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ATTORNEYS FOR UNITED STATES

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

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

Plaintiffs,

v.

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

Defendants.

Case No. C09-03798 SBA

CLASS ACTION

STATEMENT OF INTEREST OF THE UNITED STATES OF AMERICA

Hearing Date: **July 26, 2011**
Time: 1:00 p.m.
Judge: Hon. Saundra B. Armstrong
Address: 1301 Clay Street Oakland, CA 94612
Courtroom: 1, 4th Floor

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I. INTRODUCTION

The United States respectfully submits this Statement of Interest, pursuant to 28 U.S.C. § 517,[1] because this litigation implicates the proper interpretation and application of title II of the Americans with Disabilities Act, 42 U.S.C. § 12131 *et seq.* ("ADA"), and in particular, its integration mandate. *See* 28 C.F.R. § 35.130(d); *Olmstead v. L.C.*, 527 U.S. 581 (1999). The Department of Justice has authority to enforce title II and to issue regulations implementing the statute. 42 U.S.C. §§ 12133-34. The United States thus has a strong interest in the resolution of this matter.

This lawsuit alleges that the State of California's action to eliminate Adult Day Health Care ("ADHC") services on September 1, 2011, without ensuring sufficient alternative services are available, will place thousands of individuals with disabilities who currently receive ADHC services at serious risk of institutionalization, in violation of the ADA. (Second Am. Compl., ECF No. 218 (Jun. 2, 2011), ¶¶ 1, 7.) *See also* Cal. Welf. & Inst. Code §§ 14589(b), 14589.5(a) (eliminating ADHC). In their Motion for Preliminary Injunction, Plaintiffs seek an order enjoining the California Department of Health Care Services ("DHCS") and its director, Toby Douglas (collectively, "Defendants") from eliminating ADHC services until adequate, appropriate, and uninterrupted services are available to avoid unnecessarily forcing Plaintiffs into segregated, institutional settings. (Pls.' Mot. for Prelim. Inj., ECF No. 225 (Jun. 9, 2011) ("Pls.' Mot.") at 1-2)[2]

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[1] 28 U.S.C. § 517 permits the Attorney General to send any officer of the Department of Justice "to any State or district in the United States to attend to the interests of the United States in a suit pending in a court of the United States."

[2] Plaintiffs have asked this Court to enjoin the State's termination of ADHC *as a Medi-Cal benefit*. (*See* Pls.' Mot. at 1.) CMS has approved the State Plan Amendment that eliminates ADHC as a federal/state Medi-Cal benefit. *See* Section II(B), *infra*. We recommend that this Court enter an injunction preserving ADHC services unless and until adequate, appropriate, and uninterrupted replacement services are provided to prevent unnecessary institutionalization, without specifically addressing the services' status as federal/state Medi-cal benefit as the Plaintiffs originally proposed in their Motion.

This Court has already twice granted Plaintiffs' requests for preliminary injunction, enjoining the State from (1) reducing the maximum number of days of available ADHC services per week, and (2) implementing more restrictive eligibility criteria for the ADHC service. *See Brantley v. Maxwell-Jolly*, 656 F. Supp. 2d 1161 (N.D. Cal. 2009); *Cota v. Maxwell-Jolly*, 688 F. Supp. 2d 980 (N.D. Cal. 2010), *appeal pending*, No. 10-15635 (9th Cir. filed Mar. 24, 2010). Both injunctions rested, in part, on a finding that Defendants' reduction in available ADHC services, without ensuring provision of sufficient replacement services, would place impacted ADHC recipients at risk of institutionalization in violation of the ADA. *See Brantley*, 656 F. Supp. 2d at 1175; *Cota*, 688 F. Supp. 2d at 994-95.

The rationale supporting the issuance of this Court's two prior injunctions applies with even more force to Plaintiffs' present motion for preliminary injunction. Now, the State is not only reducing, but entirely eliminating a service that this Court has found to be "critical to [Plaintiffs'] ability to avoid institutionalization, and to remain in a community setting." *Cota*, 688 F. Supp. 2d at 994; *see also Brantley*, 656 F. Supp. 2d at 1174. Although Defendants posit that the same or a similar array of medically necessary services will be available to Plaintiffs through other existing State Medicaid ("Medi-Cal") services, Defendants have failed to meaningfully develop or implement "any means of ensuring that… the necessary alternative services will be identified and in place for Plaintiffs so that there will not be a period where they are not receiving the care prescribed by their [Individual Plans of Care (IPCs)]." *See Brantley*, 656 F. Supp. 2d at 1174. Plaintiffs have produced substantial evidence regarding the devastating effects of Defendants' current plan to implement termination of the ADHC program, including institutionalization, deteriorating physical and mental health, and even death. Indeed, class members have already begun to enter nursing facilities and other segregated, institutional

settings as ADHC centers have begun to shut their doors and additional centers are starting to close.[3]

II. STATEMENT OF FACTS

A. Overview of the ADHC Program

ADHC is a community-based day program for low-income elderly individuals and younger adults with disabilities that is offered through California's Medi-Cal State Plan. *Brantley*, 656 F.Supp.2d at 1164. The California legislature specifically designed the ADHC program as a community-based alternative to institutional care. *See* Cal. Health & Safety Code § 1570.2. Services are provided through privately-run ADHC centers throughout the State, and each center must be licensed by DHCS. *Brantley*, 656 F. Supp. 2d at 1164. There are approximately 309 licensed and Medi-Cal certified ADHC centers in 34 of California's 58 counties. (Missaelides Decl. ¶¶ 38-39.) As of May 13, 2011, those centers served approximately 34,735 ADHC program participants. (Missaelides Decl. ¶ 41.)

Each ADHC center must directly provide the following services on-site: rehabilitation services (including physical therapy, occupational therapy, and speech therapy), medical and nursing services (including skilled nursing care rendered by a professional nursing staff and other self-care services), nutrition services (including one meal per day and dietary counseling and nutrition education), psychiatric and psychological services, medical social services, necessary nonmedical and medical transportation services to and from participants' homes, and planned recreational and social activities to prevent deterioration and stimulate social interaction.

[3] (*See* Decl. of Lydia Missaelides, ECF No. 245, ("Missaelides Decl.") ¶¶ 77-79, 107-110; Decl. of Denise Houghton, ECF No. 241 ("Houghton Decl.") ¶¶ 10-11, 21-24; Decl. of Peter Behr, ECF No. 229, ("Behr Decl.") ¶¶ 18, 21, 33, 36; Decl. of Debbie Toth, ECF No. 256, ("Toth Decl.") ¶¶ 65-66; Decl. of Diane Puckett, ECF No. 251, ("Puckett Decl.") ¶¶ 17, 19; Decl. of Tracy McCloud, ECF No. 244, ("McCloud Decl.") ¶¶ 15-16, 43-52; Decl. of Dawn Myers Purkey, ECF No. 246, ("Myers Purkey Decl.") ¶¶ 40-44; Decl. of Celine Regalia, ECF No. 252, ("Regalia Decl.") ¶¶ 57-58; Decl. of Nina Nolcox, ECF No. 248, ("Nolcox Decl.") ¶¶ 13, 15; Decl. of Catherine Davis, ECF No. 232, ("Davis Decl.") ¶¶ 36-40; Suppl. Decl. of Lydia Missaelides, ECF No. 290 ("Suppl. Missaelides Decl.") ¶¶ 8-12).

Cal. Code Regs. tit. 22, § 54309 (2010). The ADHC centers are authorized to provide care at a daily all-inclusive Medi-Cal rate of $76.26 for all required services. (Missaelides Decl. ¶ 26.)

Authorization for an individual to receive ADHC services is only granted if the service is certified to be medically necessary. Cal. Welf. & Inst. Code § 14526.1(d). To be eligible for ADHC, a participant must be certified in their Individual Plan of Care ("IPC") as having "one or more chronic or post acute medical, cognitive, or mental health conditions" requiring either monitoring, treatment, or intervention, "without which the participant's condition will likely deteriorate and require emergency department visits, hospitalization or other institutionalization." Cal. Welf. & Inst. Code § 14526.1(d)(1); (*see also* Ex. C to Missaelides Decl., at 2 (Medical Necessity Criterion #1)). The participant's network of non-ADHC supports must be "insufficient to maintain the individual in the community," either because the participant lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision, or because the participant lives with one or more related or unrelated individuals who are "unwilling or unable to provide sufficient and necessary care or supervision to the participant." Cal. Welf. & Inst. Code § 14526.1 (d)(3); (*see also* Ex. C to Missaelides Decl., at 3 (Medical Necessity Criterion #3)). The participant must also be certified as having a "high potential … 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 if ADHC services are not provided." Cal. Welf. & Inst. Code § 14526.1(d)(4); (*see also* Ex. C to Missaelides Decl., at 5 (Medical Necessity Criterion #4)). Each participant's IPC must also state the individualized ADHC services that the participant's condition or conditions require each day, and such services must be "designed to maintain the ability of the participant to remain in the community and avoid emergency department visits, hospitalizations or other institutionalization." Cal. Welf. & Inst. Code § 14526.1(d)(5); (*see also* Ex. C to Missaelides Decl., at 6 (Medical Necessity Criterion #5)).

B. Elimination of ADHC Under Assembly Bill 97

On March 24, 2011, Governor Jerry Brown signed Assembly Bill 97 (Chapter 3, Statutes 2011) ("AB 97"), which provides for the elimination of ADHC as an optional benefit under the California State Medicaid Plan. *See* Cal. Welf. & Inst. Code §§ 14589(b), 14589.5. On May 12, 2011, Defendants submitted a State Plan Amendment ("SPA") to the Centers for Medicare and Medicaid Services ("CMS"), requesting approval to eliminate ADHC effective September 1, 2011.[4] (*See* Ex. K to Missaelides Decl.) CMS recently granted approval of this SPA, establishing September 1, 2011 as the effective date for the elimination of ADHC. (*See* Ex. A to Suppl. Missaelides Decl.)[5]

Although AB 97 states that Defendants must implement a "short-term program" to provide transition to alternative services for those beneficiaries impacted by the elimination of ADHC, there is no requirement for this program to be implemented prior to the effective date of the ADHC elimination. *See* Cal. Welf. & Inst. Code §§ 14589(b), 14589.5, 14590(a). Nor is there any assurance that ADHC participants will not experience gaps in critical services that are necessary to prevent their institutionalization. (*See* Missaelides Decl. ¶¶ 50-51.) AB 97 contains no details as to how, when, or whether the impacted ADHC beneficiaries will receive appropriate replacement services without gaps and/or reductions in care. *See* Cal. Welf. & Inst. Code. § 14590(e).

[4] AB 97 calls for implementation of ADHC elimination on "the first day of the first calendar month following 60 days after the date the department secures all necessary federal approvals to implement this section." Cal. Welf. & Inst. Code § 14589.5(d).

[5] In the cover letter to the SPA approval, CMS Associate Regional Administrator Gloria Nagle notes that approval of the SPA "does not in any way address the State's independent obligations under the Americans with Disabilities Act or the Supreme Court's Olmstead decision." (Ex. A to Suppl. Missaelides Decl. at 1.)

III. ARGUMENT

A. Olmstead and the Integration Mandate

Congress enacted the ADA in 1990 "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. § 12101(b)(1). Congress found that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem." 42 U.S.C. § 12101(a)(2). For those reasons, Congress prohibited discrimination against individuals with disabilities by public entities:

> [N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

42 U.S.C. § 12132.

As directed by Congress, the Attorney General issued regulations implementing title II, which are based on regulations issued under section 504 of the Rehabilitation Act.[6] *See* 42 U.S.C. § 12134(a); 28 C.F.R. § 35.190(a); Executive Order 12250, 45 Fed. Reg. 72995 (1980), *reprinted in* 42 U.S.C. § 2000d-1. The title II regulations require public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d). The preamble discussion of the "integration regulation" explains that "the most integrated setting" is one that "enables

[6] In all ways relevant to this discussion, the ADA and Section 504 of the Rehabilitation Act are generally construed to impose similar requirements. *See Sanchez v. Johnson*, 416 F.3d 1051, 1062 (9th Cir. 2005); *Zukle v. Regents of Univ. of California*, 166 F.3d 1041, 1045 n. 11 (9th Cir. 1999). This principle follows from the similar language employed in the two acts. It also derives from the Congressional directive that implementation and interpretation of the two acts "be coordinated to prevent[ ] imposition of inconsistent or conflicting standards for the same requirements under the two statutes." *Baird ex rel. Baird v. Rose*, 192 F.3d 462, 468-9 (4th Cir. 1999) (citing 42 U.S.C. § 12117(b)) (alteration in original).

individuals with disabilities to interact with nondisabled persons to the fullest extent possible…." 28 C.F.R. Pt. 35, App. A at 572 (2010) (addressing § 35.130).

Twelve years ago, the Supreme Court applied these authorities and held that title II prohibits the unjustified segregation of individuals with disabilities. *Olmstead*, 527 U.S. at 596. There, the Court held that public entities are required to provide community-based services to persons with disabilities when (a) such services are appropriate; (b) the affected persons do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of others who are receiving disability services from the entity. *Id.* at 607.

To comply with the ADA's integration requirement, a state must reasonably modify its policies, procedures, or practices when necessary to avoid discrimination. 28 C.F.R. § 35.130(b)(7). The obligation to make reasonable modifications may be excused only where a state demonstrates that the requested modifications would "fundamentally alter" the programs or services at issue. *Id.*; *see also Olmstead*, 527 U.S. at 604-07.

B. Plaintiffs Satisfy the Requirements for a Preliminary Injunction

"A plaintiff seeking a preliminary injunction must establish [(1)] that he is likely to succeed on the merits, [(2)] that he is likely to suffer irreparable harm in the absence of preliminary relief, [(3)] that the balance of equities tips in his favor, and [(4)] that an injunction is in the public interest." *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, ___ (slip op. at 10), 129 S. Ct. 365, 374 (2008); *see also Brantley*, 656 F. Supp. 2d at 1169; *Cota*, 688 F. Supp. 2d at 991.

1. Plaintiffs Are Likely to Prevail On Their ADA Claim

Plaintiffs have submitted substantial evidence of the devastating effects that Defendants' planned implementation of AB 97 will have, including placing at risk of institutionalization thousands of individuals with disabilities who rely on ADHC to remain in the community. The

first two prongs of Plaintiffs' *Olmstead* claim do not appear to be in dispute – Defendants have determined that community-based care is appropriate and Plaintiffs do not oppose receiving services in the community. Plaintiffs also satisfy the last prong – that the modification to Defendants' policies they request is reasonable and would not fundamentally alter the State's programs. Plaintiffs request that the Defendants not terminate ADHC services until adequate services are provided to replace the care Plaintiffs need in order to avoid institutionalization, and that Defendants transition the Plaintiffs from ADHC to alternative services in a way that does not place Plaintiffs at risk of institutionalization. (Pls.' Br. at 1.) This request will not fundamentally alter the State's programs, because the State will face increased expenditures from Plaintiffs' more frequent hospitalizations, emergency room visits, and entry into long-term care facilities in the absence of medically necessary ADHC or equivalent services.[7]

a. Plaintiffs have Article III standing to assert a violation of the ADA's Integration Mandate

Defendants argue that Plaintiffs lack standing for a preliminary injunction because plaintiffs "fail to establish that they will imminently have no alternative but to submit to institutionalization solely because a transition program, or an adequate one, is not yet in place." (Defs.' Opp. to Pls.' Mot. for Prelim. Inj., ECF No. 267, ("Defs.' Br.") at 19-20.) This argument is without merit and conflates the requirements of standing with the merits of Plaintiffs' ADA claims. It is well settled that to establish standing, a litigant must show (1) that he suffered actual or threatened injury; (2) that the condition complained of caused the injury or threatened injury, and (3) that the requested relief will redress the alleged injury. *See Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992). When examining whether plaintiffs suffered actual or threatened injury, the inquiry focuses on whether the injury-in-fact is (1) "concrete and

[7] *See* pp. 19-21, *infra*, discussing increased costs of hospitalizations, emergency room visits, and entry into long term care facilities.

particularized," and (2) actual or imminent, not 'conjectural' or 'hypothetical.'" *Lujan*, 504 U.S. at 560.

Plaintiffs have standing because the loss of their ADHC services is concrete, actual and not hypothetical and thus this injury alone is sufficient to establish standing. *See Cal. Pro-Life Council, Inc. v. Getman*, 328 F.3d 1088, 1095 (9th Cir. 2003); *United States v. Antelope*, 395 F.3d 1128, 1132 (9th Cir. 2005); *see also Mental Disability Law Clinic v. Hogan*, No. 06-cv-6320, 2008 WL 4104460, at *23-25 (E.D.N.Y. Aug. 26, 2008) ("the likely harm of another hospitalization and the fact that this harm could be avoided if [Plaintiff were to continue to receive existing services] is not too speculative or conjectural to preclude standing."). Defendants do not dispute that Plaintiffs will be terminated from the ADHC program because of Defendants' actions. Moreover, AB 97 and the promise of significantly reduced revenue have already prompted ten ADHC centers to close, ending services to approximately 963 participants. (*See* Missaelides Decl. ¶ 78; Suppl. Missaelides Decl. ¶ 8; Ex. F. to Suppl. Missaelides Decl..) The risk of institutionalization that directly results from this loss of services provides a secondary injury grounding Plaintiffs' standing. *See* pp. 10-13, *infra*.

b. Policies that place individuals with disabilities at serious risk of institutionalization violate the ADA

Defendants argue that, in order to state a claim under the ADA's integration mandate, Plaintiffs must show that a public entity's reduction or elimination of services will leave them with "'no choice' but to submit to institutionalization in order to receive care necessary for the preservation of their health or safety." (Defs.' Br. at 13.) This purported standard cannot be squared with title II of the ADA and well-established precedent. As this Court and numerous others have recognized, policies that place individuals with disabilities at serious risk of institutionalization are discriminatory under the ADA.[8]

[8] Defendants' assertion that Plaintiffs have not stated a claim for relief under the ADA or Rehabilitation Act because the ADA does not require the State to provide transition or replacement services, or to maintain a certain "level of services" is equally without merit. (*See*

This Court has already concluded that "the risk of institutionalization is sufficient" to state a claim for violation of the ADA's integration mandate. *Brantley*, 656 F. Supp. 2d at 1170; *see also Cota*, 688 F. Supp. 2d at 994-95. And the only Circuit Court of Appeals to directly address this issue is in accord. *See Fisher* v. *Oklahoma Health Care Auth*, 335 F.3d 1175 (10th Cir. 2003).[9] The plaintiffs in *Fisher*, like Plaintiffs in this case, received Medicaid-funded medical care in the community. They argued that Oklahoma's planned policy limiting the number of available medically necessary prescriptions covered in community-based settings, while offering unlimited coverage to individuals in institutions, placed them at risk of institutionalization. *Id*. at 1181-82. Because of the policy, they argued, they would remain in their homes only "until their health ha[d] deteriorated" and "eventually [would] end up in a nursing home." *Id*. at 1181-82,1185. The Tenth Circuit agreed that the plaintiffs had a cognizable claim under the ADA and noted that "nothing in the Olmstead decision supports a conclusion that institutionalization is a prerequisite to enforcement of the ADA's integration requirements." *Id*. at 1181.

Defendants attempt to avoid the core holding of *Fisher* – that a serious risk of institutionalization is sufficient to state a claim under the ADA – by arguing that this Court misread *Fisher* in adopting its holding in *Brantley*. (*See* Defs.' Br. at 14.) Defendants assert that

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Defs.' Br. at 11-12.) While the ADA does not mandate what specific services a state must offer, it does require states to refrain from adopting policies or engaging in practices that discriminate, including those that will render individuals at risk of institutionalization. *See Fisher v. Oklahoma Health Care Auth.*, 335 F.3d 1175, 1181 (10th Cir. 2003); *Brantley*, 656 F. Supp. 2d at 1175; *Cota*, 688 F. Supp. 2d at 994-95.

[9] The question whether institutionalization is a prerequisite to establishing a violation of Title II's integration mandate is currently pending in this Circuit in two cases addressing the application of *Olmstead* to changes in eligibility criteria for community-based services for persons with disabilities. *See Oster* v. *Wagner*, No. 09-17581 (9th Cir. filed Nov. 18, 2009), and *Cota* v. *Maxwell-Jolly*, No. 10-15635 (9th Cir. filed Mar. 24, 2010). The United States filed *amicus* briefs in both *Oster* and *Cota* arguing, *inter alia*, that neither institutionalization, nor the risk of "imminent" institutionalization, is a prerequisite to establishing a violation of Title II's integration mandate.

to state a claim for violation of the integration mandate a plaintiff must show that he has "no choice" but to enter an institution to obtain needed care. (*See id.*)[10] In support of this conclusion, Defendants can only cite to a single decision from a district court in Washington, which outlines the purported "no choice" standard. *See M.R. v. Dreyfus*, 767 F. Supp. 2d 1149,1168-70 (W.D. Wash. 2011), *appeal docketed*, No. 11-35026 (9th Cir. Feb. 10, 2011). The court's decision in *M.R.*, however, is a flawed interpretation of the integration mandate and cannot be squared with title II of the ADA and existing precedent.

Neither the ADA nor the integration regulation applies solely to institutionalized persons, or those having "no choice" but institutionalization. On the contrary, both protect "qualified individuals with disabilities." 28 C.F.R. § 35.130(d); *accord* 42 U.S.C. § 12132. Indeed, the Tenth Circuit in *Fisher* explicitly concluded that, under *Olmstead*, those "imperiled with segregation" or "threaten[ed]" with "segregated isolation" by reason of a change in state policy may bring a challenge to that policy under the ADA without first submitting to institutionalization. 335 F.3d at 1181-82. That language does not suggest that beneficiaries must be put in a position where they have "no choice" but to enter an institution to receive necessary care. In fact, Defendants' fictional "no choice" requirement appears nowhere in the *Fisher* opinion, and this Court has already explicitly rejected such an interpretation of the ADA. *See Brantley*, 656 F. Supp. 2d at 1170.

The standard suggested by Defendants would present beneficiaries who live in the community and face a reduction in services sufficient to present a serious risk of their institutionalization with a Hobson's choice: to be able to vindicate their rights under *Olmstead* and obtain services in the most integrated setting appropriate to their needs, they must either first

[10] Defendants also argue that the Tenth Circuit applied the "serious risk of institutionalization" standard only to its analysis of the likelihood of irreparable harm. (*See* Defs.' Br. at 14, n. 12.) This is an overly narrow reading of *Fisher* and was rejected by this Court in *Brantley*. *See Brantley*, 656 F. Supp. 2d at 1170-71.

be institutionalized or continue to receive reduced services and wait for a sufficient decline in health so that institutionalization is necessary (*i.e.*, so that they finally have "no choice"). As the Tenth Circuit correctly recognized, the integration mandate "would be meaningless if plaintiffs were required to segregate themselves by entering an institution before they could challenge an allegedly discriminatory law or policy that threatens to force them into segregated isolation." *Fisher*, 335 F.3d at 1181. Thus, contrary to Defendants' assertions, protection under the ADA is not limited to persons who are currently institutionalized, face "imminent institutionalization, or have "no choice" but to enter into an institution to obtain needed services.[11]

Rather, the correct standard, as recognized by the vast majority of courts, is that a state may be found liable under title II if it adopts a policy that places individuals with disabilities who receive services from the state at serious risk of being institutionalized.[12] This conclusion

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[11] Defendants argue that Plaintiffs' IPCs do not support the contention that they would face a risk of *indefinite* placement in an institution. (*See* Defs.' Br. at 16.) But even policies that risk temporary institutionalization have been recognized as actionable under the ADA. *See, e.g.*, *Marlo M. v. Cansler*, 679 F. Supp. 2d 635, 638 (E.D.N.C. 2010) (granting preliminary injunction where evidence demonstrated that plaintiffs would suffer regressive consequences if "even temporarily" returning to an institutional setting); *Cruz v. Dudek*, No. 10-23048, 2010 WL 4284955, at *3-7 (S.D. Fla. Oct 12, 2010) (granting preliminary injunction where state's denial of community-based services placed plaintiffs at risk of institutionalization and state had proposed entry into nursing home for sixty days prior to providing community-based services) (Order adopting Magistrate's Report and Recommendation, Nov. 24, 2010); *Haddad v. Arnold*, ___F.Supp. 2d___, No. 3:10-00414, 2010 WL 6650335, at *17 (M.D. Fla. July 9, 2010) (granting preliminary injunction after finding that the plaintiff would suffer irreparable injury if forced to enter a nursing home). Just as long-term isolation and segregation in an institutional setting deprives an individual of his or her freedom to interact with others in the community, temporary unjustified institutionalization similarly disrupts the individual's established life in the community, placing at risk the individual's psychological, emotional, and physical wellbeing.

[12] *See, e.g., V.L. v. Wagner*, 669 F. Supp. 2d 1106, 1109 (N.D. Cal. 2009), *appeal pending sub. nom. Oster v. Wagner*, No. 09-17581 (9th Cir. Nov. 18, 2009) (granting preliminary injunction to plaintiffs facing risk of institutionalization because of alterations to the In-Home Support Services program); *M.A.C. v. Betit*, 284 F. Supp. 2d 1298, 1309 (D. Utah 2003) (holding that the "integration mandates of the ADA and § 504 apply equally to those individuals already institutionalized and those at risk of institutionalization"); *Makin v. Hawaii*, 114 F. Supp. 2d 1017, 1034 (D. Haw. 1999) (individuals on waiting list for community-based services offered could challenge state's administration of the program as violating title II's integration mandate

follows from the principle that it is the elimination of services that have enabled beneficiaries to remain in the community, *i.e.*, the failure to provide services in the most integrated setting appropriate to the needs of qualified individuals with disabilities, that violates the ADA. This is so regardless of whether the failure to provide the services causes an individual to be immediately hospitalized, or whether it causes an individual to decline in health over time and eventually enter an institution to seek necessary care. This conclusion is consistent with title II's emphasis on ensuring that services are provided to persons with disabilities in the most integrated setting.

c. Defendants' elimination of ADHC services will place Plaintiffs and others similarly situated at serious risk of institutionalization

Defendants' plan to eliminate ADHC, without ensuring the availability of adequate replacement services, will place Plaintiffs at serious risk of institutionalization in violation of the ADA. Twice before, this Court has found that the mere *reduction* of available ADHC services would place recipients of ADHC services at risk of institutionalization. *See Brantley,* 656 F. Supp. 2d at 1171-72, 1176; *Cota,* 688 F. Supp. 2d at 997. Now Plaintiffs face the wholesale *elimination* of ADHC services. The deficiencies in Defendants' transition planning process "will likely lead to gaps in services and result in harm to vulnerable participants in the form of, for example, poor health outcomes, hospitalization, institutionalization in nursing facilities, and even

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because it "could potentially force Plaintiffs into institutions"); *Ball v. Rogers*, No. CV 00-67, 2009 WL 1395423, at *5 (D. Ariz. Apr. 24, 2009) (holding state liable under the ADA for failure to provide adequate services to avoid unnecessary institutionalization); *Pitts v.Greenstein,* No. 3:10-cv-00635, 2011 WL 1897552, at *3 (M.D. La. May 18, 2011) (denying defendants motion for summary judgment in part because defendants' planned reduction in the number of available weekly personal care hours "plainly violates the ADA by creating a greater risk of institutionalization."); *Hiltibran v. Levy*, No. 2:10-cv-04185, 2010 WL 6825306, at *4-5 (W.D. Mo. Dec. 27, 2010) *Hiltibran v. Levy*, No. 2:10-cv-04185, 2011 WL 2534332, at *7 (W.D. Mo. June 24, 2011); (Opinions granting plaintiffs' motion for preliminary injunction and motion for summary judgment in after finding that the defendants policy not to provide necessary incontinence supplies placed individuals at risk of institutionalization in violation of the ADA.)

death." (Decl. of Kathleen Wilber, ECF No. 257 ("Wilber Decl.") ¶ 7.B.) As this Court previously found, "even temporary gaps in services would present serious consequences for Plaintiffs and place them at great risk of being institutionalized." *Brantley*, 656 F. Supp. 2d at 1174.

Plaintiffs have submitted declarations from six experts, and numerous ADHC providers, as well as declarations from the individual participants or their caregivers, each of whom testifies that the loss of ADHC services, without the provision of adequate replacement services to substitute for those outlined in their IPCs, will place Plaintiffs and class members at serious risk of institutionalization. For example, Named Plaintiff Allie Jo Woodard is an 81 year-old recipient of ADHC services five days per week who has been diagnosed with bipolar affective disorder, depression, diabetes, glaucoma, hypertension, seizure disorder, and osteoarthritis. (Decl. of Linda Gaspard-Berry, ECF No. 239, ("Gaspard-Berry Decl.") ¶¶ 3-4.) Both her daughter (who is her primary caregiver) and her ADHC provider of eleven years attest that without ADHC services Ms. Woodard will be unable to receive the daily skilled nursing monitoring, and regular medical and rehabilitative care that help her avoid acute hospitalization and long-term institutionalization. (Id. ¶¶ 17-18; Davis Decl. ¶ 30.) Named Plaintiff Esther Darling is 74 years old and has been diagnosed with congestive heart failure, diabetes, post-stroke paralysis affecting her left side, atrial fibrillation, incontinence, edema, depression, hearing loss, and other disabilities. (Decl. of Esther Darling, ECF No. 231, ("Darling Decl.") ¶¶ 4, 6; Decl. of Jeffrey Yee, M.D., ECF No. 258, ("Yee Decl.") ¶ 11) She lives alone in her apartment but receives some daily assistance from a personal care worker through the State's In-Home Supportive Services ("IHSS") program. (Darling Decl. ¶ 8) In addition, she has attended the Yolo Adult Day Health Center for the last 14 years, and currently attends five days per week. (Id. ¶ 3.) The Center's Medical Director, who has been Ms. Darling's physician for more than twenty years and who helped draft her current IPC, attests that without ADHC she will not be able to remain safely in her home. (Yee Decl. ¶ 15). He states that daily monitoring by a

qualified nurse, which she receives at the ADHC, is necessary to assess changes in her condition, and that an IHSS worker is not qualified to perform these tasks. (Id.)

The impact of Defendants' actions on other Plaintiffs will be similarly devastating. (*See* Decl. of Gary Steinke, ECF No. 254 ("Steinke Decl.") ¶ 27; McCloud Decl. ¶ 39; Decl. of Gilda Garcia, ECF No. 237 ("Garcia Decl.") ¶ 18; Decl. of Vitta Perelman, ECF No. 249 ¶¶ 14-15 (Gilda Garcia's risk of acute hospitalization and institutionalization); Nolcox Decl. ¶¶ 33-34; Decl. of William I. Gardner, ECF No. 238 ("Gardner Decl.") ¶ 17 (Ronald Bell's risk of placement in a nursing facility); Gardner Decl. ¶¶ 18-19; Decl. of Dennis Arnett, ECF No. 227 ("Arnett Decl.") ¶ 18; Regalia Decl. ¶¶ 53-54 (Wendy Helfrich's risk of institutional placement); Steinke Decl. ¶ 29; Behr Decl. ¶¶ 27, 36; Decl. of Jessie Jones, ECF No. 243 ("Jones Decl.") ¶ 10; Decl. of Helene Philips, ECF No. 250 ("Philips Decl.") ¶ 14 (Jessie Jones would have to enter a nursing facility without appropriate services); Toth Decl. ¶ 49; Gardner Decl. ¶ 23 (Raif Nasyrov would have to enter a nursing facility without appropriate services); Decl. of Cordula Dick-Muehlke ECF No. 233 ("Dick-Muehlke Decl.") ¶¶ 33-34; Steinke Decl. ¶¶ 21-25; Toth Decl. ¶ 68; McCloud Decl. ¶¶ 43, 52; Puckett Decl. ¶¶ 46-48; Myers-Purkey Decl. ¶¶ 38-44; Regalia Decl. ¶¶ 29-31, 56-58; Nolcox Decl. ¶¶ 22, 35-37; Davis Decl. ¶¶ 36-40; Behr Decl. ¶¶ 34, 36; Houghton Decl. ¶ 21-24 (Class Members' risks of institutionalization)).

Defendants allege that they are developing a "short-term plan" to transition the approximately 35,000 ADHC program participants to existing Medi-Cal services by September 1, 2011.[13] Even assuming that ADHC participants or their proxies could locate, contact, apply to, be assessed for medical necessity determinations by, and admitted to these hypothetical

[13] The 2011-2012 budget for the State of California, signed into law on June 30, 2011, appropriates $85 million to fund ADHC transition assistance. *See* Budget Act of 2011, Senate Bill 87, enrolled June 28, 2011, Item 4260-101-0001 (13); Ex. H to Hendrickson Decl, "Governor's Objections to appropriations contained in Senate Bill 87.") This one-time appropriation is designed to support transition of ADHC beneficiaries to alternative Medi-Cal services but contains no instructions as to what services, if any, might be actually available before ADHC services are eliminated.

alternatives before the September 1st termination date, existing Medi-Cal services are likely insufficient to replace the ADHC services that are prescribed in recipients current plans of care.[14] For example, IHSS, which many of the Plaintiffs and other ADHC participants already receive, is a personal care program and does not offer the skilled nursing services, physical, speech, or occupational therapies, or sufficient medication management and supervision currently provided at their ADHC centers. (*See* Yee Decl. ¶ 15; Darling Decl. ¶ 8; Myers-Purkey Decl. ¶ 22; Missaelides Decl. ¶¶ 89-90.) The Multi-Purpose Senior Services Program (MSSP) is a Medicaid home and community-based waiver that provides care coordination services to a limited number of participants, is only available to individuals over the age of 65, is not available in all areas of the state, and has a waiting list. (*See* Missaelides Decl. ¶ 91; Ex. N to Missaelides Decl. at PL 00907.) Other purported alternative programs currently in existence have waiting lists, and obtaining these services after ADHC is eliminated will be difficult, if not impossible for many Plaintiffs and class members. (*See* Missaelides Decl. ¶ 81; Wilber Decl. ¶ 9.) As one of Plaintiffs' experts attests

> [t]hese services are administered by a variety of different agencies and departments, have varying eligibility requirements and assessment procedures, and may be limited in their availability in terms of the type and amount of services provided. Other services may have capped enrollment or limited or no availability in certain geographic locations. Some services are at capacity and currently rely on waiting lists.

(Wilber Decl. ¶ 11.)

[14] (*See* Dick-Muehlke Decl. ¶¶ 21-23, 26-30; Decl. of Megan Elliott, ECF No. 235 ("Elliott Decl.") ¶¶ 22-24; Decl. of Joseph Hafkenschiel, ECF No. 240 ¶12-18, 20-28, 31; Missaelides Decl. ¶¶ 80-92; Wilber Decl. ¶¶ 7, 9, 11-19, 22; Yee Decl. ¶¶ 15, 18-19; Behr Decl. ¶¶ 30-35; Davis Decl. ¶¶ 24-29, 31-35; Houghton Decl. ¶¶ 16-20; McCloud Decl. ¶¶ 21-26, 28, 40-51; Myers Purkey Decl. ¶¶ 14, 21-24, 28, 34-35, 37, 39-40; Nolcox Decl. ¶¶ 16-22, 34; Puckett Decl. ¶¶ 17, 22-34, 41-43,45; Regalia Decl. ¶¶ 20-28, 36, 39, 44, 46, 55; Toth Decl. ¶¶ 30-41, 50-51, 58-60.)

Indeed, Defendants have submitted scant evidence demonstrating concrete and realistic efforts to locate and identify alternative services and actually ensure that such services will be provided to the highly medically acute population of individuals currently receiving ADHC services when those services terminate on September 1, 2011. (*See* Defs.' Br. at 2-3.) Rather, Defendants' efforts undertaken thus far amount to pre-planning, instead of actual implementation of effective transitions. For example, there are "ongoing meetings" between five state agencies, whose staff are "reaching out to local partners … to inform them of the pending benefit elimination so that they can begin to prepare for possible referrals…. provid[ing] other departments with a contact list of thirty-three Area Agencies on Aging[15] and a map identifying each catchment area," and developing "[c]ounty-level community resource sheets identifying key local agencies … and their contact information." (Decl. of Jane Ogle, ECF No. 274, ("Ogle Decl.") ¶ 12-13; *see also* Ex. B to Ogle Decl, "Draft Community Resource Guide for Los Angeles City.") Staff from DHCS and California Department of Aging ("CDA") are reviewing the IPCs of current ADHC participants who receive four or five days per week of ADHC services in an attempt to "understand[] the most prevalent diagnoses," which will allegedly aid Defendants with "identify[ing] the community resources that may be able to provide an alternative to ADHC services" and "communicating the results to state and local agencies with requests that these results are reviewed *to determine the availability* of needed services." (*See* Ogle Decl. ¶ 15.) (emphasis added)[16] And less than sixty days before all ADHC services will

[15] Area Agencies on Aging receive federal, state and local funds to contract with local organizations for service to seniors. (Ogle Decl. ¶ 13.) California law identifies these agencies as the local units in California to administer programs in compliance with the federal Older Americans Act and applicable regulations. (Id.)

[16] Defendants assert that a "large proportion" of the IPCs they have reviewed thus far indicate the necessity for "medication management" and assert that such services are available through the IHSS program, hypothesizing that "many participants may be eligible for additional IHSS hours." As noted supra, p. 17, Plaintiffs' experts have identified a number of reasons why IHSS will likely be insufficient to provide the medication management and supervision necessary to prevent acute hospitalization and long-term institutionalization of current ADHC recipients.

abruptly end, Defendants cannot point to any viable plans to either expand existing services or create new services to replace the essential panoply of services provided on-site at ADHC centers.[17]

Rather than undertaking concrete and extensive efforts to actually ensure ADHC recipients are not imperiled with declining physical and mental health and institutionalization, Defendants instead attempt to shift their responsibilities under the ADA to other State and local agencies, and, largely, to ADHC providers, even as those providers are on the verge of shutting their doors. The Defendants have not provided specific instructions to ADHC providers regarding discharge planning, availability of replacement services, timeliness, monitoring post-discharge, or funding of the transition process.[18] This Court previously found such an approach to meeting the State's obligations under title II to be "cavalier." *Brantley*, 656 F. Supp. 2d at 1174. Indeed, Defendants "bear the burden of ensuring more than a 'theoretical' availability" of alternative services to meet needs outlined in Plaintiffs IPCs in order to satisfy Defendants' obligations under the ADA. *Id*; *see also Ball v. Rodgers*, No. 00-cv-67, 2009 WL 1395423, at *5

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[17] On June 15, 2011, the California Legislature passed a bill that would require DHCS to submit to CMS by September 1, 2011 an application to implement a new home and community-based waiver program called the Keeping Adults Free from Institutions ("KAFI") program. (*See* Suppl. Missaelides Decl. ¶ 7; Ex. E to Suppl. Missaelides Decl. "Assembly Bill 96.") If signed into law, the program would utilize ADHC centers to provide a "well-defined scope of medical, behavioral health, and social services" for Medi-cal beneficiaries who have been assessed to be at risk of institutionalization. (Ex. E to Suppl.Missaelides Decl.) As of July 12, 2011, this program has not been signed into law. (Suppl. Missaelides Decl. ¶ 7).

[18] (*See* Toth Decl., Ex. B, "ADHC Program Updates" at PL00912 (letter informing providers of their responsibilities); Missaelides Decl., Ex. I, at 5: 2-6 (provider responsibilities); 5:10-13; 18:14-23; 20:3-7; 27:19-27 (lack of information on viability of alternative services,); 8:1-6; 13:11-14; 28:6-16-19; 30:9-13 (lack of DHCS assistance for transition,); 6:7-8; 13:13-14; 19: 12-14 (lack of specificity regarding transition process); 14: 8-15; 22:13-18 (lack of information about timing and availability of KAFI program,); 6:22-24; 8: 2-6 (lack of information regarding additional funding); Wilber Decl. ¶¶ 7.C, 21 (lack of information regarding a mechanism to monitor (1) whether participants actually receive adequate alternative services; and (2) the safety of discharged participants)).

(D. Ariz. April 24, 2009) (state defendants violated title II's integration mandate because their "failure to provide adequate services to avoid unnecessary gaps in service and institutionalization was discriminatory.")

d. The request that the implementation of AB 97 occur in a manner that minimizes disruptions in care that put Plaintiffs and others similarly situated at risk of entry into costly institutional settings is reasonable and does not fundamentally alter Defendants' overall program of services

It is entirely reasonable, and not a fundamental alteration of the Defendants' programs, for Plaintiffs to request that the State, which is undertaking a dramatic elimination of a critical program for one of California's most vulnerable populations, ensure that the service alteration does not place individuals at risk of institutionalization in violation of the ADA.

Hastily terminating ADHC services without ensuring that sufficient alternative services are provided will cost the State more money, despite AB 97's purpose to address the State's budget deficit. Defendants ask this Court to rely solely on the Legislature's belief that discontinuing ADHC would save the State money, and entirely disregard evidence that the elimination of ADHC services would cost the State $51 million more than it saves in the first year alone, due to increased hospitalizations and placements in nursing facilities. (*See* Defs.' Br. at 8; Ex. B to Auerbach Decl., The Lewin Group, "Projected Economic Impact of Eliminating California's Medi-Cal Adult Day Health Care Program" ("Lewin Study"), at 1.) And Defendants have not offered any analysis of the expense involved with former ADHC participants' increased utilization of alternative home and community-based services, if any such services are in fact available. (*See* Decl. of Leslie Hendrickson, PhD, ECF No. 287, ("Hendrickson Decl.") ¶ 40.)

Instead, Defendants' fundamental alteration argument rests primarily upon the unsupported and incorrect assertion that federal financial participation would necessarily be unavailable to the State for continuing ADHC services in the short term. (*See* Defs.' Br. at 13, 17-18). Nothing in federal Medicaid law prohibits the State from requesting, through another

State Plan Amendment to CMS, to alter or restore the ADHC service as a Medi-Cal benefit, or delay the effective date of the State's approved State Plan Amendment removing ADHC as a covered service.[19] In fact, CMS has already expressed its willingness to consider such an amendment. (*See* Ex. D to Gershon Decl., "Jul. 12, 2011 Letter from CMS to Elissa Gershon.") And CMS has indicated in numerous communications that it will work with states to assist them in meeting their independent obligations under title II of the ADA and *Olmstead*.[20] Other Courts have held that requiring a state to seek to alter or amend services reimbursable by CMS would not be a fundamental alteration. *See, e.g. Radaszewski ex rel. Radazewski v. Maram*, 383 F.3d 599, 611 (7th Cir. 2004) (requiring the state to modify the services provided via its waiver program need not be a fundamental alteration); *Grooms v. Maram*, 563 F. Supp. 2d 840, 857 (N.D. Ill. 2008) (requiring that the state amend its waiver application in order to continue to provide the level of services plaintiff required to remain living in the community would not be a fundamental alteration).

That the State is experiencing a budget deficit does not exculpate it from complying with the *Olmstead* integration mandate. *Fisher*, 335 F.3d at 1183 ("that [a state] has a fiscal problem, by itself, does not lead to an automatic conclusion" that providing the community services that plaintiffs seek would be a fundamental alteration). Further, "[i]f every alteration in a program or service that required the outlay of funds were tantamount to a fundamental alteration, the ADA's integration mandate would be hollow indeed." *Fisher*, 335 F.3d at 1183; *see also Pennsylvania*

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[19] *See* State Medicaid Manual, § 13026 (outlining process for approving State Plan Amendments and reserving authority for the CMS Administrator to determine that a previously approved plan no longer meets the requirements for approval) *available at*: http://www.cms.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021927&intNumPerPage=10

[20] *See, e.g.* State Medicaid Director Letters – No. 10-008: "Community Living Initiative" (May 20, 2010), No. 01-007: "Olmstead Update No. 5" (Jan. 10, 2001), No. 01-006: "Olmstead Update No. 4" (Jan. 10, 2001), "Olmstead Update No. 3" (Jul. 25, 2000), "Olmstead Update No. 2" (Jul. 25, 2000), "The recent Supreme Court Decision in Olmstead v L.C. , 119 S. Ct. 2176 (1999)" (Jan. 14, 2000), *available at*: http://www.cms.gov/SMDL/SMD/list.asp

Protection and Advocacy, Inc. v. Pennsylvania Dept. of Pub. Welfare, 402 F.3d 374, 380 (3d Cir. 2005). Congress was aware that integration "will sometimes involve substantial short-term burdens, both financial and administrative," but the long-term effects of integration "will benefit society as a whole." *Fisher*, 335 F.3d at 1183, *citing*, H.R. Rep. No. 101-485, pt.3, at 50, *reprinted* in 1990 U.S.C.C.A.N. 445,773. Thus, Plaintiffs requested modification to Defendants' planned elimination of the ADHC program is reasonable and will not fundamentally alter the Defendants' programs.

In sum, Plaintiffs have established that they are likely to succeed on the merits of their ADA and Rehabilitation Act claims.

2. Plaintiffs Will Suffer Irreparable Harm Absent a Preliminary Injunction

As discussed above, the elimination of ADHC services under AB 97 and Defendants' ill-conceived and poorly described short term transition plan put Plaintiffs at serious risk of unnecessary institutionalization, constituting irreparable harm. In enjoining prior reductions in available ADHC services, this Court held 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." *Cota*, 688 F. Supp. 2d at 997; *Brantley*, 656 F. Supp. 2d at 1176; *see also, Beno v. Shalala*, 30 F. 3d 1057, 1063-64, n. 10 (9th Cir. 1994). Further, this Court found that "[e]ach of the Plaintiffs [threatened with reduction of ADHC services] suffers from debilitating physical and/or mental conditions for which the availability of ADHC services is critical to ensuring that their tenuous physical and mental conditions remain stable, enabling them to remain in the community." *Brantley*, 656 F. Supp. 2d 1176. This Court granted the Plaintiffs' requested injunction, reasoning that,"[g]iven the tenuousness and complexities of their conditions, an interruption in their care, even if temporary, will have serious consequences for Plaintiffs." *Id*; *see also V.L. v. Wagner*, 669 F. Supp. at 1112.

Courts have routinely recognized that the harm associated with institutionalization – even on a short term basis – is severe. *See Long v. Benson*, No. 08cv26, 2008 WL 4571903, at *2 (N.D. Fla. Oct. 14, 2008) (unpublished) (granting a preliminary injunction based in part on the reasoning that forcing the individual to leave his community placement and enter a nursing home "will inflict an enormous psychological blow" and that "*each day* he is required to live in the nursing home will be an irreparable harm.") (emphasis added); *Marlo M.*, 679 F. Supp. 2d at 638 (granting a preliminary injunction where plaintiffs established that they would "suffer regressive consequences if moved [to a nursing home], *even temporarily*.") (emphasis added); *Crabtree v. Goetz*, No. 08-0939, 2008 WL 5330506, at *25 (M.D. Tenn. Dec. 19, 2008) (unpublished) (granting a preliminary injunction enjoining state defendants from reducing available home health care services and explaining that institutionalization "would be detrimental to [plaintiffs'] care, causing, *inter alia*, mental depression, and for some Plaintiffs, a shorter life expectancy or death."); *Haddad v. Arnold*, No. 3:10-00414, 2010 WL 6650335, at *17 (M.D. Fla. July 9, 2010) (granting preliminary injunction after finding that the plaintiff will suffer irreparable injury if forced to enter a nursing home.)

3. The Balance of Hardships Weighs Heavily in Plaintiffs' Favor and Granting Plaintiffs' Request for a Preliminary Injunction is in the Public Interest

The final two factors to be considered on a motion for preliminary injunction – the balance of hardships and the public interest – may be viewed together. *Brantley*, 656 F. Supp. 2d at 1177 (citing *Independent Living Ctr. Of S. Cal., Inc. v. Maxwell-Jolly*, 572 F.3d 644, 657-58 (9th Cir. 2009), *cert granted on other grounds*, *Douglas v. Independent Living Ctr. Of S. Cal., Inc.*, Nos. 09-958, 09-1158, 10-283 (Jan. 18, 2011). As this Court has recognized, "where the issue concerns the proposed reduction in medical benefits to indigents due to budgetary concerns, the Ninth Circuit has recognized that both the balance of hardships and public interest favor plaintiffs." *Brantley*, 656 F. Supp. 2d at 1177 (citing *Independent Living Ctr. Of S. Cal., Inc.*, 572 F. 3d at 657-58).

Further, because the additional costs of providing institutional care is so high – estimated at $51 million – any financial hardships that Defendants may incur will likely be offset by the cost savings that accrue from avoiding unnecessary institutionalizations. (*See* Lewin Study at 5.) This Court has recognized that that "financial considerations attributable to [a] state's 'fiscal crisis' are outweighed by the 'robust public interest in safeguarding access to healthcare for those eligible for Medicaid, whom Congress has recognized as the most needy in the country.'" *Cota*, 688 F. Supp. 2d at 999 (*citing Independent Living Ctr.*, 572 F. 3d at 657-58) (internal citations omitted); *see also V.L.*, 669 F. Supp. 2d at 1122 (determining that the risk of institutionalization and inability to access necessary medical care harm to the beneficiaries facing reductions in IHSS hours outweighs the Defendants' budget considerations).

Lastly, there is a public interest in eliminating the discriminatory effects that arise from segregating persons with disabilities into institutions when they can be appropriately placed in or remain in community settings. As the Supreme Court explained in *Olmstead*, the unjustified segregation of persons with disabilities can stigmatize them as incapable or unworthy of participating in community life.[21] *Olmstead*, 527 U.S. at 600.

IV. CONCLUSION

For the reasons stated above, the Court should grant Plaintiffs' Motion for Preliminary Injunction and enjoin the State from eliminating ADHC services unless and until adequate, appropriate, and uninterrupted services are provided. With the Court's permission, counsel for the United States will be present at any upcoming hearings.

DATED: July 12, 2011

[21] *See also* Brief for the United States as Amicus Curiae Supporting Respondents at 16-17, *Olmstead v, L.C.*, 527 U.S. 581 (1999) (No. 98-536) (1999 WL 149653) ("To be segregated is to be misunderstood, even feared," and "only by breaking down barriers between people can we dispel the negative attitudes and myths that are the main currency of oppression.") (citing 136 Cong. Rec. H2603 (daily ed. May 22, 1990) (statement of Rep. Collins).

Respectfully submitted,

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