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U.S. COURT OF APPEALS

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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I. Section 30(A) is Enforceable under §1983.

Like the opinion below, Appellees ask this Court to ignore the controlling structure of the "entitlement" to care and services bestowed upon eligible individual recipients in Title XIX of the Social Security Act. Instead they mistakenly seek to transmogrify Gonzaga's example of rights creating language ("No person shall be . . ." used in various civil rights acts, Title VI and IX as well as in Section 504 and the ADA) into an exclusive, talismanic formula. But Gonzaga University v. Doe, 536 U.S. 273, 281 (2002) requires no such thing. To the contrary, Gonzaga confirms the continued vitality of the Blessing, Wright and Wilder instructions on how to determine when Congress has created individual, enforceable federal rights. Appellees would have this Court depart from the long-standing, unbroken course of decisions, from King v. Smith, 392 U.S. 309 (1968), (cited affirmatively as a model of enforceable statutes by Justice Rhenquist in Pennhurst State School and Hospital v. Halderman, 451 U.S. 1, 17-8 (1981)) through Sabree v. Richman, 367 F.3d 180 (3rd Cir. 2004), holding the substantive requirements of Social Security Act entitlements create federal rights. Appellees ask this Court to become the only appellate court to refuse to enforce Title XIX's

substantive requirements for Medicaid beneficiaries.[1]

Going well beyond the narrow issue of whether Section 30(A) creates individual rights raised by the court below, the state attempts to diminish Medicaid enforcement by pushing this Court into rejecting well established decisions:

1. Although Wilder, Blessing, Arkansas Medical Society, Evergreen, Sabree, and numerous other cases declared that 42 U.S.C. §1396(c) does not preclude a Section 1983 action to enforce a provision of the Medicaid Act, that argument is repeated by Defendants in their Brief on appeal ("DBr.").

2. Although every court to have considered the question has declared that the quality and access provisions of Section 30(A) are "phrased in terms benefitting" Medicaid beneficiaries and that they "are the persons Congress intended to benefit," see, e.g., Arkansas Medical Society, Evergreen Presbyterian Ministries, and Pennsylvania Pharmacists Assoc., Defendants

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[1] Defendants wrongfully assert that Plaintiffs have abandoned their argument that providers have a right to enforce Section 30(A). The lower court did not rule against or address providers' standing to enforce recipients' rights, but merely held providers were not intended as direct beneficiaries. The Clayworth court explicitly upheld the rights of providers to assert the rights of members and third party beneficiaries. Clayworth v. Bonta, 295 F.Supp.2d 1110 (E.D.Calif. 2003), appeal pending. See also Pennsylvania Psychiatric Soc'y v. Green Springs Health Serv. Inc., 280 F.3d 278 (3rd Cir.), cert. denied, 537 U.S. 841 (2002); Ohio Ass'n of Indep. Sch. v. Goff, 92 F.3d 419, 421-2 (6th Cir. 1996); Pediatric Specialty Care, Inc. v. Arkansas Dept. of Human Services, 293 F.3d 472, 478 (8th Cir. 2002).

ask this court to ignore Blessing's direction to consider carefully each provision, arguing the quality of care and equal access provisions are so inextricably tied to the efficient and economical services provisions protecting the interests of the state that they are not intended to be for the benefit of recipients.[2]

3. In the teeth of this Court's decision in Orthopeadic Hospital v. Belshe, 103 F.3d 1491 (9th Cir. 1997), cert. denied 521 U.S. 1116 (1998), followed by the court below in this case, and contrary to the unanimous holdings of every other court of appeals to address the issue for determining when the requirements of quality and access have been violated, Appellees ask this Court to repudiate those prior decisions and declare those provisions too vague and amorphous to be enforceable, without even acknowledging that Gonzaga did not raise a question about this prong of the Wilder-Blessing decisions.

The duty created by Section 30(A) of the Medicaid Act is to provide payments that "assure" that the "care and services" provided eligible individuals are consistent with quality of care and enlist enough providers to give access to

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[2] For the continuing applicability of Blessing see Sabree v. Richman, supra, Rolland v. Romney, 318 F.3d 42 (1st Cir. 2003) and the Solicitor General's brief opposing certiorari in Haveman v. Westside Mothers, available at http://www.usdoj.gov/osg/briefs/2002/Oresponses/2002-0277.resp.pdf at 8.

such care and services equal to that available to the general public.

The second and third prongs of the Blessing-Wilder test are met here. The duties of Section 30(A) are clearly mandatory; appellees do not argue to the contrary. As this Court has held, the Section 30(A) requirements of quality and access are not so vague and amorphous as to be unenforceable. Finally, Congress has not "shut the door" to private enforcement with a comprehensive alternate enforcement scheme, a critical factor influencing the decision that no individual rights existed in Gonzaga.

Like the court below, Defendants assert, however, that the statutory duty to assure quality of care and equal access is merely a duty to have a policy and is not owed to the recipients because of the absence of the particular rights creating language referred to in Gonzaga. This ignores all of the other criteria Gonzaga considered in determining that Congress did not intend to create enforceable individual rights, including FERPA's explicit substantive focus on a policy or practice, the creation of the duty in the section that says "no funds shall be made available to . . . an institution which has a policy or practice. . ." and the presence of an administrative structure for individual complaints. None of those factors exist here.

More importantly, Defendants' argument ignores the entitlement "of

individuals" to care and services created by Sections 8 and 10 of the Medicaid Act, held enforceable in Sabree, supra, Bryson v. Shumway, 308 F.3d 79 (1st Cir. 2002), Westside Mothers v. Haveman, 289 F.3d 852 (6th Cir.), cert. denied, 123 S.Ct. 618 (2002), Miller by Miller v. Whitburn, 10 F.3d 1315 (7th Cir. 1993), Pediatric Specialty Care, Inc. v. Arkansas Dept. of Human Services, supra, Lewis v. New Mexico Dep't of Health, 261 F.3d 970 (10th Cir. 2001), Doe v. Chiles, 136 F.3d 709 (11th Cir. 1998), Antrican v. Buell, 158 F.Supp.2d 663 (E.D.N.C. 2001) affd, 290 F.3d 1178 (4th Cir. 2002), Oklahoma Chapter of American Academy of Pediatrics v. Fogarty, 205 F.Supp.2d 1265, 1272 (N.D.Okla.2002), Sobky v. Smoley, 855 F.Supp. 1123 (E.D.Cal.1994).

When considering whether Section 30(A) duties create individual rights it is important to note that the "care and services" which are being paid for under Section 30(A) are those required in 42 U.S.C. §1396a(a)(10)(A)(I) as part of "the medical assistance . . .to. . . all individuals." The definition of medical assistance, set forth at 42 U.S.C §1396d(a), is all or part of the cost of the "following care and services . . .for individuals. . . ." Clearly if this full definition had been spelled out in Section 30(A) so that it read "provide such methods and procedures relating to the . . . payment for *medical assistance to individuals* 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 *medical assistance to individuals* are available under the plan at least to the extent that such services are available to the general population in the geographic area" there would be no colorable issue as to individual entitlement. Substitution of the defined phrase should not produce a different result.

Neither the court below nor the Defendants acknowledge that the explicit rights creating language they assert is necessary here was not present in Wilder. Gonzaga very carefully did not repudiate Wilder; this Court should not do so.

In order to build their argument that Section 30(A) does not create individual rights, Defendants are driven to challenge Plaintiffs' statement that the quality of care and equal access provisions of Section 30(A) were included to "protect the interest of service beneficiaries." (DBr.at 42-3). Courts of Appeals in Arkansas Medical Society v. Reynolds, 6 F.3d 519 (8th Cir. 1993), Evergreen Presbyterian Ministries, Inc. v. Hood, 235 F.3d 908, (5th Cir. 2000) and Pennsylvania Pharmacists Assoc. v. Houstoun, 283 F.3d 531, 538 (3rd Cir.)(en banc), cert. denied, 537 U.S. 841 (2002) explicitly reached that conclusion, after concluding that the efficiency and economy outcomes are for the benefit of the state programs:

> 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, 441 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.

Idid.

Defendants in their brief even refuse to concede that the Third Circuit was correct in Sabree v. Richman, 367 F.3d 180 (3rd Cir. 2004), that Title XIX expresses the strong, unambiguous intention of the Congress to create individual entitlements to Medicaid services. The reason is obvious: the logic and structure of the Act ties Section 30(a)'s sufficient payment to provide quality and access as a fundamental element of the right to receive care and assistance mandated in Sections 8 and 10, which Sabree held enforceable. The entitlement is to a defined set of services which includes scope, timeliness, quality and availability. Each element is part of the entitlement.

Both the Court below and Defendants overlook the critical importance in Gonzaga that there was an administrative structure for individual complaints. In this case, as in Wilder, see 496 U.S. at 521-28, there is no process for recipients without access to care or faced with high turnover low quality care to get enforcement of Section 30(A).[3] As Justice Harlan wrote in connection with

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[3] Moreover, a GAO report, "Long -Term Care. Federal Oversight of Growing Medicaid Home and Community-Based Waivers Should be Strengthened," www.gao.gov/cgi-bin/getrept?GAO-03-576 at p 22 states ". . .

another part of the Social Security Act, "We are most reluctant to assume Congress has closed the avenue of effective judicial review to those individuals most directly affected by the administration of its program." Rosado v. Wyman, 397 U.S. 397, 421 (1970).

The legislative history of the Medicaid Act is not to the contrary. Defendants are correct, as Plaintiffs' noted in their Brief at 36 n4, that the language in the House Report of the Committee on the Budget on the Omnibus Reconciliation Act of 1981 which stated:

> "The Committee wishes to emphasize that States must continue to operate their programs in conformity with approved State plans. Plan changes that would affect the rights of Medicaid beneficiaries or participating providers would be subject to approval of the Secretary, who must confirm that the State's program will continue to be operated in a lawful manner. Of course, in instances where the States or the Secretary fail to observe these statutory requirements, the courts would be expected to take appropriate remedial action"

was at page 301. H.R. Rept. 97-158 (97th Cong. 1st Sess. 1981)(emphasis added); they are wrong to suggest that the quoted language does not demonstrate Congress's views and intention that elements of the state plan "that would affect the rights of Medicaid beneficiaries" are to be enforceable in court. Nothing in the passage suggests that it is limited to the change in payment practices for laboratory

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CMS . . .does not adequately monitor HCBS waiver programs or the quality of care provided to waiver beneficiaries. . . ."

services, medical devices and drugs in the section to which it is attached. Nor do Defendants explain why this Court should disregard the Congress's statement in 1992 that:

> "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 . . . .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. Rep. No. 102-631 at 364-6 (1992)(emphasis added).[4]

Plaintiffs are representing individuals who allege they "have been injured by a state's failure" to pay rates which assure quality care for community based services for persons who otherwise would be institutionalized. As detailed at considerable length in Appellants' Opening Brief and in the opinion of the District Court (ER10/253/28), the record is replete with evidence, including numerous

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[4]Defendants misrepresent Plaintiffs' argument concerning the Suter override provision. Plaintiffs' have not claimed that "a provision is enforceable because it is in a state plan." (DBr. at 46). Plaintiffs' argument is simply that the language of state plan requirements is always different than that in classic rights creating statutes since it is directed at the state actor, and the Congress in the Suter override directed the Court to continue to look, as it had in Wilder, at who benefits from the rights and duties, and not at whom the statutory language is directed. This is the holding of Rabin v. Coker-Wilson, 362 F.3d 190, 201-02 (2d Cir. 2004). The court below never acknowledged this fundamental difference when it sought–and failed to find-- talismanic language directed at the recipient.

admissions by Defendants, as to the devastating impact of the 50 percent turnover rates and high vacancies of direct care workers which "puts at significant risk the health, safety, and well-being" of persons with disabilities dependent upon such care.

In Antrican v. Buell, 158 F.Supp.2d 663, 669 (E.D.N.C. 2001), while holding that "Congress must *unambiguously* confer an *individual* entitlement to services on a particular plaintiff to state a claim under §1983"(emphasis in original), the court held that both the Quality of Care and Equal Access provisions of Section 30(A) provides such individual right to recipients. Upon a motion for reconsideration filed post-Gonzaga, the court reversed its prior decision that 42 U.S.C. §1396a(a)(1) creates individual rights, McCree v.Odum, No.4:00-CV-173 (H)(4) (E.D.N.C., Nov. 26, 2002) at 21,[5] but reaffirmed that Section 30(A) creates enforceable individual rights:

> Once this section is "broken down into manageable analytic bites," see Blessing, 520 U.S. at 342, 117 S.Ct. at 1360, all courts which have addressed this issue agree that the "quality of care" and "adequate availability" provisions are intended to benefit medicaid beneficiaries, while the "efficiency" and "economy" provisions are directed toward the state. . . .Therefore, this court finds that even under Gonzaga's refocused inquiry, the "quality of care" and "adequate availability" provisions of §1396a(a)(30)(A) are directed toward medicaid beneficiaries and provide them with enforceable rights under §1983.

[5] Appellants' Reply Excerpts of Record ("ARER") Tab A at p.21.

Id. at 31-32. (Internal citations omitted.)

Defendants' raise 42 U.S.C. §1396c–the provision which allows the Secretary of HHS to suspend payments to a state if it fails to "comply substantially" with its obligations under Title XIX-- as evidence that Section 30(A) does not confer individual rights has been rejected by every court to consider it. No provision of Title XIX would be enforceable based on that argument, because §1396(c) applies across the board to every state duty under Title XIX, and this argument was rejected in Wilder, supra; Evergreen, supra; Sabree, supra; Antrican v. Odom, 290 F.3d 178, 190 (4th Cir.), cert. denied, 537 U.S. 973 (2002), Westside Mothers v. Haveman, 289 F.3d 852 (6th Cir.), cert. denied, 123 S.Ct. 618 (2002). By contrast, in Blessing the "substantial compliance" section was part of the substantive standard sought to be enforced, clearly demonstrating that a particular individual might not have a right to redress. Here it does not govern the substantive duties of the state to the recipients, but merely limits one remedial measure available to the Secretary– cutting off funds.

Similarly, Defendants' claim that the quality of care provision[6] is too vague

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[6]Defendants never assert the access to care provision is too amorphous to be enforced. The district court denied Defendants' summary judgment on that claim. ER 10/253/52 ("Plaintiffs have presented evidence from which a reasonable fact finder could conclude that rates are not 'sufficient to enlist enough providers so that care and services are available under the plan'.")

and amorphous to be judicially enforced flies in the face of this Court's holding in Orthopaedic Hosp. v. Belshe, 103 F. 3d 1491 (1997), which is binding on subsequent panels of the Court. While Orthopaedic did not consider whether the "quality of care" provision of Section 30(A) creates an enforceable right under Blessing, it did construe the scope of the obligation under that provision, finding its meaning sufficiently specific and objective for a court to enforce. And enforce it, it did. It is not an open question in this Circuit whether the quality of care or access to care provisions are too vague and amorphous to be judicially enforced.

Defendants' brief is completely incorrect in its assertion that the "only two courts to have considered the issue" have found the "efficiency, economy, and quality of care" provision too vague to be judicially enforceable. (DBr. at 56) Besides ignoring this Court's opinion in Orthopaedic, it overlooks the fact that the District Court in this case has twice found to the contrary. ER 1/136/1-20, September 24, 2001; and ER 1/156/1-5 February 28, 2002. Secondly, it ignores the District Court in Clayworth. Thirdly, it ignores the reported decision in Antrican v.Buell, supra, which dealt explicitly with this issue. Fourthly, it fails to disclose that not only did the court in Arkansas Medical Soc'y v. Reynolds, 6 F.3d 519 (8th Cir. 1993) explicitly hold the quality of care provision not vague and amorphous, but the Eighth Circuit discussed and rejected the district court

decision in Fulkerson v. Commissioner, 802 F.Supp.529 (D.Me. 1992) which Appellees press upon this Court. 6 F.3d at 527-8. As a consequence, that court held the state "must consider the relevant factors of equal access, efficiency, economy and quality of care as designated in the statute when setting reimbursement rates." Id.

While the Solicitor General's November 1997 brief, cited by Defendants at DBr. 57-8, opposing certiorari in Orthopaedic Hospital asserted, inter alia, that providers should not be able to enforce Section 30(A) - - a position which it also took regarding the Boren Amendment which the Supreme Court rejected in Wilder, 496 U.S. at 513 n.11 - - and that enforcing the statutory criteria of "quality of care" would strain judicial competence, the agency with responsibility to administer the statute, the Health Care Financing Administration ("HCFA") was arguing in a district court that instead of applying the Boren Amendment to out-of-state providers, Section 30(A) should be applied. See, Children's Hospital and Health Center v. Belshe, 188 F.3d 1090, 1103-4 (9th Cir. 1999)(dissent), "In short, in the view of HCFA, this provision [Section 30(A)] requires a state to ensure that its payments to out-of-state providers are *reasonable*. . . ." (Emphasis in original). This is an enforceable standard.[7] In this case, where payments yielded turnover

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[7] The Solicitor General's principal opposition to the Orthopaedic decision was its requirement that the provider hospitals' costs be covered, even in the

rates of 50% and the Defendants admitted they put in jeopardy the safety and well-being of program recipients as well as compliance with the statutory mandate to "help. . . individuals attain or retain capabilities for independence or self care" 42 U.S.C. §1396, the central importance of the quality of care provision to the entitlement to services can not be doubted.[8] The lower court had no hesitancy in believing that it could ascertain whether services were "consistent with quality of care." ER 10/253/ 51. The basis for such determinations would be statutory and regulatory indicia of care such as adherence to safety codes and staffing levels, meeting recognized professional standards of care, appropriate programing, and compliance with regulatory requirements such as those set forth at 42 CFR §483.400 et seq. for ICFRs.

The Fourth Circuit summarized the reason for enforcing Section 30(A) when it stated "[T]he Medicaid Act clearly mandates that a state provide a certain

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absence of any evidence of lack of access or lack of quality. By contrast, the courts in Evergreen, supra, and Methodist Hospitals v. Sullivan, 91 F.3d 1026 (7th Cir. 1996), did focus on the result, not on the cost methodology, of the payment. In Orthopaedic the particular facts of the case, that the result of sufficient out-patient access (the service for which the payments were at issue) arose not from the payment rates but because hospitals were otherwise required to provide the services, may have been critical to the cost methodology standard.

[8] Staff stability (turnover and vacancies) is one of the core indicators of quality chosen by the National Association of State Directors of Developmental Disabilities Services National Core Indicators Project. See Declaration of William J. Bowman, ARER 391/2-3.

level and quality of . . . care. In light of this duty, a federal court can direct the affirmative action of complying with this duty." Antrican v. Odom, 290 F.3d at 191(internal quotes omitted). A Medicaid recipient's entitlement to receive that level and quality of care does not exist without a private right to enforce the Quality of Care and Equal Access provisions of Section 30(A).

II. No Finding of the District Court with Respect to the Named Plaintiffs Affects the Maintainability of the Class.

Contrary to the arguments made at pages 16-18 of Appellees' Brief, no finding by the District Court in its August 6, 2002 opinion ruling on the Motion for Summary Judgment with respect to the named plaintiffs affects the maintainability of this class action. The fact that at least three of the seven named plaintiffs were deinstitutionalized, between the May, 2000 filing of the complaint and the August, 2002 District Court's decision on the Motion for Summary Judgment does not affect the maintainability of the class, nor does the prospect that two more named plaintiffs might be deinstitutionalized shortly after the District Court's decision.

The court certified the class by an order dated August 2, 2001, ER 1/108/1-11, and confirmed all seven of the named plaintiffs individuals as class representatives.

The District Court's August 6, 2002 opinion granting Defendants' Motion

for Summary Judgment discusses the seven named plaintiffs at pages 29-33, ER 10/253/29-33. The District Court's findings with respect to named plaintiffs Tobiason, De Santo and Compton is that they have, since the filing of the complaint, been moved from an institution to the community. ER 10/253/30-33.

Named plaintiff Sanchez (who has been institutionalized for 33 years) remained institutionalized at the time of the summary judgment motions despite the recommendation for community placement in his IPPs. ER 10/253/29. The District Court noted that he had been put on the Lanterman DC's CPP list for community placement for a projected move date of July, 2002. Similarly, named plaintiff Nigian has been institutionalized since 1991, has been recommended for placement since 1992, and remained institutionalized as of the time of decision of the District Court. ER 10/253/30. The District Court noted that Nigian's CPP anticipated a placement in January, 2003. Whether Sanchez or Nigian has been placed in the community since the District Court's decision does not appear of record, but even if one or both were this does not affect the maintainability of the class of unjustifiably institutionalized persons.

At least since Sosna v. Iowa, 419 U.S. 393 (1975), federal law has been clear that once a class has been certified, "the class of unnamed persons described in the certification acquired a legal status separate from the interest asserted by

[the named plaintiff]," 419 U.S. at 399 and the fact that later the plaintiff no longer suffers the injury of which he originally complains does not affect the maintainability of the class action as long as there are unnamed class members who continue to have that injury. United States Parole Commission v. Geraghty, 445 U.S. 388, 398-99 (1980):

> 'Given a properly certified class', the live interests of unnamed but identifiable class members may supply the personal stake required by Art III when the named plaintiff's individual claim becomes moot.

[citations omitted] 445 U.S. at 413. Gerstein v Pugh, 420 U.S. 103 - 111 at n. 11 (1975); See Deposit Guaranty Nat'l Bank v. Roper, 445 U.S. 326, 342 at n.1 (1980) (Stevens, J. concurring):

> "There is general agreement that, if a class has been properly certified, the case does not become moot simply because the class representative's individual interest in the merits of the litigation has expired."

At no time after certification of the class, have Defendants moved to decertify the class, nor could they.

III. Plaintiffs Did Raise a Material Issue of Fact in the District Court That California's Conduct Resulted in Widespread Unjustified Institutionalization

In the August 6, 2002 opinion of the District Court, it concluded that Defendants' motions for summary judgment must be granted because the evidence of instances of unjustifiable institutionalization of class members were only

"sporadic" and "isolated", and there was no evidentiary basis for concluding the existence of "systematic" discrimination. ER 10/253/46. Plaintiffs, in their brief on appeal at pp.48-50, demonstrated that the conclusion was based on an erroneous failure to take into account the inferences which may be drawn from the 1125 individuals referred to in the document entitled "Developmental Center Residents That Have Been Recommended for Placement as of May, 2001" produced by Defendants in discovery. Instead, the Court wrongfully resolved the disputed issue of fact by accepting the vague and imprecise Declaration of a California official attempting to explain away that document. ER 6/183/7-8. The Court erred, therefore, by concluding there were no material issues of disputed fact as to whether there is a widespread and systematic unjustified institutionalization that warrants class-wide relief.

At pp. 18-19 of Defendants' brief on appeal they seek to avoid this conclusion by contending that it was "plaintiffs' burden" to demonstrate that in granting Defendants' motions for summary judgment, the trial court "abused its discretion" by basing "its decision on an erroneous legal standard or on clearly erroneous findings of fact." Defendants' then further define a "clearly erroneous" finding as: "although there is evidence to support it, the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been

committed" citing U.S. v. Alisal Water Corp., 370 F.3d 915, 921 (9th Cir. 2004) and Anderson v. City of Bessemer City, 470 U.S. 564, 573 (1985).

Defendants' articulation of the standard for reviewing the correctness of the District Court's granting of defendants' own motions for summary judgment is profoundly mistaken, and indeed almost the opposite of the correct standard. Neither case directly involved the grant of summary judgment denying or granting an injunction. Anderson v. City of Bessemer City, involved an appeal from the findings of fact of a district court after a non-jury trial in a gender discrimination case. United States v. Alisal Water Corp., involved a decision on a petition to intervene. The "abuse of discretion" standard of review to which the court refers in Midgett v. Tri-county Metropolitan Transportation District, 254 F.3d 546 (9th Cir. 2001)(cited by Defendants) concerns the appropriateness of the scope of the injunctive relief, not the establishment of the facts upon which liability and the grant of the injunction depend. This difference is also illustrated in Dare v. California, 191 F.3d 1167, 1170 (9th Cir. 1999).

In reaching the factual determination that there are or are not 1125 individuals in California's developmental centers who do not need institutional placements, the Court of Appeals must determine whether Plaintiffs submitted evidence which raised a material issue of disputed fact; not, as Defendants' brief

mistakenly suggests, the contrary test as to whether "although there is evidence to support it, the reviewing court on the entire evidence is left with the definite and confirm conviction that a mistake has been committed".

Summary judgment is properly granted only when no genuine and disputed issues of material fact remain after viewing the evidence most favorably to the non-moving party. Fed. R. Civ. P. 56; Celotex Corp. v. Catrett, 477 U.S. 317, 322-23 (1996); Eisenberg v. Ins. Co. of N. Am., 815 F.2d 1285, 1288-89 (9th Cir. 1987). (Emphasis supplied.)

Here, therefore, Defendants bear the burden of showing that there is no material factual dispute and the court must draw all reasonable inferences from the evidence in favor of the Plaintiffs, Intel Corp. v. Hartford Accident & Indem. Co., 952 F.2d 1551, 1558 (9th Cir. 1991).

For purposes of the District Court's deciding Defendants' motions for summary judgement, therefore, Plaintiffs' evidence at least has raised a material issue of disputed fact that there are 1125 Developmental Center residents who could be placed in the community. If, because of Defendants' general policies, these individuals are not being placed in the community at a reasonable pace, Plaintiffs clearly show that unjustified institutionalization is "systematic" and not merely "isolated" or "sporadic".

Finally, Plaintiffs' undisputed evidence of Defendants' policy of low rates leading to low wages and benefits of workers providing direct care in the community clearly qualifies as a "systematic" policy of Defendants. Accordingly, the evidence submitted to the District Court in connection with the summary judgment motions raises a material issue of disputed fact that Plaintiffs seek to remedy widespread harm which flows from a systemic policy.

IV. There is Substantial Evidence in the Record Creating a Material Issue of Disputed Fact Concerning the Causal Relationship Between Low Wages and Benefits of Community Direct Care Workers and Unjustified Institutionalization of Developmental Center Residents.

The District Court's opinion granting Defendants' Motion for Summary Judgment, is based in part on its conclusion, ER 10/253/40-41, that Plaintiffs failed to support by evidence a causal link between increasing the wages and benefits of direct care community workers and reducing or eliminating unjustified institutionalization. At pp. 50-55 of Appellants Brief, Plaintiffs demonstrated the erroneousness of that conclusion. Defendants' attempt to respond to this evidence DBr. 24-27 is flawed.

In evaluating the causal relationship between increasing wages and benefits, it must be recalled that 70% or more of the costs of maintaining a developmentally disabled person in the community are accounted for by the wages and benefits

paid to direct care workers. ER 8/217/130; ER 8/217/176-180.[9] Thus the rates California's DDS pays through the Regional Centers for maintenance in the community are spent 70% for this component. In the year before the summary judgment motions were filed, California established a new CPP plan for moving developmental center residents into the community which permitted the Regional Centers to raise rates paid for community care to a level which would produce the services needed to move some of the individuals still in the developmental centers. ER 6/183/2 et seq. In their declarations filed in this case, directors of two different Regional Centers, Michael Clark and James Shorter,[10] both averred that experience to date demonstrates that it requires a doubling of rates to secure the services needed. In Mr. Shorter's case he based his conclusions on his knowledge of the placements in his region and the data available in the spring of 2002, that the doubling of rates means that the direct care and wages have doubled. Shorter

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[9]See Appellants' Response to Appellees' Motion to Strike filed June 29, 2004 and (assigned to this panel) at page 5 correcting the location in the District Court docket where certain testimony included in the Excerpts of Record is found.

[10]The regional centers and their directors are not parties to this action. The regional centers are independent non-profit organizations through which California operates programs under the Lanterman Act. Mr. Clark has been a regional center director for 15 years with responsibility for about 4600 consumers, ER 7/213/2. Mr. Shorter has been a regional center director for 10 years and involved in California's developmental disabilities service system for more than thirty years. ER 8/238/3.

goes on to say:

> "For all the reasons and considerations discussed above, I conclude that the state's new Community Placement Program demonstrates that, in order to obtain quality programs for consumers, it is necessary for service providers to double the wages and benefits paid to direct care workers."

ER 8/238/6. Appellees' Brief at pp. 24-27 attacks this conclusion because it is not based on actual data of what wages and benefits have actually been paid, but rather on these deductions by officials from their knowledge of the field. But, the evidence is sufficient under all the circumstances to raise a material issue of disputed fact.

Moreover, Diane Anand, a third Regional Center director, in March of 2002 gave a declaration which confirms the causal link between the continued unjustifiable institutionalization and the level of wages and benefits of direct care workers in the community with respect to a list of Developmental Center residents who are recommended for placement in the community as follows:

> "Each of the people with developmental disabilities referred to in the records as capable of handling and benefitting from community living, needing or wanting community services but admitted or committed or recommitted to a state institution were placed or retained there because the community services required for the person are not available in the community. They are not available because the payments for community services, including particularly the component to pay for wages and benefits for direct services professionals are insufficient to secure stable services of quality."

ER 5/176/5. Attached to Ms. Anand's declaration are the records of five individuals in the Lanterman Developmental Center as to whom this statement is true. ER 5/176/7-47. Defendants attempt to dismiss Ms. Anand's sworn statement as "conclusory", but as head of one of the organizations responsible to develop community placements, her statements cannot be so easily ignored. Ms. Anand's testimony also refutes the Defendants' contention at DBr. 25 that "Plaintiffs have not identified . . . a single person who is improperly institutionalized because of inadequate wages."

V. Both the District Court and Defendants Substantially Overestimate the Cost of Relief Requested by Plaintiffs.

Defendants asserted a fundamental alteration defense to Plaintiffs unjustifiable institutionalization claim. Defendants acknowledge, DBr. 27, they bear the burden of proving fundamental alteration. Defendants assert that the cost of raising wages and benefits of community direct care workers is so great that it meets their burden and continue by asserting the outlandish claim that in measuring the cost of the increase to the State's budget, "the possibility of increased federal reimbursement is irrelevant to the analysis." DBr. 35.

The District Court in its opinion, ER 10/253/44, concluded that the cost of providing the relief doubling of direct care wages and benefits would be $1.4 Billion per year and credited the April 18, 2003 Declaration of Defendants'

witness Phyllis Marquez, ER6/184/1-13, that California's opportunity for obtaining additional Federal Financial Participation (FFP) to pay for part of the wages would be about $115 million. A careful reading of Marquez's April 18, 2003 Declaration, discloses that there is as much as $790 million total of unmatched DDS' spending for developmental disabilities that is available for federal matching and that there is an additional $247.8 million available from other state agencies. ER 6/184/12.

The error of the District Court's adoption of Marquez's $115,000,000 in the face of Plaintiffs' evidence giving rise to contrary inferences is further demonstrated by subsequent developments based on documents of which the Court may take judicial notice.

In her declaration of April 18, 2002, Marquez stated she estimated that FFP in the Home and Community Based Services ("HCBS") waiver would increase over the seven years from 2000-01 to 2007-08 only by $115 million assuming "all persons who are currently eligible under the waiver are enrolled."

Not only, as noted in Plaintiffs' brief, did Ms. Marquez's later deposition refute her, but documents submitted by DDS to the legislature which are judicially noticeable under Federal Rule of Evidence 201 (b) show that in only three years, 2000-01 to 2003-04 the DDS FFP in the Medicaid Waiver increased $264 million.

The Department of Developmental Services "2001-02 May Revision Regional Centers" to the Governor's Budget, submitted May 14, 2001 at page F-1 shows the total Medicaid Waiver for the Regional Centers as $548,227,000, including both the General Fund share and the FFP. Based on the FFP share shown on page F-2 of 51.36%, the FFP for 2000-01 was $281,569,000.[11] The most recent budget documents submitted to the legislature by the Department of Developmental Services, "Regional Centers Local Assistance Estimate, May 2004 Revision of the 2004-05 Budget" submitted May 13, 2004, shows at page E-19.5, the FFP for the DDS Medicaid Waiver to be $546,490,000 for CY 2003-04.[12] The increase from $282 million to $546 million is $264 million.

The above exercise demonstrating the unreliability of Marquez's prediction merely shows what DDS has actually done in the last 3 years, with respect to the HCBS waiver. It does not begin to address the additional FFP DDS and other departments might have obtained by reconfiguring the Medicaid Program as suggested in the Lakin and Braddock declaration which the District Court wrongfully disregarded. ER 2/166/18-29.

The District Court's opinion also erred in considering the entire cost of the

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[11]ARER, JN1 at pages 2 - 3.

[12]ARER, JN2, at page 6.

increase in direct care wages and benefits in evaluating whether Defendants had discharged their burden of proving the fundamental alteration defense under Olmstead. Plaintiffs' requested relief is designed to remedy not only the unjustifiable institutionalization of about a couple of thousand consumers under the ADA and Section 504 of the Rehabilitation Act (as to which the fundamental alteration test might apply), it is also designed to remedy the Defendants' violation of the requirement of the Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A), to provide access to quality care for the multiple tens of thousands of consumers served in the community (as to which violation there is no fundamental alteration defense whatsoever). At the very least, this case should be remanded to develop a record which shows whether the cost to California of raising wages and benefits of those direct care workers needed to serve in the community just those consumers who are unjustifiably institutionalized is large enough to constitute a fundamental alteration.

Finally, while Plaintiffs have described the requested relief in general terms, as "doubling rates," whether that is the exact measure of the relief which should be ordered by the Court or whether the number is more or less is an exercise which should be dealt with at a later stage of litigation concerning the fine tuning of

relief.[13] In ruling on Defendants' motions for summary judgment, the District Court should have focused on whether Plaintiffs created a material issue of fact that Defendants are violating the deinstitutionalization mandates of the ADA and Rehabilitation Act, not on whether the particular relief demanded is appropriate. If liability is established, it will be time enough for the District Court to fine tune the relief.

VI. California Had No Olmstead Plan When the Court Granted Defendants' Summary Judgment Motions

The District Court's finding that Defendants' new CPP program constitutes a deinstitutionalization plan does not meet the legal requirements established by Olmstead v. Zimring, 527 U.S. 581 (1999) and Frederick L. v. Department of Public Welfare, 364 F.3d 487 (3d Cir. 2004) for the following reasons.

To begin with, Defendants at no time prior to the granting of their motion for summary judgment actually claimed to have an Olmstead Plan and, as Plaintiffs' Opening Brief on Appeal indicated, Defendants were just beginning in the Spring of 2002 to have community meetings to formulate one.

Secondly, there currently is no "assurance" by California that there "will be on going progress toward community placement" Frederick L, supra, 364 F.3d at

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[13]As Plaintiffs' counsel argued to the District Court in June, 2002. See Appellees' Supplemental Excerpts of Record Volume III/Tab 27/0749, 0795.

500 (emphasis supplied). The statutory sections (Welfare and Institutions Code §§ 4418.2, 4418.25) cited at DBr. 31 direct the state to prepare a comprehensive plan, and describe the nature of the plan to be prepared, but provide no commitment as to contents, no specific numbers and no aggregate standards.[14] It is not a plan. The fact that, after the instant action was filed and in the year or so just before the Defendants' motion for summary judgment was filed, DDS sought and obtained substantial increased appropriations to fund community placements over a two year period of 183 consumers, see Jackson Declaration ¶ 24, ER 6/183/10 (out of a pool arguably at least as large as 1125)[15] can not reasonably be interpreted as a future commitment to the remaining hundreds of institutionalized consumers. Indeed, as the United States Court of Appeals for the Third Circuit said:

> "There is no reference in Olmstead to a state's past progress in deinstitutionalization as relevant to analyzing a fundamental alteration defense . . . .
>
> Although the District Court did not err in taking into account the Commonwealth's [of Pennsylvania] past progress in evaluating its fundamental alteration defense, it was unrealistic (or unduly optimistic) in assuming past progress is a reliable prediction of future

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[14]In any event these statutory sections were not in effect when the District Court granted Defendants' motion for summary judgment.

[15]Nowhere in the record is it indicated how the 183 individuals upon whom DDS' current "CPP Plan" focuses were chosen. How can Defendants have a "comprehensive" plan without articulating systematic, rational and fair criteria for selecting which eligible consumers limited resources will be spent on?

programs."

364 F.3d at 499-500.

Thirdly, there is no "waiting list that moved at a reasonable pace," Olmstead, 527 U.S. at 605 that a court may review. Neither the District Court's opinion of August 6, 2002, nor Defendants' Brief on Appeal points to one.

The 1125 individuals on Defendants' list of "Developmental Center Residents That Have Been Recommended for Placement as of May of 2001," ER 7/215/1-56, must be compared with the facts that: (1) for the three year period preceding summary judgment admissions to Developmental Centers have exceeded discharges and (2) at the rate of less than 183 expected discharges every two years contemplated under the current CPP plan, it will take more than 12 years to deinstitutionalize them all. The comparison shows there is no "reasonable pace." Olmstead, 527 U.S. at 605-06.

VII. Conclusion

Defendants admit and the District Court found that at the time of the motions for summary judgment:

(1) for about a decade California had failed to raise rates for community care providers sufficiently to keep up with inflation which has caused substantial erosion of the wages and benefits paid to direct care workers, ER 10/253/11-12;

ER 9/245/60,81,160;

(2) that erosion has resulted in an inability to hire skilled workers and very high turnover, ER 10/253/26; ER 9/245/60, 81,160;

(3) very high turnover and the absence of skilled workers has significantly damaged the quality of community services to a point that Defendants have called a "crisis," ER 10/253/26-28; ER 9/245/60, 81,160;

(4) very high turnover of direct care workers in community service results in the waste of substantial dollars to recruit and train replacements, ER 10/253/27; ER 9/245/80-81;

(5) the pace of discharges from the Developmental Centers has slowed to the point that, in the three years preceding the motion for summary judgment, when deaths in the Developmental Centers are excluded, there were more admissions to Developmental Centers than discharges, ER 10/253/18;

(6) The consumers remaining in the Developmental Centers are among the more seriously challenged, ER 10/253/24;

In the new CPP program adopted by California in the year prior to the motions for summary judgment, authorization to exceed the current rate structure for community services has been given and is being used to move out or deflect from the Developmental Centers 183 more seriously challenged consumers over a

two year period. ER 6/183/10. The testimony of Stephen Miller and Charlene Holden, heads of two of the organizational plaintiffs, clearly supports the inference that maintaining in the community consumers with serious challenges requires the employment of a qualified and skilled workforce which demands higher wages and benefits. ER 8/217/16-21, 25; ER 8/217/130-138. The declarations of three regional center directors, Michael Clark, James Shorter and Diane Anand ER 7/213/1-6; ER 8/238/1-6; ER 5/176/4-5 support the conclusion that it requires a substantial increase of rates and in turn of wages and benefits of direct care workers properly to maintain in the community the seriously challenged consumers now in the Developmental Centers who are recommended for placement in the community. Even the Declaration of Julie Jackson, a senior DDS official, in discussing the substantial amounts that under DDS's new CPP plan have been budgeted to discharge and maintain in the community over the next two years 183 of the more seriously challenged consumers remaining in the Developmental Centers doesn't exclude the fact that this is being done by paying higher wages. ER 6/183/10.

In light of all of this evidence, and bearing in mind that it is Plaintiffs' burden only to raise a material issue of disputed fact, it must be concluded that the District Court erred in deciding that Plaintiffs failed to establish a causal link

between insufficient wages and California's lack of compliance with the deinstitutionalization mandates of the ADA and Section 504 of the Rehabilitation Act.

RESPECTFULLY SUBMITTED,
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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 6779 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.

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PUBLIC INTEREST LAW CENTER
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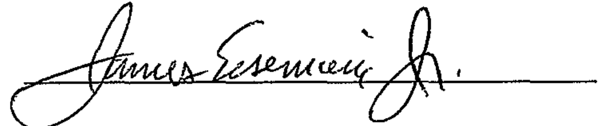
By: 

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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 Reply Excerpts of Record and two copies of Appellants' Reply Brief.

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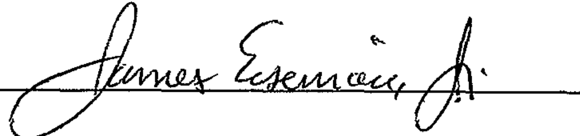
by delivering on August 13, 2004 the aforesaid items to UPS, a third party commercial carrier, for delivery by said commercial carrier to each of the said offices on August 16, 2004 with all delivery fees prepaid.

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.

Dated: August 13, 2004

ADDENDUM

STATUTES AND REGULATIONS INVOLVED

Title XIX of the Social Security Act, 42 U.S.C. §1396ff

§1396. Appropriations:

For the purpose of enabling each state ... to furnish (1) medical assistance on behalf of ... disabled individuals whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such ... individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposed of this title.

§1396a. State plans for medical assistance. (a) Contents.

A State plan for medical assistance must –

(8) provide ... that such assistance shall be furnished with reasonable promptness to all eligible individuals;

(10) provide – (A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21) of section 1396d(a) of this title, to all individuals who are [eligible];

(30)(A) 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 safeguard against unnecessary utilization of such care and services and 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;

§1396d. Definitions. (a) Medical Assistance.

The term "medical assistance" means payment of part or all of the cost of the following care and services ... for individuals ... who are [eligible] but whose income and resources are insufficient to meet all of such cost

§1396n(c). <u>Home and community based services for disabled</u>.

(1) The Secretary may by waiver provide that a State plan approved under this subchapter may include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan....

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that – (A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver...

(4) A waiver granted under this subsection may, consistent with paragraph (2) – (B) provide medical assistance to individuals ... for case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and such other services requested by the State as the Secretary may approve and for day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services ... for individuals with chronic mental illness....

(5) For purposes of paragraph (4)(B), the term "habilitation services" – (A) means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings....

Title II of the Americans With Disabilities Act, 42 U.S.C. §12131ff

§12131. Definitions.

As used in this title:

(1) Public entity. The term "public entity" means –
  (A) any State or local government;
  (B) any department, agency, special purpose district, or other instrumentality of a State or States or local government; ...

(2) Qualified individual with a disability. The term "qualified individual with a disability" means an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.

§12132. Discrimination.

Subject to the provisions of this title, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

§12134. Regulations.

(a) In general. Not later than one year after the date of enactment of this act [enacted July 26, 1990], the Attorney General shall promulgate regulations in an accessible format that implement this subtitle....

(b) Relationship to other regulations. ...[R]egulations under subsection (a) of this section shall be consistent with this chapter and with the coordination regulations under part 41 of title 28, Code of Federal Regulations (as promulgated by the Department of Health, Education, and Welfare on January 13, 1978), applicable to recipients of Federal financial assistance under section 794 of title 29....

28 CFR 35.130 - General prohibitions against discrimination

(d) A public entity shall administer services, programs, and activities in the

most integrated setting appropriate to the needs of qualified individuals with disabilities.

28 CFR 35, App. A - Attorney General's preamble to Title II regulations

[T]he public entity must administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities, i.e. in a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.

The Rehabilitation Act, 29 U.S.C. §701ff

§794. Nondiscrimination under Federal grants and programs.

(a) Promulgation of rules and regulations. No otherwise qualified individual with a disability in the United States ... 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.... The head of each such agency shall promulgate such regulations as may be necessary to carry out the amendments to this section made by the Rehabilitation, Comprehensive Services, and Developmental Disabilities Act of 1978. Copies of any proposed regulation shall be submitted to appropriate authorizing committees of the Congress, and such regulation may take effect no earlier than the thirtieth day after the date on which such regulation is so submitted to such committees.

Civil action for deprivation of rights, 42 U.S.C. §1983

§1983. - Civil action for deprivation of rights

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not