NO. 04-15228
IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

STEPHEN SANCHEZ, et al.

Plaintiffs - Appellants

v.

GRANTLAND JOHNSON, et al.,

Defendants - Appellees

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA NO. C 00-01593 CW

THE HONORABLE CLAUDIA WILKEN, JUDGE

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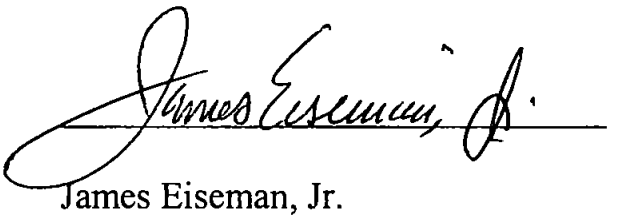
FEDERAL RULE OF APPELLATE PROCEDURE 26.1

None of the Plaintiffs - Appellants which is a corporation has a parent corporation. No publicly held corporation owns any stock in any of the Plaintiffs - Appellants which are corporations.



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STATEMENT OF JURISDICTION

Plaintiffs-Appellants (Plaintiffs) filed this lawsuit against Defendants-Appellees (Defendants) pursuant to the Medicaid Act, Title XIX of the Social Security Act, 42 U.S.C. § 1396-1396(v), 42 U.S.C. § 1983, Title II of the Americans with Disabilities Act, 42 U.S.C. § 12131-12134 and Section 504 of the Rehabilitation Act, 29 U.S.C. § 729. Excerpts of Record hereinafter "ER" 1/1/7[1] [Complaint ¶ 15]. The subject matter jurisdiction of the District Court over the claims in this matter arises under 28 U.S.C. §§ 1331 and 1343. The order of the Court below dated August 6, 2002, ER 10/253/1-59 granted summary judgment against Plaintiffs on two of Plaintiffs' three claims. The Court's order of August 6, 2002 did not, however, contain "an express determination that there is no just reason for delay" or "for the entry of judgment" under Federal Rule of Civil Procedure 54 (b). The order of the Court below dated January 5, 2004 (which was entered January 6, 2004) granted judgment on the pleadings against Plaintiffs on their third claim and terminated the entire case on the merits. ER 10/507/1-11 and 10/508/1-3. Thus both the Court's August 6, 2002 order and its January 6, 2004

[1]The Excerpts of Record ("ER") are contained in ten volumes. Each volume contains one or more tabs corresponding to the number in the docket of the court below where the item referred to is filed. Pagination of the contents of each tab begins with 1. References to the Excerpts of Record are in the form: Volume Number/Tab Number/Page Number.

order first became appealable on January 6, 2004. The Notice of Appeal in this action was filed on February 4, 2004. ER 10/510/1-4. This Court has appellate jurisdiction pursuant to 28 U.S.C. § 1291.

STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

1. Do the Plaintiffs, developmentally disabled Medicaid recipients and their advocates, have a private right of action to enforce the Medicaid Act's 42 U.S.C. § 1396a(a)(30)(A) right to payments consistent with quality of care and access to services in the community through the Civil Rights Act, 42 U.S.C. § 1983?

2. Did the Court below, in granting Defendants' Motions for Summary Judgment on Plaintiffs' deinstitutionalization claims under Title II of the Americans With Disabilities Act and Section 504 of the Rehabilitation Act err: (a) by making determinations against Plaintiffs that ignored evidence which creates material issues of fact; and (b) by applying incorrect legal principles.

STATEMENT OF THE CASE

This action was instituted on May 4, 2000 by the filing of a complaint ER 1/1/1-39 in the United States District Court for the Northern District of California. The complaint sought injunctive and declaratory relief under: (1) Title XIX of the Social Security Act (the Medicaid Act), 42 U.S.C. § 1396 et seq. (particularly 42

U.S.C. § 1396a(a)(30)(A)); and (2), under Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. §§ 12131-12134 and Section 504 of the Rehabilitation Act, 29 U.S.C. § 794 (a) and regulations thereunder. Enforcement of the Medicaid Act claims was premised on 42 U.S.C. § 1983.

The complaint sought certification of a class of persons with developmental disabilities. Seven individual developmentally disabled individuals, each through his or her mother or parents as next friend, were named as plaintiffs and class representatives. Also named as plaintiffs were six organizations engaged in advocacy on behalf of persons with developmental disabilities. ER 1/1/13-18 [Complaint ¶ 54-69]. Defendants are four individuals served in their capacities as officials of the State of California charged with managing California's programs for the developmentally disabled as well as administering California's Medicaid programs for the developmentally disabled. ER 1/1/70-73 and 1/9/7-8 [Complaint ¶70-73; Answer ¶70-73].

An answer was filed on June 22, 2000. ER 1/9/1-20. On August 2, 2001, the Court below granted Plaintiffs' (renewed) motion for class certification. ER 1/108/1-14.

On September 24, 2001, the Court below denied Defendants' Motion for Partial Judgment on the Pleadings ER 1/136/1-20, and on February 28, 2002, the

Court below denied Defendants' application for certification to take an Interlocutory Appeal from that denial. ER 1/156/1-8. Both the Court's September 24, 2001 and February 28, 2002 orders and opinions involved the Court's holding, inter alia, that Plaintiffs were entitled to enforce rights granted to them under the Medicaid Act's section, 42 U.S.C. § 1396a(a)(30)(A) by means of 42 U.S.C. § 1983. The decision denying certification went on to say that "there are not substantial grounds for difference of opinion as to whether § 1396a(a)(30)(A) is judicially enforceable and provides a private cause of action under Section 1983". ER 1/156/4.

During March, April and early May of 2002, Plaintiffs and Defendants filed cross-motions for summary judgment with respect to various aspects of the case. Extensive exhibits, declarations and objections to evidence were also filed. See the docket of the Court below at numbers 162-176, 178-189, 195-208, 211-219, 227-231, 238. ER 10/Docket Entries/25-32.

By an opinion and order dated August 6, 2002, ER 10/253/1-59 the Court below ruled on the cross motions for summary judgment. The Court denied all of Plaintiffs' motions for summary judgment and granted in part and denied in part Defendants' motions for summary judgment. In particular, the Court's opinion granted summary judgment on Plaintiffs' ADA and Section 504 claims that the

state had discriminated by failing to set payment rates high enough to provide sufficient disabilities services in an integrated community setting forcing persons to remain in segregated institutional settings. Plaintiffs' claim alleged that the rates for direct care workers' wages and benefits in community facilities were so low as to reduce the availability of community placements. The Court determined that 1) Plaintiffs had not shown that the instances of developmentally disabled persons unable to move into the community were widespread and more than 'isolated' and 'sporadic'; (2) that Plaintiffs had failed to demonstrate that there is a casual link between the low level of wages and benefits for direct care workers in community programs and the failure to deinstitutionalize developmentally disabled persons; (3) that California had a "comprehensive plan" to adequately move persons on "a waiting list" for deinstitutionalization; and (4) the dollar cost of the relief demanded by Plaintiffs would constitute "a fundamental alteration" of California's developmental disabilities budget. In arriving at these conclusions the Court improperly made determinations of disputed facts adverse to Plaintiffs as well as misconstrued the scope of the fundamental alteration defense.

The August 6, 2002 opinion of the Court below denied Plaintiffs' motion for summary judgment on its claims under the Medicaid Act, 42 U.S.C. § 1396 a(a)(30)(A) and also denied Defendants' motion for summary judgment as to

whether Defendants had violated the "quality of care" and "access" portions of the Medicaid Acts 42 U.S.C. § 1396 a(a)(30)(A) and ordered the case to go forward on these issues with submission of a written record. ER 10/253/50-52; 56-57.

Following August 6, 2002, for a period of almost a year, the parties took discovery and filed evidence additional to that which had been taken and submitted, including written testimony of a number of experts. See e.g. Docket entries 297-330; 332-365; 367-368; 376-380; 383-395; 397-412; 414-417; 419-420; 428; 438; 452-454; 469-471. ER 10/Docket Entries/38-53. In July of 2003, pursuant to the Court's schedule, Plaintiffs submitted proposed Findings of Fact and Conclusions of Law. See Docket entries 482-485. ER 10/Docket Entried/55. In August of 2003, Defendants submitted their proposed Findings of Fact and Conclusions of Law. See Docket entries 492-493. Ibid.

On August 6, 2003, in the midst of this exchange of proposed Findings of Fact and Conclusions of Law, Defendants filed a motion seeking to have the Court below reconsider, in light of Gonzaga University, et al v. Doe, 536 U.S. 273 (2002), its previous decisions holding Plaintiffs were entitled to enforce the Medicaid Acts', 42 U.S.C. § 1396a(a)(30)(A) through 42 U.S.C. § 1983. After briefing, the issue was submitted to the Court in late September of 2003.

By an opinion and order dated January 5, 2004 and reported at 301

F.Supp.2d 1060 (N.D. Calif, 2004)(entered January 6, 2004), ER 10/507/1-11 the Court below reversed the findings of its opinions of September 24, 2001 and February 28, 2002 and held that neither Plaintiff Medicaid recipients nor Plaintiff Medicaid providers and advocacy organizations could enforce the "access" or "quality of care" mandates of the Medicaid Act's 42 U.S.C. § 1396a(a)(30)(A) by means of 42 U.S.C. § 1983. The order of January 5, 2004 accordingly disposed of what remained of Plaintiffs' case.

A Notice of Appeal was filed by Plaintiffs February 4, 2004 ER 10/510/1-4 with respect to the Court below's January 5, 2004 order as well as that of August 6, 2002.

SUMMARY OF THE FACTS

This case concerns how California cares for more than 180,000 individuals with developmental disabilities. Of these, approximately 3800 live in large, congregate institutions known as Developmental Centers (DCs) which are directly operated by California through its Department of Developmental Services (DDS). ER 9/245/16; 2/166/3-32; 7/187/5 [Exh. P-7, Page 16; Lakin & Braddock Decl. ¶¶ 12-13; Carleton Decl. ¶13]. The balance receive care under one of a number of programs in community-based residential facilities, day care facilities or at home. Ibid. Most of the care provided to this vast majority of developmentally disabled

consumers in community residential, day and home programs is under contracts controlled by DDS. ER 7/187/1-17 [Carleton Decl.].

In the 1960s, California enacted a comprehensive law entitled the Developmental Disabilities Services Act (and known as the "Lanterman Act"). California Welfare and Institutions Code (Cal. Welf. & Inst. Code) §§ 4500-4846. The Lanterman Act provided for the establishment of 21 Regional Centers (RCs) which were to manage, but not necessarily directly provide, care for developmentally disabled individuals not residing in the DCs. RCs are non-profit organizations independent of the state. ER 7/187/3 [Carleton Decl. ¶6]. Under the Act, the RCs either furnish or coordinate the services provided to individuals with developmental disabilities Cal. Welf. & Inst. Code § 4020, 4630, 4648). DDS establishes uniform systems of accounting, budgeting and reporting § 4631(a) and sets the rates for community, day and home care which is provided by or through the RCs §§ 4681, 4689 and 4690. Rates for residential care in Intermediate Care Facilities (ICF) are set by the Department of Health Services headed by Defendant, Secretary of Health. ER 7/188/2-3; 6/181/3 [Dent Decl. ¶3, Tamai Decl. ¶3]. DDS sets rates for residential care in Community Care Facilities (CCFs), as well as home-based care through Family Home Agencies (FHAs), Foster Family Agency (FFAs), Independent Living Programs (ILPs) and

Supported Living Services (SLS) which support various programs for consumers in private homes. DDS also sets rates for and funds through RCs a variety of non-residential day programs to assist consumers. The delivery of community residential, day and home-based services in California to the developmentally disabled is, accordingly, made by a large array of providers other than the state itself.

Federal dollars constitute a significant portion of the total dollars which fund California's program for the developmentally disabled, both those conducted directly by the State through the DCs, as well as those which fund the residential, day and home programs which are delivered by the RCs or providers under contract with the RCs. ER 7/187/11; 6/181/3 [Carleton Decl. ¶¶ 32-33, Tamai Decl. ¶3]. Most of these federal dollars flow out of the Medicaid program established under Title XIX of the Social Security Act, 42 U.S.C. § 1396 - 1396(v). Medicaid "authorizes federal grants to states for medical assistance of low income persons who are aged, blind, disabled, or members of families with dependent children. This program is jointly financed by the federal and state governments and is administered by the states. The states, in accordance with federal laws, decide eligible beneficiary groups, types and ranges of service, payments of services, and administrative and operational procedures. Payment for

services is made directly by the states to the individuals or entities furnishing the services. 42 C.F.R. § 430.0. To receive matching federal financial participation for such services, states must agree to comply with the applicable federal Medicaid Law." Orthopaedic Hospital v. Belshe, 103 F.3d 1491, 1493 (9th Cir. 1997) cert. denied, 521 U.S. 1116 (1998). "Thus, for those States that opt to participate in the program, the requirements of the Medicaid Act are mandatory." Antrican v. Odom, 290 F.3D 178, 188 (4th Cir. 2002). "The Medicaid Act requires a participating state to develop a state plan which describes the policy and methods to be used to set payments rates for each type of service included in the program. C.F.R. § 447.201(b)" Orthopaedic, supra, 103 F.3d at 1494.

One of the purposes of the Medicaid Act with regard to developmentally disabled individuals is to "enable[e] each State . . . to furnish . . . rehabilitation and other services to help such families and individuals attain or retain the capacity for independence and self-care." 42 U.S.C. § 1396. (Emphasis added).

California and every other state has elected to join Medicaid. Under Medicaid, the federal government pays a share of the costs of covered programs which in the case of most of the California programs at issue in the instant appeal is 50%. ER 7/187/11; 6/181/3 [Carleton Decl. ¶32, Tamai Decl. ¶3]. The services which California provides the developmentally disabled directly in DCs or

indirectly through private providers in facilities known as Intermediate Care Facilities (ICFs) may be eligible for Medicaid reimbursement. ER 7/187/11 [Carleton Decl. ¶ 32.] Finally, the care for developmentally disabled in smaller, residential settings (CCFs), day and home-based programs may also be eligible for Medicaid reimbursement pursuant to the 42 U.S.C. § 1396n(c) "waiver" program for Home and Community-Based Services ("HCBS"). See ER 4/172/117 [P. Exh. 106 at 1]

The HCBS waiver, like the overall state Medicaid plan itself, is an agreement between California and the United States setting forth special conditions under which services may be provided to a group of developmentally disabled persons. These services are eligible for Medicaid reimbursement if they will avoid placement in an institution and if the cost is less than the cost of institutional care. Medicaid HCBS waivers are set-up with a defined number of "slots." On July 1, 2001 there were 31,570 enrolled, and on January 1, 2002, 35,403. California has requested and received approval to increase its slots to 70,000 by October, 2005. ER 6/184/1-13; 10/314/22-23 [Marquez Declaration, Ex. A; Marquez Deposition pp. 32-33]

California's recovery of federal dollars under the waiver program is low. California in 2000 ranked 43rd in federal per capita payments under the HCBS

program. The U. S. average per capita federal payment was more than double the California per capita federal waiver payment. ER 2/166/22 [P. Ex. A. Declaration of Lakin and Braddock at 19]. New York with its smaller population received $600 million more in federal waiver funding than California ER 2/166/23 [Id. at 20]. The low utilization of community services by California can further be seen by the fact that the percentage of a state's total Medicaid expenditures expended on HCBS and ICF-MR for persons with MR/DD in FY 2000 was lower in California than in any other state. ER 2/166/23 [Id. at 23].

The parties disputed how much state spending on persons with disabilities was unmatched by federal funds. The Defendants' submitted a declaration stating "unmatched general fund expenditures for DDS programs was $790.2 million for fiscal year 1999-2000." ER 6/184/4-5 [Marquez Declaration at ¶9]. At a subsequent deposition she admitted this excluded $721 million in unmatched expenditures on developmentally disabled persons by the departments of Health Services, Social Services and Rehabilitation even though Federal Financial Participation under the HCBS program can be drawn by the state if the expenditures are made by other departments. ER 10/314/67-70 [Marquez Deposition, at 98-99 and 101-102].

Both the Lanterman Act as well as the Medicaid law contain provisions

which encourage placing developmentally disabled individuals in an environment which is the least restrictive –i.e. most integrated– and which avoids "institutionalization" whenever possible. In particular, the Medicaid Act's 42 USC § 1396n(c) encourages deinstitutionalization through use of HCBS waivers. Olmstead v. Zimring, 527 U.S. 581, 601 (1999). It also encourages services which maximize growth–i.e. acquisition of skills–and independence while eschewing "custodial" care.

Finally, as more particularly detailed below, the mandates of Title II of the ADA and § 504 of the Rehabilitation Act, and regulations promulgated thereunder, as construed by the United States Supreme Count in Olmstead v. Zimring, 527 U.S. 581 (1999), require, subject to certain conditions, that developmentally disabled persons for whom the state provides services be served in "the most integrated setting appropriate", i.e. in community-based rather than institutional settings Id. at 599-603. As used hereafter in this brief the term "community services" for developmentally disabled people excludes services provided in the DCs, but encompasses all of the services described above including the ICFs as well as other residential, day and home-based services.

State data shows that California since 1990 has increased the numbers of persons receiving care in the community and decreased the number of persons

confined to institutions. ER 10/253/18 [8/16/02 opinion at 18]. Spending on community care has also increased significantly. ER 10/253/20 [8/6/02 opinion at 20]. In recent years, however, placements into the community have slowed. ER 10/253/18 [8/6/02 opinion at 18]. For the three years prior to the lower court's decision admissions to the Development Centers was greater than discharges. Ibid. Importantly, the Regional Centers had determined in a process called In re Hop hearings that persons in the Developmental Centers were capable of being in the community but were not being placed due to lack of spaces. ER 10/253/39-40 [8/6/02 opinion at 39-40]. The Defendants also submitted to Plaintiffs in response to a discovery request a list of 1125 persons entitled "Developmental Center Residents That Have Been Recommended for Placement as of May, 2001" . ER 7/215/1-56 [Ex.1 to Plaintiffs' Reply to Defendants' Opposition to Summary Judgment]. The state has asserted that these persons are not all "ready for placement" and are not a waiting list for community placement. The state, however, did not state what it meant by "ready for placement" nor what is necessary to be on a "waiting list." ER 6/183/7-8 [Jackson Decl. ¶17]

Plaintiffs' also submitted evidence that the state did not have, at the time of the summary judgment motions, any "Olmstead" plan for providing community placements in accordance with a schedule which would timely provide placements

to those on a waiting list. That evidence consisted of a Declaration of Deborah Doctor that on April 25, 2002, after Defendants had filed their motion for summary judgment, a public meeting was held to discuss beginning to formulate such a comprehensive plan. ER 8/218/1-5.

Defendants' data shows that for every category of disability in Developmental Centers there are literally thousands more persons with that configuration of disability in the community. ER 2/169/1-3 [P.Ex. 51].

The quality of care mandate of the Medicaid program, contained in 42 U.S.C. §1396a(a)(30)(A) quoted above must be viewed in light of the preference of Medicaid and the mandates of the Lanterman, ADA and Section 504 for community vs. institutional treatment and for attainment of independence versus custodial care. In 1998 HCFA found, inter alia, the state did not provide quality care and suspended additional enrollments in the HCBS Waiver Program until October 2000. HCFA Compliance Review, ER 4/172/119-123 [P.Ex. 106 at p.1-4].

In 1998 California formally abrogated using cost data for setting rates for CCFs, day programs, in-home respite care and supported living services. WIC §§4690.4 and 4681.1. Despite legislative direction to develop a new methodology, no new regulations have been adopted. The legislative abolishment of its rate

setting formula merely confirmed the abandonment of a system which had rarely been implemented.

DDS admitted: "In the last ten years there has been only one rate adjustment based on cost statements. The one rate adjustment provided in 1998-99 is based on 1995-96 cost statements, which were already depressed due to a lack of biannual rate adjustments." ER 9/245/60 [Ex. P-3 at 4]. "The history of inadequate funding of the rate methodology has resulted in the current crisis. . . ." ER 9/245/61 [Id. at 5]. For CCFs, no cost data has been collected since 1988 despite legislation mandating triennial cost surveys.

The conclusion that California's community services for the developmentally disabled fail to meet quality of care because of inadequate wages causing high turnover and high level's of vacancies derives from Defendants' own admissions and the Report of California's State Auditor.

In the May Revision of Defendants' 2001-2002 Budget Change Proposal for the RC Service Delivery Reform Rate Stabilization, Defendants admitted that:

> "Since the current rate methodologies were introduced beginning nearly 13 years ago, rate increases have not kept pace with the cost of providing services (cf., Endnote1). The growing gap between the cost of doing business and rates means service providers struggle to provide quality services without being able to offer competitive wages and benefits . . . .
>
> . . . . .

> Since the relationship between consumer or family and service provider is essential to the provision of quality services, turnover and inexperienced staff has led to gaps in service provision, lengthy waits to receive services and the high cost of repeatedly training anew and inexperienced workers. Additionally, inexperienced staff expose consumers and families to unnecessary health and safety issues."

ER 9/245/158-159 [P.Ex. 10 at pp 1-2 (DDS-20379-080)].

In another Budget Change Proposal, for Fiscal Year 2000-2001, the Department stated: "The historic lack of fully funding the rate methodology has resulted in the current direct service professional turnover rate and the associated reduction in quality of services to consumers and families." ER 9/245/83 [Exhibit P-4, at 5].

The lower court at page 28 of its 8/6/02 opinion, ER 10/253/28, drew the same conclusion, stating:

"DDS has acknowledged the potential for low quality services due to low reimbursement rates, which result in low wages and benefits and high turnover and vacancy rates. With regard to quality of care in community day programs, DDS has stated:

> Without funding sufficient to recruit, train, and retain a skilled labor force, the Department puts at significant risk the health, safety, and well-being of consumers . . . .

Pls' Ex. P-4 at DDS-16732. See also Pls.' Ex. P-3 at DDS-005126 ("The Department concludes that a lack of additional funding sufficient to reduce staff turnover will cause service quality decline, adversely affecting over 77,000 consumers and families.")

DDS has voiced its concern multiple times about diminishing quality of services by failing to fund rate increases.

> Research on staff compensation and turnover supports concerns about quality of care . . . . Direct care staff turnover is directly linked to the quality of care. The effects of staff turnover on care include discontinuity of treatment and care, inability to implement individual program plans, increased risk to health and safety, and chronic staff shortages.

Pls. Ex. P-2 at DDS-19052."

A 1999 study by the California State Auditor, submitted to but not cited by the Court below, found that the turnover rate of direct care workers was 50%, along with high vacancy rates. It concluded, as did DDS, that the turnover was a consequence of the low wages and reimbursement rates. The State Auditor found the average wage for a direct support professionals working in community services to be statewide $18,500 annually based on the average hourly wage. Sixty-one percent of providers did not offer benefits such as health insurance or sick leave or retirement. ER 4/172/23, 46, 60 [P. Exh. P-101 pp. 1, 23, 37].

In his letter of conveyance, the State Auditor wrote:

> "This report concludes that although the State's service delivery system was designed to provide optimal services to consumers, its success has been undermined by insufficient state funding and budget cuts. The providers we surveyed unequivocally agree that their inability to compete for direct care staff—those individuals who work directly with the consumers—and receiving insufficient state

> financial support are the primary obstacles to consistently delivering quality services. Providers report that most of their direct care staff, who earn an average of $8.89 per hour, remain on the job barely two years. It takes providers almost three months to replace these staff, thus creating disruptions in services and impeding continuity for the consumers."

ER 4/172/23 [Ex. P. 101 p. 1]

The constant cost of continuous arduous recruitment, orientation, training and supervision of new employees and of the constantly necessary extra-intensive supervision of underqualified, inexperienced, untrained direct care workforce is large. It doubles around to further diminish the already insufficient resources of service providers to deliver and to achieve quality in the services they have undertaken by contract with the Regional Centers to provide, consuming the resources necessary to design and provide new services for people who are waiting for them. ER 8/217/140 and 8/217/166 [P. Exh. C, supra at 132 and Exh. 6 to P. Exh. C].

Defendants admit that:

> "In 1997-98, given a turnover rate averaging 61% (Institute for Social and Behavioral Research, Kansas State University), it is estimated that California service providers spent $63.5 million, or 18% of total adult day service expenditures, replacing staff. Therefore, the $31.9 million allocated for 1999-00 day program, infant, and in-home respite services rate increase did not fund the cost of replacing staff, much less allow for wage and benefit increases."

ER 9/245/60-61 [P. Exh. P-3 at 4-5].

For the fiscal years 2001-2002, California budgeted $2,057,803,000 for the Community Services Program and $617,831,000 for the Developmental Centers Program ER 4/173/4 [P. Ex 119] or a total of $2,675,634,000. The Developmental Centers program, thus, accounted for about 23% of the total, even though, as noted above, the population of the Developmental Centers is only about 2% of the developmentally disabled in the California System.

SUMMARY OF ARGUMENT

Although Gonzaga University v.Doe, 536 U.S. 273 (2002) directs courts to determine whether a statute creates individual rights by looking at the "text and structure" of the statute, the court below concluded that Section 30(A) of the Medicaid Act does not create enforceable rights solely by looking at whether it had "rights creating language." Section 30(A) must be considered in the context of a Medicaid statute which creates entitlements to services enforceable by recipients under Section 1983. The Congressional mandates in Section 30(A) to quality and access are an integral part of the entitlements created. The structure of the entire Act, its legislative history, and the enactment of the Suter v. Artist M. override provisions confirm the Congressional intent to create an enforceable right in Section 30(A). The lower court's conclusion that Section 30(A) was unenforceable because it has an aggregate focus overlooked the fact that the Supreme Court reached the opposite conclusion in the Wilder case involving a nearly identical provision. By contrast with the opinion below, the well reasoned decision in Clayworth v. Bonta, 295 F.Supp.2d 1110 (E.D.Calif. 2003), appeal pending, held Section 30(A) creates rights enforceable under Section 1983. Consequently, the order dismissing on the pleadings Plaintiffs' claim that Section 30(A) has been violated by the state's failure to assure payments at a level

consistent with quality of care for persons with developmental disabilities receiving community based services must be remanded for determination of that claim on a full record.

To grant Defendants' motion for summary judgment on the ADA and Section 504 claims the court had to improperly resolve numerous issues of disputed material facts. (1) The court's holding that Plaintiffs had not shown more than sporadic or isolated instances of developmentally disabled persons living in institutions unable to obtain community based placements ignored the list of 1125 persons "recommended for placement" in Defendants' own records, the declining number of placements from institutions, and other records of institutionalized persons unable to find placements in the community. (2) The holding that Plaintiffs failed to demonstrate a causal link between low wages for direct care workers and the lack of available community placements overlooks the fact that Defendants admitted that they themselves have doubled the payment rates in order to place persons under the Community Placement Plan process. Although Plaintiffs introduced Defendants' records to show there already are persons in the community with the same severity of problems as persons in the institutions, the court improperly concluded that it was the nature of the disabilities which was slowing the pace of placements out of the institutions, and not the financial

policies of Defendants. (3) The Court's finding that the state had a "comprehensive plan" for moving persons out of institutions and into the community "at a reasonable pace" that satisfied the "Olmstead" requirements ignored a declaration that no such plan had been started to be developed, the fact that more persons are being admitted than discharged, and that it would take at least 12 years to take care of those persons recommended for placement at the rate proposed for the next two years. (4) The final disputed issue arises from the court's conclusion that the cost of relief would constitute a "fundamental alteration" of the state's disabilities program. The state never established how much it would cost to raise wages sufficiently to create the necessary placements–the Court used a figure for raising wages of persons already served in the community. The Plaintiffs and Defendants disputed how much money was available from new federal reimbursements available against unmatched current state expenditures. Plaintiff's experts said there was $1.2 billion in unmatched expenditures; Defendants' expert said there was only $790 million unmatched and the most that could be raised in five years was $115 million. The court improperly resolved this dispute by dismissing Plaintiffs' estimate. Evidence admitted in connection with the Medicaid claim shows that within two years the state budget included a $285 million increase in Federal funds and that the Defendants' expert

admitted that there was another $721 million in unmatched state expenditures not included in the earlier declaration.

Summary judgment on the ADA and Section 504 claims should be reversed and the case remanded for consideration upon a full record on which these contested issues could be properly resolved.

ARGUMENT

I. Section 1396a(a)(30(A) of the Medicaid Act Creates Rights Enforceable under Section 1983.

Judge Wilken held that Gonzaga University v. Doe, 536 US 273 (2002), changed the standard for determining whether a statute creates rights enforceable under 42 U.S.C. Section 1983 so drastically that Section 1396a(a)(30)(A) of the Medicaid Act, which several Courts of Appeals as well as she twice previously, had held enforceable by Medicaid recipients, no longer is enforceable. In doing so, the court disregarded the continuing vitality of the Supreme Court's decision in Wilder v.Virginia Hosp. Ass'n., 496 U.S. 498 (1990), unduly focused on one criteria for determining whether Congress intended to create individual rights, and ignored important Congressional directives and legislative history.[2]

The Supreme Court has frequently referred to parts of the Social Security Act, which includes Medicaid, as entitlements, because Congress votes open ended appropriations to cover the costs so that whomever is eligible can receive the services to which they are entitled (42 USC §1396), and because those Congressional directives are binding upon state officials and can be enforced by

[2]This Court reviews de novo the entry by the Court below of judgment on the pleadings Enron Oil Trading & Transportation Co. v. Waldbrook Ins. Co., 132 F.3d 526, 528 (9th Cir. 1997).

beneficiaries. King v. Smith, 392 U.S. 309, 333 (1968); Rosado v. Wyman , 397 U.S. 397, 422-3 (1970) (It is . . . peculiarly part of the duty of this tribunal, no less in the welfare field than in other areas of the law, to resolve disputes as to whether federal funds allocated to the States are being expended in consonance with the conditions that Congress has attached to their use."); Schweiker v. Gray Panthers, 453 US 34, 36-7 (1981)("An individual is entitled to Medicaid if he fulfills the criteria established by the state in which he lives."). In Pennhurst State School and Hosp. v. Halderman, 451 U.S. 1, 17-8 Justice Rhenquist pointed to the Social Security Act as a model of where, when Congress "intended the States to fund certain entitlements as a condition of receiving federal funds, it has proved capable of saying so explicitly" citing to King v. Smith, supra.

42 U.S.C. § 1983 provides a claim for relief against any person who, acting under color of state law, deprives a person "of any rights, privileges, or immunities secured by the Constitution and laws." To enforce that right, a plaintiff "must assert the violation of a federal *right,* not merely a violation of federal *law.*" Blessing v. Freestone, 520 US 329 , 340 (1997).

The most recent statement by the Supreme Court of how to determine if a federal statute creates a federal right, Gonzaga University v. Doe, 536 US 273 (2002), builds on a series of cases, including Wilder v. Virginia Hospital

Association, 496 US 498 (1990), Suter v. Artist M., 503 US 347 (1992), and Blessing v. Freestone, 520 US 329 (1997). Each of these cases, except Gonzaga, involved provisions of the Social Security Act.

That body of law applies a three-part test to determine whether a statute creates enforceable rights: (1) Was the provision intended to benefit the plaintiff; (2) is the provision so "vague and amorphous" that its enforcement would strain judicial competence; and (3)does it unambiguously impose a binding obligation by using mandatory, rather than precatory, language. Blessing at 340-1; Wilder at 509. If a plaintiff meets these criteria, "the right is presumptively enforceable unless the defendant demonstrates Congress has "shut the door to private enforcement." Gonzaga University, supra 536 U.S. at 285, n.4.

A. Gonzaga's Changes to Wilder Are Limited

In determining whether a statute was intended to benefit the plaintiff, the Court in Gonzaga was concerned that "[s]ome language in our opinions might be read to suggest that something less than an unambiguously conferred right is enforceable by §1983." 536 US at 282. "This confusion has led some courts to interpret Blessing as allowing plaintiffs to enforce a statute under §1983 so long as the plaintiff falls within a general zone of interest that the statute was intended to protect[.]" Id. The Court then clarified that "it is *rights*, not the broader or vaguer

'benefits' or 'interests,' that may be enforced under the authority of that section." Id. (Emphasis in original). The Court concluded that the language "simply require[s] a determination as to whether or not Congress intended to confer individual rights upon a class of beneficiaries." Id. at 286.

In analyzing whether Congress intended to confer individual rights, the Gonzaga Court looked at the same factors that it had looked at in earlier cases, including "the text and structure of a statute" to see if they provide any "indication that Congress intended to create new individual rights" 536 US at 286, whether there is "rights creating language" 536 US at 287, whether the structure of the act indicated individual enforcement and whether the provision is concerned with "institutional policy and practice" or rights of individuals. 536 U.S. at 288. The Court placed significant emphasis on the fact that under FERPA there is a structure by which students and others can bring administrative complaints about a violation of FERPA. 536 U.S. at 289. By contrast, there is no provision in the Medicaid Act which provides recipients with a comparable structure to obtain relief from the state's failure to comply with Section 30(A). Indeed, Gonzaga points out that "These [FERPA] administrative procedures squarely distinguish this case from Wright and Wilder, where an aggrieved individual lacked any federal review mechanism." 536 U.S.at 289-90.

B. Wilder Was Not Overruled and its Conclusion Still Is Valid

In Wilder the Supreme Court had before it the enforcement of the Boren Amendment to Title XIX, 42 USC §1396a(a)(13)(A)(1982 ed. Supp.V) which provided that states must:

> "use rates (determined in accordance with methods and standards developed by the State. . .)which the State finds . . . are reasonable and adequate. . . in order to provide care and services . . .and to assure that individuals have reasonable access . . .to . . .services of adequate quality."

The Court held that Section 13(A) conferred on providers an "enforceable right" to reasonable and adequate rates. 496 US at 510-20. All four courts of appeals which had previously considered the matter had arrived at the same conclusion. Id. at n.16. As the Third Circuit Court of Appeals recently noted, nothing in Gonzaga alters the fundamental principles set forth in Wilder nor the reasoning that led the Wilder court to find that §1396a(a)(13)(A) bestowed enforceable rights. Sabree v. Richman, 2004 U.S. App. Lexis 9180 (3rd Cir. May 11, 2004).

C. The Access and Quality Provisions of Section 30(A) are Intended to Benefit Medicaid Recipients.

The provision at issue here is that found at 42 USC §1396a(a)(30)(A) which provides that states must:

> "provide such methods and procedures relating to the utilization of, and the payment for care and services available under the plan. . .as may be necessary. . .to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

Judge Wilken, focusing solely on the statements in Gonzaga looking for rights creating language, held this provision did not show an intention to create individual rights and that it concerns aggregate results rather than individual rights. By contrast, Judge Levi in Clayworth v. Bonta, 295 F.Supp.2nd 1110 (E.D. Cal. 2003), decided a week before, concluded that the provision creates individual rights enforceable by beneficiaries.

When the text and structure of Section 30(A) are taken together, as Gonzaga directs, they demonstrate Congressional intention to create an enforceable right for beneficiaries. The requirement of payments sufficient "to assure ...quality of care" and access "at least to the extent that such care and services are available to the general population" are solely for the direct benefit of the service recipients. These provisions, in contrast to the requirements of payments consistent with economy and efficiency, do not further the objectives of the state; they are to protect the interests of the service beneficiaries by directing that state payments be sufficient in amount to attain these objectives which are in

the statute for the sole purpose to benefit the service recipients. While other provisions of the Act create the entitlement to services, this provision sets forth one of the standards for determining the nature, scope, and availability of the services which must be provided to the Medicaid recipient. When read with the clear entitlement provisions set forth in 42 U.S.C. §§ 1396a(a)(8) and (a)(10),[3] this section is a description of the services to which individuals have rights.

The lower court, however, objected that the provision does not use rights creating language like "no person shall be deprived" and noted that the Supreme Court found the absence of such language highly relevant in construing the Family Educational Rights and Privacy Act, which provided "No funds shall be made available . . .to any educational agency or institution which has a policy or practice of permitting the release of education records. . . ." 301 F.Supp.2d 1060, 1063-64. However, the Supreme Court, had not relied solely on the absence of such

[3] The court below apparently was influenced by the district court decision in Sabree v. Houston, 245 F.Supp.2d 653 (E.D. PA.2003) holding that none of the state plan requirements in 1396a are enforceable. That decision was reversed, sub nom Sabree v. Richman, 2004 U.S. App. Lexis 9180 (3d Cir. May 11, 2004) by the Court of Appeals which carefully analyzed Gonzaga and concluded that §§1396a(a)(8) and (a)(10) create individual entitlements enforceable pursuant to Section 1983. Section (a)(8) requires that the state plan "provide. . .such [medical] assistance shall be furnished with reasonable promptness . . . to all eligible individuals;" Section (a)(10) requires the plan "must. . . provide. . .for making medical assistance available, . . . to . . .all [eligible] individuals. . . ." Earlier Appellate decisions enforcing §(a)8 or §(a)10 were Bryson v. Shumway, 308 F.3d 79 (1st Cir. 2002); Pediatric Specialty Care, Inc. v. Arkansas Dep't of Human Services, 293 F.3d 472 (8th cir. 2002);. Westside Mothers v. Haveman, 289 F.3d 852 (6th Cir.), cert. denied, 123 S.Ct. 618 (2002); Doe 1-13 v. Chiles, 136 F.3d 709 (11th Cir. 1998).

language, examining in addition the structure of FERPA which it found also demonstrated no intention to create individual rights.

In looking for "rights creating language" similar to that found in Title VI and Title IX and which the Court found missing in Gonzaga, the lower court ignored an important difference between the conditions in FERPA and those in the Medicaid Act. The FERPA conditions on the expenditure of federal funding are not set forth as requirements of a state plan; the Medicaid conditions are. As Judge Levi noted in Clayworth, 295 F.Supp.2d at 1122 the language used is a function of its inclusion as a state plan requirement. In that context, the lower court failed to consider the impact of the Suter v. Artist M., supra override provision adopted by the Congress in 1992. In the Suter case the Supreme Court had said, inter alia, that Social Security Act beneficiaries can not maintain an action to enforce a funding condition which the Act requires to be set forth in a state plan. In response to the Suter case, Congress amended the Act to provide:

> In an action brought to enforce a provision of the Social Security Act, such provision is not to be deemed unenforceable because of its inclusion in a section of the Act requiring a State plan or specifying the required contents of a State plan."

42 USC §1320a-2; accord 42 USC §1320a-10.

In enacting this statute, Congress recognized the importance of suits

enforcing state plan conditions:

> Social Security beneficiaries, parents, and advocacy groups have brought hundreds of successful lawsuits alleging failure of the State and/or locality to comply with State plan requirements of the Social Security Act. . . .Much of this litigation has resulted in comprehensive reforms of Federal-State programs operated under the Social Security Act, and increased compliance with the mandates of the Federal statutes.

H.R. Rep. No. 102-631, at 364-65 (1992).

As a result, two years after Wilder Congress endorsed and codified that decision's implied cause of action analysis. "The purpose of this provision is to assure that individuals who have been injured by a state's failure to comply with the state plan requirements are able to seek redress in the federal courts to the same extent they were able to prior to the decision in Suter v. Artist M." H.R. Conf. Rep. No. 102-1034 at 1304 (1992)(quoting H.R. Rep. No. 102-631 at 366 (1992)).

As the court in Clayworth, 295 F.Supp. at 1122 noted, it is not surprising that classic rights creating language is not used in the context of rights expressed as part of a state plan requirement. Congress in Section 1320a-2 has told the courts that conditions set forth as requirements of state plans shall not be considered any less worthy of enforcement, a provision which the court below did not consider in assessing the import of the language used by Congress in Section

30(A).

The second criteria used by the court below to find no intention to create a right was its conclusion that Section 30(A) has an "aggregate focus" speaking to "institutional policy or practice" because it speaks to the state's obligation to develop "methods and procedures." That conclusion again overlooks the similarity of Section 30(A) and the Boren Amendment upheld in Wilder. In Section 30(A) the state is directed to use "methods and procedures . . . as may be necessary . . .to assure that payments are consistent with . . .quality of care and are sufficient to enlist enough providers . . . ." In Section 13(A) upheld in Wilder the state is directed to " use rates (determined in accordance with methods and standards developed by the State). . . to assure that individuals have reasonable access . . .to . . .services of adequate quality." The substantive right in Wilder was to rates which were sufficient to provide reasonable access and adequate quality. Similarly under 30(A) the right is to payments which are consistent with quality and sufficient to provide enough providers. The "methods and procedures" of Section 30(A) and the "methods and standards" of Section 13 (A) are merely the means that the state is required to use in satisfying its basic obligation.

Judge Levi in the Clayworth case concluded that the quality and access requirements of Section 30(A) "are not phrased in aggregate or indirect terms -

such as requiring a general policy or requiring substantial compliance - that might suggest that no single beneficiary is entitled to quality care or equal access." 295 F.Supp.2d at 1122. Thus he required proof that individuals were being deprived of equal access and/or quality care and evidence that such deprivation was the result of insufficient rates. 295 F.Supp.2d at 1127-8.

D. The Legislative History Demonstrates a Congressional Intention to Create Enforceable Rights.

Since the ultimate touchstone of whether Section 30(A) confers a right to sue under Section 1983 is Congressional intent, in addition to statutory language, legislative history is another guidepost. The legislative history demonstrates Congress intended, at the least, that Medicaid recipients are to be vested by the statute with a right of action under 42 U.S.C. §1983.

Section 30(A) was originally enacted in 1967 and amended in 1981. The Third Circuit described the legislative history as follows:

> ". . .the effect of the 1981 amendment was to sharpen the focus on Medicaid beneficiaries. Language referring to providers' charges was removed and language providing a further protection for beneficiaries was added.
> ". . . the House Committee Report on the 1981 amendment observed that 'in instances where the States or the Secretary fail to observe these statutory requirements, the courts would be expected to take appropriate remedial actions.' H.R.Rep. No. 158, 97th Cong., 312-313

(1981).[4] This statement certainly suggests that the committee anticipated that some class of plaintiffs would be able to sue to enforce Section 30(A), but it does not show that the Committee anticipated that Medicaid providers, as opposed to recipients, would be able to do so.

Pennsylvania Pharmacists, 283 F.3d at 541 (Emphasis supplied).

This legislative history is strong evidence that the equal access and quality of care provisions of Section 30(A) were intended to be enforceable by Medicaid recipients. There is a second piece of legislative history which further confirms Congressional intent that recipients have a right of action consistent with that permitted in Wilder for Section (13)(A), which is the Suter v. Artist M. override referred to above. Concerned that Suter "dramatically limits the ability of program beneficiaries to enforce State plan titles of the Social Security Act" H.R. Conf. Rep. No. 102-1034, at 1304 (1992), the Congress endorsed and codified the analysis of Wilder, with the House Conference Report declaring that the purpose of 42 U.S.C. §1320a-2 is to assure redress in the courts "to the same extent. . .[as] prior to the decision in Suter v. Artist M." H.R. Conf. Rep. No. 102-631, at 634-5.

E. Section 30(A) is Not Too Vague or Ambiguous to be Enforced.

Judge Wilken in her January 5, 2004 opinion did not address the second

[4] The quote from the Committee Report actually appears at p. 301 of the Report, not at 312-313 as the opinion states.

prong of the Wilder test–whether the rights at issue are too vague and ambiguous for judicial enforcement. In her September 24, 2001 opinion denying Defendants' Motion for Summary Judgment, however, she carefully addressed that issue and concluded Section 30 (A) was not too vague or ambiguous to be enforced. See pp. 7-8. ER 1/136/7-8. Judge Levi in Clayworth, supra had no difficulty in concluding that equal access or availability of services equivalent to privately insured persons is sufficiently definite for enforcement by courts, 295 F.Supp.2d at 1123. The right in the Boren Amendment to services of adequate quality found enforceable in Wilder is nearly identical to Section 30(A)'s requirement for quality care. This test was not changed by Gonzaga. As Judge Levi pointed out, this Court has already construed and given content to the term "quality of care" in Orthopaedic Hosp. v. Belshe, 103 F.3d 1491 (9th Cir. 1997). At a minimum Belshe means that the failure of the state in setting rates to consider providers' costs creates a presumption that the complete range of required services can not be delivered at effective levels, thereby violating the access and quality requirements. 295 F.Supp. at 1127. The provision's enforceability is also demonstrated by the fact the Secretary has suspended certain Medicaid programs because of failures of service quality, measured against program goals, and federal and state regulations. See, for example, the HCFA "Compliance Review of California's HCBS waiver

Program for the Developmentally Disabled," January 12, 1998, ER 4/172/114-127. Defendants themselves have repeatedly issued statements requesting increases in Section 30(A) payment rates because of the impact on quality of care and access. See, e.g.: "Direct care staff turnover [resulting from insufficient rates] is directly linked to the quality of care. The effects of staff turnover on care include discontinuity of treatment and care, inability to implement individual program plans, increased risk to health and safety, and chronic staff shortages." ER 9/245/25 [P-2 at DDS19052] [5]

F. No Appellate Court has Concluded that Recipients Can Not Enforce Section 30(A).

There is no appellate decision since Gonzaga which is directly on point. All five of the Circuit Courts of Appeals to consider the enforceability of rates to assure access and quality of care prior to Gonzaga came to the same conclusion: that Section 30(A) creates an individual right enforceable by Medicaid recipients,

[5]The Clayworth court's statement that there is "no point of reference" for quality 295 F.Supp.2d at 1123, is only true if limited to the text of Section 30(A), but the Act itself, the CMS regulations, and the CMS Services and Standards for Waiver Applications provide points of reference. See, e.g. the opening language of Title XIX, 42 U.S.C.§1396: "For the purpose of enabling each State. . . to furnish. . . services to help. . . [disabled] individuals attain or retain capabilities for independence or self care. . . ."; 42 CFR §483.440 defining a standard for active treatment: "Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of . . . services. . .that is directed toward–. . . (ii)the prevention or deceleration of regression or loss of current optimal functional status." Quality of care includes maintaining safety and health standards. For children's health services under Medicaid there exist guidelines setting forth required components of screens and the testing necessary. See, e.g. 42 U.S.C. § 1396d(r).

finding that they are beneficiaries of the quality and access provisions of Section 30(A) and that those provisions as clearly create rights as the similar provisions of Section 13(A) upheld in Wilder. They were split, however, on the issue of whether Section 30(A) created any rights for providers, with most courts of appeals deciding that it did not. Pennsylvania Pharmacists Assn. v. Houstoun, 283 F.3d 531 (3rd Cir.)(en banc), cert. denied, 537 U.S. 821 (2002)(not enforceable by providers; enforceable by recipients (dicta)); Evergreen Presbyterian Ministries, Inc., 235 F.3d 908 (5th Cir. 2000)(enforceable by recipients, not by providers); Methodist Hospitals, Inc. v. Sullivan, 91 F.3d 1026 (7th Cir. 1996)(enforceable by providers); Visiting Nurse Ass'n of North Shore, Inc. v. Bullen, 93 F.3d 997 (1st Cir. 1996), cert. denied, 519 U.S. 1114 (1997)(enforceable by providers); Arkansas Medical Society, Inc. v. Reynolds, 6 F.3d 519 (8th Cir. 1993)(enforceable by recipients and providers).

In the only post-Gonzaga appellate decision concerning Section 30(A) the First Circuit has now joined the list of courts holding that it does not provide explicit rights for providers. Long Term Care Pharmacy Alliance v. Ferguson, 362 F.3d 50 (1st Cir. 2004). Although the opinion declares that Section 30(A) does not contain rights creating language and does not identify any discrete class of beneficiaries, it is careful to limit its conclusion that Section 30(A)'s language

does not suggest any "intent to confer rights on a particular class of people" by then stating "or at least not providers." [6] 362 F.3d at 57.

In Pennsylvania Pharmacists the Court majority used the clarity of recipients' rights under Section 30(A) as the basis for its conclusion that Section 30(A) does not confer a right of action upon providers because, as it emphatically noted, the provision was focused on recipients' needs. The majority specifically noted that the "quality of care" and adequate access provisions demonstrate Congressional intent to confer a right of action on Medicaid recipients:

> "That leaves the directives to provide 'quality of care' and adequate access. These directives are 'drafted . . . with an unmistakable focus on' Medicaid beneficiaries, not providers. *Cannon*, 411 U.S. at 691. They are 'phrased in terms benefitting' Medicaid recipients, *Wilder*, 496 U.S. at 510 and these are the persons that Congress intended to benefit."

283 F.3d at 538.

The dissent, written by then Chief Judge Becker on behalf of five of the panel's eleven members, discussed Section 30(A) at length and concluded that it confers an enforceable right to sue on both providers and recipients. 283 F.3d at

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[6] A different panel of the First Circuit, also writing post-Gonzaga, upheld the enforceability of a different Medicaid provision, 42 USC § 1396r, holding recipients can enforce nursing facility standards, based on the structure of the statute and legislative history in the absence of any explicit rights creating language. Rolland v. Romney, 318 F.3d 42, 47-56 (1st Cir. 2003). ("We gather clues of congressional intent from several separate provisions in the statute, ever mindful of its overriding purpose, to protect individuals from being . . . denied necessary services." 318 F.3d at 48).

544-560.

Post Gonzaga, there has been no District Court decision, other than the one under review here, which concluded that Section 30(A) can not be enforced by beneficiaries, except for the court in Sabree v. Houston, 245 F.2d 653 (E.D.Pa. 2003) which concluded no provision of 42 U.S.C. 1396a(a) could be enforced. That decision, as noted above, was overruled by the Third Circuit Court of Appeals, sub nom Sabree v. Richman, 2004 U.S. App. Lexis 9180 (3d Cir. May 11, 2004). Three district courts post Gonzaga have concluded that recipients can enforce Section 30(A): Association of Residential Resources v. Goodno, 2003 U.S. Dist. Lexis 15056 (D.Minn) (providers and recipients); American Society of Consultant Pharmacists v. Concannon, 214 F.Supp.2d 23 (D.Me. 2002); and Clayworth v. Bonta, 295 F.Supp.2d 1110 (E.D. Calif. 2003)(recipients only)(pending on appeal). Three other district courts have post Gonzaga found that Section 30(A) does not confer rights on providers: California Association of Health Facilities v. State Dept. of Health Services, Case No. C. 03-736 (VRW)(N.D.Cal. 2003); Burlington United Methodist Family Services, Inc. v. Atkins, 227 F.Supp.2d 593, 596 (D.W.Va. 2002)(noting "quality of care" and "adequate access" provisions are "drafted . . .with an unmistakable focus" on Medicaid beneficiaries.); and Belen Consolidated Schools v. Otten, 259 F.Supp.2d

1203 (D.N.Mex. 2003). Sanders v. Kansas Department of Soc. and Rehab. Services, 2004 U.S. Dist. Lexis 8572, concluded in contrast to Sabree that Section 8 is not enforceable and in dicta opined Section 30(A) is not enforceable. Id. at 40 n.5.

G. Conclusion

Gonzaga does not overrule Wilder and subsequent case law, but more modestly attempts to clarify it. It is not a decision concerning the Medicaid Act and it did not seek to up-end the considerable judical and legislative history affirming Congressional intent to create entitlements and rights enforceable by recipients. More particularly, Gonzaga does not say that rights creating language must appear in any particular place or way; it does say courts are to look at the text and structure and legislative history of the statute. Section 30(A), with its clear direction that state reimbursements assure quality of care and access to service, defines the individual recipient's rights and is a vital component of the individual's entitlement to services.

II. The Lower Court Improperly Resolved Factual Disputes in Granting Defendants Summary Judgment on the ADA and Section 504 Claims that the State has Failed to Provide Sufficient Medicaid Services in Community-based Settings for Persons with Developmental Disabilities.

A. Introduction

The August 6, 2002 opinion of the Court below acknowledges that in the three years preceding the filing of the motions for summary judgment, the rate of deinstitutionalization of developmentally disabled people in California had "slowed"

> "and from FY 1999 to FY 2001 was less than one-third the average annual decrease in all the other states. In California's FY 1999, 2000 and 2001, State institution admissions exceed the number of discharges; the overall 2.2% decline during those years is attributable to deaths of institutional residents."

(Emphasis supplied). ER 10/253/18 [8/6/02 opinion at 18]. These numbers contrast starkly with the substantial declines in the population of the DCs in the preceding 7 years. Ibid. In addition, as the Court also notes, the record before her demonstrates that there are a number of developmentally disabled individuals whose Individual Placement Plans and/or judicially ordered annual reviews show they are recommended for discharge from the DC, but cannot be discharged solely because of the lack of an appropriate community placements. ER 10/253/21-23. [8/6/02 opinion at 21-23]. Moreover, as noted below, there were over 1,100 residents of DCs whom staff had recommended were candidates for community placement under the right circumstances.

Despite these findings, the Court's August 6, 2002 order grants Defendants'

motion for summary judgment on Plaintiffs' claims under the provisions of Title II of the Americans With Disabilities Act (ADA) and § 504 of the Rehabilitation Act (RA). The Court's grant of summary judgment makes the following four improper determinations: (1) that Plaintiffs have failed to demonstrate entitlement to class wide relief because of a failure to show more than "isolated" and "sporadic" instances of developmentally disabled individuals who were ready for community-based services but who are still institutionalized; (2) that Plaintiffs failed to demonstrate a causal link between low wages and benefits for direct care workers in community service programs for the developmentally disabled and the low rate of deinstitutionalization; (3) that California has a "comprehensive plan" for deinstitutionalization which meets the requirements of showing reasonable progress; and (4) that the cost of the relief sought by Plaintiffs constitutes a "fundamental alteration" of California's Developmental Disabilities Program. As discussed in detail below, each of these determinations improperly resolves a factual dispute and, accordingly, the Court's grant of summary judgment must be reversed.

Summary judgment is only properly granted when there is an absence of genuine and disputed issues of material fact viewing the evidence most favorably to the non-moving party. F.R.Cir. P. 56, Celotex Corp. v. Catrett, 477 U.S. 317,

322-23 (1986); Eisenberg v. Ins. Co. of North America, 815 F.2d 1285, 1288-89 (9th Cir. 1987). The Court must draw all reasonable inferences in favor of the party against summary judgment it sought Matushita Elec. Indus. Co. v. Zenith Radio Corp, 465 U.S. 564, 587. Intel. Cop. v. Hartford Accident & Indemnity Co., 952 F.2d 1551, 1558 (9th Cir. 1981). On appeal, the Court's review of the grant of a motion for summary judgment is de novo as to whether there is a genuine issue for trial. Messick v. Horizon Industries, Inc., 62 F.3d 1227, 1229 (9th Cir. 1995); Light v. Social Security Administration, 119 F.3d 789, 791 (9th Cir. 1997).

B. Federal Law Mandates California Deinstitutionalize Developmentally Disabled Except in Limited Circumstances

Title II of the ADA provides that:

> "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefit of services, programs or activities of a public entity, or be subjected to discrimination by any such entity."

42 U.S.C. § 12132. The ADA largely mirrors Section 504 of the RA, which states as follows:

> No otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance . . .

29 U.S.C. § 794(a). The elements of a claim under the cited sections of ADA and Section 504 are essentially the same. Olmstead v. Zimring, 527 U.S. 581, 590–592 (1999).

The ADA and Section 504 both contain integration mandates which direct states to "administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities" C.F.R. § 35.130(d). "The most integrated setting appropriate to the needs of qualified individuals with disabilities" is "a setting that enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible," 28 C.F.R. pt 35, App. A, p. 450 (1998).

Another regulation provides:

> "A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity."

28 C.F.R. § 35.130(b)(7) 1998.

This Court in Townsend v. Quasim, 328 F.3d 511, 516-17 (9th Cir. 2003) stated that in Olmstead "the Supreme Court interpreted the failure to provide Medicaid services in a community-based setting as a form of discrimination on the

basis of disability." Similarly, in Fisher v. Oklahoma Health Care Auth., 335 F.3d 1175 (10th Cir. 2003), the Court of Appeals for the Tenth Circuit held a rule change in the Oklahoma Medicaid Program setting different limits on prescription drug coverage for individuals in their own homes and individuals in nursing homes states a cause of action for violating the integration mandate of the ADA.

The Supreme Court recognized that:

> institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life.

and that:

> confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.

Id. at 600-01 (Citations omitted)

The Supreme Court went on to hold that the ADA anti-institutionalization mandate applies to individuals who do not oppose community placement and who are qualified for community placement based on the "reasonable assessment of the State's own professionals", Id. at 602. Ibid.

Grappling with the meaning of the required "reasonable modification" and

with the limited defense that such change would cause a "fundamental alteration" in 28 C.F.R. § 35.130(b)(7) 1998 (cited above) the Supreme Court in Olmstead concluded, among other things that:

> If, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met.

527 U.S. at 605-06.

If the state does not demonstrate that it has such a "comprehensive plan" plaintiffs will prevail unless the state can demonstrate that provision of the community based services will "fundamentally alter" the nature of the services. Olmstead, supra 527 U.S. at 603-06; Townsend, supra 328 F.3d at 517-518.

C. Plaintiffs Raised a Material Issue of Fact That There Were Sufficient Numbers of Developmentally Disabled Persons Unjustifiably Institutionalized to Warrant Class Wide Relief

Although the Court below accepted that Plaintiffs had raised a material issue of disputed fact concerning whether California is unnecessarily institutionalizing certain individuals with developmental disabilities, ER 10/253/40 [8/6/02 opinion at 40], it then asserted that Plaintiffs failed to show enough instances of unjustified institutionalization to warrant class wide relief.

ER 10/253/46 [8/6/02 opinion at 46]. Upon a motion for summary judgment and, in view of the record before the Court below, this determination is clearly in error. The evidence already discussed establishes the slow down since 1998 in deinstitutionalization, with more persons admitted to the Developmental Centers than discharged. The Court found that many IPPs submitted to the court and numerous In re Hop orders demonstrated persons remain in institutions solely because no appropriate community placement is available. ER 10/253/21-25; 5/176/1-211; 3/170/1-177 [8/6/02 opinion at 21-25; Exhibits P56a, 56b, 61c, 63a, 63c-63i, 65b, 65c, 66e-66i, 67c]. Most importantly, the Court failed to consider the 1125 persons "recommended for placement" by Defendants' own staff.[7] The attempt by Defendants through the Declaration of Julia Jackson ER 6/183/7-8 to claim this is not a list of persons "ready" to be placed in the community, which may mean only that a placement has not been identified, only raises a factual question to be resolved at trial. Clearly Plaintiffs have established a substantial issue that persons are not being provided services in the community.

[7]See ER 7/215/1-3 [Declaration of Larisa Cummings of May 8, 2002 authenticating and attaching as Exhibit 1 to Plaintiffs Reply to Defendants' Opposition to Summary Judgment and Plaintiffs' Opposition to Defendants' Cross Motion (hereinafter "Plaintiffs' Reply") a document produced by Defendants in discovery entitled "Developmental Center Residents That Have Been Recommended for Placement as of May, 2001 which contains approximately 1125 entries [ER 7/215/4-56]. This is not the list in Exhibit P-123 to Plaintiffs' Motion for Summary Judgment which the Court excluded from evidence because of the failure to authenticate or explain it.

The opinion of the Court below reiterates Defendants' points that, during the last decade, the number of individuals with disabilities receiving community services, has increased ER 10/253/19 [8/16/02 opinion p.19], the total expenditures for these services has increased. ER 10/253/20 [8/6/02 opinion p.20], some plaintiff organizations programs have grown ER 10/253/21 [8/6/02 opinion p. 21], and the number of vendors of community services has increased. ER 10/253/20 [8/6/02 opinion p. 20]. That record, however, is just not relevant to the issue of whether there is an unmet need for community services in order to satisfy the ADA and Section 504 mandates.

D. Plaintiffs Raised a Material Issue of Fact Concerning the Causal Link Between the Level of Compensation for Community Service Workers and the Failure to Deinstitutionalize

Secondly, after agreeing that Plaintiffs had raised a material issue of disputed fact concerning whether California is unjustifiably institutionalizing certain individuals with developmental disabilities. ER 10/253/40. [8/6/02 opinion at 40], the Court proceeds to conclude that Plaintiffs have failed to place evidence in the record allowing the inference of a causal connection between an increase in the wages and benefits of direct care workers in community services and increasing the availability of quality community service workers who are essential to moving out of the DCs and preventing admission to the DCs of individuals with

particularly special and complex needs. ER 10/253/40-41[8/6/02 opinion 40-41]. This determination is clearly inconsistent with the evidence in the record. As the Court itself notes,

> "one RC Executive Director opined that the unavailability of community-based services was not due to the complex needs and specialized services required for those individuals, but because the payments for community services, including the component to pay for wages and benefits for direct services professionals are insufficient to secure stable services of quality. Pls. Ex. P-56(a)"

ER 10/253/39-40; 5/176/3-5 [8/6/02 opinion pp. 39-40; Plaintiffs Exhibit 56 (a)]. In addition, the testimony of one of Plaintiffs' own directors was that his organization simply can't continue to accept placement from the Developmental Centers of any more consumers with complex needs because it can't hire enough qualified personnel at the wages available to provide the quality services required. ER 8/217/16-27 [P.Ex.B.p 111-122].

Defendants own actions, furthermore, are particularly powerful proof of the causal connection: in order to make new community placements Defendants have drastically increased rates for direct care compensation. In fiscal year 2001-2002, in their Community Placement Plan (CPP), Defendants claim they have been doing something different. ER 6/183/1-49 [Jackson Declaration]. They call this

new process "person centered" planning, ER 6/178/18 [Defendants Cross-Motion for Summary Judgment and Opposition to Plaintiffs' Motion for Summary Judgment (hereinafter referred to as "Defs' Opp") at 10], and describe it as including, identifying and obtaining the extra services necessary to prevent admissions, and committing additional staffing and funding to effectuate deflection, and to stabilize community placements, ER 6/178/20 [Defs. Opp. at 12], placing "persons whose medical conditions and/or behavioral conditions make community placement very difficult," . . . "despite these barriers" ER 6/178/26 [Defs. Opp. at 18]. What Defendants have done that is truly new, and, by their own statements, necessary and effective, is to assure both quality and availability of community services ER 6/183/15-16 [Jackson Decl. ¶ 41, 46] by authorizing rates which average twice the usual community service rates and, concomitantly, support twice the direct care wages and benefits. ER 7/213/4; 8/238/4; 6/183/2-4; 7/187/15 [Clark Decl.¶ 11; Shorter Decl. ¶ 8; Jackson Decl. ¶ 2, 4, 5; Carleton Declaration ¶ 44]. It is, therefore, clearly inferable from Defendants' own design and description of this new CPP that there is a causal relationship between the level of community based direct care workers' wages and benefits and successful implementation of the process of reducing the institutionalized population of developmentally disabled.

The Court ignored this evidence of higher wages as necessary to place additional disabled persons in the community and accepted Defendants' claim that the new CPP Plan, ER 10/253/25; 6/183/1-49 [8/6/02 opinion p.24 and Budget Change Proposal there cited; Jackson Decl.] and higher payments arise because of the particularly difficult and complex needs of those remaining in the institutions. But for the ADA and 504 claims, this defense is a non-sequitur as far as causation is concerned. If it takes more funds because people are more "difficult" to place in the community, then do it. The complaint is that Defendants have not done it enough to "clear" the demand.

The Court's statement "If anything, it appears that the complex medical and behavioral issues of those that continue to reside in institutions, after more than a decade of deinstituionalization, may be the primary reason for their continued institutionalization" ER 10/253/41[Op. at 41] is a matter of deep factual dispute. Since Defendants have placed additional persons that it describes as complex and difficult with increased rates, this argument fails to establish that such rates aren't necessary, even if other conditions also must be met. But more importantly, there is ample evidence that the community is able and indeed deeply experienced in providing services to individuals with these very same difficult needs.

Defendants describe the consumers to whom the new CPP program is

addressed as being self-injurious, assaultive, anti-social and/or requiring skilled medical intervention. ER 6/183/4-6; 7/187/14; 6/186/4-6 [Jackson Decl. ¶ 7-12; Carleton Dec. ¶ 41; Moise Decl. ¶¶ 10-15]. But, there is ample precedent for providing developmental services to such people in the community and Defendants' own statements show this. DDS publishes from its information systems a report entitled "Major Characteristics of Clients in Developmental Centers Compared to Clients in the Community." The report dated October 7, 1999, ER 2/169/2-15 [P. Exh. P-51], discloses that while 1,563 and 1,910 people in the DCs respectively have retardation and cerebral palsy, 27,484 and 29,363 people who are clients in the community do, respectively. While 540 in DCs have autism, 11,346 in the community do. While 540 people in DCs have severe levels of retardation, 13,176 people in the community do. While 2,403 DC residents are said to have profound levels of retardation, 8,931 community clients do. While 1, 554 people in DCs have severe behavior problems, 12, 270 community clients do. While 1,592 people in the DCs are not ambulatory without mobility device assistance, 27, 438 community clients are not. While 803 in DCs do not understand spoken words, 5,506 in community do not. While 1,496 in the DCs are frequently violent, 14,500 community clients are. While 1619 residents in DCs are self-injurious, 1,971 have unacceptable social behavior, and 1,402 will run

away, among community clients, 17,561 are self-injurious, 27,745 have unacceptable social behavior and 21,021 will run away. The statements in Defendants' report certainly cast serious doubt on Court's suggestion that the severity of the problems in the residents of the DCs explain the recent slow pace of providing community services for persons in institutions.

E. Plaintiffs Raised a Material Issue of Fact That California Has No Comprehensive Plan or Waiting List for Deinstitutionalization

Third, despite the acknowledged, dramatic slowing in the pace of the deinstitutionalization process, noted above, the Court below concluded ER 10/253/45. [8/6/02 opinion at 45] that the:

> "Defendants have shown that they have just such a plan [as called for by Olmstead] in place, and that it is operating at a reasonable pace . . ."

In support of this conclusion, the Court cites the Defendants' evidence of various proposals and plans adopted only in the year before filing of the motions for summary judgment to spend considerable sums to deinstitutionalize or deflect from institutions a very limited number of individuals. ER 6/183/1-49 [Jackson Declaration].

This finding of the Court misconstrues what Olmstead requires for an acceptable "comprehensive plan" and is clearly factually erroneous. The Court

utterly ignores the fact that California did not have and did not even explicitly claim it has "a comprehensive plan" or a "waiting list" so that the Court below actually could apply the above quoted test from Olmstead. As late as April 25, 2002 (which was subsequent to the filing of Defendants' Motions for Summary Judgment), Defendants were just directing their staff "to draft a description of the process by which California will produce an Olmstead plan." ER 8/218/1-5 [Declaration of Deborah Doctor]. Indeed Defendants in the Declaration relied upon by the Court make no claim to having an "Olmstead Plan" and go out of their way to deny that there is anything the Court or parties could argue is a "waiting list" by denying that the database containing the list of DC residents "recommended for community placement in their individual placement programs" can be relied on as persons "ready" to be moved. ER 6/183/7-8. [Jackson Declaration, ¶ 17]. Interestingly, no definition of "ready" to be placed is provided. (It may mean only that no placement has been identified or the state has not undertaken other necessary steps that it controls. In either case it still would be a "waiting" list.) The requirement of Olmstead that to meet the reasonable modification test, the state must have a comprehensive plan means more than that the state describe its past progress and generalized testimony about what the state is doing; it requires "a plan which is communicated in some manner" and in which

the state "has given assurance that there will be" ongoing progress toward deinstitutionization, Frederick L. v. Dept. of Public Welfare, 2004 U.S. App. Lexis 7151 (3rd Cir. 2004) at 10. This California and Defendants have not done.

Indeed, Olmstead requires that a state show that it has a waiting list that moves at a reasonable pace. The CCP plans are simply a listing of persons the regional centers may move in the next two years. ER 6/183/2-3 [Jackson Decl. ¶¶ 4-5.] Defendants never quite exactly say how many people will be moved from the DCs to community services during the two year period of this new CPP process, but it is clear that the process is strictly limited. Thus, Defendants say that the "current CCP . . . [serves] 183 consumers. ER 6/183/8-10 [Jackson Declaration ¶¶ 20, 24]. If only 183 consumers were deinstitutionalized over a 2 year period, it would take over 12 years to deinstitutionalize the 1125 individuals in DCs who Defendants' recommended for community placement. But in fact the pace will be even slower, for the CCP process also covers individuals "whose unstable community living arrangements have resulted in referral to the RRDP" ER 6/183/2-3 [Jackson Decl. ¶ 4] which means an unknown number of persons who are being deflected from going into the institution are included in those 183 consumers, thus reducing the number coming out of the Developmental Centers. This can not be deemed as a matter of law as a satisfactory pace.

F. Plaintiffs Raised a Material Issue of Fact That There Are Untapped Federal Funds Available to Pay for Community Services Which the Court Ignored in Considering the Defense of Fundamental Alteration

Finally, the Court held that the relief sought under the ADA and Section 504 claims–to raise direct care wages sufficiently to be able to provide the capacity in the community to provide a community placement for those who are capable of receiving services in a non segregated non-institutional environment –would constitute a fundamental alteration in the program because its cost would be a "drastic re-allocation," diverting funds from other programs and services. ER 10/253/44 [8/6/02 opinion at 44]. This conclusion was premised on the cost being $1.4 billion increase to a $2.2 billion State budget for all services to the developmentally disabled.

In reaching this conclusion, the Court appears to have looked at the potential cost for doubling wages of all direct care workers–for persons already receiving services in the community as well as for the far fewer either in the Development Centers who were prevented from receiving community services by the insufficient payment rates and those new admissions to the DCs who fail to be deflected into community services because of the payment rates available. Neither Plaintiffs nor Defendants made any calculation of the cost of increases necessary solely to satisfy the ADA and Section 504 claims of unnecessary

institutionalization, even though expenditure of funds to increase wages in existing community facilities to comply with the Medicaid Act are not to be included in the cost of complying with the Olmstead mandate. (The burden of showing that the relief would constitute a fundamental alteration is upon the Defendants. Townsend v. Quasim, supra, 328 F.3d at 518; see 28 C.F.R. 35.150(a)(3)). For this reason alone, the Court below's conclusion concerning the "fundamental alternation" defense was in error.

But even if the Court below had not incorrectly commingled the dollars required for fulfilling the Olmstead mandate and the Medicaid mandate, in making a determination of fact about the amount of untapped federal dollars available for raising wages and benefits for direct care workers in community programs, the Court ignored the inferences which must be drawn from Plaintiffs' evidence. Plaintiffs asserted to the Court that whatever the figure of increased expenditures for compliance with the combined ADA and Medicaid claims, it was not a fundamental alteration to the program due to its costs because some or all of the amounts needed could come from federal dollars currently not collected from CMS. See Plaintiffs' Motion for Summary Judgment, pp. 47-50. ER 1/162/52-55; Plaintiffs' Reply to Defendants' opposition to Summary Judgment and Plaintiffs' Opposition to Defendants" Cross-Motion pp. 16-18. ER 7/211/20-22. The

Plaintiffs' experts opined there was at least $1.2 billion of unmatched federal dollars available to the state ER 7/214/2-3; 2/166/3-32 [Lakin Decl. ¶5 and P.Ex. A Braddock and Lakin Declaration] which Defendants' expert at first revised to $790.2 million ER 6/184/3-4 [Marquez Decl. ¶9] and then asserted was no higher than $115 million. Ibid. The Court improperly resolved this dispute by simply dismissing Plaintiffs' evidence with the cryptic statement that "There is no basis for Plaintiffs' estimate which does not take into account state expenditures that do not qualify for federal matching funds." ER 10/253/44 [8/6/02 opinion at 44 n.17]. Plaintiffs' declarations show, however, that nationally only 17 percent of Medicaid MR/DD expenditures do not qualify and in California 40 percent currently are unmatched, and that in particular, for residential services for the developmentally disabled, the California unmatched expenditures are more than twice the national average. ER 2/1656/27-8. Plaintiffs' declarations thus provide a basis for inferring the availability of substantial additional amounts, and the Court improperly resolved this dispute by accepting Defendants' contention. Moreover, the evidence submitted in connection with the cost of the Medicaid claim conclusively confirmed that it was the Marquez Declaration which had no basis. Although Paragraph 6 of Marquez's April 18, 2002 Declaration stated that $115 million was the total increase in annual federal reimbursement that would be

available by 2007-08, by 2003-04 the state budget already included a $285 million increase. ER 10/314/54 [Marquez Deposition at 72]. Ms. Marquez benignly describe her earlier declaration as "outdated." Ibid. She also admitted that her calculation that the "unmatched general expenditures for DDS programs was $790.2 million for fiscal year 1999-2000" in Paragraph 9 of her declaration did not include an additional $721 million in unmatched expenditures by the departments of Health Services, Social Services and Rehabilitation even though expenditures made by other departments can be drawn upon for Federal Financial Participation under the HCBS program. ER 10/314/67-70, [Marquez Deposition at 98-99, 101-102].

G. Conclusion

By federal statute, Justice Department regulations, U.S. Supreme Court decisions and the decision of this Court there has developed a strong and clear commitment to the proposition that developmentally disabled citizens are entitled to live in the least restricted and most integrated setting which reasonably can be provided by the state. California's own Lanterman Act also articulates this same policy Ass'n for Retarded Citizens v. Dept. of Developmental Services, 211 Cal. Rptr. 758, 759 (1985). Fulfilling this commitment in the face of serious challenges, both financial and otherwise, is not easy or simple, and the evolving

"reasonable modification" and "fundamental alteration" standards reflect at once the complexity of the adjustments which must be made as well as the strength of the law's commitment to integration. The evidentiary record before the Court on Plaintiffs' ADA and Section 504 claims was significant in volume and complexity. The Court's grant of Defendants' motions for summary judgment of those claims stubs its toe on this factual complexity. Careful examination shows that, contrary to the Court's determinations, there are at least material issues of fact in the record with respect to each of the four major determinations that the court made in order to grant Defendants' motions for summary judgment. The Court's grant of Defendants' motions for summary judgment should, therefore, be reversed by this court.

CONCLUSION

For all the reasons stated above, Plaintiffs request the Court to reverse and remand with direction to enter judgment in favor of Plaintiffs (1) denying Defendants' Motion for Reconsideration of the Courts' Decision granting Defendants' Motion for Judgment on the pleadings with respect to the enforceability of 42 U.S.C. § 1396a(a)(30)(A) under 42 U.S.C. § 1983 and (2) denying Defendants' Motions for Summary Judgment on Plaintiffs' claims under Title II of the ADA and Section 504 of the Rehabilitation Act.

RESPECTFULLY SUBMITTED,

PUBLIC INTEREST LAW CENTER

OF PHILADELPHIA

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STATEMENT OF RELATED CASES AND PROCEEDINGS

The instant appeal is related to the following consolidated appeals currently pending in this Court Clayworth v. Bonta, No. 04-15498 and California Medical Association v. Bonta, No. 04-15532 because all three cases raise the same legal issue, i.e. whether there is a private right of action to enforce the access and quality of care mandates of 42 U.S.C. § 1396a(a)(30)(A) through 42 U.S.C. § 1983.

CERTIFICATE OF COMPLIANCE WITH FED. R. APP. P. 32(a)(5) AND 32(a)(7)(B)

1. This brief complies with the type-volume limitation of Fed.R.App. P. 32(a)(7)(B) because it contains 13,912 words, excluding parts of the brief exempted by Fed.R.App.P. 32(a)(7)(B)(iii).

2. This brief complies with the type face requirements of Fed.R.App.P. 32(a)(5) and the type style requirements of Fed.R.App.P. 32(a)(6) because it has been prepared in proportionately spaced typeface using 14 point type.

RESPECTFULLY SUBMITTED,

PUBLIC INTEREST LAW CENTER

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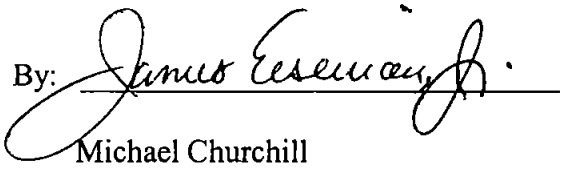
By: 

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DECLARATION OF SERVICE

Sanchez, et al v. Johnson, et al No. 04-15228
in the United States Court of Appeals for the Ninth Circuit

I am over the age of 18 years and have no interest in the above matter. I am employed in the County of Philadelphia, Commonwealth of Pennsylvania. My place of employment is Public Interest Law Center of Philadelphia, Suite 700, 125 S. 9th Street, Philadelphia, PA 19107.

I served on each of Defendants' below listed counsel's offices a Copy of the Excerpts of Record and two copies of Appellants' Opening Brief.

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by delivering on May 21, 2004 the aforesaid items to UPS, a third party commercial carrier, for delivery by said commercial carrier to each of the said offices on May 24, 2004 with all delivery fees prepaid.

I certify and declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

BY: James Eiseman Jr.

JAMES EISEMAN, JR.

Dated: May 21, 2004