EDMUND G. BROWN JR.
Attorney General of California
KARIN S. SCHWARTZ
SUSAN M. CARSON
Supervising Deputy Attorneys General
JOSHUA N. SONDHEIMER
GREGORY D. BROWN (State Bar No. 219209)
MICHAEL A. ZWIBELMAN
Deputy Attorneys General
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5461
Fax: (415) 703-5480
E-mail: Gregory.Brown@doj.ca.gov
Attorneys for Defendants

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

V.L. et al., Plaintiffs, **v.** **JOHN A. WAGNER, et al.,** Defendants.	CV 09-4668 CW **DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND/OR PRELIMINARY INJUNCTION** Date: October 19, 2009 Time: 10:00 a.m. Dept: Courtroom 2, 4th Floor Judge: The Honorable Claudia Wilken Trial Date: None Set Action Filed: October 1, 2009

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INTRODUCTION

Plaintiffs ask this court to take the extraordinary step of issuing a preliminary injunction against a duly enacted State statute that plaintiffs believe to be unwise. Defendants strongly disagree with plaintiffs' assessment, but in any event it is entirely irrelevant because a statute's wisdom, or alleged lack thereof, is not a valid basis for injunctive relief. To prevail, plaintiffs must be able to show that the statute, whether wise or unwise, is *legally improper*. And they cannot do so here.

Plaintiffs are not entitled to injunctive relief because there is no likelihood that they will prevail on the merits of any of their claims challenging the reduction in In-Home Support Services (IHSS) under ABX4 4.

- The Notices of Action provided to IHSS recipients affected by ABX4 4 comply with due process by providing recipients with clear and concise notice of their reduction in benefits, the reasons therefor, their right to a hearing, and their right to receive benefits pending the outcome of their hearing;
- Plaintiffs fail to state a "comparability" claim under the Medicaid Act because the service thresholds under ABX4 4 are based entirely on recipients' levels of need for services, and do not discriminate against any category of recipients;
- Plaintiffs fail to state a "reasonable standards" claim under the Medicaid Act both because plaintiffs lack a private right of action to enforce 42 U.S.C. § 1396a(a)(17) and because the service standards are based on a reasonable, individualized assessment by trained social workers of each recipient's level of need;
- Plaintiffs fail to state a "sufficiency" claim under the Medicaid Act both because plaintiffs lack a private right of action to enforce 42 C.F.R. § 440.230 and because ABX4 4's need-based standards fully comply with the Medicaid Act's sufficiency requirements; and
- Plaintiffs fail to state a claim under the Americans with Disabilities Act (ADA) or Section 504 of the Rehabilitation Act because ABX4 4 does not discriminate against

any category of recipients on the basis of any disability, but instead determines service levels based solely on an assessment of need.

An injunction also is improper because plaintiffs cannot demonstrate any "real or immediate threat of an irreparable injury" if ABX4 4 is allowed to take effect. Plaintiffs' various claims of irreparable harm are based entirely upon several fundamental misunderstandings of how recipients' levels of need for services are determined under ABX4 4, and accordingly plaintiffs' purported "evidence" of irreparable harm cannot withstand even the most basic scrutiny. Nor can plaintiffs meet their burdens of demonstrating that the balance of equities tilts in their favor, or that an injunction would be in the public interest, as the injunction that plaintiffs request would further worsen California's unprecedented fiscal crisis and almost certainly result in cuts to other programs or services that the Legislature has deemed to be *more essential* than the services at issue here. For each of these reasons, plaintiffs' motion should be denied.

STATEMENT OF FACTS

A. The IHSS Program

The In-Home Support Services (IHSS) program began in 1973, at which point it was funded with state-only general funds. Declaration of Eileen Carroll (Carroll Decl.), ¶ 3. In 1994, in order to be able to draw down federal funds, California added the personal care services program (PCSP), which is an optional service under Medicaid, to the State Plan. Declaration of Toby Douglas (Douglas Decl.), ¶¶ 8, 10; Carroll Decl., ¶ 5. In 2004, the state applied to the Centers for Medicare and Medicaid Services (CMS) for a waiver to the State Plan in order to provide two additional services, one of which allows spouses and parents to become IHSS providers (the IHSS Plus Waiver). CMS approved this IHSS Plus Waiver, allowing IHSS recipients to receive services from a spouse or parent. Douglas Decl. ¶¶ 10-11; Carroll Decl., ¶ 7. On October 1, 2009, the IHSS Plus Waiver program transitioned into a State Plan program, the IHSS Plus Option program. Douglas Decl., ¶ 11 & Exh. A. The IHSS program consists of three subprograms – the PCSP program, IHSS Plus Option program, and IHSS Residual program[1] –

[1] The IHSS Residual program provides services to certain individuals who do not qualify for PCSP and accounts for approximately 2 percent of those served under the overall IHSS (continued…)

which are collectively referred to as "IHSS" herein, and which collectively provide services to over 440,000 individuals and include over 360,000 IHSS providers. Carroll Decl., ¶¶ 2, 10. Approximately 62% of IHSS recipients are served by a relative, and 48% of recipients live with the person from whom they receive services. *Id.*, ¶ 10. IHSS is governed by Welfare and Institutions Code section 12300, et seq., and CDSS Manual of Policies and Procedures section 30-700, et seq. *Id.*, ¶ 3.

B. Assessing Recipients' Needs for IHSS

Since 1988, Welfare and Institutions Code section 12309 has required that counties conducting IHSS assessments use a uniform needs assessment tool, requiring a five-point scale for ranking each of the recipient's functional abilities. The State developed functional ranks under which recipients' functional abilities are ranked on a scale of 1 to 5 by trained social workers in each of fourteen areas: housework; laundry; shopping and errands; meal preparation and clean-up; mobility inside; bathing and grooming; dressing; bowel, bladder, and menstrual; transfer; eating; respiration; memory; orientation; and judgment. The ranks are defined as follows:

- Rank 1 means that the individual can perform the tasks in that area independently;
- Rank 2 means that the individual can perform the tasks in that area but requires verbal reminding or guidance from another;
- Rank 3 means that the individual requires minimal human assistance with the tasks;
- Rank 4 means that the individual requires substantial human assistance with the tasks; and
- Rank 5 means that the individual cannot perform any part of the task, with or without human assistance.

Carroll Decl., ¶ 11 & Exhs. A & B.

Assessments are conducted for each person on an individualized basis by the county social worker, and the social workers receive extensive training in using these rankings. *Id.*, ¶ 12. From

(…continued)
program. Carroll Decl., ¶¶ 5, 8.

2005 through the present, CDSS has conducted social worker training academies, specifically training over 16,000 social workers who conduct IHSS assessments, with the overarching purpose of helping to ensure uniformity in these assessments. *Id.* Accordingly, the functional ranks provide an accurate measure of each recipient's need for human assistance with each of the eleven functional tasks. *Id.*, ¶¶ 11-12 & Exh. A. The functional ranks identify those who have a great need for the services and are severely impaired, as opposed to individuals for whom services may improve their quality of life, but who would be considered much higher functioning. *Id.*, ¶¶ 11, 16 & Exh. A. CDSS has been using these rankings since 1988. *Id.*, ¶¶ 11-12.

Each recipient is also given an overall Functional Index (FI) Score that is calculated based on a weighted average of the recipient's eleven functional ranks for non-mental tasks (i.e., excluding the functional ranks for memory, orientation, and judgment). Carroll Decl., ¶¶ 11-12; Declaration of Ernest Cowles (Cowles Decl.), ¶ 2. The FI Score provides a reasonable measure of each recipient's individual need for service by providing an overall measurement of each recipient's relative dependence on human assistance for IHSS tasks. Carroll Decl., ¶¶ 11-13, 19 & Exh. A; Cowles Decl., ¶ 3. As CDSS reported to the Legislature in 1989, the ranking system and FI Scores provide a reasonable measure of a recipient's IHSS need and overall functional abilities. Carroll Decl., ¶ 13 & Exh. A at 17. The ranks and FI Scores are the bases of the Uniformity system that has been the core of the IHSS program individual assessment process to determine functional ability and level of need for service since the implementation of the Uniformity system in 1988. *Id.*, ¶ 12. The ranks have been evaluated and found to be a consistent measure over time of functional limitations, and they have been validated repeatedly by State and County review teams over the years. *Id.*, ¶ 13.

While recipients' functional ranks in the three mental categories – memory, orientation, and judgment – are not factored into their FI Scores, these ranks are used to determine a recipient's need for protective supervision. *Id.*, Exh. A at 12. Recipients can receive scores of only 1, 2, or 5 in the three mental categories, and if they receive a 5 in any one of these three categories they would be considered at risk if not supervised and therefore authorized to receive protective supervision services. *Id.*

C. Enactment of ABX4 4

On July 28, 2009, the Governor signed ABX4 4, which created a need threshold for recipients to receive IHSS services. Specifically, ABX4 4 amended section 12309 and added new section 12309.2 to the California Welfare and Institutions Code, to provide that recipients must have an FI Score of at least 2.0 to receive IHSS services, and must have a functional rank of at least 4 in the appropriate category to receive domestic and related services (housework; laundry; shopping and errands; and meal preparation and clean-up). Thus, ABX4 4 ensures that those with genuine needs for these services will still receive them, while reducing or eliminating services only for people who have the least need for them. *Id.*, ¶¶ 14-16.

Additionally, because FI Scores do not measure mental functions such as memory, orientation, and judgment, ABX4 4 exempts individuals authorized to receive either protective supervision or paramedical services, meaning that such individuals may continue to receive all of their IHSS services regardless of their FI Scores and functional ranks for domestic and related services. *Id.*, ¶ 16; Cal. Welf. & Inst. Code §§ 12309(e)(2) & 12309.2(a)(3). Numerous other protections are in place to ensure that recipients who have a genuine need for these services will continue to receive them: For example, recipients have a right to request a needs reassessment, including reassessment of their functional ranks by a social worker; a right to a fair hearing of their assessment; and an entitlement to receive aid pending a hearing. California Department of Social Services Manual of Policies and Procedures (MPP) §§ 22-003.1, 22-073.1 & 30-755.21. Recipients also have a right to an annual assessment, and can raise concerns about their functional ranks or FI Scores then. *Id.*, § 30-761.1. Additionally, individuals with developmental disabilities are covered by the regional centers, which can arrange the same services as their providers under the IHSS program. Declaration of Brian Winfield (Winfield Decl.), ¶ 5. And for those who are determined not to need these services but who still desire them, each individual's county social worker is responsible for determining whether there are other services available, including but not limited to programs offered through other State departments, County programs, and community-based programs. Declaration of Janet Nicholson (Nicholson Decl.), ¶ 13.

D. Notices and Appeal Rights

CDSS has arranged to deliver timely Notices of Action to recipients whose IHSS benefits are being reduced or eliminated by ABX4 4. Carroll Decl., ¶ 17. For minors and other recipients who have an authorized representative due to disability, senility, or other reasons, the Notices of Action will be sent to the authorized representative. The Notices of Action explain in plain and simple terms what services are being terminated and the reasons why, including the statutory basis for the termination. *Id.*, Exh. C. For recipients whose services are being terminated in their entirety on the ground that their FI Scores are below 2.0, CDSS will also include a one-page "Stuffer" explaining and providing an example of the way the FI Score is calculated. *Id.*, ¶ 17 & Exh. C.

The Notice of Action advises recipients that they have a right to a "conference with representatives of CDSS to talk about this intended action." *Id.*, Exh. C. It is the practice of CDSS, through the county offices, to attempt to resolve challenges to Notices of Action, if possible, before any need for an administrative hearing. *See* MPP §§ 22-073.2 – 22.073.23; Carroll Decl., Exh. C. Such a resolution may include providing a needs reassessment pursuant to a conditional withdrawal of the hearing request. *See* MPP § 22-073.231 (county representative has authority to resolve case using conditional withdrawal procedure when representative believes that county action was incorrect). The back of the Notice of Action further advises the recipient of his or her "RIGHT TO REQUEST A STATE HEARING," and provides both a form and address for requesting a hearing in writing, as well as a toll-free telephone number to make an oral request for a hearing. Carroll Decl., Exh. C. The Notice of Action also states:

> IF YOU REQUEST A STATE HEARING ANYTIME BEFORE THE EFFECTIVE DATE OF THE COUNTY'S PROPOSED ACTION, YOUR SERVICES MAY CONTINUE UNTIL THE HEARING. You will not be liable for repayment of services monies received pending the hearing, even if the result is a denial, provided your request is made in good faith.

Id.

E. California's Unprecedented Fiscal Crisis and Overall Cuts to Services

It is well-known that California is facing an unprecedented fiscal crisis. Douglas Decl., ¶¶ 3, 14. Because the Medi-Cal program is the second largest general fund expenditure in the state

budget, second only to K-12 education, policymakers often must contemplate reductions in Medi-Cal spending to balance the budget as required under the law. *Id.*, ¶ 4. One way to reduce overall Medi-Cal spending is to reduce payments to providers. *Id.*, ¶ 5. Another option would be for the Legislature to eliminate Medi-Cal coverage of optional services that California currently provides, but that are not required to be provided under the Medicaid Act. Optional services include, but are not limited to, prescription drugs, adult dental services, physical therapy, speech therapy, hospice care, eyeglasses, audiology, and psychology services. *Id.*

These options, among other potential Medi-Cal cuts, have long been discussed and debated by the Department, the Governor, and the Legislature, and were available policy options to the Legislature when it passed Assembly Bill (AB) X3 5 in February 2008. *Id.*, ¶ 6. ABX3 5, which took effect on July 1, 2008, reduced by 10 percent the reimbursement paid for various providers, including pharmacies. Because of a federal court injunction, the State was prohibited from implementing the 10 percent reduction for some services, including prescription drugs for dates of service beginning August 18, 2008. Other legislation provides for further cuts to other Medi-Cal providers. *Id.*

In emergency legislation, the following optional benefits were excluded from coverage under the Medi-Cal program starting on July 1, 2009: acupuncture services; adult dental services; audiology services; chiropractic services; incontinence creams and washes products; optometric and optician services, including services provided by a fabricating optical laboratory; podiatric services; psychology services; and speech therapy services. *Id.*, ¶ 7. Although it could have, the Legislature did not exclude IHSS even though it is an optional service under Medi-Cal and as such could have been eliminated entirely. *Id.*, ¶ 8. However, since the time that the Legislature reduced rates for certain services and eliminated these optional Medicaid services, the budget crisis in California has worsened. California faces a multi-billion dollar deficit over the next 13 months and beyond, which the Legislature has attempted to resolve through a combination of tax increases and additional cuts in State spending. *Id.*, ¶ 14. The IHSS reductions based on recipients' need levels under ABX4 4 were factored into the Legislature's attempted resolution of the budget deficit. *Id.* In other words, if the IHSS cuts were enjoined, it would further exacerbate

the current budget crisis and require further cuts to be drawn from other essential programs. In this unprecedented fiscal climate, the reduction in these optional services for those who need them least is a difficult, but appropriate, response that will help alleviate California's current fiscal dilemma. *Id.*

ARGUMENT

Plaintiffs bear a heavy burden on their motion. They must show: "(1) a strong likelihood of success on the merits, (2) the possibility of irreparable injury to plaintiff if preliminary relief is not granted, (3) a balance of hardships favoring the plaintiff, and (4) advancement of the public interest (in certain cases)." *Guzman v. Shewry*, 552 F.3d 941, 948 (9th Cir. 2009) (internal quotation marks omitted). If plaintiffs "show[] no chance of success on the merits," the inquiry ends, and "the injunction should not issue." *Arcasmuzi v. Continental Airlines, Inc.*, 819 F.2d 935, 937 (9th Cir. 1987). A plaintiff seeking a preliminary injunction also has the burden "to demonstrate that irreparable injury is *likely* in the absence of an injunction." *Winter v. Natural Resources Defense Council, Inc.*, __ U.S. __, 129 S. Ct. 365, 375 (2008) (emphasis added). "Issuing a preliminary injunction based only on a possibility of irreparable harm is inconsistent with our characterization of injunctive relief as an extraordinary remedy that may only be awarded upon a clear showing that the plaintiff is entitled to such relief." *Id.* at 375-76. Here, plaintiffs' motion must be denied because plaintiffs have *no* likelihood of success on the merits. Further, plaintiffs have not demonstrated a likelihood of irreparable injury; the balance of hardships strongly favors the State; and an injunction would be contrary to the public interest.

I. PLAINTIFFS HAVE NO LIKELIHOOD OF SUCCESS ON THE MERITS

Plaintiffs motion for a temporary restraining order and/or preliminary injunction must be denied because plaintiffs have no likelihood of success on the merits of any of their claims.[2]

[2] Plaintiffs' Amended Complaint contains nine causes of action, but plaintiffs seek a preliminary injunction only on the basis of their first seven causes of action. Plaintiffs' eighth and ninth causes of action are without merit, and plaintiffs do not contend that they can succeed on the merits of either their eighth or ninth cause of action. Accordingly, they cannot obtain preliminary injunctive relief on the basis of either of those causes of action.

A. Plaintiffs Have No Likelihood of Success on Their Due Process Claim Because the Notice Provided Is Timely and Adequate

Plaintiffs' Plaintiffs' argument that CDSS's Notices of Action violate due process is entirely without merit. Due process simply requires that recipients receive "timely and adequate notice" of the reduction or termination of their benefits and the reasons therefor, and be given a reasonable opportunity to challenge the reduction or termination. *See Goldberg v. Kelly*, 397 U.S. 254, 262-69 (1970); *Garrett v. Puett*, 707 F.2d 930, 931-932 (6th Cir. 1983) (notices that identified intended action, reason for the action, citation to relevant statute, and notice of right to appeal "satisfy due process and statutory requirements"); *Doston v. Duffy*, 732 F. Supp. 857, 872 (N.D. Ill. 1988) ("The due process clause requires that a state agency explain, in terms comprehensible to the client, exactly what the agency proposes to do and explain the agency's reasons for its action in enough detail that the client can assess the correctness of the agency's decision, make an informed decision as to whether to appeal, and be prepared for the issues to be addressed at the hearing."). CDSS regulations, consistent with federal requirements, provide that CDSS must give adequate notice of any action decreasing or discontinuing aid, *see* MPP § 22-071.13, and define "adequate notice" as:

> A written notice informing the claimant of the action the county intends to take, the reasons for the intended action, the specific regulations supporting such action, an explanation of the claimant's right to request a state hearing, and if appropriate, the circumstances under which aid will be continued if a hearing is requested.

Id., § 22-001(a)(1)(a); *see also* 45 C.F.R. § 205.10(a)(3) & (a)(4)(i)(B). CDSS's Notices of Action provide notice that directly complies with due process and all applicable regulations.

The one-page, double-sided Notice of Action states in plain and simple terms what action is being taken and why, referring to the change in law and citing the relevant portions of the California Welfare and Institutions Code. *See* Carroll Decl., Exh. C. The front of the Notice states that "YOU HAVE THE RIGHT TO FILE A WRITTEN OR ORAL REQUEST FOR A STATE HEARING," and refers recipients to the Department's address for requests sent in writing. The front also, in large, bold type, refers recipients to the back side of the Notice for

further information with the message: "PLEASE SEE REVERSE SIDE OF THIS NOTICE FOR FURTHER DETAILS." *Id.*

The back of the Notice of Action states in plain and simple terms that the recipient has a "RIGHT TO REQUEST A STATE HEARING," and provides both a form and address for requesting a hearing in writing, as well as a toll-free telephone number to make an oral request for a hearing. *Id.* The Notice of Action also states:

> IF YOU REQUEST A STATE HEARING ANYTIME BEFORE THE EFFECTIVE DATE OF THE COUNTY'S PROPOSED ACTION, YOUR SERVICES MAY CONTINUE UNTIL THE HEARING. You will not be liable for repayment of services monies received pending the hearing, even if the result is a denial, provided your request is made in good faith.

Id. In addition to these one-page Notices of Action, CDSS is also including a one-page "stuffer" to recipients losing services because their FI Score is below 2.0 that explains in detail how FI Scores are calculated and provides an example of the calculation. *Id.* If any recipient has an authorized representative (e.g., because the recipient lacks the capacity to receive, read, or comprehend the notices), notices will be provided to those representatives rather than directly to the recipient.

Plaintiffs' challenge to the adequacy of these Notices of Action is misguided and based on a misunderstanding as to the materials being provided to recipients or their representatives. First, plaintiffs contend that CDSS's 22-page Annotated Assessment Criteria, which plaintiffs misapprehend as being a "stuffer" sent to all recipients, is too complicated and is misleading because it refers to assessment of mental functions that are not part of the FI Score. Motion at 22:1-24. However, the Assessment Criteria document is not being provided to recipients. *See* Carroll Decl., ¶ 17 & Exh. C. Plaintiffs' arguments regarding this document are inapposite.

The only "stuffer" CDSS will send is the one-page explanation and example of the calculation of an FI Score; this is being sent to recipients losing all IHSS services because their FI Scores are below 2.0. *Id.* Plaintiffs' contend that the notices are constitutionally deficient because this calculation is too complicated. But plaintiffs do not contend that the one-page *Notice of Action* is too complicated, and the Notice of Action meets the constitutional and regulatory requirements for adequate notice. CDSS's inclusion of *additional* information to help

recipients understand how an FI Score is derived—including an example of the calculation to address any difficulty in conceptualizing the written explanation—does not render the Notice of Action constitutionally inadequate.

Finally, plaintiffs' argument that the Notices of Action will not allow recipients to ascertain whether counties have made errors in their FI Scores or functional ranks is also incorrect. *See* Motion at 22:25-23:2. The Notices of Action expressly state that FI Scores and functional ranks are used to measure a recipient's need for IHSS services, and the Notices of Action clearly and concisely define each of the five levels of functional rank and notify the recipient of his or her functional rank in each relevant category. *See* Carroll Decl., Exh. C. Thus, each recipient can readily evaluate whether his or her functional ranks were correctly assessed by simply looking at the rank he or she was given and the definition for each rank; if the recipient believes that his or her level of functioning is not within the rank assessed, then the recipient will have a valid basis for contesting the determination.

Plaintiffs' suggestion that the notice is not tailored to the capacity of persons who may be incompetent is similarly misguided. As noted above, for those recipients who have an authorized representative due to incompetency, disability, or for other reasons, the notice will be provided to their representative. In any event, none of the adult named plaintiffs allege any particular impairment that affects their ability to comprehend the notice, so plaintiffs' argument is not properly before the court. *See Steinberger v. Apfel*, 134 F.3d 37, 41-42 (2d Cir. 1997) (court will permit claim of ineffective notice due to mental impairment to invoke federal court jurisdiction "only upon a particularized allegation of mental impairment of plausibly sufficient severity to impair comprehension").

B. Plaintiffs Have No Likelihood of Success on Their Medicaid Act Claims

Plaintiffs' claims under the Medicaid Act are entirely without merit and are not a valid basis for injunctive relief.

1. Statutory Overview

Congress created the Medicaid program in 1965 as a purely voluntary program in which states could elect to receive federal funds in exchange for providing medical services to certain

individuals statutorily defined as "needy." *See generally* 42 U.S.C. § 1396 *et seq.*; *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990). In exchange for federal funding, states must meet certain statutory and regulatory conditions. *See Schweiker v. Gray Panthers*, 453 U.S. 34, 37 (1981). The most significant condition for federal Medicaid funding is that states must submit for federal approval a "plan for medical assistance" (Medicaid Plan). 42 U.S.C. § 1396a(a). A state's Medicaid Plan contains a comprehensive statement of the nature and scope of the state's Medicaid program. *See Wilder*, 496 U.S. at 502. As codified, Section 1396a(a) of the Medicaid Act includes 71 subparts describing the procedural and substantive requirements for state Medicaid Plans. *See* 42 U.S.C. §§ 1396a(a)(1)-(71).

2. The FI Scoring System Satisfies the Comparability Requirement of the Federal Medicaid Act.

Section 1396a(a)(10)(B) provides:

> A State plan for medical assistance must – provide . . . that the medical assistance made available to any individual described in subparagraph (A)—(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and (ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A).

42 U.S.C. § 1396a(a)(10)(B); *see also* 42 C.F.R. § 440.240. This provision is known as the "comparability" provision.[3] Essentially, this provision requires a state to provide a comparable level of services between the categorically needy and the medically needy groups as well as within each of these groups. Courts have found that states violated the comparability requirement when some recipients are treated differently from other recipients where each has the same level of need. *Schott v. Olszewski*, 401 F.3d 682, 688-89 (6th Cir. 2005) (finding treatment was not comparable when Medicaid did not reimburse recipient for medical expenses she paid out of pocket during period when she was wrongfully denied coverage); *White v. Beal*, 555 F.2d 1146, 1151-52 (3d Cir. 1977) (finding statute was illegal when it covered eyeglasses for those suffering from eye diseases but did not cover glasses for patients when refractive error caused poor eyesight).

[3] Under the State Plan Option that permits spouses and parents to provide services, comparability may be waived. *See* 42 C.F.R. § 441.462.

However, the comparability requirement is not violated when a state limits the eligibility requirements. A state may "place appropriate limits on a service based on (such criteria as) medical necessity or on utilization control procedures." 42 C.F.R. § 440.230(c)(2). It just may not do so based solely because of "diagnosis, type of illness, or condition." 42 C.F.R. § 440.230(c)(1). "Once a state designates services it will subsidize, it may distinguish between eligible and ineligible recipients only on the basis of their degree of medical need." *Hodgson v. Board of County Commissioners*, 614 F.2d 601, 608 (8th Cir. 1980).

Here, plaintiffs are essentially contending that because recipients qualified for a certain level of services at one point, a state may never amend the eligibility requirements as this would somehow violate the comparability requirement. Plaintiffs fail to cite any authority to support this contention. And, the case authority they do cite is easily distinguishable. *Jenkins v. Washington State Dep't of Social and Health Services*, a case that plaintiffs contend is "directly on point," does not support their position at all. 157 P.3d 388 (Wash. 2007). In that case, the State of Washington adopted the "shared living rule" which automatically reduced the level of household services to recipients who lived with someone else. In other words, the reduction was not made on an individual's needs for service, but rather the individual's living situation without regard to whether the other persons in the household performed these tasks for the recipient or not. The court found a violation of comparability because under the rule some recipients would receive less services than others with the same needs. "Without such an evaluation, DSHS cannot automatically reduce, in shared living situations, a recipient's need for assistance with housekeeping, shopping, meal preparation, and wood supply; rather, DSHS must assess those needs in the same way and to the same extent that services are provided to meet the needs of other recipients who do not live in a shared living situation." *Id*. at 393. Thus, the comparability requirement was violated in *Jenkins* precisely because individuals with the same needs were being treated differently from each other – the exact opposite of the situation here. The other cases cited by plaintiffs suffer from the same flaw. *See*, *e.g.*, *Parry v. Crawford*, 990 F. Supp. 1250, 1257 (D. Nev. 1998) (individuals with mental retardation entitled to receive services but not individuals with other developmental disabilities); *Sobky v. Smoley*, 855 F. Supp. 1123, 1139

(E.D. Cal. 1994) (methodone was available to Medi-Cal recipients in some counties, but not in others).

Here, individuals with the same level of need are not being treated differently. Each recipient of IHSS receives an individualized assessment of their needs based on a ranking system that applies to all recipients equally. *See* Carroll Decl., ¶¶ 11-13. People who demonstrate the same level of need will receive the same services. There is no limitation of services based on diagnosis, type of illness, or condition that would violate the comparability provision.

Plaintiffs' contention that the services will be reduced or termination without "any examination of their individual circumstances" is simply not true. In order to be eligible for IHSS, each of the recipients has been assessed (and reassessed on an annual basis) on an individualized basis in his/her own home by a trained and qualified social worker. *See id.*, ¶¶ 11-13 & 17. The very same rankings plaintiffs now criticize have been used since 1988 to determine recipients' level of need for IHSS and the services to be provided. *See id.*, ¶¶ 11-13. Use of these rankings and the FI score are reasonable and sound. *See id.*; Cowles Decl. ¶¶ 3-4. Plaintiffs only now challenge the use of these rankings because the Legislature has made a policy decision – permissible under the Medicaid Act – to limit IHSS to those who need it most. The new need thresholds under ABX4 4 do not violate the comparability provision.

3. The FI Scoring System Satisfies the Reasonable-Standards Requirement of the Federal Medicaid Act, 42 U.S.C. § 1396a(a)(17).

The functional index (FI) scoring system provides a sound and reasonable basis upon which California may determine a recipient's level of need for in-home support services under the IHSS program. Defendants' use of this system under ABX4 4 falls well within the broad discretion afforded to them under the "reasonable standards" provisions of the federal Medicaid Act, 42 U.S.C. § 1396a(a)(17). Section 1396a(a)(17) states in relevant part:

> A State plan for medical assistance must . . . include reasonable standards . . . (which shall be comparable for all groups . . .) for determining eligibility for and the extent of medical assistance under the plan which . . . are [*inter alia*] consistent with the objectives of this subchapter.

42 U.S.C. § 1396a(a)(17).

In the seminal case interpreting Section 1396a(a)(17), the Supreme Court held:

> [N]othing in the statute suggests that participating States are required to fund every medical procedure that falls within the delineated categories of medical care … Th[e] language [of Section 1396a(a)(17)] confers broad discretion on the States to adopt standards for determining the extent of medical assistance, requiring only that such standards be 'reasonable' and 'consistent with the objectives' of the Act.

Beal v. Doe, 432 U.S. 438, 444 (1977) (quoting Section 1396a(a)(17)) (footnote omitted).[4] *See also State of Washington v. Bowen*, 815 F.2d 549, 555 (9th Cir. 1987) (quoting the "broad discretion" language from *Beal*). The Supreme Court also noted in *Beal* that "although serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage, it is hardly inconsistent with the objectives of the Act for a State to refuse to fund unnecessary though perhaps desirable medical services." 432 U.S. at 444-45.

a. Congress Did Not Intend for Private Individuals to Enforce the "Reasonableness" Requirement of Section 1396a(a)(17).

The Ninth Circuit in *Watson v. Weeks*, 436 F.3d 1152 (9th Cir. 2006), held that Congress did not intend for Section 1396a(a)(17) to create a private right of action for individuals and organizations:

> Section 1396a(a)(17) is a general discretion-granting requirement that a state adopt reasonable standards …. [T]he parenthetical statement in section 1396a(a)(17) that the state's reasonable standards 'shall be comparable for all groups' puts a focus on the standards themselves and on their aggregate impact, rather than on the benefits to individuals.

436 F.3d at 1162. The Ninth Circuit has therefore squarely held that Section 1396a(a)(17) does not contain statutory language sufficient to evince a congressional intent to create individually-enforceable federal rights, and that its language is too "vague and amorphous for judicial enforcement." *Id.* at 1162-63.[5]

[4] In *Beal*, the Supreme Court upheld a Pennsylvania regulation that denied Medicaid coverage to pregnant women seeking nontherapeutic (*i.e.*, medically unnecessary) abortions: "[W]e do not agree that the exclusion of nontherapeutic abortions from Medicaid coverage is unreasonable under [Section 1396a(a)(17)]." 432 U.S. at 445.

[5] In *Watson*, the Ninth Circuit applied the principles of *Gonzaga University v. Doe*, 536 U.S. 273 (2002). In *Gonzaga*, the Supreme Court explained that, regardless of whether plaintiffs seek to enforce a federal statute under an "implied" rights theory or under Section 1983, the court "must first determine whether Congress intended to create a federal right" with its enactment. *Id.* at 286. This is because, "[l]ike substantive federal law itself, private rights of action to enforce federal law must be created by Congress." *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001).

The plaintiffs in *Watson* were elderly and disabled individuals who received home- and community-based services as an alternative to Medicaid institutional nursing facilities. (This was part of the Home and Community Based Services waiver program.) To determine eligibility for this program, the State of Oregon used a scoring system that classified individuals into service levels based on medical need, from a score of one to 18. For purely budgetary reasons, Oregon denied coverage to any individuals who scored less than 14. Plaintiffs alleged that Oregon violated Section a(a)(17) "by assessing Plaintiffs' medical need for nursing facility services using agents who lacked the necessary professional qualifications and training and who employed subjective and inaccurate judgments." 436 F.3d at 1157. The Ninth Circuit rejected these claims, holding that plaintiffs had no private right of action under the statute.

In particular, the Ninth Circuit held in *Watson* that Section 1396a(a)(17)

> does not provide meaningful instruction for the interpretation of 'reasonable standards' in terms of medical need. It provides guidance only regarding the financial means of a potential beneficiary…. [T]he only guidance of section 1396a(a)(17)(A) regarding medical need eligibility is that state standards be 'consistent with the objectives of this subchapter.' Judicial enforcement of section 1396a(a)(17) under Plaintiffs' argument would require a court to delve into the medical necessity of particular types of care. If Congress had intended that result, it would have provided more concrete standards in the statute for determining eligibility based on medical need.

Id. at 1162-63. The administratively thorny questions related to which services are medically necessary under a state's Medicaid Plan and which are not are therefore best left to the institutions in the best position to make such judgments: the defendants in this case and the federal agency that regulates them. *See Pharm. Research & Mfrs. of Am. v. Walsh (PhrMA)*, 538 U.S. 644, 672-73 (2003) (Breyer, J., concurring).

Plaintiffs may contend that, under *Independent Living Center of Southern California, Inc. v. Shewry*, 543 F.3d 1050 (9th Cir. 2008), they are entitled to assert a private right of action for injunctive relief under the Supremacy Clause. However, *Independent Living* is distinguishable on the ground that it addressed claims under 42 U.S.C. § 1396a(a)(30)(A), which the Ninth Circuit held creates specific standards that evince a Congressional intent to preempt state law, thereby giving rise to a federal preemption claim under the Supremacy Clause. Here, in contrast, plaintiffs seek to bring a private cause of action to enforce a different statutory provision –

§ 1396a(a)(17) – which the Ninth Circuit has squarely held does *not* create any "concrete standards" or indicate any Congressional intent to create a private right of action or preempt state law. *Watson*, 436 F.3d at 1162-63. Under *Watson*, it is settled law in the Ninth Circuit that § 1396a(a)(17) is not privately enforceable, and this court is bound by that decision.[6]

b. Defendants' Use of the Functional Index Scoring System Is a Reasonable Means of Determining Recipients' Need for (and the Extent of) Services.

If required to "delve into the medical necessity of particular types of care" — an area the Ninth Circuit in *Watson* expressly held Congress did not intend courts to explore — this court should conclude that, in light of the "broad discretion" afforded by Congress, California's functional index (FI) scoring system is a "reasonable standard" for determining recipients' need for (and the extent of) services under the IHSS program.

The FI scoring system was developed in 1988 to provide a uniform assessment tool for determining a recipient's need for services, and the FI Score measures a recipient's relative dependence on human assistance for performance of basic IHSS tasks. Carroll Decl., ¶¶ 11-13; Cowles Decl., ¶¶ 3-4. The weights used to calculate FI Scores were re-assessed in 2009, and the original 1988 weights were found to be reasonable and consistent over time. Cowles Decl., ¶ 3. Additionally, CDSS provides county social workers with extensive training to help achieve and maintain uniformity in the use of functional rankings and FI scores statewide. Carroll Decl., ¶ 12. Accordingly, FI Scores have proven to be particularly effective at measuring an individual's IHSS need and functional abilities. Carroll Decl., ¶¶ 11-13 & Exh. A; Cowles Decl., ¶ 3.

Moreover, ABX4 4 does not utilize FI Scores and functional ranks in a vacuum, but rather carves out explicit exemptions for recipients who are authorized to receive protective supervision or paramedical services, thereby ensuring that any potentially at-risk individuals will receive

[6] Additionally, *Independent Living* was wrongly decided because it conflicts with numerous Supreme Court precedents, including *Gonzaga University v. Doe*, 536 U.S. 273 (2002), and because the Supremacy Clause does not itself create any substantive rights. *See Dennis v. Higgins*, 498 U.S. 439, 450 (1991); *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 107 (1989); *Chapman v. Houston Welfare Rights Org.*, 441 U.S. 600, 615 (1979). Defendants recognize, however, that this court cannot overrule the Ninth Circuit's decision in *Independent Living*, and therefore raise this argument to preserve it for later appellate proceedings.

services regardless of their FI Scores and functional ranks. *See* Cal. Welf. & Inst. Code §§ 12309(e)(2) & 12309.2(a)(3); Carroll Decl., ¶ 19 & Exh. B. Numerous other protections are built into the system to further ensure that at-risk individuals will receive the services that they need. For example, the individual's county social worker is responsible for determining whether there are other services available, including Medi-Cal waivers and county only services, and for making referrals to those services. Additionally, any recipient who believes that his or her FI Score or functional ranks have been incorrectly assessed is entitled to a hearing and will continue to receive all of his or her current IHSS benefits pending the outcome of the hearing. *See* MPP §§ 22-003.1, 22-073.1 & 30-755.21; Carroll Decl., ¶¶ 17 & 19. ABX4 4 represents a reasonable way to provide services to those most in need, and is consistent with the overall objectives of the Medicaid Act, which are to provide medically necessary services "as far as practicable under the conditions in such state." 42 U.S.C. § 1396-1.

c. The Cases Cited by Plaintiffs Are Inapposite

The cases cited by the plaintiffs in support of their § 1396a(a)(17) arguments are inapposite. For example, plaintiffs rely on *Lankford v. Sherman*, 451 F.3d 496 (8th Cir. 2006), but *Lankford* is an Eighth Circuit case that, to the extent it conflicts with *Watson*'s holding that § 1396a(a)(17) is not privately enforceable, is not valid law in this Circuit. In any event, *Lankford* also is distinguishable. There, the Eighth Circuit struck down a Missouri regulation that made unreasonable distinctions between the types of durable medical equipment that would be covered under Medicaid. These distinctions were so unreasonable that they bordered on the absurd. One provision funded wheelchairs but not the batteries, accessories, and replacement parts necessary to keep those wheelchairs running; another provision funded oxygen and other respiratory equipment, but not the suction pumps, apnea monitors, and humidification devices that were medically necessary to assist in breathing. *See* 451 F.3d at 511. The FI scoring system in California creates no such anomalies. Indeed, ABX4 4 sets a new threshold for services that is based entirely on recipients' level of need, and will ensure that those will the highest level of need continue to receive all necessary services. *See* Carroll Decl., ¶¶ 11-14 & Exh. B; Cowles Decl., ¶ 3.

Plaintiffs also rely on *White v. Beal*, 555 F.2d 1146 (3d Cir. 1977), a case that never mentions § 1396a(a)(17). In *White*, Pennsylvania's Medicaid program paid for eyeglasses for individuals who had an eye disease but refused to pay for eyeglasses for those without such a disease. Both groups of individuals (those with eye disease and those without) had a medical need for eyeglasses, but Pennsylvania based its funding distinction on the individuals' conditions, not their medical needs. The Third Circuit held this distinction to be improper. No such condition-based distinctions are made under the FI scoring system, which instead assesses recipients' need for services – precisely what *White* and *Lankford* require. *See* Carroll Decl., ¶¶ 11-14 & Exh. B; Cowles Decl., ¶ 3.

Plaintiffs also cite a Michigan district court case that involved the requirement than an individual seeking a Medicaid-financed liver transplant must have first abstained from alcohol for two years. *See Allen v. Mansour*, 681 F. Supp. 1232 (E.D. Mich. 1986). In *Allen*, the court found that Michigan failed to rely on statistical data, reports from agencies, and other related information to determine the proper length of abstinence. *See id.* at 1238. Here, in contrast, the FI scoring system was developed over 20 years ago and has stood the test of time as an accurate and reliable means to measure a recipient's level of need for services. Cowles Decl., ¶ 3; Carroll Decl., ¶ 13.

Finally, plaintiffs rely on abortion cases in which two states impermissibly sought to limit Medicaid funding for medically necessary abortions. *See Hern v. Beye*, 57 F.3d 906 (10th Cir. 1995); *Preterm, Inc. v. Dukakis*, 591 F.2d 121 (1st Cir. 1979). Specifically, Colorado and Massachusetts funded abortions in cases where the mothers faced imminent, life-or-death situations but denied funding for medically necessary (but not life-threatening) cases. The courts struck down such distinctions as unreasonable.[7] No such condition-based distinctions are made in this case. Indeed, both the *Hern* and *Preterm* courts expressly articulated the difference between need-based and condition-based distinctions: "[W]hen a state singles out one particular

[7] The *Preterm* court noted, by way of analogy, "[i]f only those suffering at death's door from sickle cell anemia or syphilis could receive publicly provided medical care, but not those condemned to a lifetime of dependency, one would be hard put to discern any rational social objective being thereby served." 591 F.2d at 126.

medical condition … and restricts treatment for that condition to life and death situations it has … crossed the line between permissible discrimination based on degree of need and entered the forbidden discrimination based on medical condition." *Hern*, 57 F.3d at 910; *see also Preterm*, 591 F.2d at 126. The California FI scoring system, which makes distinctions based solely on need and not medical condition, *see* Carroll Decl., ¶¶ 11-14 & Exh. B, falls squarely on the "permissible" side of the line under the very authorities cited by plaintiffs.

4. The FI Scoring System Satisfies the Sufficiency Requirement of Federal Medicaid Law, 42 C.F.R. § 440.230(b).

The "broad discretion" afforded to states to determine "the extent of medical assistance" they will provide under Medicaid is further checked by the "sufficiency" requirement of 42 C.F.R. § 440.230(b), which requires that "[e]ach service must be sufficient in amount, duration, and scope to reasonably achieve its purpose." *See* Plaintiffs' Sixth Claim for Relief, at Amended Compl. ¶¶ 212-15. As discussed below, even assuming that plaintiffs can privately enforce this regulation, defendants satisfy the sufficiency rules under federal Medicaid law.

a. Overview.

States that voluntarily participate in the Medicaid program may, under their sole discretion, elect to offer "optional" services such as prescription drugs or in-home support services. *See* 42 U.S.C. § 1396d(a)(12). Once a state elects to offer such a service, "[e]ach service must be sufficient in amount, duration, and scope to reasonably achieve its purpose." 42 C.F.R. § 440.230(b). As the Supreme Court has repeatedly made clear, the Medicaid Act gives states "substantial discretion to choose the proper mix of amount, scope, and duration limits on coverage as long as care and services are provided in the recipients' best interest." *PhrMA*, 538 U.S. at 665 (plurality opinion); *Alexander v. Choate*, 469 U.S. 287, 303 (1985). The key focus under the sufficiency regulation is therefore whether the provided services "achieve [their] purpose" under the federal statutory framework. *See Curtis v. Taylor*, 625 F.2d 645, 651 (5th Cir. 1980).

b. Plaintiffs Have Failed to Tie the "Sufficiency" Regulation to any Statutory Right of Action Under the Medicaid Act.

Plaintiffs' "sufficiency" claim under 42 C.F.R. § 440.230(b) fails as a matter of law because a federal regulation cannot, by itself, serve as the basis for a private lawsuit, but instead must be tied to a privately enforceable right created by a Congressional statutory enactment. *See Alexander*, 532 U.S. at 286-87, 291; *Lonberg v. City of Riverside*, 571 F.3d 846, 850-51 (9th Cir. 2009) ("[R]egulations that do not encapsulate [a] statutory right and corresponding remedy are not privately enforceable."). This is because, "[l]ike substantive federal law itself, private rights of action to enforce federal law must be created by Congress." *Sandoval*, 532 U.S. at 287. Here, plaintiffs have not tied 42 C.F.R. § 440.230(b) to *any* statute. *See* Amended Complaint, ¶¶ 212-215. Accordingly, this claim fails as a matter of law.

In their moving papers, plaintiffs assert that 42 C.F.R. § 440.230(b) is "related" to 42 U.S.C. § 1396a(a)(17). Mem. at 27:12. Because this "relationship" is not mentioned in the complaint, this claim is legally insufficient as a matter of law. *See* Fed. R. Civ. P. 8(a)(2) (complaint must including "a short and plain statement of the claim showing that the pleader is entitled to relief"). Beyond that, and even assuming arguendo that § 440.230(b) implements § 1396a(a)(17), that statute cannot supply a basis for private enforcement of § 440.230(b) because § 1396a(a)(17) itself does not itself create any privately enforceable rights. *See Watson*, 436 F.3d at 1162-63.[8]

c. ABX4 4 Satisfies the Sufficiency Requirement.

Even if plaintiffs could establish a private right of action under the "sufficiency" regulation, they could not prove that ABX4 4 falls outside of the "substantial discretion" afforded to Congress to limit the amount, scope, and duration of IHSS benefits. *PhrMA*, 538 U.S. at 665; *Alexander*, 469 U.S. at 303. Under the very authorities cited by the plaintiffs, ABX4 4 meets the sufficiency standard. In *Curtis v. Taylor*, 625 F.2d 645 (5th Cir. 1980), for example, the court

[8] The cases cited by plaintiffs in their moving papers (Mem. at 27-28) are inapposite on their facts and predate both *Alexander v. Sandoval*'s holding that a regulation, alone, cannot support a private right of action, and the Ninth Circuit's holding in *Watson v. Weeks* that Section 1396a(a)(17) is not privately enforceable.

analyzed a Florida statute that limited the number of paid physician visits to three per calendar month. The court properly asked the following question under the "sufficiency" requirement of 42 C.F.R. § 440.230(b), namely, "whether three visits are sufficient 'to reasonably achieve' the purpose of going to the doctor's office." 625 F.2d at 651. The *Curtis* court upheld the Florida statute for the same reason this court should uphold ABX4 4: the state properly exercised its judgment in limiting care to those with the highest degree of need:

> Florida's decision to pay for no more than three physicians' visits per month does not discriminate on the basis of 'condition' between persons who need three or fewer visits and those who need four or more. Neither does its decision to pay for emergency visits beyond the three-visit limitation discriminate against those with less severe 'conditions.' It simply reflects a judgment by the state that those persons who need emergency care have a higher degree of medical necessity than those who do not. That conclusion is compassionate as well as rational.

Id. at 652. The *Curtis* court also noted that federal regulators had previously approved state plans that included "precisely the type of limitation on physicians' visits per month that Florida seeks to adopt." *Id.* at 652-53 (service limitations appropriate if resulting coverage "is adequate to serve the medical needs of most of the individuals eligible for Medicaid assistance"). Similarly, in the instant case, the service limitations are based solely on recipients' level of need, and will ensure that individuals with a moderate to high level of need will continue to receive all necessary services. *See* Carroll Decl., ¶¶ 11-14, 16 & Exh. B.

In the same way, the court in *Mitchell v. Johnson*, 701 F.2d 337 (5th Cir. 1983), focused on the Congressional purpose underlying preventive dental care for children, the Medicaid services at issue in that case. Mem. at 27. In *Mitchell*, the court noted Congress's express intent to provide a comprehensive package of preventive dental services for eligible children under Medicaid. When the State of Texas eliminated seven of the eight elements of that comprehensive package, that unreasonably high percentage was held to be well outside the bounds of the "substantial discretion" afforded to states under federal Medicaid law. *See* 701 F.2d at 350-51. In the instant case, the modest, need-based limitations on IHSS services do not approach the massive level of cuts (seven out of eight elements of the dental plan) seen in *Mitchell*.[9]

[9] The plaintiffs also cite to *Charpentier v. Belshe*, 1994 WL 792591 (E.D. Cal.), to support their "sufficiency" arguments. Although the *Charpentier* court cited the sufficiency regulation (continued…)

C. Plaintiffs Have No Likelihood of Success on Their Claims Under Title II of the ADA and Section 504 of the Rehabilitation Act

Plaintiffs' ADA and Rehabilitation Act claims fail as a matter of law because plaintiffs cannot demonstrate that ABX4 4 discriminates on the basis of any disability. Section 12131 of Title II of the ADA provides in pertinent part: "[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by such an entity."[10]

> To prove a public program or service violates Title II of the ADA, a plaintiff must show: (1) he is a "qualified individual with a disability"; (2) he was either excluded from participation in or denied the benefits of a public entity's services, programs or activities, or was otherwise discriminated against by the public entity; and (3) *such exclusion, denial of benefits, or discrimination was by reason of his disability*.

Weinreich v. Los Angeles County Metropolitan Transp. Authority, 114 F.3d 976, 978 (9th Cir. 1997) (emphasis in original).

Here, plaintiffs cannot show that any named plaintiff (or other IHSS recipient) will be denied benefits *by reason of his or her disability*. Indeed, ABX4 4 does precisely the opposite, basing service levels entirely on need to ensure that the people with the greatest need for services will continue to receive them, and eliminating or reducing services only for those recipients who have been determined by trained social workers not to have a genuine need for them. Carroll Decl., ¶¶ 11-14; Cowles Decl., ¶ 3.

Nor is there any evidence that any of the named plaintiffs will suffer any injury as a result of ABX4 4, much less end up institutionalized:

(…continued)
(once), it did not analyze the regulation or discuss it. The *Charpentier* case involved a glancing discussion of comparability, and Defendants address that issue above. Plaintiffs also point to *Weaver v. Reagen*, 886 F.2d 194 (8th Cir. 1989), a case that cites the sufficiency regulation (subpart (b) of 42 C.F.R. § 440.230) but does not discuss it. The *Weaver* case focuses on subparts (c) and (d) of 42 C.F.R. § 440.230, which involve the ability of a state to limit Medicaid services. Defendants address that issue in the "reasonable standards" discussion above.

[10] The language of section 504 of the Rehabilitation Act is essentially the same, and analyzed the same way. *Pennsylvania Protection & Advocacy v. Pennsylvania Dep't of Public Welfare*, 402 F.3d 374, 379 n. 3 (3d Cir. 2005).

- Plaintiff C.R. is a client of the San Andreas Regional Center and has a developmental disability as defined under the Lanterman Developmental Disabilities Services Act (Lanterman Act), California Welfare and Institutions Code §§ 4500 et seq. Carroll Decl., ¶ 18. Accordingly, he is entitled to continue to receive the same services that he currently receives through IHSS through another provider arranged by his regional center, and he will not suffer any loss of services. *Id.*; Winfield Decl., ¶ 5; Cal. Welf. & Inst. Code § 4646.5.
- Plaintiff David Oster has autism, which is a developmental disability under the Lanterman Act. Carroll Decl., ¶ 18. Mr. Oster is a client of the Harbor Regional Center, and he is entitled to continue to receive the same services that he currently receives through IHSS through another provider arranged by his regional center, and he will not suffer any loss of services. *Id.*; Winfield Decl., ¶ 5; Cal. Welf. & Inst. Code § 4646.5.
- Plaintiff Willie Beatrice Sheppard has an FI Score of 2.56, and the only service that she will lose as a result of ABX4 4 is shopping, for which she currently receives just one hour per week. Carroll Decl., ¶ 18. Because Ms. Sheppard has a functional rank of less than 4 for shopping, her social worker has by definition determined that she does not require substantial assistance to engage in this activity. Moreover, Ms. Sheppard's own declaration indicates that shopping services are a convenience but not a true necessity for her, as she states that she has a daughter who lives nearby and with whom she goes to church every Sunday, and she does not provide any indication that her daughter, although quite busy, could not help her with shopping for just one hour per week. Sheppard Decl., ¶¶ 2, 11. She also fails to identify any irreparable harm that would occur if she lost her shopping services, focusing instead on the consequences that she believes she would suffer if she lost her *other* services, which she will not lose under ABX4 4. *Id.*, ¶¶ 7-11; Carroll Decl., ¶ 18. Finally, in the event that Ms. Sheppard believes that she has a greater need for shopping services than her functional rank indicates, she is entitled to seek a hearing and

reassessment, and will continue to receive benefits pending the outcome of her hearing. Carroll Decl., ¶¶ 17, 19.

- Plaintiff Dottie Jones has an FI Score of 2.28, and she will continue to receive services for laundry, shopping, and dressing, losing only her services for housework (six hours per month), meal preparation (three hours per month), and meal clean-up (one-and-one-half hours per month). *Id.*, ¶ 18. Because Ms. Jones has functional ranks of less than 4 in these categories, by definition her social worker has determined that she does not require substantial assistance with these activities. If she believes that her functional ranks have been incorrectly assessed, she is entitled to a hearing and/or reassessment, and she will continue to receive her current benefits pending the outcome of her hearing. *See id.*, ¶¶ 17, 19. Moreover, Ms. Jones has failed to demonstrate that there are no other community resources available to her, such as Meals on Wheels or other volunteer community or religious support networks. *See id.*, ¶ 18.
- Plaintiff V.L. is a 14-year-old boy whose current IHSS provider is his older brother, who lives in the house with him. *Id.*, ¶ 18. V.L.'s mother also receives IHSS services (which will not be cut under ABX4 4), and his mother's provider also lives in the house with them, along with his mother's husband. *Id.* V.L. receives only 44.8 hours of services per month (approximately 11 hours per week), and his services can be, and are, provided by the family members living in the house with him. *Id.*; Lagahid Decl., ¶ 4. There is no evidence that V.L. will stop receiving any services, the only change being that his family members will no longer be paid for providing those services to him. Lagahid Decl., ¶¶ 1-13. Moreover, if V.L. believes that his FI Score of 1.87 does not accurately reflect his level of need, he is entitled to a hearing and/or reassessment, and he will continue to receive his current benefits pending the outcome of his hearing. Carroll Decl., ¶¶ 17, 19. Finally, V.L. lives in San Francisco, and under Proposition J there are numerous resources available for children in San Francisco. *Id.*, ¶ 18. There is no indication that V.L.'s parents have

sought any assistance from the City of San Francisco, which may be able to provide many of the same services that IHSS currently provides. *Id.*, ¶ 18; Lagahid Decl., ¶¶ 1-13.

Plaintiffs' contention that the reductions in the IHSS program "will have a uniquely detrimental effect upon people with psychiatric and cognitive disabilities and exclude them from IHSS" is completely without foundation. Plaintiffs' Motion at 32. Plaintiffs fail to provide any credible evidence to support this assertion, as, among other things, they overlook the fact that functional ranks and FI scores are assessed by trained social workers for the specific purpose of measuring the recipient's level of need for services, and thus anyone with a genuine need for services will receive them unless they have been mis-assessed. Carroll Decl., ¶¶ 11-14. And anyone who believes that he or she has been mis-assessed is entitled to a hearing and/or reassessment, and will continue to receive benefits pending the outcome of that hearing. *Id.*, ¶¶ 17 & 19. Recipients with developmental disabilities will not lose any services because they are entitled to receive the same services through their regional centers under the Lanterman Act, and many people with psychiatric or cognitive disabilities are likely to fall into this category. Winfield Decl., ¶ 5. Further, recipients with serious cognitive or psychiatric disabilities will almost certainly be authorized to receive protective supervision, which will automatically exempt them from any service reductions under ABX4 4. Carroll Decl., Exh. A at 12 & Exh. B; Cal. Welf. & Inst. Code §§ 12309(e)(2) & 12309.2(a)(3). In short, there is no evidence that anyone with significant cognitive or psychological difficulties will lose any IHSS services. Under such circumstances, plaintiffs cannot show that any named plaintiff (or any other recipient) is likely to be significantly harmed by the reduction in IHSS, much less end up being admitted to a skilled nursing facility or other institution as a result of ABX4 4.

Moreover, a state is not precluded in every instance from reducing or eliminating services under its Medicaid Plan such that it will be in violation of the ADA or section 504 of the Rehabilitation Act. As the Sixth Circuit noted, a State is not required to maintain optional Medicaid services that it can no longer afford.

> [I]t may occasionally happen that the zero-sum fiscal realities of administering a state budget will prohibit the State from sustaining [its previous] level of [Medicaid services]. If that should happen, *it is not for the federal courts to compel the State to maintain non-mandatory Medicaid programs that it no longer can support*. So long as the State's disenrollment process satisfies the requirements of the Medicaid regulations and statute . . . , those policy choices must be left to the elected representatives of the residents of the State.

Rosen v. Goetz, 410 F.3d 919, 933 (6th Cir. 2005) (emphasis added).

The bottom line is that the new eligibility requirements do not discriminate against individuals with disabilities. The majority of those who receive IHSS are disabled.[11] These new requirements are narrowly tailored and based on individual assessments of IHSS recipients. Nothing about the new standards for determining recipients' need for IHSS services violates the Medicaid Act or the ADA/section 504, and therefore, plaintiffs have failed to show that they can prevail on the merits of their claims.

II. PLAINTIFFS' MOTION MUST BE DENIED BECAUSE PLAINTIFFS CANNOT DEMONSTRATE A LIKELIHOOD OF IRREPARABLE HARM OR THAT THE BALANCE OF EQUITIES OR PUBLIC INTEREST WOULD FAVOR AN INJUNCTION

Plaintiffs have not met their burden of demonstrating that any named plaintiffs or purported class members face "a real or immediate threat of an irreparable injury" when ABX4 4 goes into effect. *Hangarter v. Provident Life & Acc. Ins. Co.*, 373 F.3d 998, 1020 (9th Cir. 2004); *see also Winter*, 129 S. Ct. at 375-76. Indeed, plaintiffs' claims of irreparable harm are based entirely upon several fundamental misunderstandings of how recipients' levels of need for services are determined under ABX4 4, and accordingly plaintiffs' purported "evidence" of irreparable harm cannot withstand even the most basic scrutiny.

A. None of the Named Plaintiffs Can Show a Likelihood of Irreparable Harm

As discussed above, plaintiffs have failed to show that any of the named plaintiffs will go without needed services. *See* Section I.C at pp. 23-25, *supra*.

B. Plaintiffs Have Not Shown Any Likelihood of Irreparable Harm for Other Purported Class Members

[11] An individual could qualify for these services based on their age and income status. Such individuals would not necessarily be "disabled" within the meaning of the ADA.

In order to obtain a preliminary injunction, plaintiffs must show that one or more of the "*named plaintiffs*" is likely to suffer "imminent, irreparable harm," *Mandrigues v. World Savings, Inc*., 2009 WL 160213 at *3 (N.D. Cal. Jan. 20, 2009) (emphasis added), and plaintiffs have utterly failed to meet that burden. Moreover, plaintiffs also have failed to show that *any* IHSS recipients – members of the purported class or otherwise – are likely to suffer irreparable harm under ABX4 4. Plaintiffs' claims of alleged irreparable harm are based entirely on plaintiffs' fundamental misunderstandings of the relevant facts and law.

First, plaintiffs describe numerous recipients *whose benefits will not be cut* under ABX4 4, and then allege a parade-of-horrors that might happen to those recipients in the hypothetical event that their benefits were cut. *See* Nicholson Decl., ¶ 6; *see also* Anderson Decl., ¶ 10 (admitting no services will be lost); Addison Decl., ¶ 7 (provider admitting recipient will not lose services); Brown Decl., ¶¶ 2 & 5 (admitting facts that show child's services will not be cut). Specifically, throughout their declarations and briefs plaintiffs completely overlook the fact that all individuals who are authorized to receive protective supervision or paramedical services are exempt from the changes in ABX4 4. *See* Cal. Welf. & Inst. Code §§ 12309(e)(2) & 12309.2(a)(3). Individuals with a functional rank of 5 in any of the three mental functioning categories – memory, orientation, and judgment – are automatically entitled to receive protective supervision, and accordingly will be exempt from any cuts under ABX4 4. Carroll Decl., Exh. A at 12. Thus, any individuals with moderate or severe cognitive or psychological disabilities will be authorized to receive protective supervision and will not have any services cut.

Plaintiffs further overlook the fact that individuals with developmental disabilities have an entitlement to services under the Lanterman Developmental Disabilities Services Act (Lanterman Act), and therefore are entitled to the services they need whether they are provided through the IHSS program or some other vendor or contractor. *See* Winfield Decl., ¶ 5; *see also* Gardner Decl., ¶¶ 26, 32, 37 (plaintiffs' purported expert incorrectly stating that recipients with developmental disabilities will lose services and suffer harm). These individuals receive case management services from regional centers located throughout California, and they need only

contact their case manager at the regional center to ensure that they will continue to receive any IHSS services that they would otherwise lose as a result of ABX4 4. Winfield Decl., ¶ 5.

Plaintiffs also incorrectly allege that social workers do not know how to assess functional rank and frequently make errors, and that this will supposedly harm recipients. Plaintiffs have no evidence to support this claim. Social workers are given extensive training in how to use functional ranks and properly assess recipients, including such things as basing the assessment on the recipient's "worst" days rather than average or best days. Carroll Decl., ¶ 12; Nicholson Decl., ¶ 7. Social worker assessments are subject to routine auditing and review, and have been found to be very consistent across the state over time. Carroll Decl., ¶ 13. Moreover, in the event that a social worker makes an error in assessing a recipient, the recipient has a right to a reassessment and/or a state hearing, *and the recipient will continue to receive all of their current benefits pending the outcome of the hearing*. *Id.*, ¶¶ 17 & 19. Indeed, many of the recipients identified in plaintiffs' declarations claim to have disabilities that are far worse than what is reflected in their functional ranks and FI scores. Nicholson Decl., ¶¶ 8, 11. Where those claims are true, the recipients can simply ask to have their functional ranks reassessed and/or request a state hearing and they will receive all of the services that they need. *Id.*; Carroll Decl., ¶¶ 17 & 19.

All of the protections in place under the IHSS program and related programs render it extremely unlikely that any recipient will suffer irreparable harm if ABX4 4 goes into effect, and plaintiffs have made no showing to the contrary. Indeed, in order to show irreparable harm, plaintiffs would first have to identify a recipient who will lose services as a result of ABX4 4: i.e., an individual with a functional rank below 4 for one or more domestic and related services, and/or an FI Score below 2, who is not developmentally disabled and who is not authorized to receive protective supervision or paramedical services. Then, plaintiffs would have to show that such person's functional ranks were correctly assessed; otherwise, that person would be entitled to a reassessment that would give him or her the services he or she needs. After that, plaintiffs would have to show that that recipient – who has been *correctly* diagnosed by a social worker as not needing services (otherwise he or she would be reassessed) – in fact has a genuine need for those services. Then, plaintiffs would have to show that the recipient has no reasonable alternative

other than IHSS to receive those services (i.e., no family member, friend, state or county service, or charity service that can provide the equivalent services). And finally, plaintiffs would have to show that the absence of such services will be *likely* (not merely possible) to cause that recipient to suffer a concrete and irreparable harm. Plaintiffs' evidence does not come close to making this showing, and accordingly plaintiffs have failed to meet their burden of demonstrating a likelihood of irreparable harm.

C. The Balance of Equities and Public Interest Tilt Strongly Against Plaintiffs' Request to Enjoin a State Statute

California is facing an unprecedented fiscal crisis, and the Legislature has little choice but to make budget cuts to popular programs. The cuts in ABX4 4 were made after careful consideration by the Legislature and were specifically designed to preserve services for those who need them most, while eliminating only those services that, while undoubtedly providing great convenience to the recipients, are not truly necessary. *See Beal*, 432 U.S. at 444-45 ("it is hardly inconsistent with the objectives of the Act for a State to refuse to fund unnecessary though perhaps desirable medical services"). Basic separation-of-powers principles dictate that the courts should not interfere with the Legislature's reasoned judgment about how to address the budget crisis and how to assess recipients' need for services. *See Watson*, 436 F.3d at 1162-63 (Congress did not intend for courts to "delve into the medical necessity of particular types of care"). If the court issues a preliminary injunction to prevent ABX4 4 from taking effect, it will directly worsen the State's budget crisis and almost certainly force the Legislature to cut other programs and services that the Legislature has deemed *more essential* than the services cut under ABX4 4. Indeed, there is a realistic possibility that the Legislature could eliminate the IHSS program entirely, as it is an optional program under Medicaid that was almost eliminated during the State budget crisis in 2003-04. *See* Douglas Decl., ¶ 11; *Rosen*, 410 F.3d at 933 ("it is not for the federal courts to compel the State to maintain non-mandatory Medicaid programs that it no longer can support"). ABX4 4 makes reasonable cuts to the IHSS program in order to preserve those services for the most needy, and if ABX4 4's cuts are enjoined the entire program could be

put at risk. Accordingly, the balance of equities and public interest tilt strongly against plaintiffs' request for a preliminary injunction, and the court should deny plaintiffs' request.

III. CLASS CERTIFICATION IN NEITHER NECESSARY AT THIS STAGE NOR PROPER IN THIS CASE

Defendants agree that there is no need for the court to consider plaintiffs' motion for class certification at this time. "[D]istrict courts are empowered to grant preliminary injunctions 'regardless of whether the class has been certified,'" *Brantley v. Maxwell-Jolly*, __ F. Supp. 2d __, 2009 WL 2941519, at *14 n.14 (N.D. Cal. Sept. 10, 2009) (quoting Schwarzer, Tashima and Wagstaffe, *Fed.Civ.P. Before Trial*, § 10:773 at 10-116 (TRG 2008)), and thus if plaintiffs meet the requirement for a preliminary injunction as to the named plaintiffs *and* they establish that putative class members will suffer the same harm, plaintiffs can obtain classwide preliminary injunctive relief without certifying a class. *See Mandrigues*, 2009 WL 160213 at *3 (When seeking a preliminary injunction on a classwide basis, "the moving party must prove that (1) the named plaintiffs face imminent, irreparable harm, and (2) there is reason to believe that the putative class members face the same harm."). However, because plaintiffs cannot meet the requirements for a preliminary injunction, they are not entitled to any relief, and the issue of class certification is moot.[12]

IV. IN THE EVENT THAT THE COURT DOES NOT DENY PLAINTIFFS' MOTION, THE COURT SHOULD REFRAIN FROM RULING UNTIL DEFENDANTS HAVE BEEN GIVEN A REASONABLE OPPORTUNITY TO RESPOND

Plaintiffs' motion should be denied – or, at a minimum, the court should postpone its ruling – because defendants have not been afforded a fair and reasonable opportunity to prepare a response. After ABX4 4 was enacted on July 28, 2009, plaintiffs spent 69 days preparing their preliminary injunction papers and supporting documents – which total over 1,100 pages – before filing them on the evening of October 5, 2009. Plaintiffs then used their own delay as a basis for seeking to shorten defendants' time to respond to plaintiffs' motion, and despite defendants'

[12] In any event, plaintiffs have not met, and cannot possibly meet, the requirements for class certification under Rule 23, as they cannot meet the basic requirements of commonality, typicality, or adequacy, among other deficiencies. Accordingly, if the court deems it necessary to rule on plaintiffs' motion for class certification at this time, class certification must be denied.

objections the court shortened defendants' time to respond to just seven days (four court days).[13] Despite this unreasonably short schedule, defendants have demonstrated herein that plaintiffs have no likelihood of prevailing on the merits and cannot show any likelihood of irreparable harm, and therefore that plaintiffs' motion for a preliminary injunction must be denied. Nonetheless, in the unlikely event that the court is inclined to grant plaintiffs' motion, defendants request that they first be given a reasonable opportunity to submit additional arguments and evidence that they have not been able to present to the court in the unreasonably short time that defendants were given to respond.

First, there is no urgency to plaintiffs' motion because any plaintiffs and/or putative class members who might be affected by ABX4 4 are currently empowered to maintain the status quo (and keep their exact same level of benefits) by requesting an administrative hearing. *See* Carroll Decl., ¶¶ 17, 19 & Exh. B at 7; MPP § 22-073.1. Thus, the plaintiffs and putative class members will be able to maintain the status quo and continue to receive their *exact same level of benefits* without this court intervening on their behalf. Second, the purported "emergency" to decide the preliminary injunction motion (which, as discussed above, is no emergency at all) was caused by the plaintiffs themselves, who waited *more than two months* after enactment of the challenged statute to bring these matters to the attention of the court. Third, due process and fundamental fairness require that defendants be given more than a few days to respond to more than 1,100 pages of legal arguments and evidence, including more than 50 supporting declarations. These due process concerns are particularly acute in this case because giving defendants a reasonable time to respond will not prejudice the plaintiffs in any way (because they can keep their exact same level of benefits by requesting an administrative hearing).

Finally, a compressed briefing schedule – under which plaintiffs had months to prepare their motion and defendants were given a few days to respond – is particularly inappropriate in this case because it involves a challenge to a statute duly enacted by a state. State statutes are presumed constitutional and judicial orders preliminarily enjoining them are disfavored. In

[13] Plaintiffs also continued to file declarations and corrections during defendants' seven-day response period, giving defendants a moving target to shoot at.

granting plaintiffs' request to shorten time, this court has rewarded plaintiffs' delay and has implicitly sanctioned a litigation-by-ambush approach that turns the traditional presumptions and burdens of litigation on their head. Plaintiffs bear the burden of proving the preliminary injunction factors, overcoming the presumptions favoring the validity of state laws, and establishing the urgent need for such extraordinary judicial relief. If the court grants a preliminary injunction without first allowing defendants a fair opportunity to contest plaintiffs' claims and offer countervailing evidence, the court will essentially be issuing a default judgment, despite defendants' best efforts to be heard.

CONCLUSION

The court should deny the motion for a temporary restraining order and/or a preliminary injunction. Plaintiffs have no likelihood of success on the merits because their allegations fail to state a claim as a matter of law. In addition, plaintiffs have failed to make any showing of irreparable harm; the balance of hardships tips strongly in favor of the State; and an injunction would be contrary to the public interest.

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Respectfully Submitted,

EDMUND G. BROWN JR.
Attorney General of California
KARIN S. SCHWARTZ
SUSAN M. CARSON
Supervising Deputy Attorneys General

/s/ Gregory D. Brown

JOSHUA N. SONDHEIMER
GREGORY D. BROWN
MICHAEL A. ZWIBELMAN
Deputy Attorneys General
Attorneys for Defendants

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