NO: 04-16963

IN THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

PEG BALL, CREE JAMES, a minor person by and through her grandfather and guardian BENNIE JAMES, JEANNE SPINKA, VENETTA GRAHAM, COLLIN PHELAN, a minor person by and through his mother KIM BOWMAN, JUDETH HINTON, and VIRGINIA HASKELL, as individuals and as representatives of a class of persons similarly situated,

Plaintiffs-Appellees,

vs.

ANTHONY D. RODGERS, Director of the Arizona Health Care Cost Containment System, and THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION,

Defendants-Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF ARIZONA

APPELLEES' ANSWERING BRIEF

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MISCELLANEOUS

JURISDICTIONAL STATEMENT

The Plaintiffs-Appellees (Plaintiffs) agree with the jurisdictional statement outlined in the Defendants-Appellants' (Defendants) Opening Brief regarding the district court's jurisdiction over this matter pursuant to 28 U.S.C. § 1291. However, this is an appeal from an order entered on August 13, 2004, that was final in all material respects. Appellee's Supplemental Excerpts of Record (Supp. ER) 212. Only the schedule for implementation of remedies was left to be determined, which the district court subsequently ordered on June 28, 2005. Supp. ER 248. Therefore, interlocutory appeal jurisdiction pursuant to 28 U.S.C. § 1292(a)(1) is not applicable.

STATEMENT OF ISSUES PRESENTED FOR REVIEW

I. Whether the district court issued judgment for Plaintiffs on all claims?

II. Whether the evidence showed that Defendants violated several provisions of the Medicaid Act, the Americans with Disabilities Act, and the Rehabilitation Act?

III. Whether the court's findings provided a strong factual basis for issuing the prospective relief ordered?

IV. Whether the district court abused its discretion by denying Defendants' motion for a new trial?

STATEMENT OF THE CASE

On June 28, 2005 Judge Carroll supplemented his Order of August 13, 2004, by establishing an implementation schedule, and more particularly specifying the steps Defendants must take to afford relief for Plaintiffs. Supp. ER 212, 248.

Defendants-Appellants' Statement of the Case is correct in most respects.[1]

STATEMENT OF FACTS

This lawsuit challenges policies of the Arizona Health Care Cost Containment System (AHCCCS) that deprive elderly and disabled persons of home care services that they need to remain living in the community.

A. Plaintiffs' Situations

The Plaintiffs are named individuals and a class of persons in Arizona who have been or will be eligible for Medicaid Home and Community Based Services

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[1] However, Defendants stated that Plaintiffs' Complaint alleged violation of "at least a dozen federal statutes and rules," but failed to explain that most of these are subsections of the Medicaid statute, 42 U.S.C. § 1396, requiring state Medicaid agencies to provide mandatory health services promptly and adequately.

Defendants also failed to state that Plaintiffs' motion in limine and motion to amend the pretrial order, filed in November, 2002, sought to include witnesses already identified in exhibits to Plaintiffs' motion for summary judgment in October, 2001and in Plaintiffs' second supplemental disclosure statement filed July, 2001, as well as evidence of continuing problems experienced by HCBS beneficiaries obtaining home care worker services. CD 129 - 132, documents lodged 12/18/02 and admitted 139, 141, 147.

(HCBS), but are not provided with the full amount of such services prescribed in their care plans. Civil Docket (CD) 31, Supp. ER 212, Findings of Fact (FOF) ¶4.

Persons like Plaintiffs who are either elderly, physically disabled, or developmentally disabled can be eligible for Arizona Long Term Care Services (ALTCS), including HCBS services, if they pass both a financial and a medical screen. Supp. ER 212, FOF ¶¶4-5. The financial eligibility is based on the Supplemental Security Income (SSI) limit of $1,593.00 per month for an individual as of August 2001. Supp. ER 212, FOF ¶6. The medical eligibility test is that the individual be "at risk of institutionalization." Supp. ER 212, FOF ¶7.

Thus, HCBS services are designed to be an alternative to institutionalization, such as care in a nursing facility or hospital. Supp. ER 212, FOF ¶8. In 2001, 7,319 elderly or physically disabled persons in Arizona were receiving HCBS services in their own homes. Supp. ER 212, FOF ¶11.

Four representative class members, Peggy Ann Ball, Melissa Richardson, Jeanne Spinka, and Judeth Hinton testified at trial. They testified that, on numerous occasions, each was left with no home health care attendant to care for them. These gaps in services caused Plaintiffs to suffer grave consequences, such as complete immobility, hunger, thirst, muscle aches and other physical and mental distress. Supp. ER 212, FOF ¶64. Charts prepared by defendant

AHCCCS show that the named Plaintiffs failed to receive medically necessary and prescribed HCBS services on numerous occasions. CD 203, ¶¶88, 92, 94, 95, 100, 106, 109, 113, 115, 118.

B. Defendant AHCCCS and the HCBS Program

AHCCCS is the state agency which receives federal funding in order to ensure provision of health care services to Arizona's Medicaid beneficiaries. Supp. ER 212, FOF ¶1. It provides Medicaid long term care benefits, both institutional and in-home, to persons who are elderly or disabled through the ALTCS program. Supp. ER 212, FOF ¶¶2, 3. ALTCS is primarily a capitated managed care program whereby AHCCCS pays Program Contractors a dollar amount per beneficiary regardless of the number or type of services received. Supp. ER 212, FOF ¶14.

AHCCCS contracts with managed care organizations called Program Contractors to provide ALTCS services including HCBS services. Supp. ER 212, FOF ¶17. There are eight Program Contractors serving different counties, who agree to deliver a specific package of health care to beneficiaries in return for a monthly capitation payment for each beneficiary served. Supp. ER 212, FOF ¶¶8-19. The Program Contractor for individuals with developmental disabilities is the Division of Developmental Disabilities in the Department of Economic Security.

Supp. ER 212, FOF ¶22. The monthly capitation payment is a blended rate including weighted costs for nursing facility, HCBS, acute medical care, behavioral health, and case management services. Supp. ER 212, FOF ¶20.

The Program Contractor assigns each beneficiary a Case Manager who prescribes a specific package of services based on the individual's medical needs, including the amount and frequency of HCBS services to be received. Supp. ER 212, FOF ¶¶23, 25, 26. All HCBS services in the beneficiary's plan have been determined by the Program Contractor to be medically necessary. Supp. ER 212, FOF ¶27. HCBS services can include 1) personal care (bathing, toileting, dressing, etc.); 2) homemaker (cleaning, laundry, shopping, etc.); 3) attendant care (bathing, toileting, dressing, plus cleaning); and 4) respite care (short term care to give the primary caregiver time off). Supp. ER 212, FOF ¶28.

Program Contractors often subcontract with provider agencies to supply the home care workers, at negotiated hourly rates. The provider agencies then hire and pay workers to provide the actual services in the homes. Supp. ER 212, FOF ¶24. Attendant care services constitute around 60% of all HCBS costs. Supp. ER 212, FOF ¶29. Training requirements for attendant care workers are minimal. Supp. ER 212, FOF ¶31.

C. Shortages in HCBS Attendant Care Workers

In November, 1999, wages for HCBS attendant care workers ranged from $6.25 to $7.50 per hour. Supp. ER 212, FOF ¶32. There was difficulty recruiting attendant care workers due to low wages. Supp. ER 212, FOF ¶33. The shortage of workers was community wide during the relevant time period, and Program Contractors in both Pima and Maricopa counties had extensive waiting lists of beneficiaries who qualified for attendant care workers. Supp. ER 212, FOF ¶¶34, 35. The Division of Development Disabilities, which provides HCBS services to developmentally disabled beneficiaries, also had a waiting list for attendant care workers due to the shortage of workers. Supp. ER 212, FOF ¶¶22, 36, 37.

A statewide Community Based Report in 1998 found that the State was "already experiencing problems in the HCBS delivery. If left unresolved, the demand for these services may not be met." This report suggested "expanding paraprofessional networks, ensuring wages are competitive, ensuring quality of services, supporting the client and family, and revising public policy to limit barriers to care." Supp. ER 212, FOF ¶¶38-39. In 1999 the Auditor General advised AHCCCS that its contractors were failing to provide necessary services, resulting in quality of care problems. Supp. ER 212, FOF ¶40. In 2000, the Director of AHCCCS acknowledged that it was "researching strategies to hire

paraprofessionals to meet the consumer demand." Supp. ER 212, FOF ¶41. Multiple studies and reports indicated a shortage of attendant care workers in Arizona. Supp. ER 212, FOF ¶42.

D. The Private Home Care Market Compares Favorably to ALTCS HCBS

Rates for HCBS attendant care workers historically were lower than those who work for Medicare or private paying clients. Supp. ER 212, FOF ¶44. Most rates for HCBS attendant care workers ranged from $6.50 per hour to $8.50 per hour during the relevant time period. As of April 26, 1999 Maricopa County paid regular attendants $7.15 per hour. Supp. ER 212, FOF ¶45. By comparison, private paying clients typically paid between $10.00 and $12.00 for providers of home care services in Maricopa County. Supp. ER 212, FOF ¶46.

Dr. Dorie Seavey, an expert labor economist and researcher, testified that the AHCCCS payment rates for home health care workers were too low to garner the needed number of workers. The workers were available, but would not work for the pay offered. Defendants failed to offer a high enough hourly pay to meet the needs of their beneficiaries. Supp. ER 212, FOF ¶¶47-50.

Program Contractors can increase their profit by paying a lower hourly wage to providers. Maricopa County made in excess of $10 million in profit in the contract year ending in 2000. Supp. ER 212, FOF ¶¶52-53.

E. Failure of Defendants to Take Corrective Action

In order to determine an appropriate hourly wage, Defendants should collect data on whether beneficiaries are receiving the care authorized for them. Supp. ER 212, FOF ¶54. This data would have helped in determining "actuarially sound capitation rates." Supp. ER 212, FOF ¶55. But AHCCCS does not collect data from its Program Contractors on the difference between HCBS services authorized for beneficiaries in their care plans and the services actually delivered by Program Contractors. Supp. ER 212, FOF ¶56.

The Member Handbooks given to HCBS recipients do not provide beneficiaries with a grievance process regarding gaps in services. Instead, beneficiaries are instructed to contact their Case Managers, who work for the Program Contractors. Supp. ER 212, FOF ¶57. Surveys to beneficiaries did not always ask whether they were receiving their prescribed services. Supp. ER 212, FOF ¶59. Defendants failed to adequately gather information about, or monitor, gaps in services. Supp. ER 212, FOF ¶58.

AHCCCS was aware that not all of its beneficiaries were receiving their prescribed services. Supp. ER 212, FOF ¶62. But it is the policy of AHCCCS that an HCBS beneficiary assumes the risk that services he or she is dependant upon will not be delivered, by choosing to remain at home rather than be

institutionalized. Supp. ER 212, FOF ¶61. AHCCCS does not require its agencies to have a contingency plan for beneficiaries when attendant care workers are unavailable, or do not show up as scheduled. Supp. ER 212, FOF ¶43. No penalty or poor performance rating for failure to fill care plans had been given to a Program Contractor by Defendants between at least November 1999, the earliest date for which information about penalties and performance rating was sought in discovery, and February 2002. Supp. ER 212, FOF ¶60.

Evidence presented after trial with respect to the formulation of relief showed that there are continuing gaps in delivery of services. Supp. E.R. 239. Exs. A-D.

STANDARD OF REVIEW

"Findings of fact, whether based on oral or documentary evidence, shall not be set aside unless clearly erroneous, and due regard shall be given to the opportunity of the trial court to judge of the credibility of the witnesses." Federal Rule of Civil Procedure 52. The Court of Appeals reviews a district court's findings of fact for clear error. Sawyer v. Whitley, 505 U.S. 333, 346 n.14 (1992).("Under this deferential standard, we must accept the lower court's finding of fact unless upon review we are left with the definite and firm conviction that a mistake has been committed.") Phoenix Engineering v. Universal Electric Co.,

Inc., 104 F.3d 1137, 1140 (9th Cir. 1997)("[f]indings of fact are reviewed for clear error.") The trial court's conclusions of law are subject to a *de novo* review, without deference to the state's interpretation of the Medicaid statute. Orthopaedic Hospital v. Belshe, 103 F.3d 1491, 1495-1496 (9th Cir. 1997). If the application of the law to the facts requires an inquiry that is essentially factual, however, review is for clear error. United States v. McConney, 728 F.2d 1195, 1203 (9th Cir. 1984).

SUMMARY OF THE ARGUMENT

The evidence presented at trial abundantly supports the district court's ruling that Defendants' ongoing failure to provide adequate numbers of home care workers for HCBS beneficiaries violates federal law.

Evidence clearly established a pattern of worker shortages, so that home care services were delayed in starting and terminated without warning. As a result of these gaps in service, elderly and disabled Medicaid beneficiaries were stranded alone without assistance in basic life activities.

Evidence further established that wages paid by Defendants' managed care contractors were too low to recruit and keep sufficient numbers of home care workers. Worker wages were lower, and gaps in services greater, in the Arizona Medicaid program than for individuals covered by other insurance. Although

Defendants increased capitation payments after this lawsuit was filed, they did not require the increases to be passed through to workers.

Defendants' policies with respect to monitoring and enforcement of home care service obligations were remarkably lax. The state did not require its managed care contractors to report gaps between services prescribed and services delivered, and imposed no monetary penalties nor terminated any of their Program Contractors for failure to supply services.

The lower court correctly ruled that this body of evidence established violations of the equal access provision of the Medicaid statute, 42 U.S.C. §1396a(a)(30)(A) and the freedom of choice provision of the Medicaid statute, 42 U.S.C. §1396n(c)(2)(C) and (d)(2). By imposing risk on beneficiaries who chose services at home rather than in a nursing facility, the Defendants violated the Americans With Disabilities Act, 42 U.S.C. §§12131-12134, and the Rehabilitation Act of 1973, 29 U.S.C. §794. Their actions also violated the reasonable promptness provision of the Medicaid statute, 42 U.S.C. §1396a(a)(8), and the continuation of services provision of the Medicaid regulations, 42 C.F.R. §435. 930(b).

The court's prospective relief ordering Defendants to timely provide all the "critical" HCBS services prescribed in a beneficiary's care plan was necessary and

appropriate because of Defendants' longstanding practices of using inadequate methods and procedures relating to payment rates, tolerating gaps in services, and requiring beneficiaries to "assume the risk" of such gaps.

ARGUMENT

I. THE DISTRICT COURT ISSUED JUDGMENT FOR PLAINTIFFS ON ALL CLAIMS

Defendants' assertion that some of the claims in this action were not resolved by the district court and that, therefore, these claims should be deemed to be dismissed is not only legally incorrect, but also not supported by the record.

Defendants cite to no legal authority to support its position that unresolved claims can be deemed dismissed by the appellate court. It is a fundamental principle of appellate review that this Court is empowered to hear appeals "from all final decisions of the district courts of the United States." 28 U.S.C. § 1291. If all the issues have not been finally resolved, as Defendants argue, then this Court is not empowered to hear this appeal pursuant to 28 U.S.C. § 1291, but rather under 28 U.S.C. § 1292(a)(1). In that situation, the proper action as to the outstanding claims would be to remand, rather than dismiss them. However, remand is not necessary in this case because "a final decision of the district court

on the merits that disposes of all parties' claims" has been entered.[2] Appellants' Opening Brief (Opening Brief), p. 2, ¶D.

The language of the August 13, 2004 Order indicates that the district court intended this to be a final judgment, with some modifications in timelines for carrying out specific directives. Supp. ER 212, 14:fn. 8. A final decision is one that "ends the litigation on the merits and leaves nothing for the court to do but execute the judgment." Catlin v. United States, 324 U.S. 229, 233 (1945); Casey v. Albertson's Inc., 362 F.3d 1254, 1258 (9th Cir. 2004); United States v. Lummi Indian Tribe, 235 F.3d 443, 448 (9th Cir. 2000).

The court resolved the four claims in this lawsuit in Plaintiffs' favor in Conclusions of Law (COL) ¶¶18, 19, and 20, and granted Plaintiffs all the relief they requested. Supp. ER 212; CD 209. The court reserved jurisdiction solely for the purposes of executing the judgment entered. Supp. ER 212, 14, fn. 8; Supp. ER 248, ¶8. At no time did the court state that it was entering an interlocutory

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[2] This appeal can proceed despite the fact that a document titled "Final Judgment" has not been set forth on a separate document and entered into the docket pursuant to Federal Rules of Civil Procedure, Rules 58 and 79. Kirkland v. Legion Ins.Co., 343 F.3d 1135, 1140 (9th Cir. 2003) ("Although a final judgment requires a 'separate document,' neither the Supreme Court nor this court views satisfaction of Rule 58 as a prerequisite to appeal.") (citations omitted); see also, Federal Rule of Appellate Procedure 4(a)(7)(B) ("A failure to set forth a judgment or order on a separate document when required by Federal Rule of Civil Procedure 58(a)(1) does not affect the validity of an appeal from that judgment or order.")

injunction nor making the two certifications necessary under Fed.R.Civ.P. Rule 58 to indicate that it was entering judgment on only some, but not all, of the claims.[3]

Finally, subsequent actions taken by the parties and the court indicate that a final judgment on all claims has been entered. First, on August 26, 2004, Defendants filed Defendants' Motion for a New Trial or, In the Alternative, Stay. CD 214. If Defendants thought that claims remained outstanding, it would not have been appropriate to ask for a new trial, as judicial economy demands that such requests for relief occur after final judgment has been entered.[4]

Second, Defendants filed a timely notice of appeal on September 13, 2004. Supp. ER 220; See, Bankers Trust Co. v. Mallis, 435 U.S. 381 (1978) (filing of appeal evidenced parties' acknowledgment that final judgment had been entered). Casey, 362 F.3d 1254, 1259 (9th Cir. 2004) (evidence that party filed a Rule 60 motion was acknowledgment that final judgment had been entered). Such a timely filing would not have been required if judgment had not been entered. Further, the

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[3] The lower court was well aware of the nature and extent of the claims before it as both parties filed extensive pre-trial mememoranda, Proposed Findings of Fact and Conclusions of Law and Post-Hearing Memoranda outling the claims. CD 149, 152, 168-169, 206-211.

[4] Interestingly, at no time in any of the five pleadings Defendants filed (CD 214, 219, 222, 236, and 245) or at any of the three hearings held before the court (CD 231, 240, and 247) after the August 23rd Order did Defendants raise the issue of allegedly outstanding claims.

notice did not state that Defendants were filing an interlocutory appeal, which is consistent with the position in their Opening Brief that this is an "appeal from a final decision." Supp. ER 220; Opening Brief, p. 2, ¶D.

Finally, Defendants concurred in the Plaintiffs' Motion to Extend Time for Filing for Attorneys' Fees, supporting the conclusion that Defendants also believed the time for filing for attorneys' fees had begun to run under Fed.R.Civ.P. 54(d)(2)(B) ("[u]nless otherwise provided by statute or order of the court, the motion must be filed no later than 14 days after entry of judgment"). CD 213. Judge Carroll granted this motion, further indicating his intention that the August 13, 2004 Order was a final judgment which started the time running for filing appeals and for attorneys fees. CD 215.

Thus, the language of the court's Orders and the procedural history of this case indicate that Judge Carroll and all parties believed judgment had been entered and all claims resolved. Therefore, this Court's jurisdiction is proper under 28 U.S.C. § 1291 and no claims should be dismissed.

II. EVIDENCE SHOWED THAT DEFENDANTS VIOLATED SEVERAL REQUIREMENTS OF THE MEDICAID ACT, THE AMERICANS WITH DISABILITIES ACT, AND THE REHABILITATION ACT

A. The Court Properly Found that Defendants Violated Medicaid's Equal Access Requirement

The Medicaid Act, in the subsection known as the equal access provision, requires that Defendants provide methods and procedures to assure that their payments for care and services are consistent with quality of care and are sufficient to enlist enough providers so that the care and services are available to Medicaid beneficiaries to the same extent that they are available to the general population in the geographic area. 42 U.S.C. § 1396a(a)(30)(A).

1. There Was Substantial Evidence That Medicaid Beneficiaries Did Not Have Access to Services Equal to That of Non-Medicaid Clients

The district court found that Defendants' inadequate payment rates, in addition to the methodologies employed by its Program Contractors in enlisting sufficient providers, were not consistent with quality of care and access." Supp. ER 212, COL ¶16. The district court held that "Defendants had, and continue to have, a duty to monitor and manage the AHCCCS program to ensure compliance with quality of care, equal access and freedom of choice requirements." Supp. ER 212, COL ¶19. The court concluded that "Defendants failed to provide the

representative class members with the equal access, quality of care, and freedom of choice to which they are entitled." Supp. ER 212, COL ¶20.

Defendants claim that the district court erred because "there was no evidentiary basis to find that the state's past rates had resulted in any disparity compared to the care and services available to the general population." Opening Brief at 29. Defendants incorrectly state that the district court made no findings about conditions in non-Medicaid sectors . Id. The court specifically found that rates for Defendants' attendant care workers historically were lower than those working for Medicare clients or for private paying clients. Supp. ER 212, FOF ¶44. During the relevant time period, the court found that while the hourly rates paid to HCBS' attendant care workers ranged from $6.50 to $8.50 an hour, attendant care workers paid by private pay clients received rates between $10 to $12.00 an hour. Supp. ER 212, FOF ¶45, ¶46. The court specifically found that needed workers were available, but would not work for the pay offered by Defendants. Supp. ER 212, FOF ¶47.

The court was well aware that Medicaid's equal access provision required comparing the Medicaid population with the insured population, like people covered by Medicare and private insurance, in the same geographic area and made this comparison. The court's order granting the injunction stated:

> Congress intended "that Medicaid recipients are entitled to access equal to that of the insured population." Arkansas Medical, 6 F.3d at 527; and Evergreen Presbyterian Ministries, Inc v. Hood, 235 F.3d 908, 927-28 (5th Cir. 2000).

Supp. ER 212, COL ¶17. It explicitly considered whether Arizona Medicaid recipients had access to HCBS services equal to that available to the insured population and concluded that they did not. Supp. ER 212, COL ¶20.

The court had evidence from a variety of sources demonstrating these facts. For example, the court cited the testimony of Philip Pangrazio and Ann Meyer to support its finding that wages were lower for HCBS workers than non-Medicaid workers. Supp. ER 212, FOF ¶44. They are directors of agencies in Phoenix and Tucson[5] which help disabled and elderly people live in homes rather than institutions by assisting them to find HCBS workers. Mr. Pangrazio's agency, Arizona Bridge to Independent Living, is the largest provider of home care services to HCBS beneficiaries in the Phoenix area, employing 1150 attendant care workers. Supp. ER 195, 2:9; 4:8; 5:20-25. Ms. Meyer, Executive Director of the Direct Center for Independence in Tucson, runs an agency which trains disabled people -- both HCBS beneficiaries and non-ALTCS clients -- how to

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[5] Phoenix is in Maricopa County and Tucson is in Pima County. These two areas account for 75% of the statewide ALCTS HCBS caseload. Supp. ER 195, 31:19-22.

find, hire and work with personal care attendants. Supp. ER 194, 3:8-13; 4:8-9:9-14. They both testified that access to home care in Arizona was greater for people with private insurance or those who could afford to pay private rates than it was for HCBS beneficiaries, and they indicated that the higher rates of $10 to $12 an hour paid in the non-Medicaid sector resulted in better access to services. Supp. ER 194, 15:5-16:12; 25:9-26:3; 30:13-20; Supp. ER 195, 9:9-22.[6]

Named plaintiff, Peg Ball testified that, although HCBS Program Contractors could not find an attendant care worker to provide her services, when she could afford to pay for services out-of-pocket at higher rates, she was able to hire a worker. Supp. ER 193, 10:1-10.[7] Foundation for Senior Living (FSL agency), is a major provider of home care services in Maricopa and Mohave counties. It serves 30,000 people, both Medicare and other non-Medicaid sectors

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[6] In fact, Ms. Meyer's own mother needed attendant home care, and had no problem hiring workers at the private pay rate of $11.00 an hour. Supp. ER 194, 31:2-7.

[7] Ms. Ball was living and working in Tucson at the time the case was filed. Her job with the Direct Center for Independence included recruiting and maintaining a list of home care workers to refer to disabled clients. Supp. ER 193, 3:4-25. Ms. Ball became eligible for Defendants HCBS home care services in 1995 when she could not afford the long-term care health care services needed because of her spinal muscular atrophy. Supp. ER 193, 4:5-5:25. After struggling with the HCBS system for five years to get the home care she needed, she moved to Michigan in 2000 because she could not obtain adequate personal care services in Arizona from ALTCS . Supp. ER 193, 2:10-25; 6:5-8:25;11:5-12:20.

as well as HCBS beneficiaries. Plaintiffs' Exh. 286 showed that of all the funding sources for home care services by the FSL agency, the rates paid by Defendants' Program Contractors were the lowest it received. Supp. ER 203, ¶286. Eventually, the FSL agency stopped providing attendant care services to HCBS beneficiaries because Defendants' rates were too low to cover costs of paying workers a fair living wage with benefits and transportation. Id.

Finally, the Court also relied on the expert testimony of Dr. Dorie Seavey,[8] a labor economist and researcher specializing in the home health care work force and the provision of long-term care.[9] Supp. ER 212, FOF ¶¶ 47-51; Supp. ER 195,

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[8] Dr. Seavey received her Ph.D. in Economics from Yale, her Masters in Economics from the London School of Economics, and her undergraduate degree from Stanford. Supp. ER 195, 20:21-25. She is an expert on statistical analysis and survey research methodology. Supp. ER 195, 21:4-8. Dr. Seavey was the principal author conducting two major studies on other states' long-term care work forces, in New York and in Massachusetts. She also assisted in papers for Massachusetts and New Hampshire studying these issues, and served as a senior evaluator of training programs in Arkansas and New Hampshire of certified nurse assistants. Supp. ER 195, 21:12-22:12.

[9] In forming her opinion in this case, Dr. Seavey examined work force and wage statistics from the Department of Economic Security in Arizona and from the Bureau of Labor Statistics. Supp. ER 195, 23:8-16. She reviewed all of the discovery in this case, including the operational and financial reviews and case service management reviews of the HCBS system, internal memos and letters relating to wages and waiting lists and the availability of workers, declarations and depositions from both Defendants' providers and clients, examined surveys, studies, and audits of the HCBS program, and did a comprehensive search on background documents relating to the issues. Supp. ER 195, 23-24, 52:15-57:25,

21:4-20. Dr. Seavey testified:

> in Arizona it is more difficult for ALTCS beneficiaries to get services from providers than it is for non-clients. And I know this from what I've heard from clients and providers in this state. And I think it's also very apparent in the wage structure of the long-term care industry in this state.

Supp. ER 195, 64:15-20.

In short, the district court had more than sufficient evidence to support its conclusion that access for Medicaid beneficiaries was not equal to the relevant population in the same geographic area, and that a primary cause was lower payment rates for Defendants' home care workers than for other workers.

2. AHCCCS Did Not Consider Necessary and Relevant Factors in Rate Setting for HCBS As Required by the Medicaid Act and This Court's Precedents

In the Ninth Circuit case of Orthopaedic Hospital, the district court found that California's Medicaid agency had not properly considered all the relevant factors under 42 U.S.C. §1396a(a)(30)(A) in making its reimbursement rate adjustments for hospitals. The court ordered the agency to consider the relevant factors in promulgating new rates and to conduct a rate study. Orthopaedic Hospital, 103 F.3d at 1494. Ultimately, the Ninth Circuit went even further, finding that the State was obligated to consider providers' costs when establishing

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61:16-64:20, 65:22-25; Supp. ER 203, ¶¶ 141-142; CD 188.

rates:

> The Director must set hospital outpatient reimbursement rates that bear a reasonable relationship to efficient and economical hospital's costs of providing quality services, unless the Department shows some justification for rates that substantially deviate from such costs.

Id. at 1496. The Court held that the State must "satisfy the requirement that the payments themselves be consistent with quality care." Id. at 1497. The state agency must "undertake to determine what it costs an efficient [provider] economically to provide quality care. Absent some justification from the [state agency], the reimbursement rates must ultimately bear a reasonable relationship to those costs." Id. at 1498.

Here, Defendants did not know the actual costs of providing services, let alone the cost of providing quality care, because they did not require any HCBS agency cost reporting. Supp. ER 195, 81:1-4. Defendants' actuary, who established the payment rates Defendants pay to Program Contractors to deliver Medicaid HCBS services, admitted at trial that the State did not consider whether payments were sufficient to enlist enough providers so that care and services were available.

> THE COURT: What happens if they can't hire people to provide that service at those rates?
>
> MR.HOYT: That's really not something we'd factor into the rates. That

would be more an issue I guess for AHCCCS to work out with the program contractor.

Supp. ER 194, 33:15-19. Thus, the state admitted that they do not even factor into the rate setting process whether it is possible to hire people to provide the services at the rates that are paid to workers by the Program Contractors.

Nor did Defendants monitor performance of Program Contractors by comparing services prescribed in care plans with those actually delivered. Supp. ER 194, 35-36; Supp. ER PJPO, ¶57. This despite the fact that Program Contractors can generate higher profits when they minimize what they have to pay to provide home care services, either by keeping wages low, or by not providing services, or both. Supp. ER 212, FOF ¶52, Supp. ER 194, 32:10-15; 40:8-14. Maricopa County made in excess of $10 million in profit from its ALTCS contract in the contract year ending in 2000. Supp. ER 212, FOF ¶53. Pima County also made more than 5 million dollars in profits from its ALTCS program. Supp. ER 203, ¶ 246; Supp. ER, PJPO ¶56. Both counties made profits of approximately 5 to 7% on their ALTCS contracts in 1999 and 2000, when their profit margins should have been 1 to 2%. Supp. ER 203, ¶ 7; Supp. ER 194, 37:17-39:19.

The evidence in this case established that Defendants' methodology for monitoring its Program Contractors' performance is, at best, superficial. Supp. ER

206, ¶¶125-148. When performance reviews of Program Contractors revealed care plans were not being filled because of shortages in home care workers, Defendants imposed no penalties. Supp. ER 206, ¶¶134-140. It was Defendants' policy to let their Program Contractors self-monitor whether services prescribed are actually provided, because it would be "micromanagement" to measure whether individual members were actually receiving the prescribed services in their care plans. Supp. ER 196, 2:10-16.

This of course leads to the question, how did Defendants establish the rates paid to the Program Contractors to provide home care for a Medicaid beneficiary. The monthly rate, for example, was $942 for all health care services in Maricopa County in 2000. Supp. ER 194: 34:15-18; Supp. ER 212 ¶¶19, 20. Orthopedic Hospital held that in order to consider the costs of providing services, the Defendants "must rely on responsible cost studies . . . that provide reliable data as a basis for its rate setting." Id. at 1496. Defendants failed for many years to perform any HCBS cost study. Instead, rates were established in 1989 based upon limited data from other states, and thereafter were simply updated based primarily on inflation. Supp. ER 203, ¶156; Supp. ER 195, 76:2-77:14.

The study that they finally did perform – after this lawsuit was filed in 2000 – was wholly inadequate. Supp. ER 206, ¶¶116-120. Yvonne Powell, the person

conducting the survey, testified that prior to this survey AHCCCS "had no information on the cost of these providers." Supp. ER 195, 78:4-5. Only 13 out of 51 providers surveyed responded to the survey. Supp. ER 195, 79:23-24. The survey did not include any information from the largest HCBS attendant care provider agency in Maricopa County, ABIL. Supp. ER 195, 5:20-25, 80:8-12. There were no responses at all from Pima County agencies. Supp. ER 203, ¶ 182, table C2-3. One of the provider agencies which did respond, Staff Builders, stopped providing HCBS attendant care services in 1999. Supp. ER 203, ¶¶ 75, 80, 182.

Ultimately, AHCCCS did not even rely on this survey to establish the capitation rates for contract year ending in 2002. Instead, it used models estimating costs based on either Bureau of Labor Statistics data or current fee for service data increased by 30% for benefits. Supp. ER 195, 70:16-72:3; 73:21-22; 74:7-75:15.[10] Moreover, no matter how AHCCCS calculated the managed care

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[10] Defendants argued that the judge's criticisms of the state's rate setting methodology were clearly erroneous because he "ignored" the study. But given all the problems with it, and the fact that even the Defendants did not rely on the cost data it generated to establish HCBS capitation rates beginning Oct. 2001 -- after the relevant cut-off date established in this case -- the district court did not err in deciding not to specifically discuss it in the findings of fact. Indeed, probably to correct this design flaw, the court has ordered Defendants to complete a study of the "private sector's delivery of HCBS services in Arizona which analyzes the extent to which HCBS critical services are as available to AHCCCS members as

capitated payment rates paid to the Program Contractors to deliver the home care services, Defendants' failure to determine costs of the services, their failure to require their Program Contractors pay market rates, and their failure to assure that the contractors actually deliver the services required in care plans, doomed Defendants compliance with the statutory requirements.

In addition to considering the costs of providing the services in question, other factors used by this Court to measure compliance with the (30)(a) provision include the level of provider participation in the Medicaid program, utilization rates, the level of reimbursement to providers, and whether providers are opting out of the program. Clark v. Kizer, 758 F. Supp. 572, 576-578 (E.D. Cal. 1990), aff'd in part, vacated in part on other grounds sub nom., Clark v. Coye , 967 F.2d 585 (Table), 1992 WL 140278 (9th Cir. 1992) (unpublished). Supp. ER, Clark. The evidence at trial showed that here all these factors pointed to inadequate compliance and violation of the statute. The numbers of providers were insufficient as evidenced by unfilled care plans, large waiting lists throughout the state, and many studies and reports showing staffing shortages. Supp. ER 212, ¶¶35-42. As demonstrated above, the rates paid to HCBS workers were woefully inadequate and significantly less than those paid to workers for care provided to

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they are to members of the general population." Supp. ER 248, ¶3D.

non-Medicaid clients. The evidence also showed that providers were opting out of the system by withdrawing from providing HCBS services to beneficiaries. Supp. ER, 195, 46:9-12; 69:16-18; Supp. ER 203, ¶¶75, 286.

Another important factor in determining whether Medicaid reimbursement rates are adequate under (30)(A) must be whether or not Medicaid beneficiaries are getting the services the State says they need. The record establishes that named plaintiffs and other individual class members did not have access to many of the critical services prescribed in their care plans. Supp. ER 212, ¶64; Supp. ER 206, ¶¶16-55.[11] The record also shows that there was a systemic lack of HCBS workers over many years. Supp. ER 206, ¶¶56-72. The court's Findings of Fact

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[11] Defendants cite evidence, never admitted, that HCBS beneficiaries were happy with the home care they were receiving was a consumer satisfaction survey, which among many problems, never asked the critical question of whether or not care plans were being filled. Defendants cite this as "Exhibit 238 (ER 187-1)" in Opening Brief, at 15. However, this exhibit, originally identified as a plaintiff's exhibit, was withdrawn by Plaintiffs. Supp. ER 195, 517:3 - 519:23. Subsequently, the survey and report based on it were renamed Def. Exh. E &F, and were objected to on the grounds of lack of relevance, foundation, reliability and hearsay when counsel for Defendants sought to introduce it. The admission of this document was taken under advisement, but never admitted by the court. Supp. ER 195, 83:16-17, Supp. ER 196, 626:5-15, CD 197. This document should not be considered part of the record. See United States v. Sanchez-Lopez, 879 F.2d 541, 548 (9th Cir. 1989) ("Pursuant to Federal Rule of Appellate Procedure 10(a), exhibits and papers not filed with the district court or admitted into evidence are not part of the appellate record. Accordingly, we decline to consider the survey in resolving the issues presented in this direct appeal. Appellants' survey is stricken from the record.")(emphasis added)(citations omitted).

specifically address this by highlighting the studies, testimony, and documents which establish these facts over several years. Supp. ER 212, FOF ¶¶34-42.

Evergreen Presbyterian Ministries, Inc. v. Hood, 235 F.3d 908, which Defendants suggest supports their position, is inapposite. The issue in Evergreen was whether a preliminary injunction should be granted against a prospective rate change where there was a mere possibility such a reduction would reduce access to services. In the case at bar, Judge Carroll had trial evidence from many different sources of a long-term, chronic problem of inadequate rate setting resulting in not only historically lower wages, but also poorer access for HCBS beneficiaries than those receiving home health care through private insurance, private pay or Medicare.

B. The Court Properly Found that Defendants Violated The Freedom of Choice Provisions Of The Medicaid Act

The district court unambiguously held that the Defendants violated the freedom of choice provisions of the Medicaid Act (42 U.S.C. § 1396n(c)(2)(C) and 42 U.S.C. § 1396n(d)(2)(C)) when it held that "[d]efendants failed to provide the representative class members with the equal access, quality of care, and freedom of choice to which they are entitled." Supp. ER 212, COL ¶20, see also, ¶¶18-19.

The freedom of choice provisions of the Medicaid statute require the state to allow beneficiaries to choose which kind of care they will receive–institutional care or home and community based care. The courts have held that if one of the choices is underfunded and thus unavailable, the beneficiary's right to freely choose is violated. Cramer v. Chiles, 33 F.Supp.2d 1342, 1352 (11th Cir. 1998) (holding that the challenged state plan gave "no real choice," in part, because the HCBS waiver option gave "no assurance that the supports and services will meet individuals needs"); Martinez v. Ibarra, 759 F.Supp. 664 (D.Colo. 1991).

Substantial evidence supports the lower court's findings that the Defendants violated these two Medicaid Freedom of Choice provisions, contrary to Defendants' assertions. Overwhelming evidence was presented at trial that shortages of workers, waiting lists for services, and the Defendants' policy that beneficiaries must "assume the risk" of living at home, restricted Plaintiffs' ability to choose between institutional and community based care.

The court found that there was a shortage HCBS workers due to low wages, making recruitment difficult. Supra, 2-9, 16-21. It also found that this shortage of workers was affecting quality of care, stating "[i]n 1999, the Auditor General advised AHCCCS that its contractors were failing to provide necessary services resulting in quality of care problems." Supp. ER 212, ¶40. In addition, the court

also found that at least three Program Contractors had extensive waiting lists for HCBS services and that these waiting lists were a result of a shortage of workers. Id., ¶¶35, 36, 37. Finally, the court found that "[i]t is the policy of AHCCCS that an HCBS beneficiary assumes the risk, by choosing to remain at home rather than be institutionalized, that services he or she is dependent upon will not be delivered." Id, ¶61.

This final finding was buttressed by much testimony and many exhibits offered at trial. First, Alan Schafer, ALTCS Manager, testified that "[t]here are going to be instances when someone is not going to be available [to provide back up services], I admit that. This is a very large program. . . . When consumers make the choice to live in the community . . . they are aware of the responsibility they have to develop an informal network to support them as well when there is a situation where you cannot get a substitute worker." Supp. ER 195, 87:1-18. Further, Mr. Schafer testified that, in the case of a person whose worker did not show up, he would "advise that person of the risks they are taking by living alone at night." Supp. ER 195, 86: 3-6. The testimony of Phyllis Biedess, AHCCCS Director, further solidified AHCCCS's position that beneficiaries who choose to live in the community assume the risk that their services will not be provided. Supp. ER 196, 4:7-23. AHCCCS acknowledged that there will be cases where an

HCBS worker will not show up and a substitute cannot be found, thereby admitting that there is always someone who is not getting services to which they are entitled and that the solution is that beneficiaries must develop their own contingency plans. Supp. ER 195, 87:15-18; Supp. ER 196, 3:7-11 and 5:9-14; and Supp. ER 203, ¶102 "MMCS [Maricopa Managed Care Systems] has members sign risk agreements when they live in their own home. . . . Members who want to continue to live in their own homes and rely on contracted service providers understand that they need to have back-up caregivers should a worker not be available. (emphasis added)"). Finally, named plaintiffs Peg Ball, Melissa Richardson, and Judeth Hinton all testified that they were threatened with institutionalization when they asked to be provided with the services in their HCBS care plans that were not being delivered due to shortages in care workers. Supp. ER 193, 9:4-8, 13:16-23, and 20:11-14. See also, Supp. ER 194, 20:13-16.

Just as in Cramer, where that court found that an HCBS option that gave no assurances that needed services would actually be delivered meant there was "no real choice," so too in this case where the Defendants' acceptance of shortages of workers, waiting lists, and gaps in the delivery of HCBS services means that beneficiaries have no meaningful choice because they can either go without care which jeopardizes their health or be institutionalized .

Finally, Defendants incorrectly assert that the freedom of choice provisions were not violated because only one Plaintiff, Peg Ball, testified about being institutionalized as a result of gaps in care. First, the issue when analyzing a potential violation of the freedom of choice provisions is not just whether beneficiaries actually are placed in institutional care, but whether the choices that are provided are real and meaningful. Cramer, 33 F.Supp. 2d at 1352. In this case, telling beneficiaries that they need to develop their own contingency plans to address gaps in service or else be placed in an institution means that choosing to remain at home is not a real choice.

Moreover, there was further evidence of unnecessary institutionalization as a result of failures in the HCBS delivery system in addition to plaintiff Peg Ball needing institutional care. Plaintiffs Grace Collier and Judeth Hinton also required nursing home care as a result of these failures. Supp. ER PJPO, ¶30 and Supp. ER 193, 20:11-14. Further, as the district court found, the failures of the HCBS system resulted in significant hardships to the Plaintiffs. Supra, 3, 4. Importantly, testimony of executive directors of local social service agencies, whose missions are to assist disabled persons remain out of nursing homes, confirmed that the lack of HCBS services kept beneficiaries out of the community and in nursing homes. Supp. ER 194, 20:17-25 to 22:1-5, Supp. ER 195, 11:2-8,

Therefore, there is substantial evidence to support the court's finding that the Defendants violated the freedom of choice provisions of the Medicaid Act.

C. The Court Properly Found that Defendants Violated the Americans With Disabilities Act and the Rehabilitation Act

While the court did not explicitly cite to statutes or regulations, its language in Conclusions of Law 19 and 20 indicates that it found the Defendants to be in violation of the integration mandate of the Americans with Disabilities Act of 1990 (ADA) and § 504 of the 1973 Rehabilitation Act (§ 504). The same factual underpinning that allowed the court to find a violation of the Medicaid freedom of choice provisions also supports the finding of a violation of the ADA and § 504. Cramer v. Chiles, 33 F.Supp.2d at 1353.

Both the ADA and § 504 protect individuals with disabilities from segregation, and require that public services be provided to people with disabilities in the most integrated setting possible. In the ADA, Congress characterized the "'segregation' of persons with disabilities as a 'form of discrimination,' and referred to discrimination that persists in the area of 'institutionalization.' § 12101(a)(2),(3), (5)." Olmstead v. L.C., 527 U.S. 581(1999).[12]

[12] The four findings necessary to make out claims under the ADA and § 504 are that (1) the individuals have a disability, (2) the individuals are qualified to

Identifying the policies underlying the ADA, the Olmstead court noted that institutionalization "perpetuates unwarranted assumptions that these individuals are incapable or unworthy of contributing to life in the community." Id. at 600. Moreover, segregation of disabled individuals in institutions prevents them from enjoying the family contacts and social, work, economic, educational and cultural opportunities of every day life. Id. at 601.

Contrary to the Defendants' assertions, the integration mandate of the ADA protects not only individuals who are institutionalized, but also individuals in the community who are at risk of institutionalization. See Fisher v. Oklahoma Health Care Auth., 335 F.3d 1175, 1181-82 (10th Cir. 2003); Townsend v. Quasim, 328 F.3d 511 (9th Cir. 2003) (applying the ADA's integration mandate to an individual who lived in a community-based adult family home, but who was informed by the State of Washington that he would have to move into a nursing home to continue receiving Medicaid benefits); Makin v. Hawaii, 114 F. Supp. 2d 1017, 1034 (D.

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receive services, (3) the Defendant is a public entity (ADA) and receives federal funding (§ 504), and (4) the individuals are being discriminated against on the basis of their disability. The Defendants' main argument is that the Plaintiffs did not prove the fourth element. The court found the Plaintiffs satisfied the first three elements. Supp. ER 212, FOF ¶¶2,4, and 5 (finding that the Plaintiffs are individuals with disabilities eligible for ALTCS); Supp. ER 212, FOF ¶1 (finding that AHCCCS is the state agency that receives federal funding to provide Medicaid health care services).

Haw. 1999) (explaining that "the Hawaii statute [at issue in the case] could potentially force Plaintiffs into institutions in violation of the ADA's non-discrimination policy").

Further, like the ADA, § 504 requires that services be provided in the most integrated setting appropriate to the person's needs. Makin v. Hawaii, 114 F. Supp. 2d at 1036; 28 C.F.R. § 41.51(d); 45 C.F.R. § 84.4(b)(2). In addition, the U.S. Department of Health and Human Services has issued a letter stating that the integration mandate as interpreted by Olmstead applies to § 504.

> Section 504 and the ADA use the same definition of disability. Title II of the ADA extends Section 504's prohibition of discrimination in Federally assisted programs to all activities of State governments, including those that do not receive Federal financial assistance. Although the Olmstead decision interpreted the ADA, unjustified segregation by a Federally funded program would also constitute disability discrimination under Section 504.

Letter from U.S. Dep't of H.H.S. (Health Care Financing Administration and Office for Civil Rights) to State Medicaid Directors, Olmstead Update No. 2 (July 25, 2000), answer to question 15, available in http://cms.hhs.gov/states/letters/smd72500.asp.

Finally, and perhaps most importantly in this case, denying disabled individuals a choice between institutional and home based care violates the ADA integration mandate, and by analogy violates § 504, because it unnecessarily

segregates individuals from the community. Cramer v. Chiles, 33 F.Supp. 2d at 1353 (finding that administrative or economic convenience is not a valid justification for denying a choice of services under Title II of the ADA). Further, under funding of a particular service, such as HCBS services, negates a meaningful choice under the ADA. Cramer, id. (finding that under funding a HCBS waiver program compels institutionalization and thus negates a meaningful choice under the ADA); Helen L. v. Didario, 46 F.3d 325 (3d. Cir. 1995), cert. denied sub nom. Pennsylvania Sect'y of Public Welfare v. Idell S., 516 U.S. 813 (1995) (finding that the failure of the state to adequately fund its attendant care program, resulting in waiting lists, violated the ADA).

Thus, the factual findings detailed above which support the district court's ruling regarding violation of the Freedom of Choice provisions of the Medicaid Act also support its findings regarding violation of the ADA and § 504.

It is disability discrimination under the ADA and § 504 for the state to allow shortages of HCBS workers and waiting lists for HCBS services. As outlined above, shortages in workers and waiting lists mean that beneficiaries are forced into nursing homes, as in the case of plaintiffs Peg Ball, Grace Collier and Judeth Hinton, or cannot get out of nursing homes, as testified to by the executive directors of two advocacy agencies. It is likewise disability discrimination for

Defendants to have a practice of informing beneficiaries that by living in the community they "assume the risk" that services will not be provided, and that they are responsible for locating workers when scheduled workers do not show up. This institutional policy, testified to by the ALTCS manager and the Director of AHCCCS, mitigates any meaningful choice in violation of the ADA and § 504. Finally, it is disability discrimination for Defendants to threaten with institutionalization beneficiaries who ask that prescribed services actually be provided, as testified to by plaintiffs Ball, Richardson, and Hinton.

Defendants' failure to cure these deficiencies deprives HCBS beneficiaries of their right under the Medicaid statute to receive services in a community setting, and results in disability discrimination under the ADA and § 504. In these findings, the district court provided substantial evidence to support its conclusion that the Defendants had violated the integration mandates of the ADA and § 504.

D. Other Grounds Support The Court's Injunction

The injunction should be upheld even if this Court finds it is not supported under the equal access and freedom of choice provisions of the Medicaid Act, the Americans with Disabilities Act of 1990, and § 504 of the 1973 Rehabilitation Act. The findings of the district court and evidence in the record also support the

relief granted on the grounds that Defendants violated the reasonable promptness requirements of the Medicaid Act, 42 U.S.C. § 1396a(a)(8) and 42 C.F.R. 435.930(a), and the obligation that the Medicaid agency continue to provide services until the recipient is no longer eligible, 42 C.F.R. 435.930(b).[13]

It is a settled principle of judicial review that if the decision below is correct, it must be upheld. Therefore, this Court has the power to affirm the judgment below on any basis found in the record. An appellate court can uphold a decision based on any legal ground supported by the record. See e.g., Kenniston v. Roberts, 717 F.2d 1295, 1300 fn. 3 (9th Cir. 1983); Jackson v. Southern California Gas Co., 881 F.2d 638, 643 (9th Cir. 1989).

Further, Plaintiffs in this case do not seek to modify the district court's order, as Plaintiffs are satisfied that the relief ordered is sufficient to protect their rights to the HCBS services to which they are entitled. As such, Plaintiffs can raise these arguments in the appeal to support the judgment, without the need for a cross-appeal, even though the arguments were rejected by the lower court at the summary judgment stage. Massachusetts Mut. Life Ins. Co. v. Ludwig, 426 U.S. 479, 481 (1976) ("[T]he appellee may, without taking a cross appeal, urge in

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[13] These two Medicaid claims were dismissed by Judge Marquez in his order of May 8, 2002. CD 101.

support of a decree any matter appearing in the record, although his argument may involve an attack upon the reasoning of the lower court or an insistence upon matter overlooked or ignored by it."); see also, Engleson v. Burlington Northern Railroad Co., 972 F.2d 1038, 1041 (9th Cir. 1992) ("A cross appeal is unnecessary even where the argument being raised has been explicitly rejected by the district court").

1. Defendants Violated the Reasonable Promptness Requirements of the Medicaid Act

The Medicaid statute requires that covered health services, such as the HCBS services at issue in this case, "shall be furnished with reasonable promptness to all eligible individuals." 42 U.S.C. § 1396a(a)(8). Further, administrative procedures may not delay the provision of Medicaid services. 42 C.F.R. 435.930(a) (stating that the Medicaid agency must "[f]urnish Medicaid promptly to recipients without any delay caused by the agency's administrative procedures.")

This statute and regulation require that there be no delay in providing Medicaid services. They mean that Medicaid services not only must be initially provided promptly after the eligibility determination, but also that services must

continue to be furnished with reasonable promptness.[14] Further, the Medicaid agency cannot insufficiently fund services, such that eligible recipients are placed on waiting lists for medically necessary services. See Bryson v. Shumway, 308 F.3d 79, 81 (1st Cir. 2002); Boulet v. Cellucci, 107 F.Supp.2d 61 (D.Mass. 2000); Doe v. Chiles, 136 F.3d 709, 714 (11th Cir. 1998); Rolland v. Celluci, 52 F.Supp.2d 231 (D.Mass. 1999); Sobky v. Smoley, 885 F.Supp. 1123, 1149 (E.D. Cal. 1994) (finding that insufficient funding which cause providers of services to develop waiting lists was "precisely the sort of state procedure that the reasonable promptness requirement was designed to prevent"). See also Jefferson v. Hackney, 406 U.S. 535, 545 (1972) (interpreting parallel section of Aid to Families With Dependant Children statute).

The court here found significant evidence of delays or gaps in services and waiting lists. For example, it found that three of the state's contractors had extensive waiting lists of beneficiaries waiting for attendant care services. Supp. ER 212, FOF ¶¶35-36.[15] The court also found that "AHCCCS was aware that not

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[14] This analysis is further supported by the inclusion of subparagraph (b) of the regulation, which requires that Medicaid continue to be furnished until the beneficiary is no longer eligible.

[15] Evidence was presented at trial that a forth provider, Pascua Yaqui Tribe, also maintained a waiting list for services as of July, 2000. Supp. ER 203, ¶72.

all of its beneficiaries were receiving their prescribed services." Supp. ER 212, FOF ¶62. Despite the Defendants' knowledge of waiting lists and gaps in services, they looked the other way rather than taking steps to effectively monitor the performance of Program Contractors. Supp. ER 212, FOF ¶¶56, 58, and 60.[16]

The existence of waiting lists and gaps in the provision of services shows that Defendants have failed to protect HCBS beneficiaries from unreasonable delays in receiving needed services, in violation of 42 U.S.C. §1396a(a)(8), thereby providing another ground to support the order.

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[16] Evidence in the record further supports the court's findings. For example, there was extensive evidence regarding the existence of waiting lists for services (Supp. ER 203, ¶¶ 48, 72, 75, 234, 235, 236 and 265) and extensive evidence regarding beneficiaries not getting their prescribed services due to lack of workers (Supp. ER 203, ¶¶ 118, 195, 196, 235, and 67).

Evidence was also presented that the named Plaintiffs faced significant delays in getting services. In the year prior to filing this lawsuit, plaintiff Ball received none of her prescribed services on the weekends and was forced to get by on 31 of the 50 hours of attendant care she was prescribed during the week. Supp. ER PJPO, ¶¶15-17. Plaintiff Phelan did not receive any of his authorized 720 hours per year of respite or 740 hours of personal/attendant/habilitation care per year until 19 months after the services were authorized. Supp. ER PJPO, ¶27. Plaintiff James received none of her 60 hours a month of attendant care and 60 hours per month of respite care during January and February of 2000. Supp. ER 203, ¶94; Supp. ER 193, 18:6-15. Finally, plaintiff Hinton received no attendant care for seven months in 1999, despite being authorized to receive 120 hours of care. Supp. ER 203, ¶¶88, 118, and Supp. ER 193, 19:7-14.

2. Defendants Violated the Medicaid Requirement That Services Continue to Be Provided Until the Recipient Is No Longer Eligible

The Medicaid Act regulations require the responsible state agency to "continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible." 42 C.F.R. § 435.930(b). This regulation is violated if, during a period of eligibility, Medicaid ceases to be regularly provided to the beneficiary.

The same factual findings that established that Defendants violated the reasonable promptness requirements, also establish that Defendants failed to regularly furnish Medicaid to eligible individuals until they were found ineligible. As explained above, the court found that Defendants knew beneficiaries were not getting all of the services to which they were entitled, and that Defendants failed to monitor for gaps in services and protect beneficiaries against these gaps. In addition, evidence showed that named and class plaintiffs frequently found themselves suddenly stranded without home care services when their workers did not show up or quit. Periods of days, weeks, and in some cases months, typically followed in which no home care services were provided to plaintiffs.

Defendants' acceptance of gaps in services to beneficiaries, resulting in beneficiaries not getting services while they are still eligible for services, clearly

violates the requirement of 42 C.F.R. § 435.930(b) that Medicaid services be furnished regularly until an eligible individual becomes ineligible for Medicaid. needed to resolve the issues.

III. THE COURT'S FINDINGS PROVIDE A STRONG FACTUAL BASIS FOR THE PROSPECTIVE RELIEF ORDERED

A. Prospective Injunctive Relief Is Necessary To Correct Defendants' Pattern Of Unlawful Policies And Practices

The evidence of ongoing unlawful behavior by Defendants that was presented at trial easily satisfies the legal standard for injunctive relief. This Court, in Gomez v. Vernon, (255 F.3d 1118, 1128 (9th Cir. 2001)), described the past factual circumstances that justified prospective injunctive relief:

> As found by the district court, the inmates have proven that the Department retaliated against them for exercising their right to access the courts on a number of occasions spanning a decade, and that the retaliation was pursuant to a custom or policy. Despite supervisors' knowledge of this pattern, no investigation, no discipline, and no corrective action followed. . . . . [N]o policy or mechanism is in place to back up [the defendant's] promise [that retaliation would not happen again.

Gomez v. Vernon, 255 F.3d at 1120 (citation omitted). Relevant to Defendants' argument, this Court also observed that "[c]ourts must be aware of attempts to forestall injunctions through remedial efforts and promises of reform that seem timed to anticipate legal action, especially when there is the likelihood of

recurrence." Gomez, id. at 1129, quoting United States v. Odessa Union Warehouse Co-op, 833 F.2d 172, 176 (9th Cir. 1987).

All of the elements identified by this Court in Gomez as establishing a likelihood of harm are present here. The evidence showed an on-going pattern of wrongs committed by the Defendants pursuant to custom or policy. In addition to the testimony of witnesses at trial, voluminous documentary evidence was admitted that confirms the Defendants' pattern and practice of failing to provide reliable home care services. The court relied on this evidence, as well as the testimony of witnesses, in its Findings of Fact. These findings, based on the trial judge's unique ability to view the witnesses and weigh all of the documentary evidence, are controlling unless there is clear evidence to the contrary. As Defendants stated, the issuance of a permanent injunction can be overturned only if it is found to be an abuse of discretion. Krug v. Lutz, 329 F.3d 692, 695 (9th Cir. 2003).

In addition, the court explained how these findings supported the necessity for prospective injunctive relief in the Order denying Defendants' motion for a new trial, filed on January 4, 2005:

> Here, past violations of Plaintiffs' Medicaid rights are highly probative of the possibility of future violations. The Court's August 13, 2004 Order sets forth specific findings of fact demonstrating "a

very significant possibility of future harm" to plaintiffs.

Supp. E.R. 233 at 3:5-8.

Defendants claim that the testimony of Phil Pangrazio, one of Plaintiffs' witnesses, proves that "the problems [shortage of HCBS workers] this witness testified used to exist no longer did because of the 2000-2001 rate increases." Opening Brief, 35. However, while Mr. Pangrazio did testify that his agency's ability to find workers improved with the rate increases in the two years after the lawsuit was filed, he did not say that the shortages of HCBS workers were solved statewide or permanently.

In fact, Mr. Pangrazio's testimony shows that his agency, Arizona Bridge for Independent Living (ABIL), is unique among health care providers. It is a "grass roots advocacy organization that provides quite a diverse range of programs and services to people with disabilities hoping to empower them to live – to be personally responsible and live independently in the community." Supp. ER 195, 2:11-15. As a non-profit public service agency, ABIL chose to pass the increased HCBS wage rate through to its workers, but Defendants did not require that it be passed through to workers and there was no evidence that other agencies did so. Supp. ER 195, 17:24-18:1. Thus, Mr. Pangrazio's testimony provides no showing that the shortage of attendant care workers was corrected beyond his organization,

or even for his organization beyond that particular year.

Although Defendants cite Methodist Hospitals Inc. v. Sullivan, 91 F.3d 1026, 1030 (7th Cir. 1996), for the proposition that there is no violation of 42 U.S.C. § 1396a(a)(30) here because Defendants raised rates in 2000 and 2001, the state behaved very differently in Methodist Hospitals. There, shortly after the challenged reduction in rates the state conducted a study, and raised rates again within the year when it found they were inadequate. Unlike this case, no providers were shown to have withdrawn from the program, and there was no ongoing practice of tolerating inadequate supplies of workers.

This Court has made it clear that injunctive relief is appropriate even where there is evidence of some later improvement. Withrow v. Concannon, 942 F.2d 1385, 1387-1390 (9th Cir. 1991) (holding that plaintiffs were entitled to injunctive relief ordering compliance with the federal requirements of public benefits programs, even where defendants were in "substantial compliance"). The Court explained that a mere cessation of a defendant's illegal conduct does not moot the need for relief in a case unless "it is 'absolutely clear that the allegedly wrongful behavior could not reasonably be expected to recur.'" Id., at 1387-1389. See also, Adarand Constructors, Inc. v. Slater, 528 U.S. 216, 222 (2000) (quoting United States v. Concentrated Phosphate Export Ass'n, Inc, 393 U.S. 199, 203 (1968)).

Dr. Seavey identified a pattern and practice by Defendants of providing inadequate rates and tolerating gaps in service over a period of years. Supp. ER 195, 408:2-447:20. She explained that Defendants' failure to monitor delivery of services or collect empirical data about rates, wages and gaps in delivery of services created a systemic problem. Supp. ER 195, 37:7-25, 43:13-45:20, 48:1-25, 50:14-51:10, 56:2-20, and 66:9-68:11. The fact that Dr. Seavey could not give an opinion about whether the 2001 (CY 2002) rates to Program Contractors were sufficient to know whether it would result in a positive enough impact on wages and benefits to the workers to solve the access problems does not establish, as Defendants suggest, that there is a lack of evidence of ongoing harm to Plaintiffs. Without the State collecting the empirical data subsequent to the increase it is impossible for the state to know it either. Dr. Seavey's testimony identified a pattern and practice by Defendants of providing inadequate rates and tolerating gaps in home care services over a period of years. Supp. ER 195, 25:2-64:20. Withrow, 942 F.2d at 1387-1390.

Ms. Meyer, Executive Director of DIRECT, provided additional testimony concerning the ongoing gaps in home care worker services from Defendants.[17]

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[17] Defendants argue that Director Meyer's testimony was hearsay, but Plaintiffs showed that she qualified to testify under the lay opinion rule, and the district court properly allowed her testimony. Supp. ER 194, 28:15-22; Fed. R.

Like Mr. Pangrazio and Dr. Seavey, Ms. Meyer testified that there was a longstanding pattern of inadequate wages and benefits, causing shortages of HCBS workers for many people in the area served by her agency. Supp. ER 194, 15:5-23, 18:4-21:24.

Finally, even the testimony of Defendants' own managers and employees openly acknowledged the agency's policy of accepting gaps in services as adequate performance by its contractors, its knowledge of shortages of workers, and its failure to correct these gaps and shortages preferring to make the beneficiaries get their own services or do without. Supra, 8, 30, 31, 40.

Defendants' stated position in this appeal show that their policies remain unchanged, and are the reason a prospective injunction is necessary.

B. Plaintiffs Had Standing To Seek Prospective Relief Because They Rely On Defendants To Provide HCBS Care

The cases cited by Defendants to argue that Plaintiffs lack standing to obtain injunctive relief are clearly inapplicable to the facts herein.

The lead case in their argument is very different from this case. City of Los Angeles v. Lyons, 461 U.S. 95, 111 (1983). It involved a chokehold placed on the plaintiff by a police officer after a traffic stop. The Supreme Court held that

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Evid. 701.

the plaintiff lacked standing to seek an injunction because there was no real or immediate threat of harm to him, and so no case or controversy. It reasoned that even if the LAPD practice regarding chokeholds were to continue, this particular individual was unlikely to again be stopped by the police and to be injured by another chokehold.

O'Shea v. Littleton, 414 U.S. 488 (1974), is also easily distinguished from the instant case. Plaintiffs, who were civil rights workers, had no standing because they could not show they had suffered injury in the manner specified (discriminatory bondsetting, sentencing, jury-fee practices), or that there was any likelihood that they would commit crimes subjecting them to the challenged practices in the future. O'Shea, 414 U.S. at 495-496. The same considerations would also cause issuance of the injunction to be denied even if the plaintiffs had standing. Id., at 499, 500.

Finally, Nava v. City of Dublin, 121 F.3d 453 (9th Cir. 1997), also involved a choke hold by law enforcement officers that unnecessarily killed someone. In Nava, the majority held that the plaintiff had standing to seek injunctive relief. Then, however, it held that plaintiff, a son of the deceased, could not prevail on the merits for the same reason as the plaintiff in City of Los Angeles: it was not likely that he would ever be subjected to a chokehold.

Plaintiffs in this case are quite different from those in the cases relied on by Defendants. By definition, Plaintiffs are persons who are eligible for HCBS services. Their ongoing status as HCBS beneficiaries means that they are constantly at risk of harm from Defendants' unlawful policies, in contrast to plaintiffs in the cited cases, who were held to lack standing because their isolated encounters with defendants were unlikely to be repeated.

C. The Court's Order That Defendants Provide Prescribed HCBS Services Is Consistent With The Medicaid Act

Defendants object to the district court's mandate of "rates that 'guarantee' the lack of service 'gaps,' as well as a system of monitoring and backup that is able to fill 'unforeseen' gaps within two hours." Defendants argue that the relief is too intrusive, citing Touissant v. McCarthy, 801 F.2d 1080, 1087 (9th Cir. 1986).

Touissant involved criminal law enforcement by the state, which differs greatly from the federal/state Medicaid system at issue here. Furthermore, the injunction affecting state prison policies that was partly modified by this Court in Touissant was far more intrusive than that issued by the court here. First, Touissant involved permanent orders, while the reports required here end in three years – just long enough to assure implementation. Second, the prospective

injunction in Touissant required a special master, while there is none here. Third, the special master issued orders concerning the day to day conduct of the prison system (e.g. release of specific prisoners from segregation) while nothing of that sort was ordered here.

In this case, the court issued the challenged orders only with respect to critical services, which were defined as "personal care services such as bathing, toileting, dressing, feeding, transferring to or from beds or wheelchairs, and assistance with other similar daily activities." Supp. ER 248, 2, ¶1(A). In so doing, the district court carefully tailored the relief to appropriately ameliorate the greatest harm caused by Defendants' maladministration of the HCBS program. The relief ordered is well within the court's discretion to effectuate its judgment. Clark v. Cove, 60 F.3d 600, 603 (9th Cir. 1995) (reciting district court's implementation orders); Swan v. Charlotte-Mecklenburg Board of Education , 402 U.S. 1, 15-16 (1971).

Defendants incorrectly argue that the district court's orders go beyond the requirements of the Medicaid statute because they require "foolproof provision of services." The Defendants' continuing assumption that the Medicaid statute allows AHCCCS to go through the motions, but not to reliably provide mandatory health services, summarizes the problem at the heart of this lawsuit. See supra,

29-31. Numerous courts have held that Medicaid beneficiaries like Plaintiffs have property interests in the receipt of their health services that are enforceable under the Constitution. Goldberg v. Kelly, 397 U.S. 254, 262-263, n.8 (1970); Perry v. Chen, 985 F.Supp. 1197 (D.Ariz. 1996); J.K. By and Through R.K. v. Dillenberg, 836 F.Supp. 694, 699 (D. AZ 1993).

Courts routinely order that Medicaid services must be provided, and that if a Medicaid agency chooses to contract out its responsibility for providing services, it must "monitor these activities and enforce these contractual provisions in order to assure that they are fully carried out." Salazar v. District of Columbia, 954 F.Supp. 278, 324, 329-334 (D.D.C. 1996), remedial order, 1997 WL 306876, *10-11 (D.D.C. 1997). In Salazar, the court entered a remedial order stating that "Defendants shall provide or arrange for the provision of . . . services when they are requested by or on behalf of children." Id. at *10. The court also required the agency to adopt and maintain a tracking system" to ascertain whether children have received Medicaid EPSDT services. That was a far more complex undertaking than the tracking ordered in this case because EPSDT consists of a variety of services from a vast array of medical specialists in many different locations. See also, Salazar, C.A. No. 93-452 (GK) (D.D.C. Memorandum Opinion and Order, Nov. 15, 2004) (further relief ordered), CD 225.

In addition, this Court has held that a Medicaid program can be ordered to pay rates adequate to assure quality services:

> The Director must set hospital outpatient reimbursement rates that bear a reasonable relationship to efficient and economical hospital's costs of providing quality services, unless the Department shows some justification for rates that substantially deviate from such costs.

Orthopaedic Hospital, 103 F.3d 1491 at 1495-1496. It is the state's burden to "satisfy the requirement that the payments themselves be consistent with quality care." Id. at 1497.

A similar order was upheld in Arkansas Medical Society, 6 F.3d. 530, in a suit brought by Medicaid recipients and non-institutional providers. The Eighth Circuit found, like the lower court here, that the Medicaid agency's rate setting methodology violated the Medicaid equal access provision. It affirmed the district court's order that the State establish a plan within 120 days which would conform with federal law. 6 F.3d at 522 and 531. See also, Amisub v. Colorado Dep't. of Social Services, 879 F.2d 789, 801 (10th Cir. 1989) (ordering the Director of the Colorado Department of Social Services to comply with the federal Medicaid Act and "to engage in a bona fide funding process before submitting any new plan and/or assurances to HCFA.").

Finally, Defendants cite a Medicaid regulation, 42 C.F.R 440.230(d), that

requires services under a Medicaid state plan to be "sufficient in amount, duration and scope," as supporting their argument that Medicaid law does not require "perfection." This regulation and the case law under it do not relate to the issue for which Defendants cite it, but rather to what health services must be included in the package of services in a state's Medicaid plan. The regulation reads:

> Sufficiency of amount, duration and scope
>
> (a) The plan must specify the amount, duration, and scope of each service that it provides for --
>
> . . .
>
> (b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.
>
> (c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required services under §§440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.
>
> (d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

42 C.F.R. §440.230 .[18] Subparagraph (d) of this regulation allows a state plan to limit the number or type of services required – for example, the plan could cover only 40 days of inpatient hospitalization a year. But this regulation does not excuse a state's failure to provide all the services that are specified in a state plan,

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[18] The overall thrust of 42 C.F.R. §440.230(d), as well as the Third Circuit's decision in White v. Beal, is to require the state Medicaid plan to provide services that are adequate rather than to limit services. Thus, even if it were relevant it would not support Defendants' position in this lawsuit.

such as the HCBS services here.

The case cited by Defendants in support of this line of argument, White v. Beal, 555 F.2d 1146 (3d Cir. 1977), shows the complete misdirection of the Defendants' argument. There the predecessor of 42 C.F.R. §440.230 was applied to hold the state plan's classification covering glasses for eye disease but not refractive error violated the coverage requirements of the Medicaid statute. White v. Beal, 555 F.2d 1150-1152, fn 3. The court observed that "[a]ppropriate limits may be placed on services based on such criteria as medical necessity or those contained in utilization or medical review procedures." Id. The random shortages in Defendants' provision of home care services does not fall into these types of authorized limits on services.

For the foregoing reasons, the district court properly issued an injunction against the Defendants.

IV. The Court Did Not Abuse Its Discretion By Denying Defendants' Motion For New Trial

A. The Court Correctly Found That Defendants' Policies Present A Significant Possibility Of Future Harm To Plaintiffs.

The court properly denied the motion for a new trial, disagreeing with Defendants' argument that the evidence heard at trial was insufficient to support injunctive relief. Supp. ER 233, 2-3. Plaintiffs have shown there was abundant

evidence presented at trial to support the court's findings of fact and legal conclusion that Plaintiffs faced a significant possibility of future harm due to the ongoing nature of Defendants' unlawful behavior. See supra, 2-9, 16-21, 29-31. Indeed, Defendants' continuing resistance to complying with the court's orders since August, 2004, shows how deeply imbedded in their agency culture is the belief that providing some of a beneficiary's prescribed home care services is good enough. Supra, 29-31.

This Court reviews a district court's denial of a motion for a new trial for abuse of discretion. Wharf v. Burlington Northern Railroad Co., 60 F.3d 631, 637 (9th Cir. 1995); Beverage Distribs., Inc. v. Olympia Brewing Co., 440 F.2d 21 (9th Cir.), cert. denied, 403 U.S. 906 (1971). "A new trial is properly granted where a party can: (1) prove by clear and convincing evidence that the verdict was obtained through fraud, misrepresentation, or other misconduct [and] (2) establish that the conduct complained of prevented the losing party from fully and fairly presenting his case or defense." Wharf, at 637, citing Jones v. Aero/Chem Corp., 921 F.2d 875, 878 (9th Cir. 1990).

This very high standard for overturning a judge's denial of a motion for a new trial is definitely not met here, where there is no allegations of misconduct or allegations that Defendants were prevented from fully and fairly presenting their

case. Rather, the Defendants sole arguments for a new trial were that the evidence at trial did not include facts about current conditions to support injunctive relief, the same grounds as are set out in their opening brief in Section III.A. and C. As explained above, the injunction was proper, and therefore, the denial of the motion for new trial was not an abuse of discretion.

Thus, there is no basis for this Court to overturn the lower court's denial of the motion for a new trial. Discussing Defendants' contentions that they had improved their compliance after August 31, 2001, the Court held that "to the extent that Defendants did not present further evidence of those efforts, Defendants have only themselves to blame." Supp. ER 233, 3:18-19. In fact, the Court even gave them an opportunity, until Jan. 21, 2005, to show that they were now in compliance, indicating the court would consider modifying the Order if they did so. But Defendants failed to present any evidence that the problems were resolved. Supp. ER 233, at 3, CD 236, 239, Supp. ER 248.

B. Defendants Are Estopped From Arguing Prospective Injunctive Relief Is Inappropriate Where They Successfully Excluded Evidence Past August 2001.

Defendants are judicially estopped from objecting to the implementation of prospective injunctive relief based on the August, 2001 evidentiary cut-off, because they themselves demanded and obtained the cut-off in their motions in

limine.[19] Supp. ER 233; See also, 135, 136, 144. This action by Defendants meets the standard for estoppel set out in Hamilton v. State Farm Fire & Casualty Company, 270 F.3d 778, 782 (9th Cir. 2001). See also, Russell v. Rolfs, 893 F.2d 1033, 1037 (9th Cir. 1990).

First, Defendants themselves demanded the August 31, 2001 evidentiary cutoff. CD 135, 136, 144. They obtained the cut-off order over Plaintiffs' objections, who wished to introduce evidence that the shortage of HCBS home care workers was continuing. CD 130, 140, 141, 147, 150. Now Defendants seek to use the evidentiary limit that they themselves sought and obtained as grounds for a reversal based on lack of current evidence. Under these circumstances the Defendants should be estopped from changing their position by claiming that the evidentiary cut-off is grounds for reversing the court's grant of relief. State of New Hampshire v. State of Maine, 532 U.S. 742, 749 (2001).

Defendants argue that the test for estoppel, inconsistency between a party's earlier and later positions, is not met by its actions in objecting to Plaintiffs' request to amend the pre-trial order "on the eve of trial." Plaintiffs offered this

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[19] After obtaining the exclusion of evidence about conditions after August 31, 2001, Defendants not only argued that the absence of such evidence required a judgment in their favor, but also represented incorrectly that it was Plaintiffs who had sought the exclusion. CD 233.

evidence before the Joint Proposed Pretrial Order had been filed with the Court. CD 150. But while some of the evidence that Plaintiffs vigorously sought to introduce was new rebuttal evidence, another part of the evidence that Defendants successfully excluded was their own quite recent report on current HCBS conditions. CD 129, 130 Ex. 1. This report contained exactly the kind of newer information that Defendants now claim was needed to resolve the issues. Defendants' "inference" that Plaintiffs "were content" with the exclusion of their contemporary evidence because they did not move for reconsideration of the exclusion order or an opportunity to take additional discovery is unsupported and blatantly incorrect.

The two other considerations in applying the doctrine of judicial estoppel, are also met here. Defendants mischaracterize the second consideration as whether the court was misled by them, but a correct description of this factor is whether the court was persuaded to accept their earlier position. Hamilton, 270 F.3d at 782. Here Judge Marquez clearly accepted Defendants' position that the recent evidence should be excluded. CD 150. Finally, a third consideration for estoppel is whether the party asserting an inconsistent position would derive an unfair advantage, or impose an unfair detriment on the opposing party if not estopped. Hamilton, 270 F.3d at 783. This consideration supports estoppel here,

as Defendants' previous success in excluding evidence is now the basis for their argument that injunctive relief is foreclosed.

CONCLUSION

As the foregoing discussion shows, the district court's findings of fact, conclusions of law, and relief ordered are abundantly supported by the evidence and relevant legal authority, and should be affirmed by this Court.

Dated: August 3, 2005.

Respectfully submitted,

Sally Hart
Sarah Lenz Lock
Jennifer L. Nye

Attorneys for Plaintiffs-Appellees

CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(a)(7)(C) and Circuit Rule 32-1
for Case Number 04-16963

I certify that pursuant to Fed. R. App. P. 32(a)(7)(C) and Ninth Circuit Rule 32-1, the attached answering brief is proportionately spaced, has a typeface of 14 points or more, and contains 13,785 words.

8/3/05
Date

Counsel for Plaintiffs-Appellees

STATEMENT OF RELATED CASES

Pursuant to Circuit Rule 28-2.6, the Plaintiffs-Appellees state that they know of no cases pending in this court which would be deemed related.

CERTIFICATE OF SERVICE

STATE OF ARIZONA)
)ss.
County of Pima)

I, Mavis Lauritzen, being first duly sworn upon her oath, deposes and says:

That she has made service of the original and fifteen (15) copies of the foregoing Appellees' Answering Brief and five (5) copies of Appellees' Supplemental Excerpts of Records, Volumes I and II, by causing to be mailed via Federal Express to:

Office of the Clerk
U.S. Court of Appeals for the Ninth Circuit
95 Seventh Street
San Francisco, CA 94103-1526

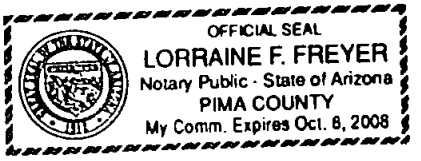
and by causing to be mailed via Federal Express this day two (2) copies of Appellees' Answering Brief and one (1) copy of Appellees' Supplemental Excerpts of Records, Volumes I and II, to:

Logan T. Johnston
Johnston Law Offices, P.L.C.
One North First Street, Suite 250
Phoenix, AZ 85004

DATED this 3rd day of August, 2005.

Mavis Lauritzen

SUBSCRIBED AND SWORN TO before me this 3rd day of August, 2005.



Lorraine F. Freyer
NOTARY PUBLIC

My Commission Expires:

October 6, 2008