk for decompensation, hospitalization, and institutional placement. ER000668-669; ER000342-343; ER000615; ER000333-343. Nonetheless, they will be terminated from ADHC, despite their established risk factors.

Putative Class Member Chuck Peterson is also threatened with termination of ADHC despite his blindness and multiple chronic health conditions because he does not require “substantial human assistance” with two or more qualifying daily activities. ER000372-373; ER000417-419. He is at high risk for hospitalization and institutionalization without ADHC. ER000418-419. According to Mr. Peterson, “I am really afraid I will end up in a nursing home if I am unable to attend the center.” ER000373.

Many programs will be forced to discharge dozens of their participants, which in turn may jeopardize their ability to continue operating, thus threatening access to services even for people who remain eligible. ER000863.

## **VI. STANDARD OF REVIEW**

Plaintiffs do not dispute the standard for reviewing the granting of a preliminary injunction put forth by Defendants. Plaintiffs concur that a claim of preemption is reviewed *de novo*.

## **VII. SUMMARY OF ARGUMENT**

The district court correctly held that Plaintiffs have demonstrated a likelihood of success on all of their claims. ABx4 5 terminates the ADHC services of seniors and people with disabilities who have been determined by Defendants to need such services in order to avoid institutionalization or hospitalization. The new, restrictive eligibility criteria contained in ABx4 5 are unreasonable in that they, *inter alia*: 1) fail to consider already established risk factors for institutionalization; 2) shrink from 15 to eight the list of qualifying daily activities to be considered for eligibility (while maintaining the requirement that individuals demonstrate deficits in at least two areas), thus removing from consideration activities that involve

cognition or judgment which disproportionately harms people with mental illness or cognitive impairments; and 3) raise the bar for the level of assistance required by people without cognitive impairments or mental illness to require, for the first time, a demonstration of a need for “hands-on” assistance, notwithstanding any need for ADHC to maintain stable health and avoid institutionalization.

These new, restrictive criteria do not, as Defendants contend, maintain ADHC services for the “most needy” or most “at risk” individuals. AOB 1-2, 7, 17. This contention is contrary to the ample evidence put forth by Plaintiffs, and was rejected by the district court as “conclusory,” “unsupported,” and “unpersuasive.” ER000013 n.6; ER000017 n.8. Rather, ABx4 5 requires a mechanical application of state-imposed eligibility criteria without regard to the individualized determinations made by ADHC professionals and approved by Defendants.

As such, the district court properly determined that ABx4 5 would terminate from ADHC individuals who have similar needs to those who would remain eligible, and that ABx4 5 therefore likely violates Medicaid’s “comparability” and “reasonable standards” requirements, which require states to provide the same level of services to individuals with similar needs,

and employ “reasonable standards...for determining” the availability of Medicaid services. 42 U.S.C.A. §§ 1396a(a)(10)(B) & (17) (West supp. 2010). Defendants’ procedural arguments as to why Plaintiffs may not enforce Medicaid’s reasonable standards requirement have already been rejected by this Circuit. *See Independent Living Ctr. of S. Cal. v. Shewry*, 543 F.3d 1050, 1064 (9th Cir. 2008), *cert. denied*, 129 S. Ct. 2828 (2009) (holding that plaintiffs may challenge to Medicaid cuts based on federal preemption).

The district court also correctly held that Plaintiffs have shown a likelihood of success on their claims under the ADA and the Rehabilitation Act. Specifically, Plaintiffs showed that they were at risk of institutionalization if their ADHC services were terminated, which the district court properly found establishes a claim under the ADA’s “integration mandate” set forth in 28 C.F.R. § 35.130(d) (2009) and as interpreted by the United States Supreme Court in *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999). Moreover, the district court properly found that Defendants utilize discriminatory methods of administration and illegal eligibility criteria, and thus, Plaintiffs are likely to prevail on these claims.

The district court's findings are supported by substantial evidence in the record, including undisputed evidence from Plaintiffs' IPCs. ER000016.

Defendants do not dispute that under that the 14<sup>th</sup> Amendment to the United States Constitution, the Medicaid Act and the Supreme Court's decision in *Goldberg v. Kelly*, 397 U.S. 254 (1970), "Medicaid recipients, such as Plaintiffs, are entitled to notice and an opportunity to be heard at an administrative hearing before their benefits can be terminated." ER000019. The district court correctly found that even though ADHC providers are private entities licensed by Defendants, Defendants are the single state agency responsible for administering the Medi-Cal program and as such, are responsible for compliance with federal law, including Constitutional and federal due process requirements.

Finally, the district court did not err in finding that the named Plaintiffs and other class members would suffer irreparable harm without injunctive relief. By itself, the loss of medical benefits for low-income individuals constitutes irreparable injury. In addition, substantial evidence in the record supports the district court's determination that implementation of ABx4 5 would cause ADHC participants irreparable harms that include hospitalization, unnecessary institutionalization, illness and death.

## VIII. ARGUMENT

### A. The District Court Did Not Abuse Its Discretion in Concluding That Plaintiffs Would Suffer Irreparable Harm Without a Preliminary Injunction.

The record amply supports the district court's finding that Plaintiffs will suffer irreparable harm in the absence of an injunction. ER000021-22.

First, the district court properly found that “the reduction or elimination of public medical benefits is sufficient to establish irreparable harm to those likely to be affected by the program cuts.” ER000021; *see also Beltran v. Myers*, 677 F.2d 1317, 1322 (9th Cir. 1982); *Beno v. Shalala*, 30 F.3d 1057, 1063 n.10 (9th Cir. 1994); *Edmonds v. Levine*, 417 F. Supp. 2d 1323, 1342 (S.D. Fla. 2006); ER000002.

Second, Defendants' contention that the district court erred because “plaintiffs have not shown that any named plaintiff is likely to suffer irreparable harm if ABx4 5 is not enjoined” is simply wrong. Specifically, the district court found that harm, in the form of loss of services and risk of institutionalization, would result to each named Plaintiff if the preliminary injunction were not granted. ER000005-6 (Plaintiff Bell's “receipt of ADHC services has likely prevented him from suffering from a catastrophic medical incident and has helped him avoid being placed in a nursing home,”

and that “he will be terminated from ADHC under the new eligibility requirements”); ER00006-7 (Plaintiff Cota “is subject to termination from ADHC under the new criteria . . . [and] [w]ithout ADHC services, Mr. Cota is at risk for deterioration and injury, faces hospitalization and nursing home placements”); ER000008 (Plaintiff Konrai “may no longer will [sic] qualify for ADHC services when the new criteria go into effect . . . [and] [w]ithout ADHC services, Mrs. Konrai’s family will have to place her in a nursing home”).

Moreover, the irreparable harm that Plaintiffs will suffer is discussed extensively in the record, which includes multiple declarations by Plaintiffs, their families, their treating professionals, and Plaintiffs’ experts. *See* ER000005-8, 000021-22, 000032-35, 000049-50, 000273-278, 000280, 000283-295, 000320-324, 000378-379, 000387-392, 000395-408, 000616-617, 000645-656, 000660-661, 000668-669, 000715-717, 000721-732, 000736-739, 000782-783, 000785-791, 000792-798, 000800-813, 000814-819, 000823-824, 000829-831, 000859-864, 000903-914 (discussing the irreparable harm specific to each named Plaintiff); *see supra* Section V.E; *see infra* Section VIII.B.1.a.(3).

Because injury to named Plaintiffs is well supported, Defendants' reliance on *Hodgers-Durgin v. de la Vina*, 199 F.3d 1037 (9th Cir. 1999), is unavailing. AOB 37-38. Moreover, Defendants' reliance on *Hodgers-Durgin* for the proposition that the government should be given the "widest latitude" when dealing with the operations of its internal matters is misplaced. AOB 38. *Hodgers-Durgin* and the line of cases it cites are distinguishable because they all involved "attempts by plaintiffs to entangle federal courts in the operations of state law enforcement and criminal justice institutions," *LaDuke v. Nelson*, 762 F.2d 1318, 1324 (9th Cir. 1985), *modified*, 796 F.2d 309 (9th Cir. 1986); *Hodgers-Durgin*, 199 F.3d at 1043, which is not the case here. The district court's grant of preliminary injunction was proper because Plaintiffs have made a sufficient showing that they and others similarly situated are likely to suffer imminent, irreparable harm if ABx4 5 is not enjoined.

**B. The District Court Did Not Abuse Its Discretion in Determining That Plaintiffs Demonstrated a Likelihood of Success on the Merits.**

**1. Plaintiffs Are Likely to Prevail on Their ADA and Rehabilitation Act Claims.**

The district court found, and Defendants do not dispute, that Plaintiffs' ADA claims and Rehabilitation Act claims may be analyzed

together since the same standards apply to each. ER000015 n.7. Further, Defendants do not dispute that Plaintiffs are qualified individuals with disabilities, or that Defendants are subject to Title II of the ADA and the Rehabilitation Act.

As Defendants concede, to establish an ADA claim Plaintiffs may show that ABx4 5 violates the ADA's "integration mandate." *Olmstead*, 527 U.S. at 607; AOB 25-26. Plaintiffs are therefore likely to prevail in showing that ABx4 5 violates the ADA's integration mandate by placing ADHC recipients at risk of institutionalization; and the ADA's regulations which prohibit discrimination based on illegal "methods of administration" and eligibility criteria.

**a. ABx4 5 Likely Violates the Integration Mandate of the ADA and Rehabilitation Act.**

The district court properly found that implementation of the new ADHC eligibility requirements in ABx4 5 would violate the ADA's "integration mandate" by placing Plaintiffs at risk of unnecessary institutionalization. ER000016-17.

In *Olmstead*, the Supreme Court held that "[u]njustified isolation" of people with disabilities constitutes discrimination in violation of the ADA's "integration mandate." 527 U.S. at 597; *see also* 42 U.S.C.A. § 12101(a)(2)

(West 2005). The ADA's implementing regulations provide that public entities must "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified persons with disabilities." 28 C.F.R. § 35.130(d) (2009). "The 'most integrated setting' is defined as 'a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.'" *Brantley*, 656 F. Supp. 2d at 1170 (citing 28 C.F.R. pt. 35, appx. A (1991); *Olmstead*, 527 U.S. at 592).

To establish an *Olmstead* violation, a plaintiff must show: (1) the state's treatment professionals have determined that community-based services are appropriate; (2) the individual with disabilities does not oppose community-based treatment; and (3) the provision of community-based services can be reasonably accommodated, taking into account the resources available to the state and the needs of other individuals with disabilities.<sup>4</sup>

527 U.S. at 587; ER000015-16. Notably, Defendants do not challenge Plaintiffs' showing of these elements but instead question whether Plaintiffs

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<sup>4</sup> The Ninth Circuit has also analyzed integration mandate claims under the more general test applicable to Title II ADA claims. *See Townsend v. Quasim*, 328 F.3d 511, 516 (9th Cir. 2003). Plaintiffs prevail under either formulation.

have established an adequate risk of institutionalization to invoke *Olmstead* at all.

Defendants also do not assert, and thus have waived, any fundamental alteration defense based on budgetary considerations. Even if they had raised this defense, “budgetary constraints alone are insufficient to establish a fundamental alteration defense.” *Pennsylvania Prot. & Advocacy, Inc. v. Pa. Dep’t of Pub. Welfare*, 402 F.3d 374, 380 (3d Cir. 2005); *see also Frederick L. v. Dep’t of Pub. Welfare*, 364 F.3d 487, 495-96 (3d Cir. 2004); *Fisher v. Oklahoma Health Care Auth.*, 335 F.3d 1175, 1182-83 (10th Cir. 2003). The district court properly rejected Defendants’ unsupported statements regarding their fiscal circumstances. ER000016-17.

**(1) Defendants Conflate Article III Standing Requirements with Plaintiffs’ *Olmstead* Claim.**

Relying on *Lujan v. Defenders of Wildlife*, 504 U.S. 555 (1992), Defendants contend that Plaintiffs must establish that their institutionalization is “certainly impending.” AOB 27. They are wrong. Defendants conflate the standards for an injury in fact that must be shown for Article III standing purposes with the showing necessary to establish Plaintiffs’ *Olmstead* claim on the merits. *See Covington v. Jefferson County*,

358 F.3d 626, 639 (9th Cir. 2004) (warning against conflating these inquiries).

Courts “have been instructed to take a broad view of Article III standing in civil rights cases where private rights of action are the primary means of enforcing the statute.” *Doran v. 7-Eleven, Inc.*, 524 F.3d 1034, 1043 (9th Cir. 2008) (citing *Traficante v. Metropolitan Life Ins. Co.*, 409 U.S. 205, 209 (1972)). To satisfy Article III standing requirements for an injury in fact, plaintiffs must allege “an invasion of a legally protected interest which is (a) concrete and particularized; and (b) actual or imminent, not conjectural or hypothetical.” *Independent Living Center*, 543 F.3d at 1065 (quoting *Lujan*, 504 U.S. at 560).

Here, named Plaintiffs and class members will suffer an actual and concrete injury in fact if the new, restrictive eligibility criteria go into effect—namely, the loss of ADHC services that they have been determined to need to avoid hospitalization or institutionalization. *See* ER000006-9. Thus, they meet Article III standing requirements because they have alleged injury resulting from Defendants’ conduct, *i.e.*, implementation of ABx4 5. This is not a situation in which the loss of Plaintiffs’ legally protected

interest in receiving ADHC services is speculative. Notably, Defendants have not challenged Plaintiffs' standing to bring this lawsuit.

In contrast, the question of whether Plaintiffs have demonstrated a sufficient risk of institutionalization goes to the merits of their *Olmstead* claim, and not whether they have standing to bring the claim at all. As discussed below, Plaintiffs have made a sufficient showing on the merits as well.

Assuming *arguendo* that the risk of institutionalization required for an *Olmstead* claim must meet Article III standards, Plaintiffs would also prevail. When the injury asserted is a risk of future harm, a "credible" or "reasonable probability" or "reasonable concern" that the harm will result suffices to establish Article III standing. *See Covington*, 358 F.3d at 638 & n.15. Thus, in *Harris v. Board of Supervisors*, 366 F.3d 754 (9th Cir. 2004), this Court concluded that chronically ill plaintiffs could rely on the likelihood that they would need medical services in the future as well as the risk that the reduction of hospital beds would exacerbate treatment delays to establish injury for standing purposes. *Id.* at 761-62; *see also Friends of the Earth, Inc. v. Laidlaw Envtl. Svcs. (TOC), Inc.*, 528 U.S. 167, 183-84 (2000); *Cent. Delta Water Agency v. United States*, 306 F.3d 938, 948-50

(9th Cir. 2002). Here, Plaintiffs' showing that they are at risk of institutionalization suffices to establish Article III standing.

**(2) Risk of Unnecessary Segregation Is Sufficient to Demonstrate a Violation of the Integration Mandate.**

The district court correctly held that plaintiffs who are not currently institutionalized may establish an *Olmstead* violation by showing a risk of institutionalization. ER000015; *See also Fisher*, 335 F.3d at 1182 (plaintiffs who “stand imperiled with segregation” may challenge state policy). If this were not the rule, and “plaintiffs were required to segregate themselves by entering an institution before they could challenge an allegedly discriminatory law or policy,” the ADA’s “protections would be meaningless.” *Id.* at 1181. Here, the district court properly found that “the loss. . . of ADHC services is sufficient to establish violation of the integration mandate.” ER000015.

Those courts that have considered whether the risk of institutionalization is sufficient to establish an *Olmstead* violation have not applied any precise formula as to the level of risk required. Nonetheless, no court has demanded “certainty” or “imminence” as Defendants contend without citing any *Olmstead* cases in support. In *Fisher*, for example, the

Tenth Circuit found that Plaintiffs could bring an *Olmstead* challenge when the State of Oklahoma imposed a cap on prescription drugs for individuals living in the community, but allowed unlimited prescription drugs for those living in institutions, finding the Plaintiffs to be at “high risk for premature entry into a nursing home.” 335 F.3d at 1181-82, 1184. Moreover, the plaintiffs did not allege immediate or certain institutionalization; in fact, some of them testified only that they “would rather die than be placed in a nursing home, or that they would not enter a nursing home...” *Id.* at 1184. Nevertheless, the court concluded “[t]hat they have emphatically stated their desire to remain in the community does not mean that they do not face a substantial risk of harm” and that some plaintiffs faced immediate, and others eventual, institutionalization. *Id.*

Numerous district courts have upheld claims under the integration mandate where Defendants’ actions place them at risk of institutionalization. In the first, unappealed injunction issued in this case, the district court rejected Defendants’ assertion that to establish a claim under *Olmstead*, Plaintiffs would have to show that they had “no choice” but to receive services in an institutional setting. *Brantley*, 656 F. Supp. 2d at 1170. The court stated that “Defendants fail to cite any relevant authority imposing a

‘no choice’ requirement. Rather, cases involving ADA integration claims have recognized that the *risk* of institutionalization is sufficient to demonstrate a violation of Title II.” *Id.* See also *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. 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”); *Ball v. Rodgers*, 2009 WL 1395423, at \*5 (D. Ariz. Apr. 24, 2009) (Defendants’ failure to provide plaintiffs with necessary services “threatened Plaintiffs with institutionalization” in violation of ADA); *Mental Disability Law Clinic v. Hogan*, Civ. No. 06-6320, 2008 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 County*, Civ. No. 04-193, 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”); *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 institutions”).

Here, the express statutory purpose of ADHC is to “provide a viable alternative to institutionalization for those elderly persons and adults with disabilities who are capable of living at home with the aid of appropriate health care or rehabilitative and social services.” CAL. HEALTH & SAFETY CODE § 1570.2(b) (West 2009). Moreover, all participants must have an Individual Plan of Care (IPC), approved by Defendants, which certifies that they need ADHC, on each day of attendance, to avoid hospitalization or institutionalization, and that they have a “high potential” for deterioration or institutionalization in the absence of ADHC. CAL. WELF & INST. CODE §§ 14526.1(d)(4-5) (West 2009); ER000003. “High potential” is defined by Defendants as “having at least a 50 percent probability of occurring within [six months] . . . (more likely to occur than not to occur).” ER000569. Thus, and as discussed further below, named Plaintiffs and class members have adequately demonstrated that they are at risk of institutionalization if their ADHC services are terminated.

**(3) All Named Plaintiffs and Class Members Have Demonstrated a Risk of Institutionalization.**

The district court properly found that “there is no dispute that [each named Plaintiff] has an IPC that documents their respective need for ADHC services to avoid unnecessary institutionalization.” ER000016. In addition to the evidence contained in their State-approved IPCs, Plaintiffs have offered abundant evidence that they and other class members require ADHC to prevent institutionalization and that without ADHC services, each would be left at risk.

Specifically, Plaintiff Harry Cota’s IPC states that he is at risk for institutionalization or hospitalization due to: two or more chronic conditions (including, post-stroke, diabetes, and arthritis), isolation, and fall risk. ER000721-722, 000724. Moreover, according to his treating physician, Mr. Cota’s complex and unstable medical conditions “make the daily availability of skilled nursing [at ADHC] a critical part of his ability to remain safely in the community.” ER000824. Plaintiffs’ expert agrees: “If individuals such as Mr. Cota were to lose eligibility for ADHC altogether, they would undoubtedly require hospitalizations or institutionalization which would otherwise be preventable.” ER000321.

Similarly, Plaintiff Ronald Bell's IPC states that he is at risk for institutionalization or hospitalization due to poor judgment, medication mismanagement, two or more chronic conditions (including organic brain syndrome and seizures), and isolation. ER000395, 000398. Plaintiffs' expert opines that, "[w]ithout the supports provided by his attendance at ADHC program, there is a great possibility that institutional care would be required." ER000669.

Sumi Konrai's IPC includes every possible listed risk factor, including dementia-related behavioral problems, fall risk, two or more chronic conditions (including dementia, depression, and arthritis), medication mismanagement, and self-neglect. ER000283, 000287. Plaintiffs' expert states: "Without [the] frequency and intensity of skilled services [at ADHC], she would be at great risk for institutional placement." ER000324.

In sum, Plaintiffs have offered a wealth of evidence that named Plaintiffs and class members would be at risk of institutionalization if their ADHC services are terminated. ER000005-9; *see also, e.g.*, ER000824; ER000668-669; ER000613-619; ER000417-000419; ER000392-393; ER000341-344; ER000320-324; ER000273-278; ER000325.

Defendants incorrectly state that Plaintiffs “base their [*Olmstead*] claims on the false premise” that Defendants allow assessment of only functional activities that take place at the ADHC center. AOB 28. While Plaintiffs have offered ample evidence that this practice does exist, and will serve to terminate otherwise eligible ADHC participants (*see supra* Section V.C.4), Plaintiffs have not, as Defendants assert, relied exclusively on the existence of this requirement to support their *Olmstead* claim. AOB 28. Plaintiffs agree that if the “at the center” requirement is not applied to Plaintiff Konrai, she would no longer face termination from ADHC since she needs assistance in a sufficient number of qualifying daily activities if bathing, dressing, and hygiene are allowed to be considered. Plaintiffs Cota and Bell, however, would be terminated from ADHC under the new, restrictive eligibility criteria contained in ABx4 5 even without applying the “at the center” requirement. The district court found the parties’ dispute about it “not critical” to its analysis. ER000004 n.2; ER000016; *see also supra* Section V.E. That Defendants disagree with the district court does not make its findings clearly erroneous.

Moreover, as explained by this Court in *Armstrong v. Davis*, “[w]hen a named plaintiff asserts injuries that have been inflicted upon a class of

plaintiffs, we may consider those injuries in the context of the harm asserted by the class as a whole, to determine whether a credible threat that the named plaintiff's injury will recur has been established." 275 F.3d 849, 861 (9th Cir. 2001); *see also id.* at 864. And once harm to a named plaintiff has been shown, injuries to all class members must be considered in determining the proper scope of the injunctive remedy. *Id.* at 870-71. Here, the harms to the class echo the harms to named Plaintiffs as seen from the abundant evidence provided by Plaintiffs, including the fact that each and every class member has an IPC, approved by Defendants, which documents their risk factors and provides "compelling evidence" of their need for ADHC services to avoid institutionalization. *Brantley*, 656 F. Supp. 2d at 1173.

Defendants wrongly suggest that *Hodgers-Durgin* establishes that injuries to class members other than the named plaintiffs are irrelevant. AOB 27. In *Hodgers-Durgin*, unlike here, there was no showing that the named plaintiffs were likely to suffer *any injury at all* in the future, and so they could not seek injunctive relief. 199 F.3d at 1044. Moreover, even if the Plaintiffs' showing of risk of institutionalization established here were inadequate (which it is not), *Hodgers-Durgin* does not address circumstances "in which a class, considered as a whole, was threatened with

injury, but in which none of the individual plaintiffs could make the traditional showing of ‘imminent injury.’” 199 F.3d at 1048 (Reinhardt, J., concurring) (emphasis removed) (saying that in such a case “the flexible doctrine of equity would have demanded a different approach”).

**b. Plaintiffs Are Likely to Prevail on Their “Methods of Administration” Claim.**

ADA regulations, 28 C.F.R. § 35.130(b)(3) (2009), prohibit a State from utilizing criteria or methods of administration that have the effect of subjecting individuals with disabilities to discrimination on the basis of disability. In *Kathleen S. v. Dep’t of Pub. Welfare*, 10 F. Supp. 2d 460, 473 (E.D. Pa. 1998), the court held that the defendant (DPW) had utilized discriminatory methods of administration which had the effect of discriminating against protected class members, who were individuals with mental illness who were residents of a state-operated psychiatric hospital. *Id.* at 462. The court found that DPW’s violation resulted, *inter alia*, from its failure to initiate and implement plans to place class members in the community within a reasonable time after they became eligible for community placement. *Id.* at 473.

Here, Plaintiffs alleged that Defendants’ actions violate the methods of administration provision of the ADA by denying Plaintiffs access to

community-based Medi-Cal services and by subjecting them to unnecessary institutionalization in hospitals and nursing facilities, thereby defeating or substantially impairing the very purpose of the ADHC Medi-Cal program which is to “provide a viable alternative to institutionalization” and “ensure that elderly persons and adults with disabilities are not institutionalized in appropriately or prematurely.” CAL. HEALTH & SAFETY CODE §§ 1570.7(a-b) (West 2009). The district court properly found that Plaintiffs are likely to prevail on their methods of administration claim, stating “the disparate impact occasioned by [the application of ABx4 5’s eligibility criteria] on a particular class of disabled persons is sufficient to demonstrate a violation of Section 35.130(b)(3).” ER000018.

Defendants suggest that the ADA does not preclude methods of administration which have the effect of causing a disparate impact on one group of individuals with disabilities as opposed to another group with different disabilities. AOB 30-31. However, the Supreme Court rejected this illogical position, analogizing the ADA to the Age Discrimination in Employment Act, and stating, “the fact that one person in the protected class has lost out to another person in the protected class is thus irrelevant, so long as he has lost out because of his age.” *Olmstead*, 527 U.S. at 598 n.10

(quoting *O'Connor v. Consolidated Coin Caterers Corp.*, 517 U.S. 308, 312 (1996). That is, discrimination between members of a protected class is still discrimination, if the discrimination is based on the prohibited trait or characteristic. Here, the district court found that “the mere fact that Defendants are imposing the same eligibility requirements upon all persons seeking access to ADHC services does not insulate Defendants from liability.” ER000018.

Defendants mischaracterize cases relied upon by the district court. In *Smith-Berch v. Baltimore County*, 68 F. Supp. 2d 602, 621 (D. Md. 1999), and *Crowder v. Kitagawa*, 81 F.3d 1480, 1484 (9th Cir. 1996), the courts struck down facially neutral policies which were struck down because, as here, they disproportionately burdened people with certain disabilities because of their disabilities.

Defendants offer no evidence that the district court’s findings are clearly erroneous, and Plaintiffs thus have demonstrated a likelihood of success on the claim that Defendants’ new, restrictive eligibility criteria violate 28 C.F.R. § 35.130(b)(3).

**c. Plaintiffs Are Likely to Prevail on Their Claim That Defendants Utilize Discriminatory Eligibility Criteria.**

Defendants state, in a footnote, that the district court improperly found that Plaintiffs are likely to prevail on their claim that Defendants utilize discriminatory eligibility criteria in violation of 28 C.F.R. § 35.130(b)(8) (2009) and 45 C.F.R. § 84.4(b)(4) (2009). AOB 31 n.8. The district court correctly concluded that while the new, restrictive eligibility criteria “do not overtly appear to target any particular group of disabled persons, in practice, they will.” ER000019. As was the case below, Defendants have failed to address Plaintiffs’ arguments, and have thus “tacitly conceded[ed] Plaintiffs’ probability of success on this claim.” *Id.*

**2. Plaintiffs Are Likely to Prevail on Their Medicaid Claims.**

The Medicaid program provides States with federal financial assistance for medical assistance to low-income individuals. 42 U.S.C.A. § 1396, *et seq.* (West 2003 & supp. 2010). Participation is voluntary, but when a State chooses to participate and provide benefits such as ADHC, it must comply with the Medicaid Act and its implementing regulations. *Frew ex rel. Frew v. Hawkins*, 540 U.S. 431, 433 (2004); *see also Winkelman ex rel. Winkelman v. Parma City Sch. Dist.*, 550 U.S. 516, 520 (2007); *Lankford v. Sherman*, 451 F.3d 496, 510 (8th Cir. 2006) (“once the state

voluntarily accepts the conditions . . . , the Supremacy Clause obliges it to comply with federal requirements.”). California has chosen to participate in the Medicaid program and therefore it must comply with federal Medicaid law. *California Pharmacists Ass’n v Maxwell-Jolly*, 596 F.3d 1098, 1102 (9th Cir. 2010).

In concluding that Plaintiffs could likely show that ABx4 5 violates Medicaid’s “reasonable standards” and “comparability” requirements, the district court weighed Plaintiffs’ substantial evidence regarding the “seemingly arbitrary elimination of essentially half of the qualifying impairments,” (ER000012) against Defendants’ assertions that the new criteria were geared toward identifying greatest need for services, for which the district court found “no analysis or evidentiary support.” ER000013.

Defendants essentially argue that because they have enacted cuts that they allege to be reasonable and need-based, they should be deemed to meet the reasonable standards and comparability requirements, and that any further judicial scrutiny was improper. But the Medicaid Act does not permit courts to accept such assertions uncritically, and Defendants have provided no basis upon which this Court may conclude that the district court’s contrary findings were clearly erroneous. Defendants’ other,

procedural arguments regarding Plaintiffs' preemption claim are foreclosed by the law of this Circuit.

**a. ABx4 5 Likely Violates the Comparability Requirement.**

Medicaid's comparability provision, 42 U.S.C.A. § 1396a(a)(10)(B) (West supp. 2010), mandates "comparable services when individuals have comparable needs," and is violated "when some recipients are treated differently from other recipients where each has the same level of need." *Jenkins v. Washington State Dept. of Social Servs.*, 157 P.3d 388, 392 (Wash. 2007) (en banc); *see also Hodgson v. Bd. of County Comm'rs*, 614 F.2d 601, 608 (8th Cir. 1980) (state "may distinguish between eligible and ineligible recipients only on the basis of their degree of *medical need*" (emphasis added)); 42 C.F.R. § 440.240 (2009). Courts have thus found that States violate the Medicaid Act when they fail to offer the same service to all with the same need. *See, e.g., Parry v. Crawford*, 990 F. Supp. 1250, 1257 (D. Nev. 1998) (comparability violated where state provides certain services only to those with mental retardation, not those with "related conditions").

The parties agree that, in order to prevail on their comparability claim, Plaintiffs must show that they "would be treated differently under ABx4 5 than other recipients with the same level of need." AOB 21. Plaintiffs have

done that. The evidence in the record shows that ABx4 5 will cause providers to exclude individuals whose need for ADHC is the same or greater than others who will remain eligible, including the named Plaintiffs whose circumstances the district court examined at length. ER000322, ER000324; ER000669; ER000343-344; *see generally* Section V.C-E *supra*. Defendants fail to address or rebut this evidence.

For instance, Plaintiff Konrai only needs medication management provided to her at the ADHC center but will lose services, despite the fact that she is at risk of institutionalization due to *all* of the risk factors considered under the program, while other participants with fewer risk factors will remain eligible. ER000277. Likewise, her risk of institutionalization is higher than others who will remain eligible. ER000278. As one provider stated, “it is my belief that participants in our program who we will have to discharge because of the new, restrictive eligibility requirements, are among the participants who need ADHC the most. Someone who requires “assistance,” even “cueing” (as opposed to “substantial human assistance”) is already demonstrating a low level of functioning. That individual’s need for “assistance” is as critical as needing “substantial human assistance.” ER000417.

In their Opening Brief, Defendants rely heavily on the fact that ADHC utilizes an individualized assessment process for determining initial and continuing eligibility for the program. AOB 23-24. This argument is misplaced because ABx4 5 actually requires a mechanical application of newly narrowed, State-imposed criteria that causes some people to lose ADHC services, while others with similar levels of need will continue to receive services, notwithstanding an individualized assessment process.

To the extent that Defendants are attempting to argue that the use of an individualized assessment inoculates them from any challenge to comparability requirements, Defendants offer no legal support for this position. Instead, courts carefully test States' proffered explanations for restrictive eligibility criteria to determine if they actually provide comparable services to those with comparable needs. For instance, in *White v. Beal*, 555 F.2d 1146, 1148-49 (3d Cir. 1977), the state limited the provision of eyeglasses "to those individuals it considers most in need of the aid" by covering people suffering from eye disease but not refractive error. The district court, after consideration of expert affidavits, found the state's factual premise to be unsupported by record evidence, because individuals with refractive error may, in fact, be more in need of glasses than those with

diseases of the eye. *Id.* at 1150-51 & n.3. The court therefore held the state's plan invalid, reasoning that it was "arbitrary since it is based upon a factor not reasonably related to the medical need." *Id.* at 1151.

As in *White v. Beal*, here, the new, restrictive eligibility criteria fail to distinguish among ADHC participants on the basis of medical need. For instance, class member Fred Palmer, who has schizophrenia and critically needs assistance with medication management in order to avoid hospitalization, will be discharged from ADHC, since medication management is the only activity with which he needs assistance on the new, shortened list. ER000619. Others with mental health diagnoses whose medical needs are the same or less than his will nonetheless remain in the program because they need assistance in two or more activities on the abbreviated list. *Id.*

Likewise, Plaintiff Cota, who has no cognitive impairments, will be discharged because he does not need substantial human assistance in two or more of the shortened list of activities, despite the fact that he faces hospitalizations and nursing facility placements without ADHC. ER000830-831. As Mr. Cota's treating nurse stated, "the medical needs of

many of those who will be discharged because of ABx4 5 are as high as or higher than those individuals who will continue to be eligible.” ER000834.

Defendants rely on 42 C.F.R. § 440.230(d) (2009) (erroneously cited as 42 C.F.R. § 440.230(c)(2)) to no avail. That provision merely permits “appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.” *Id.* It does not override the statutory comparability mandate or otherwise permit a state to devise a system that will result in the provision of disparate levels of assistance to recipients with the same level of need.

In sum, Defendants have asserted that the new criteria are “indisputedly need-based,” AOB 23, while failing to acknowledge Plaintiffs’ contrary evidence. The district court found that the need for services and risk of institutionalization for individuals who would lose access to ADHC was “the same as individuals who are able to meet the new requirements.” ER000012. This finding is amply supported by the record. *See supra* Section V.C, E. The district court thus did not err in concluding that the new, restrictive eligibility criteria likely violate the comparability requirement.

**b. ABx4 5 Likely Violates the Reasonable Standards Requirement.**

Section 1396a(a)(17) requires that all states participating in Medicaid employ “reasonable standards” that are “consistent with [Medicaid’s] objectives” for determining the extent of medical assistance under the plan. 42 U.S.C.A. § 1396a(a)(17) (West supp. 2010); *see also Wisconsin Dep’t of Health & Family Serv. v. Blumer*, 534 U.S. 473, 479 (2002); *Schweiker v. Gray Panthers*, 453 U.S. 34, 36-37 (1981). The primary objectives of Medicaid are to provide medical assistance to individuals whose resources are insufficient to meet the costs of necessary medical services and to furnish “rehabilitation and other services to help such . . . individuals attain or retain capability for independence or self-care.” 42 U.S.C.A. § 1396-1 (West supp. 2010).

Courts have a duty to determine whether States’ Medicaid rules comply with the federal mandate for reasonable standards. In *Weaver v. Reagan*, 886 F.2d 194 (8th Cir. 1989), for example, the state defended its policy of providing Medicaid coverage for the anti-AIDS drug AZT, but denied coverage to patients unless they met certain criteria unrelated to medical necessity. *Id.* at 196. The Eighth Circuit held that the state’s policy interfered with medical judgment and violated the reasonable standards

requirement. *Id.* at 198, 200. *See also White v. Beal*, 555 F.2d at 1150-51 & n.3<sup>5</sup>; *Allen v. Mansour*, 681 F. Supp. 1232, 1233-34 (E.D. Mich. 1986).

Defendants do not dispute the district court's interpretation of the "reasonable standards" legal requirement. Instead, they argue that the district court erred in its findings. Defendants are incorrect on all counts. First, Defendants claim that the district court failed to cite authority for its finding that the new eligibility criteria are "seemingly arbitrary." ER000012. In fact, substantial evidence supporting this conclusion is cited elsewhere in the district court's order and in the record. *See, e.g.*, ER000013; ER000747-748; ER000833-834; ER000386-388; ER000277-278; *Tahoe Sierra Preservation Council, Inc. v. Tahoe Regional Planning Agency*, 322 F.3d 1064, 1077 (9th Cir. 2003) (the Court may affirm on any ground squarely presented in the record, even if the ground is not relied on by the district court).

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<sup>5</sup> The *White* Court further held that the rule discriminated based on "diagnosis, type of condition, or illness" in violation of 45 C.F.R. §249.10(a)(5)(i). 555 F.2d at 1151-52. ABx4 5 suffers from the same defect, in that *inter alia* it discriminates against individuals whose need for ADHC arises out of cognitive or psychiatric disabilities. *See supra* Section VIII.B.1.b & c.

Second, Defendants argue that the IPCs provide conclusive evidence that ABx4 5 will allow for proper individualized determinations of who needs ADHC services the most. AOB 18. While Plaintiffs disagree that this is true, this argument misses the point of Plaintiffs' reasonable standards claim. Plaintiffs do not attack the new IPC form *per se*, or the multidisciplinary team process on which the IPC is based (which ABx4 5 did not change). Instead, Plaintiffs argue that the new limiting criteria required by ABx4 5 (*see* ER000164 (new criteria #6b-d)) conflict with the Medicaid mandate to set reasonable standards. And, as noted above, Plaintiffs have submitted abundant evidence that these newly narrowed criteria are *not*, as Defendants claim, "geared toward determining who needs ADHC the most." AOB 18; ER000013 n.6; 000017 n.8.

Finally, Defendants claim that the district court erred by relying on the declarations of Drs. Gardner and Steinke to conclude that the new eligibility requirements would impose disproportionate burdens on individuals with cognitive impairments. Both experts clearly explained why the new criteria are inadequate, despite the lower standard ("assistance" versus "substantial human assistance") for those with mental illness or cognitive impairments. ER000323-324; ER000667-669. Dr. Gardner specifically addressed the

impact of ABx4 5 on individuals with cognitive impairments when he explained that the new, much shorter list of qualifying activities addressed primarily individuals' physical care needs, not those that arise from impaired judgment or cognition. ER000667-668.

Defendants have failed to show how the district court's holdings are clearly erroneous. Accordingly, the Court should affirm the lower court's finding that Plaintiffs are likely to succeed on the merits of their reasonable standards claim.

**c. Under Controlling Law of This Circuit, Plaintiffs May Maintain Their Reasonable Standards Claim Directly Under the Supremacy Clause.**

Binding precedent in this Circuit forecloses Defendants' challenges (AOB 12-17, 19-21) to the enforceability of the reasonable standards requirement.<sup>6</sup>

The Supremacy Clause establishes that the Constitution and the laws of the United States are the supreme law of the land, "Laws of any State to the Contrary notwithstanding." U.S. CONST. art. VI., cl. 2. State law is preempted under the Supremacy Clause:

. . . to the extent of any conflict with a federal statute. We will find preemption where it is impossible for a private party to comply with both state and federal law . . . and where under the circumstances of a particular case, the challenged state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress. What is a sufficient obstacle is a matter of judgment, to be informed by examining the federal statute as a whole and identifying its purpose and intended effects[.]

*Crosby v. Nat'l Foreign Trade Council*, 530 U.S. 363, 372-373 (2002)

(citations and internal marks omitted); *see also Sprietsma v. Mercury*

*Marine*, 537 U.S. 51, 64 (2002).

Defendants offer no law or argument to support their claim that the provision of Medicaid-funded health services is a field which the States have traditionally occupied. AOB 13. On the contrary, as the law of this Circuit makes clear, Medicaid operates as a system of cooperative federalism to which the Supremacy Clause preemption analysis does apply. *See, e.g., California Pharmacists Ass'n v. Maxwell-Jolly*, 563 F.3d 847, 851 (9th Cir.

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<sup>6</sup> Defendants do not make a similar argument regarding Plaintiffs' comparability claim, thus correctly conceding that that provision is privately enforceable under 42 U.S.C. § 1983.

2009); *Independent Living Center*, 543 F.3d at 1058; *Lankford*, 451 F.3d at 510.<sup>7</sup>

The Medicaid Act provides specific requirements for state plans, *see* 42 U.S.C.A. §1396a(a)(1)-(73) (West supp. 2010), including the reasonable standards requirement. Defendants' argument that there is no demonstration of congressional intent to displace state Medicaid law is simply irrelevant. AOB 15. As the Supreme Court has explained, "the existence of conflict cognizable under the Supremacy Clause does not depend on express congressional recognition that federal and state law may conflict." *Crosby*, 530 U.S. at 388 (internal citations omitted).

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<sup>7</sup> State laws directly implementing the federally funded Medicaid program are very different from state and local health and safety regulations at issue in the cases cited by Defendants that were presumed not to be preempted by federal law. *Cf. Hillsborough County v. Automated Med. Labs*, 471 U.S. 707, 715 (1985). Likewise, where the Medicaid Act conflicts with state family property laws, rather than state Medicaid laws, there are also issues of important state interests. *See Washington v. Bowen*, 815 F.2d 549, 556 (9th Cir. 1987) ("State family and family-property law must do major damage to clear and substantial federal interests before the Supremacy Clause will demand that state law be overridden.") (quoting *Hisquierdo v. Hisquierdo*, 439 U.S. 572, 581 (1979)) (internal quotation marks omitted). In contrast, the purported conflict here is between state Medicaid law and the superseding federal Medicaid statute.

Defendants’ analysis of the specific provision of the Medicaid Act at issue here, Section 1396a(a)(17), is confusing because it purports to address Plaintiffs’ preemption claim yet relies on case law addressing the existence of a private right of action under 42 U.S.C. § 1983. These are two entirely separate issues. And, as this Court has held, the well-established rule in both this and other circuits has “universally affirmed the right of private parties to seek injunctive relief under the Supremacy Clause regardless of whether the allegedly preemptive statute confers any federal ‘right’ or cause of action.” *Independent Living Center*, 543 F.3d. at 1058.<sup>8</sup>

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<sup>8</sup> Defendants’ attempt to apply Section 1983 legal standards to a preemption claim fails to recognize the significant differences between the two types of relief. In a preemption challenge, “it is the interests protected by the Supremacy Clause, not by the preempting statute [...] that are at issue.” *Independent Living Center*, 543 F.3d at 1060; *Aloha Care v. Haw. Dep’t of Human Servs.*, 572 F.3d 740, 745 (9th Cir. 2009); *Air Transp. Ass’n, Inc. v. Cuomo*, 520 F.3d 218, 221 (2d Cir. 2008). Significantly, Section 1983 offers potential recovery of attorneys’ fees and damages, while the Supremacy Clause is focused on preventing application of a state law that conflicts with a federal law through prospective injunctive and declaratory relief. *Compare Farrar v. Hobby*, 506 U.S. 103, 112 (1992) (“[T]he basic purpose of a § 1983 damages award should be to compensate persons for injuries caused by the deprivation of constitutional rights” (internal quotation marks omitted)) with *Bud Antle, Inc., v. Barbosa*, 45 F.3d 1261, 1269 (9th Cir. 1994) (“a private party may ordinarily seek declaratory and injunctive relief against state action on the basis of federal preemption”).

*Watson v. Weeks*, 436 F.3d 1152 (9th Cir. 2006), relied on by Defendants, AOB 16, is therefore inapposite. In that case, this Court held that Congress did not intend Section 1396a(a)(17) to create a private right of action enforceable under 42 U.S.C. § 1983. *Id.* at 1162. But this Court has explicitly held that such a conclusion does not bar a request for injunctive relief under the Supremacy Clause. *Independent Living Center*, 543 F.3d at 1055-62.

Indeed, *Independent Living Center* permitted a preemption claim based on a Medicaid provision, 42 U.S.C. § 1396a(a)(30)(A), that this Court had previously held unenforceable under Section 1983 in *Sanchez v. Johnson*, 416 F.3d 1051, 1061 (9th Cir. 2005). In so holding, the Court noted that “[t]he Supreme Court has repeatedly entertained claims for injunctive relief based on federal preemption, without requiring that the standards for bringing suit under § 1983 be met . . .”; and “a plaintiff seeking injunctive relief under the Supremacy Clause on the basis of federal preemption need not assert a federally created ‘right,’ in the sense that term has been recently used in suits brought under § 1983.” *Independent Living Center*, 543 F.3d at 1055, 1058. Just as the holding in *Sanchez* that a Medicaid Act provision that was not enforceable under Section 1983 had no

bearing on the *Independent Living Center* Court's conclusion that the provision was enforceable under the Supremacy Clause, *Watson's* similar holding also has no bearing on Plaintiffs' Supremacy Clause claim here.

Defendants further suggest that the reasonable standards requirement is too vague to adjudicate. This flies in the face of numerous circuit court decisions. *See, e.g., Lankford*, 451 F.3d at 511-13 (restriction on optional medical equipment benefit violated reasonable standards); *Hern v. Beye*, 57 F.3d 906, 910-11 (10th Cir. 1995) (restriction of abortion benefit to life-threatening pregnancies violated reasonable standards); *Preterm, Inc. v. Dukakis*, 591 F.2d 121, 131 (1st Cir. 1979) (same); *Weaver*, 886 F.2d at 197-200; *White*, 555 F.2d at 1151. In *Lankford*, the Eighth Circuit specifically held that while the reasonable standards provision is not enforceable under Section 1983, it may be asserted directly under the Supremacy Clause. 451 F.3d at 509-10; *see also Independent Living Center*, 543 F.3d at 1062-63 (relying on *Lankford* for this purpose). Arguments that no conflict preemption lies because a particular state law falls within the discretion granted to States by the reasonable standards requirement are at best relevant to the *merits* of Plaintiffs' preemption claim, addressed *supra* in Section VIII.B.2.b.

The district court correctly held that Plaintiffs could maintain their reasonable standards claim directly under the Supremacy Clause. And as demonstrated *supra*, ABx4 5 conflicts with the reasonable standards requirement of federal law.

**3. Plaintiffs Are Likely to Prevail on Their Due Process Claims.**

Defendants fail to show how the district court erred in finding state action, or in determining that Plaintiffs had shown a likelihood of success on their due process claims.

**a. The District Court Properly Found State Action.**

Defendants argue that they can disclaim responsibility for ensuring that due process requirements are met because they rely on private entities to provide ADHC services. AOB 31-36. On the contrary, the district court correctly found that as the single state agency responsible for administering California's Medi-Cal program, Defendants are obligated to ensure due process:

Defendants' attempt to "pass the buck" is unpersuasive. As the sole state agency administering Medi-Cal, Defendants are obligated to ensure compliance with federal law. [citations omitted]. As such, Defendants cannot disclaim responsibility for compliance with federal law

based on its [sic] decision to rely on private entities to administer ADHC services.

ER000020; *see also* *McCartney v. Cansler*, 608 F. Supp. 2d 694, 701 (E.D.N.C. 2009), *aff'd on other grounds*, *D.T.M. v. Cansler*, 2010 WL 2377066 (4th Cir. Jun 11, 2010); *J.K. ex rel. R.K. v. Dillenberg*, 836 F. Supp. 694, 699 (D. Ariz., 1993) (holding that it was “patently unreasonable to presume that Congress would permit a state to disclaim federal responsibilities by contracting away its obligations to a private entity”); *Hillburn v. Maher*, 795 F. 2d 252, 261 (2d Cir. 1986) (holding that the reason for the requirement that a state designate a “single State agency” to administer its Medicaid program was to avoid a lack of accountability for the appropriate operation of the program).

In interpreting state action in the Medicaid context, courts have repeatedly found that the State is responsible for ensuring compliance with federal and constitutional requirements when it exercises control over providers of Medicaid-funded services, pays for covered services, regulates activities, issues directives which cannot be ignored, and creates the legal framework that governs their activities. *Catanzano v. Catanzano by Dowling*, 60 F.3d 113, 119-20 (2d Cir. 1995); *Perry v. Chen*, 985 F. Supp. 1197, 1205 (D. Ariz. 1996); *J.K. supra*, 836 F. Supp. at 698. *See also* *Parry*

*ex rel. Parry v. Crawford*, 990 F. Supp. 1250, 1258 (D. Nev. 1998).

Defendants assert that courts should rarely find state action but the cases they cite in support of this proposition, with the exception of *Blum v. Yaretsky*, 457 U.S. 991 (1982), discussed below, do not involve the Medicaid program.

In *Catanzano*, for example, Medicaid-funded home health services were provided by Certified Home Health Agencies (CHHAs) licensed and regulated by the state. 60 F.3d at 114. CHHAs were the only entities permitted to provide home health care under Medicaid, and were required to evaluate all potential recipients and determine whether the health and safety of the recipient could be maintained, as defined by the state. *Id.* at 119. The state mandated a four step system CHHAs were required to follow in determining whether and how much home health care should be provided to Medicaid applicants and recipients. The first two of these steps gave individuals who disputed the CHHA determination no opportunity for review. *Id.* at 115-116. Only if a CHHA reached step three or four in determining eligibility was a fair hearing available. *Id.* at 116. Citing *Blum v. Yaretsky*, the court in *Catanzano* held that the state had “exercised coercive power [and] has provided such significant encouragement...that the

[CHHA's determinations in steps one and two] must in law be deemed th[ose] of the state" and that those determinations triggered fair hearing rights. *Id.* at 118.

As in *Catanzano*, California's statutory and regulatory framework for provision of ADHC services dictates every aspect of the program. ADHC providers "are not simply regulated by the State; rather, they are deeply integrated into the regulatory" and statutory schemes set forth under California law. *Catanzano*, 60 F.3d at 119; ER000155-000160. Medi-Cal eligible recipients must have Treatment Authorization Requests (TARs) submitted by a provider, and approved by the Medi-Cal field office in order for Medi-Cal to authorize payment. ER000157; ER000446-447. Directives by Defendants regarding program rules, including those issued through the Provider Manual and IPC form, cannot be ignored. ER000155, ER000159-160. The services available, types of staff required to provide those services, program eligibility criteria, and medical necessity criteria are all under the control of the State. CAL. WELF. & INST. CODE §§ 14550 *et seq.* (West 2009); CAL. WELF. & INST. CODE §§ 14525; 14526.1; 14529 (West 2009).

Likewise, the new medical necessity criteria under ABx4 5 will effectively compel discharge of Plaintiffs and class members, who have been

previously found to need ADHC services. As in *Catanzano*, the resulting loss of benefits is not due to a “purely medical judgment” made according to professional standards that are independent of the State, but rather is due to ADHC providers’ application of Defendants’ compulsory changes to the eligibility criteria. 60 F.3d at 119.

Defendants’ reliance on *Blum v. Yaretsky* for the proposition that there is no state action is misplaced. The challenge in *Blum* was whether or not state action attached to a nursing facility’s discharge or transfer of a patient based on the clinical decisions of administrators and private physicians. 457 U.S. at 1003. Contrary to Defendants’ assertion, the criteria at issue in *Blum* were not established by the state, AOB 32-33, nor did the plaintiffs in *Blum* challenge state regulations or procedures. *Id.* In *Blum*, federal regulations required that each nursing facility establish a utilization review committee (URC) whose functions included periodically assessing whether each patient was receiving the appropriate level of care and whether continuing stay at the facility was justified. *Id.* at 994. URC-initiated transfers were not the subject of the case; the Court in *Blum* addressed only the due process rights of nursing facility residents who were discharged based on decisions made

by administrators and private physicians, not by the URC.<sup>9</sup> *Id.* at 1008 n.17.

The Court found that there was no state action where decisions of administrators and physicians were not “influenced in any degree by the State’s obligation to adjust benefits in conformity with changes in the cost of medically necessary care.” *Id.* at 1005. In contrast, here Defendants acknowledge, and the district court properly found, that the new criteria set forth under ABx4 5 are a cost saving measure implemented by the State.

ER000022.

In declining to find state action, the *Blum* Court noted that: “the State is [not] responsible for the decision to discharge or transfer particular patients. Those decisions ultimately turn on medical judgments made by private parties according to professional standards that are not established by the State.” *Blum*, 457 U.S. at 1008. The Court also noted it would have had a different question before it were the State “affirmatively command[ing]”

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<sup>9</sup> Defendants’ repeated assertion that California complies with federal Medicaid Act utilization review requirements through its TAR process is not disputed by Plaintiffs. AOB 34-35. The existence of the TAR process is not at issue here, rather, at issue is the fact that the TAR review process—which Plaintiffs agree provides due process—is available only when a provider submits a TAR for review, and not when an ADHC participant is terminated from or denied ADHC because of the new, restrictive eligibility requirements. ER000020.

the discharge or transfer of the plaintiffs.” *Id.* at 1004-1005. As Defendants acknowledge here, private providers have been tasked by the State with the responsibility of implementing the State-imposed changes to eligibility standards for ADHC services. AOB 34-35.

As amply demonstrated by the evidence, and contrary to Defendants’ assertion, Defendants do not merely influence—they compel—the discharge of thousands of class members even if in their professional judgment they have concluded that a participant needs the services for medical reasons. ER000089, 000272; 000280; 000341; 000344; 000366; 000368; 000384; 000416; 000698-609; 000715; 000782; AOB 35. Defendants are therefore “*responsible* for the specific conduct of which the plaintiff complains” *i.e.*, the implementation of the new, restrictive eligibility criteria by private ADHC providers. *Blum*, 457 U.S. at 1004.

**b. The District Court Properly Concluded That Due Process Is Required.**

In *Goldberg v. Kelly*, the Supreme Court held that individuals receiving public assistance are entitled to due process under the 14<sup>th</sup> Amendment to the United States Constitution, which includes a pre-termination hearing. 397 U.S. 254, 261-264 (1970). Defendants do not challenge the district court’s ruling that “Medicaid recipients, such as

Plaintiffs, are entitled to notice and an opportunity to be heard at an administrative hearing before their benefits can be terminated.”<sup>10</sup>

ER000019.

The district court was persuaded by the abundance of evidence Plaintiffs provided showing Defendants’ failure to provide a mechanism to ensure due process, and correctly determined that *Goldberg* was implicated where an ADHC provider determines that no TAR should be submitted.

*See*, ER000278- 280; ER000311; ER000358; ER000366-367; ER000420-421; ER000609-613; ER000622-624 ER000626-627; ER000629;

ER000718.

The district court correctly found that Defendants’ scheme “does not address Plaintiffs’ legitimate due process concerns” and that therefore

Plaintiffs are likely to prevail on their due process claims:

No TARs will be sent to Defendants for review in those cases where the individual does not meet the new requirements. As a result, potentially

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<sup>10</sup> Defendants have not established that their informational flyer (AOB 37) satisfies federal and state requirements governing legally adequate notice. The flyer fails: to be timely; to be specific as to the effect of ABx4 5 on individual participants; to provide a reason for the action; and to inform individuals of their right to request a hearing and the timeframe for doing so. 42 C.F.R. § 431.206(c)(2) (2009); 42 C.F.R. §§ 431.210, 431.211, 431.230(a) (2009); CAL. CODE REGS. tit. 22, § 51014.1(c) (2010).

thousands of individuals who currently receive ADHC services will never have a TAR submitted on their behalf, meaning that the termination of their services will never be reviewed.

ER000020. Thus, the district court did not abuse its discretion.

**c. Defendants' Argument That Notice Is Not Required Because of a Change in Law Is Misplaced.**

According to Defendants, no fair hearing is required because the implementation of the new, restrictive eligibility criteria falls under the exception in federal regulations that there need not be a hearing where the “sole issue is a Federal or State law requiring an automatic change adversely affecting some or all recipients.” AOB 36. But the regulation at issue, 42 C.F.R. § 431.220(b) (2009), does not apply here. Individuals slated to be terminated from ADHC under ABx4 5 could challenge the application of the new criteria to their diagnoses, functional deficits, and circumstances. Thus there is no “sole issue [of law] . . . requiring automatic change,” and the exception provided under 42 C.F.R. § 431.220(b) does not apply. *See Soskin v. Reinertson* 353 F.3d 1242, 1262-63 (10th Cir. 2004).

Even if Defendants are correct, however, this would not relieve them of their obligation to provide adequate notice: the implementing regulations of the Medicaid Act are explicit that adequate notice as set forth under 42

C.F.R. § 431.206(c)(2) is required “at the time of any action affecting [Medicaid applicant or recipient’s] claim,” including where the action is based on change in law. *See Eder v. Beal*, 609 F.2d 695, 699-700 (3d Cir. 1979) (holding that even in cases of across-the-board cuts to Social Security programs, prior notice was required based on interpretation of statutory language in the Social Security Act).

### **IX. CONCLUSION**

For the foregoing reasons, this Court should affirm the district court’s grant of a preliminary injunction.

### **X. STATEMENT OF RELATED CASES**

Plaintiffs and their counsel are not aware of any other cases pending in this Court that would be deemed related under 9TH CIR. R. 28-2.6.

Dated: June 21, 2010

Respectfully submitted:

HOWREY LLP

s/ Henry C. Su

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Henry C. Su  
HOWREY LLP  
1950 University Avenue, 4th Floor  
East Palo Alto, CA 94303-2281  
Tel: (650) 798-3500  
Fax: (650) 798-3600

*Counsel for Plaintiffs-Appellees*  
HARRY COTA, *et al.*



## CERTIFICATE OF SERVICE

In accordance with Rule 25(c)(2) of the Federal Rules of Appellate Procedure and ECF Rules 6(a) and 8(c) of this Court, I hereby certify that I electronically filed the foregoing **ANSWERING BRIEF OF APPELLEES** with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system on June 21, 2010.

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system, which will send notice of such filing to:

Susan M. Carson  
Supervising Deputy Attorney General  
Jennifer Bunshoft  
Deputy Attorney General  
CALIFORNIA ATTORNEY GENERAL'S OFFICE  
455 Golden Gate Avenue, Suite 11000  
San Francisco, CA 94102-7004  
Telephone: (415) 703-5580  
Facsimile: (415) 703-5480  
Email: [susan.carson@doj.ca.gov](mailto:susan.carson@doj.ca.gov)  
Email: [jennifer.bunshoft@doj.ca.gov](mailto:jennifer.bunshoft@doj.ca.gov)

*Counsel for Defendants-Appellants*

Dated: June 21, 2010

/s/ Henry C. Su

*Counsel for Plaintiffs-Appellees*  
HARRY COTA, et al.