

Honorable Thomas S. Zilly

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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT SEATTLE

M.R., S.J., C.B., D.W., A.B., M.B., An.B, J.B.,
K.S., T.M., A.R., M.J.B., J.H., H.C., THE ARC
OF WASHINGTON, SERVICE EMPLOYEES
INTERNATIONAL UNION HEALTHCARE
775NW and PUGET SOUND ALLIANCE
FOR RETIRED AMERICANS,

Plaintiffs,

v.

SUSAN DREYFUS, in her professional
capacity as Secretary of Washington State
Department of Social and Health Services and
WASHINGTON STATE DEPARTMENT OF
SOCIAL AND HEALTH SERVICES, a
Department of the State of Washington,

Defendants.

No. 2:10-cv-02052-TSZ

MOTION FOR PRELIMINARY
INJUNCTION

Preliminary Injunction:
Friday, January 28, 2011

ORAL ARGUMENT REQUESTED

I. INTRODUCTION

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2 Plaintiffs move for a preliminary injunction that enjoins the State from implementing
3 emergency regulation WSR 11-02-041 which, effective January 1, 2011 until the Ninth Circuit's
4 order of January 14, 2011, reduced the in-home personal care service hours provided to elderly
5 and disabled Medicaid beneficiaries by an average of ten percent. These reductions of basic and
6 essential services that enable people with disabilities to remain in their homes violate due
7 process, the integration mandate of the Americans with Disabilities Act and Rehabilitation Act
8 (collectively "ADA"), and certain key Medicaid Act provisions. Unless this Court grants an
9 injunction, individuals with disabilities will suffer irreversible health declines and loss of
10 integration into the community before this Court can decide the merits of Plaintiffs' challenge.

11 Plaintiffs and prospective members of the Plaintiff Class ("Plaintiffs" or "beneficiaries")
12 have severe disabilities that render them eligible for mandatory Medicaid services in nursing
13 homes or comparable institutions for individuals with developmental disabilities. They have
14 waived their right to institutional care and instead receive less costly in-home personal care
15 services such as assistance with eating, toileting, mobility, and bathing. Providing these services
16 at home rather than in institutions fulfills the State's ADA obligations and saves the State money.

17 Without a preliminary injunction, Plaintiffs will suffer irreparable injuries from the
18 reduction of their personal care hours to levels 6-24% below that which the State authorized
19 through individualized assessments and individual care plans to meet their needs. And without
20 adequate notice and hearing protections, beneficiaries will be forced to go without adequate
21 long-term care services and won't know their right to request additional hours through the
22 Exception to Rule ("ETR") process or reassessment, or to obtain replacement Medicaid services.

II. ISSUE PRESENTED

24 Should this Court preserve the status quo by preliminarily enjoining implementation of
25 emergency regulation WSR 11-02-041, which reduces Medicaid in-home personal care services
26 by an average of ten percent, pending a final determination of the merits of this case?
27

III. EVIDENCE RELIED UPON

1 Plaintiffs rely on their Amended Complaint, declarations filed in support of the TRO, and
2 the declarations accompanying this motion, all of which are listed in Appendix A.

IV. SUMMARY OF FACTS

A. Washington's Personal Care Services Programs

3 All of the individual Plaintiffs and members of the Plaintiff Class are adult Medicaid
4 beneficiaries with severe disabilities who receive in-home personal care services through
5 programs administered by Defendants. Beneficiaries all choose to live at home and in the
6 community, often with family or friends, instead of in institutions like nursing homes or
7 community-based residential settings, where they could receive Medicaid Long Term Care
8 (LTC) services.¹ Beneficiaries' disabilities include paralysis and other physical disabilities;
9 cognitive impairments such as dementia or Alzheimer's; chronic conditions arising out of
10 traumatic brain or spinal cord injuries, Multiple Sclerosis, Muscular Dystrophy, or Diabetes; and
11 developmental disabilities such as Downs Syndrome. Reed Decl. (Dkt. 18) ¶11.

12 Approximately 15,000 beneficiaries receive in-home personal care services under the
13 State Medicaid Plan and almost 30,000 through various Medicaid waiver programs. RCW
14 74.39A.030; Reed Decl. (Dkt. 18) ¶¶19-20. Based on individualized assessment of needs and
15 through approved plans of care to meet those needs, these programs provide personal care
16 services and assistance in basic activities of daily living (ADLs) and instrumental ADLs: eating,
17 bathing, toileting, mobility, catheter and bowel care, turning and repositioning, passive range of
18 motion, dressing, medication management, essential shopping, and housework.²

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23 ¹ Defendants administer other Medicaid programs to provide personal care services in a range of
24 institutional settings, such as nursing homes and intermediate care facilities for developmentally disabled individuals
(ICF-MRs), as well as community-based residential settings such as Adult Family Homes, Boarding Homes, and
25 Assisted Living Facilities. See RCW 74.09.520, 74.39A.005; WAC 388-106-0015, 388-106-0030; Reed Decl. (Dkt.
26 18) ¶¶10, 12, 39; Black Decl. (Dkt. 19) ¶6.

27 ² See, e.g., A.H. Decl. (Dkt. 54) ¶¶6a, c-e; C.B. Decl. (Dkt. 29) ¶¶11a-c, g; D.W. Decl. (Dkt. 31) ¶¶11-12,
13d-h; Jane B. Decl. (Dkt. 33) ¶10a-d; K.S. Decl. (Dkt. 36) ¶¶8-11; Portelance Decl. (Dkt. 43) ¶3; N.N.A. Decl.
(Dkt. 57) ¶3; S.J. Decl. (Dkt. 27) ¶8a-e; Albott Decl. (Dkt. 37) ¶¶8-10; Allington Decl. (Dkt. 52) ¶¶13a-h, j-m;
Braddock Decl. (Dkt. 28) ¶¶10, 18a-e; Chatwin Decl. (Dkt. 48) ¶¶14a-e; Davis Decl. (Dkt. 30) ¶¶16a, c, e;
Dockstader Decl. (Dkt. 42) ¶¶10a-k; Faatoafe Decl. (Dkt. 56) ¶¶9-10, 12a-g; Flint Decl. (Dkt. 53) ¶¶10, 12a-g;
Frederick Decl. (Dkt. 40) ¶¶11a-g; Guin Decl. (Dkt. 55) ¶¶13a-f, 17, 18 a-g; Hayes Decl. (Dkt. 47) ¶¶13d-f; Hays

1 Without in-home personal care services, beneficiaries would be at serious and imminent
 2 risk of institutionalization. DSHS individually assessed and certified that all 30,000 waiver
 3 program beneficiaries qualify for (and without in-home services would need) nursing facility or
 4 ICF-MR care; most of the State Plan program beneficiaries have such severe disabilities that
 5 they, too, meet functional eligibility criteria entitling them to nursing facility care. *See* WAC
 6 388-106-0310(4), 388-106-0510(4), 388-845-0030(2); Reed Decl. (Dkt. 18) ¶19.³

7 The purpose of these personal care programs includes “ensur[ing] that services are
 8 provided in the most independent living situation consistent with individual needs” and enabling
 9 individuals with disabilities to remain in their homes rather than institutions. RCW
 10 74.39.005(1)-(4), 74.39A.007; WAC 388-106-0015 (“programs ... are designed to help you
 11 remain in the community ... an alternative to nursing home care”). Washington seeks a
 12 “balanced” LTC system and prioritizes less expensive in-home personal care over institutional
 13 care based on consumer preferences, the integration mandate of federal law, and cost
 14 effectiveness. Reed Decl. (Dkt. 18) ¶¶10-23, 33-36. In past years, Washington employed
 15 strategies “focused on getting as many people as possible out of nursing homes,” succeeded in
 16 reducing the nursing facility caseload from approximately 24,000 (projected) to 11,000, and now
 17 spends more serving a larger in-home and community-based population with higher acuity levels
 18 and personal care needs than most other states. Reed Decl. (Dkt. 18) ¶¶10, 21 & Ex. 1 (Dkt. 18-
 19 1) at 5, Ex. 2 (Dkt. 18-2), Ex. 3 (Dkt. 18-3); Moss Decl. (Dkt. 68) ¶4.

20 **B. Authorization of Personal Care Service Hours**

21 Since approximately 2004, DSHS has utilized the centralized, automated Comprehensive
 22 Assessment Reporting Evaluation (CARE) tool for all elements required to authorize LTC
 23 services: to assess individual functional acuity and needs, authorize in-home personal care hours
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25 Decl. (Dkt. 39) ¶¶15a-e, g-h; Ivonav Decl. (Dkt. 58) ¶¶13 a-e, g, j-k; Leamy Decl. (Dkt. 46) ¶4; Maxson Decl. (Dkt.
 26 ¶¶6-8e, 8e-f, g-h; McIntosh Decl. (Dkt. 32) ¶¶8-9c, e; Paolino Decl. (Dkt. 45) ¶¶12, 14a, c-j, m; Partridge Decl.
 (Dkt. 35) ¶¶5a-d, 9a-b, d-e, i; Starr Decl. (Dkt. 34) ¶¶6-7, 13-14, 20-21.

³ *See, e.g.*, C.B. Decl. (Dkt. 29) ¶16, Allington Decl. (Dkt. 52) ¶8, Jane B. Decl. (Dkt. 33) ¶7, Chatwin
 27 Decl. (Dkt. 48) ¶8, Davis Decl. (Dkt. 30) ¶10, Flint Decl. (Dkt. 53) ¶7, Frederick Decl. (Dkt. 40) ¶6, Guin Decl.
 (Dkt. 55) ¶9, Hays Decl. (Dkt. 39) ¶8, Ivonav (Dkt. 58) ¶8, Maxson Decl. (Dkt. 26) ¶13, Paolino Decl. (Dkt. 45) ¶8.

1 to meet those individually assessed needs, determine eligibility for services, and generate and
 2 approve a care plan with qualified providers. Reed Decl. (Dkt. 18) ¶¶26-28, 32; Black Decl.
 3 (Dkt. 19) ¶¶5-21; Moss Decl. (Dkt. 68) ¶5; WAC 388-106-0045, 388-106-0070. Prior to 2004,
 4 DSHS authorized personal care hours through a more subjective individualized needs
 5 assessment. Black Decl. (Dkt. 19) ¶¶6, 20-21; Moss Decl. (Dkt. 68) ¶5; Leitch Decl. (Dkt. 67)
 6 ¶7. In the year DSHS transitioned to the CARE tool, the budget necessary to meet the needs of
 7 the existing caseload was already forecast and set; the assessment methods and allocation of
 8 resources within the caseload changed to more consistently and fairly authorize hours based
 9 upon the individual CARE assessments of functional acuity, scientific prediction of client needs,
 10 and assessment of individual unmet needs. Black Decl. (Dkt. 19) ¶20-21; Moss Decl. (Dkt. 68)
 11 ¶5 (some recipients' hours increased, others decreased); *see also* Reed Decl. Ex. 1 (Dkt. 18-1) at
 12 7 (caseload forecasting process), *id.* Ex. 2 (Dkt. 18-2) at 5 (same); Rolf Decl ¶¶6-8, 11-13.

13 The CARE tool relies upon in-person evaluations and information from all sources to
 14 determine a beneficiary's needs; it is based upon standardized screening tools that have been
 15 proven to increase the accuracy and reliability of clinical assessments. Black Decl. (Dkt. 19)
 16 ¶¶7-12, 18, 20-21, 25 & Ex. 2 (Dkt. 19-2), Ex. 3 (Dkt. 19-3). This system uses the results of
 17 individualized assessments of cognitive performance, clinical complexity, mood/behavior
 18 symptoms, and Activities of Daily Living to classify beneficiaries into seventeen different acuity
 19 and need-based categories with common characteristics predictive of common needs and
 20 resource use. WAC 388-106-0085, 388-106-0125; Black Decl. (Dkt. 19) ¶18-21, 7-8; Def. Resp.
 21 TRO, Ex. 5 (Dkt. 66-1) at 3, 11.⁴ Each category is assigned a "base assistance level in hours of
 22 care" based on this formula. *Jenkins v. Washington State DSHS*, 157 P.3d 388, 389 (Wash.
 23 2007); WAC 388-106-0125, 388-106-1230 (1). The CARE tool's in-home algorithm then

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 25 ⁴ The base hours authorizations by category are derived from statistical analysis of the relationship between
 26 care time and multiple clinical variables, and time studies, that have been tested, refined, and incorporated into the
 27 CARE Tool itself. Reed Decl. (Dkt. 18)¶29 & Ex. 1 (Dkt. 18-1) at 6; Black Decl. (Dkt. 19) ¶¶20, 21; Def. Resp.
 TRO Ex. 5 (Dkt. 66-1) at 3 (goal of CARE tool was "to develop a resident classification system that assesses
 resident care needs and resource use and bases payments on the degree of use."); *id.* ("The purpose of the time study
 was to determine resources use when specific care needs were identified."); *id.* at 10-13; 4th Brenneke Decl. Ex. 4 at
 23:1-11 (purpose of time study was to determine if CARE authorization would meet client needs).

1 *deducts* from the base level hours to adjust for beneficiary needs that can be met through other
 2 resources (such as “informal supports”) and circumstances such as when more than one
 3 beneficiary resides in a household, and *adds* hours based on living environment considerations
 4 and accessibility of laundry, shopping and wood. *Jenkins*, 157 P.3d at 389; WAC 388-106-0055,
 5 388-106-0125, 388-106-0130; Reed Decl. (Dkt. 18) ¶30; Black Decl. (Dkt. 19) ¶¶10, 13 & Ex. 2
 6 (Dkt. 19-2) at 175-176. Through these calculations, the automated CARE tool generates the
 7 statutory “maximum” number of in-home personal care hours that can be used to develop a plan
 8 of care. WAC 388-106-0130(8). In most cases, the CARE tool’s results are a “reliable measure
 9 of actual unmet need” and the “minimum level of necessary support that takes into account all
 10 the needs of the beneficiary as well as the existing level of supports the beneficiary already
 11 enjoys.” Black Decl. (Dkt. 19) ¶¶26, 28.

12 Before authorization of personal care hours, however, the CARE tool results must be
 13 translated into a care plan (or Individual Service Plan for the developmentally disabled) through
 14 which the beneficiary has the opportunity to choose and consent to receive a certain number of
 15 authorized service hours from particular, approved providers, with summaries of the tasks they
 16 are to perform. In developing the plan of care, “The Department must take into account cost
 17 effectiveness, *client health and safety*, and program limits in determining how hours can be used
 18 *to meet your identified needs.*” WAC 388-106-0130(8) (emphasis added), 388-106-0103(9).
 19 When “the amount of hours for the person’s classification group [is] not enough to address the
 20 individual’s current circumstances,” case managers can use the Exception To Rule (“ETR”)
 21 process to authorize personal care hours above the “maximum.” Leitch Decl. (Dkt. 67) ¶4; WAC
 22 388-440-0001; *see also* Black Decl. Ex. 2 (Dkt. 19-2) at 175.⁵

23 Only after all of these steps – the CARE assessment, eligibility, consent for services and
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25 ⁵ For example, two beneficiaries are both categorized as “D Medium High,” with 240 base hours prior to
 26 the 2011 cuts. For one, taking into account informal supports and the other individual characteristics, the CARE
 27 tool generated maximum hours of 212 or 215, which were accepted and incorporated into a plan of care. Allington
 Decl. Ex. 1 (Dkt. 52-1), Ex. 2B (Dkt. 52-3) at 2, Ex. 2C (Dkt. 52-4) at 21. In contrast, Plaintiff A.R.’s CARE
 assessment generated a maximum number of 157, which was then increased by 165 hours through an ETR, to result
 in an authorization of 323 hours. Frederick Decl. Ex. 1A (Dkt. 40-1) at 1, Ex. 2 (Dkt. 40-3), Ex. 3 (Dkt. 40-4), Ex. 4
 (Dkt. 40-5). With the 2011 cuts, both will have their hours cut significantly.

1 approval of a plan of care, with chosen qualified providers – may the Department authorize LTC
 2 services. WAC 388-106-0045. Beneficiaries have the freedom to choose their preferred type of
 3 long-term care services (in-home, community residential settings, or institutional settings), select
 4 qualified providers, and agree to receive a certain number of authorized hours as set forth in the
 5 individualized care plan in exchange for waiving their right to mandatory Medicaid services such
 6 as nursing home care. WAC 388-106-0030, 388-106-0050(1)-(2), 388-106-0130(8), 388-106-
 7 0140, 388-106-0300(12), 388-106-0355; Reed Decl. (Dkt. 18) ¶¶12, 35, 38-40; Black Decl. (Dkt.
 8 19) ¶¶10, 14, 16-17; Brenneke Decl. Ex. 16 (Dkt. 17-6) (choice form). If beneficiaries disagree
 9 with the terms of the CARE assessment and care plan, they may appeal and continue receiving
 10 previously authorized services while that appeal is pending. WAC 388-106-1305; 388-458-
 11 0040; Frederick Decl. Ex. 2 (Dkt. 40-3); Black Decl. (Dkt. 19) ¶¶9-10, 14-15.

12 **C. Reductions of Personal Care Hours Based on Budget**

13 In late September 2010, in response to an executive order mandating state agency
 14 appropriations reductions of 6.287 percent, Defendants proposed to reduce Medicaid in-home
 15 personal care service hours by an average of ten percent. Brenneke Decl. Ex. 1 (Dkt. 12-1) at 2.
 16 This reduction was in addition to an average four percent decrease in 2009 and some additional
 17 targeted reductions. Brenneke Decl. Ex. 4 (Dkt. 12-8) at 6, Ex. 5 (Dkt. 12-9) at 1; Black Decl.
 18 (Dkt. 19) ¶29. Defendants’ plan for the reductions stated that, “[w]ith reduced hours, in-home
 19 clients will need to choose which tasks their employees spend their time on and there may not be
 20 enough time to complete all tasks”; at the higher percentage reductions needed tasks might not
 21 be completed on a regular basis; clients would have longer time periods without paid care; and,
 22 “[i]n some cases, a safe in-home plan of care will not be possible and clients may need to go to
 23 community residential or nursing facility settings.” Brenneke Decl. Ex. 4 (Dkt. 12-8) at 6; *see*
 24 *also id.*, Ex. 5 (Dkt. 12-9) at 1.⁶

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 26 ⁶ DSHS made these statements in the Agency Plan for 6.287 Percent GF-S Allotment Reduction submitted
 27 by the Division of Developmental Disabilities (a division of DSHS) to the State’s Office of Financial Management
 (OFM). Brenneke Decl. Ex. 4 (Dkt. 12-8) at 6-7. This Court’s order denying a TRO declined to construe the
 Agency Plan as a judicial admission and construed it as part of “internal dialogue” within DSHS. TRO Order (Dkt.
 76) at 12:17, 12:24. However, the Agency Plan should be given weight as an admission of a party-opponent, *see*

1 On November 30, 2010, Defendants issued a management bulletin with the Department's
 2 plan to implement the service reductions; it directed form letters be sent to beneficiaries and
 3 providers the week of December 6, 2010 that stated there were "no appeal rights for this
 4 change." Brenneke Decl. Ex. 1 (Dkt. 12-2), Ex. 1A (Dkt. 12-2), Ex. 1B (Dkt. 12-3). Defendants
 5 imposed the hours cuts unilaterally and without individualized reassessments, by "amending" the
 6 previously agreed upon care plans that had been generated through the individualized CARE
 7 assessment process to meet beneficiaries' needs for personal care services at home and reducing
 8 the previously authorized in-home personal care hours by a set number of hours driven by budget
 9 imperative and calculated according to the beneficiaries' "base hour" category from their last
 10 CARE assessment. Brenneke Decl. Ex. 1 (Dkt. 12-1) at 1-2.

11 **D. Procedural Background**

12 Plaintiffs filed this action on December 21, 2010, and two days later filed a motion for a
 13 temporary restraining order ("TRO") and order to show cause why a preliminary injunction
 14 should not issue, along with a motion for class certification. Dkt. 1, 11, 62. On December 28
 15 Defendants filed a response to Plaintiffs' TRO motion, and Plaintiffs filed a reply the next day.
 16 Dkt. 66, 69. The Court held a hearing on December 30, denied Plaintiffs' TRO motion that same
 17 day, and filed a written decision setting forth its reasoning on January 5, 2011. Dkt. 73, 76. A
 18 hearing on the preliminary injunction and class certification was set for January 14.

19 On January 6, 2011, Plaintiffs filed a notice of appeal from the denial of the TRO. Dkt.
 20 78. This Court stayed proceedings pending the Ninth Circuit's disposition of that appeal. Dkt.
 21 80. On January 10 Plaintiffs filed an emergency motion for an injunction pending appeal in the
 22 Ninth Circuit. Following expedited briefing, the Ninth Circuit granted Plaintiffs' motion based

23 _____
 24 Fed. R. Evid. 801(d)(2), that provides compelling evidence that some beneficiaries will be institutionalized as a
 25 result of these cuts. The Agency Plan sets forth DSHS's official views about the impacts these cuts will have. The
 26 Agency Plan is a published document provided by DSHS to OFM and is publicly available on OFM's website. See
 27 http://www.ofm.wa.gov/reductions/default.asp#agency_plans (follow link to "Division of Development
 Disabilities," under "Social & Health Services, Department of"). The same is true for the Agency Plan for 6.287
 Percent GF-S Allotment Reduction submitted by DSHS's Long Term Care division, which states, "[i]f the reduction
 results in an unsafe plan of care, some clients may need to go to community residential or nursing facility settings."
 Brenneke Decl. Ex. 5 (Dkt. 12-9) at 1 (available at <http://www.ofm.wa.gov/reductions/300-050-DSHS-LTC.pdf>).

1 on the “irreparable injury” that already was occurring and would continue to occur:

2 Appellants’ motion for a stay prohibiting the State of Washington from implementing
 3 emergency regulation WSR 11-02-041 is granted pending the district court ruling on
 4 appellants’ motion for preliminary injunction. . . . No other relief is available that will
 remedy the irreparable injury which continues to occur pending such hearing.

5 4th Brenneke Decl. Ex. 5 at 2. Defendants’ motion for reconsideration of that order and
 6 Plaintiffs’ motion for contempt sanctions were both denied on January 20, 2011. Dkt. 92.

7 V. ARGUMENT

8 A. Plaintiffs Meet the Legal Standard for a Preliminary Injunction.

9 Plaintiffs seek a preliminary injunction that will preserve the status quo. *See GoTo.Com,*
 10 *Inc. v. Walt Disney Co.*, 202 F.3d 1199, 1210 (9th Cir. 2000) (*status quo ante litem* is “last
 11 uncontested status which preceded the pending controversy”). “A plaintiff seeking a preliminary
 12 injunction must establish that he is [1] likely to succeed on the merits, [2] that he is likely to
 13 suffer irreparable harm in the absence of preliminary relief, [3] that the balance of equities tips in
 14 his favor, and [4] that an injunction is in the public interest.” *American Trucking Ass’ns v. City of*
 15 *Los Angeles*, 559 F.3d 1046, 1052 (9th Cir. 2009) (quoting *Winter v. Natural Res. Def. Council*
 16 *Inc.*, 129 U.S. 365, 374 (2008)).⁷ Where plaintiffs have made a strong showing of irreparable

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 18 ⁷ The Court noted in its TRO Order that the parties had not briefed whether the associational plaintiffs have
 19 standing. TRO Order (Dkt. 76) at 5 n.2. The Court need not reach this issue, however, if it concludes that any one
 20 of the individual named plaintiffs has standing. *See, e.g., Rumsfeld v. Forum for Academic & Institutional Rights,*
 21 *Inc.*, 547 U.S. 47, 53 n.2 (2006); *Fleming v. Pickford*, 581 F.3d 922, 924 n.3 (9th Cir. 2009) *Bates v. United Parcel*
 22 *Serv.*, 511 F.3d 974, 985 (9th Cir. 2007) (en banc). In any event, the associational plaintiffs have standing because
 23 “(a) [their] members would otherwise have standing to sue in their own right; (b) the interests [they] seek[] to
 24 protect are germane to the organization’s purpose; and (c) neither the claim asserted nor the relief requested requires
 25 the participation of individual members in the lawsuit.” *Hunt v. Washington Apple Adv. Comm’n*, 432 U.S. 333, 343
 26 (1977). Plaintiffs Arc of Washington State and Puget Sound Alliance for Retired Americans have members with
 27 standing to sue in their own right as beneficiaries of personal care services who will suffer direct injuries from the
 hours cuts. Elliot Decl. (Dkt. 50) ¶¶2, 10; Stern Decl. (Dkt. 51) ¶8. Plaintiff SEIU Healthcare 775NW’s members
 have standing to sue both as providers who will lose jobs and hours of work due to the hours reductions, Glickman
 Decl. (Dkt. 49) ¶¶7-8; *see Independent Living Center of Southern California, Inc. v. Shewry*, 543 F.3d at 1065, and
 in some cases as direct beneficiaries, because some members serve as guardians or have power of attorney over
 family members who receive personal care services and could sue on behalf of those family members, Glickman
 Decl. (Dkt. 49) ¶8. The germaneness requirement is satisfied because the organizations’ “litigation goals [are]
 pertinent to [their] special expertise and the grounds that bring [their] membership together.” *Humane Soc’y of the*
United States v. Hodel, 840 F.2d 45, 56 (D.C. Cir. 1988). *See* Elliot Decl. (Dkt. 50) ¶¶3, 5; Stern Decl. (Dkt. 51)
 ¶¶5-7; Glickman Decl. (Dkt. 49) ¶¶5, 9, 12. Finally, the participation of individual members is not necessary in suits
 such as the present case that seek only prospective injunctive relief, rather than damages. *United Food &*
Commercial Workers v. Brown Group, Inc., 517 U.S. 544, 554 (1996). Moreover, the instant case is brought as a

1 harm and that the injunction is in the public interest, a lesser showing of likelihood of success is
 2 needed, and vice versa. *See Humane Soc. of U.S. v. Gutierrez*, 527 F.3d at 789; *Golden Gate*
 3 *Restaurant Association v. San Francisco*, 512 F.3d at 1112 (9th Cir. 2008); *Alliance for Wild*
 4 *Rockies v. Cottrell*, 622 F.3d 1045, 1049-53 (9th Cir. 2010). Plaintiffs meet this test and class-
 5 wide injunctive relief is proper.⁸

6 **B. The Reduction in Personal Care Services Will Cause Irreparable Injury.**

7 **1. The Reduction in Personal Care Services Will Cause Deterioration of**
 8 **Health, Physical Injury, and Institutionalization.**

9 The Ninth Circuit expressly concluded that “irreparable injury . . . continues to occur”
 10 while the cuts remain in place. 4th Brenneke Decl. Ex. 5 at 2. Applying the same standard to
 11 substantially the same record, this Court should reach the same result.⁹ Plaintiffs have and will
 12 suffer imminent and irreparable injury, including deterioration of health, physical injury, and
 13 institutionalization, if the hours reductions are not enjoined. Although Plaintiffs believe that this
 14 Court erred in concluding otherwise when it denied Plaintiffs’ TRO motion, Plaintiffs now
 15 present 26 additional declarations that describe with particularity the harm suffered as a result of
 16 the reductions and address some of the concerns expressed by the Court in its TRO ruling.¹⁰

17 Initially, this Court seems to have assumed that Plaintiffs could prove irreparable injury
 18 only by demonstrating “that base hours bear a direct relationship to the minimum amount of
 19 personal care services required for individuals to remain safely in their homes.” TRO Order

20 _____
 21 class action seeking prospective injunctive relief, pursuant to Federal Rule of Civil Procedure 23(b)(2), which, by
 22 definition, does not require individual involvement.

23 ⁸ Although Plaintiffs have filed a motion for class certification in an abundance of caution, “[d]istrict courts
 24 are empowered to grant preliminary injunctions regardless of whether the class has been certified.” *Brantley v.*
 25 *Maxwell-Jolly*, 656 F.Supp.2d 1161, 1178 n.14 (N.D. Cal. 2009) (quotation marks omitted); *accord V.L. v. Wagner*,
 26 669 F.Supp.2d 1106, 1114 n.6 (N.D. Cal. 2009). Indeed, this is what the Ninth Circuit did here. However, if this
 27 Court disagrees, it should certify the classes for the reasons set forth in Plaintiffs’ Motion for Class Certification.

⁹ The Ninth Circuit applied the same standard for irreparable injury that applies to this motion for
 preliminary injunction. *See* 4th Brenneke Decl. Ex. 5 at 1-2 (Ninth Circuit treated Plaintiffs’ appeal as “tantamount”
 to an appeal from a denial of a preliminary injunction); *Stuhlberg Int’l Sales Cov. v. John D. Brush & Co.*, 240 F.3d
 832, 839 n.7 (9th Cir. 2001) (TRO and preliminary injunction standards are “substantially identical”).

¹⁰ Many of these new declarations were originally filed with the Ninth Circuit on January 14, immediately
 before the hours reductions were enjoined. For that reason, they follow Ninth Circuit formatting rules and in some
 cases respond directly to evidence introduced by Defendants in the Ninth Circuit, which may not currently be before
 this Court. Given the tight time frames, Plaintiffs were unable to obtain new signatures on reformatted declarations.

1 (Dkt. 76) at 14:17-19. Although Plaintiffs have proved that this is true, *see infra* at 18-23, that is
2 not the proper standard. The reduction or loss of needed medical benefits for low-income
3 disabled or elderly individuals constitutes irreparable injury justifying prospective equitable
4 relief. *See Beltran v. Myers*, 677 F.2d 1317, 1322 (9th Cir. 1982) (showing that enforcement of a
5 state’s Medicaid rule “may deny [plaintiffs] needed medical care” is “sufficient” to show
6 irreparable injury (emphasis added)); *see also Independent Living Ctr. v. Maxwell-Jolley*, 572
7 F.3d 644, 658 (9th Cir. 2009) (“needed medical care”), *cert. granted on other issue*, 2011 WL
8 134272 (U.S. Jan. 18, 2011); *Lopez v. Heckler*, 713 F.2d 1432, 1437 (9th Cir. 1983) (disability
9 benefits); *V.L.*, 669 F.Supp.2d at 1121-22 (in-home care services); *Mayer v. Wing*, 922 F.Supp.
10 902, 905, 909 (S.D.N.Y. 1996) (same). Irreparable injury results not only from termination, but
11 also from reductions, in home care services. *See V.L.*, 669 F.Supp.2d at 1109; *Mayer*, 922
12 F.Supp. at 904, 909. Any argument that the home care services at issue here do not constitute
13 “needed medical care” is belied by the fact that most beneficiaries are eligible for nursing home
14 admission, which is a mandatory Medicaid benefit, and receive home care services in lieu of the
15 nursing home placements for which they are eligible. *See also* RCW 74.09.520(1)(l) (personal
16 care services are “medical assistance”).

17 Plaintiffs also suggest that the Court erroneously characterized numerous witnesses’
18 evidence-based predictions of future harm as “speculation.” TRO Order (Dkt. 76) at 10:11.
19 “[S]pecific, predictive judgments” are not necessarily “speculative,” and are invariably necessary
20 when prospective relief is sought. *Winter*, 129 S.Ct. at 378. When seeking to enjoin an action
21 that has not yet occurred, Plaintiffs are only required to show “that irreparable injury is *likely*”—
22 not certain, and not immediate—in the absence of a preliminary injunction. *Winter*, 129 S.Ct. at
23 375 (emphasis in original); *see* Wright & Miller, Fed. Pract. & Proc. § 2948.1 & n. 11 (2010)
24 (“injury need not . . . be certain to occur; a strong threat of irreparable injury before trial is an
25 adequate basis”; citing cases). The Court seems to have misapplied this standard. *See, e.g.*, TRO
26 Order (Dkt. 76) at 10:10-15 (characterizing fact-based testimony that nursing home admission
27 was “likely” as “speculation”).

1 Plaintiffs have established the likelihood of irreparable injury through Defendants' own
 2 admissions as well as 59 declarations from former state officials, experts, service providers, and
 3 beneficiaries with specific information about personal care recipients in Washington, the need
 4 for the in-home personal care services beneficiaries receive, and the likely consequences of
 5 reductions of those services, including serious risk of injury, illness, and/or institutionalization.

6 Beneficiaries already are suffering actual injuries of the type predicted as a result of the
 7 implementation of hours cuts only two weeks ago. For example, J.P. already is experiencing
 8 skin breakdown that could lead to infection and hospitalization because her provider no longer
 9 has sufficient time to clean between her legs during the 1.5 (rather than two) hours she now has
 10 to prepare her for bed each day. J.P. also risks other infections and sores because her catheter is
 11 not being changed daily and she is not being moved enough; she must also attend medical
 12 appointments without accompaniment of a provider, which is harmful in light of J.P.'s inability
 13 to remember symptoms and doctor's instructions. Anderson-Webb Decl. ¶¶17b, 25a-c.

14 Plaintiff K.S. is suffering adverse impact to her mental health, and because she cannot
 15 remove her compression stockings all weekend when she is without a provider, is experiencing
 16 sores on her legs that may develop into cellulitis requiring hospitalization. 2nd K.S. Decl. ¶4.
 17 Plaintiffs J.B., A.B., An.B. and M.B. no longer receive daily baths, risking rashes, skin problems
 18 and worse due to incontinence. 2nd Jane B. Decl. ¶¶5-7. Their mother can no longer run
 19 necessary errands without bringing them along, which makes it impossible at times to buy
 20 groceries or fill prescriptions because M.B.'s Oppositional Defiant Disorder causes him to be
 21 uncontrollable and erratic in public. *Id.* ¶¶5-7.¹¹ A.R.'s weekend provider refused to work a
 22

23 ¹¹ This is additional evidence that supplements the declarations originally presented to the Court with
 24 respect to these Plaintiffs. The original evidence showed that the reduction of 67 collective hours of care for four
 25 sibling Plaintiffs with physical and cognitive disabilities, whose adoptive mother's physical disability limits her
 26 ability to provide much of the care they need, would present a significant risk of institutionalization. This Court
 27 criticized one declarant for failing to "quantify" the absolute minimum number of hours needed and "offer[ing] no
 concrete sense of immediacy," TRO Order (Dkt. 76) at 10:12-16, 11:1-2, but apparently failed to note two other
 declarations that explain very specifically the gaps in care that will result, needs that will go unmet, and reasons for
 concern about institutionalization. Jane B. Decl. (Dkt. 33) ¶¶10, 23a-c (reduced hours will likely cause skin
 breakdowns and behavioral issues presenting institutionalization risk); Partridge Decl. (Dkt. 35) ¶¶5-6, 9, 12-13, 25,
 27 (services that will not be performed and health problems that will result). *See also* Starr Decl. (Dkt. 34) ¶¶6-27.

1 short shift on Sundays; therefore, A.R. had to stay in bed for the entire day, placing her at risk for
 2 bed sores, because her 84-year-old mother is unable to get her out of bed. 2nd Frederick Decl.
 3 ¶¶5-6. *See also* 2nd Bowman Decl. ¶7, 9 (health has deteriorated due to reduced provider hours,
 4 and increased stress because provider will likely quit for job with more hours).

5 Other beneficiaries already have been institutionalized or are at immediate risk of
 6 institutionalization because, as a result of the hours reductions, their care plans now are unsafe or
 7 their providers must seek additional employment and cannot continue to provide uncompensated
 8 hours of personal care service. For example, 92-year-old H.C. had Alzheimer's, heart disease,
 9 and osteoarthritis that made him susceptible to falling. In a declaration presented to the Court in
 10 December, H.C.'s provider explained that reduction of H.C.'s hours from 116 to 100 would be
 11 insufficient to assist with meal preparation, toileting and incontinence care, mobility, bathing,
 12 oxygen and medication management, and predicted that H.C. would likely enter a nursing home
 13 within a matter of months. Chatwin Decl. (Dkt. 48) ¶¶2, 5-6, 11-14, 20-21. In an updated
 14 declaration filed with the Ninth Circuit on January 14, H.C.'s son explained that he "cannot care
 15 for H.C. on the hours DSHS allotted for 2011" and "the arbitrary cuts to H.C.'s home care
 16 services have made keeping him at home impossible." 2nd Chatwin Decl. ¶12. He explained
 17 that as a result of the hours reductions, H.C. would be moving into an institutional care facility
 18 within the month, as soon as all paperwork was completed. *Id.* ¶¶8, 12.¹² Similarly, Plaintiff
 19 M.J.B.'s provider inquired about openings at a nursing home after learning of the reductions, and
 20 planned to commit her as soon as there was an opening because she could not continue to
 21 provide the amount of care needed by M.J.B. on the reduced hours. 2nd Paolino Decl. ¶¶5-6.¹³
 22 The Franklin Hills Health and Rehabilitation Center has admitted two clients to its long term
 23 care facilities this month as a result of the hours reductions. Wujick Decl. ¶¶4-6.¹⁴ Other

24 _____
 25 ¹² Counsel has since learned that H.C. passed away on Saturday, January 15, 2011, before the move to a
 nursing home could be accomplished. 4th Brenneke Decl. ¶3.

26 ¹³ M.J.B. has just been notified that she will receive additional personal care hours through an ETR, an
 exception to the hours cut policy, and through that exception she will be able to remain safely at home.

27 ¹⁴ Both men have paraplegia and had lived independently at home prior to the hours reductions. *Id.* As a
 result of the hours reductions, they were left at home for longer periods of time; one developed bed sores because he
 was not turned enough and the other lay in bed without being cleaned after wetting himself. *Id.* Both are intact

1 beneficiaries are likely to move to nursing homes or group residential settings because the
 2 reduced hours will not provide for their needs.¹⁵ Former state officials and experts find that the
 3 magnitude of these cuts to below assessed need puts beneficiaries at risk of institutionalization.
 4 *See* Black Decl. (Dkt. 19) ¶¶33-34, Reed Decl. (Dkt. 18) ¶¶46-47, LaPlante Decl.(Dkt. 22) ¶¶21-
 5 22, J ¶¶12-13, Dapper Decl. (Dkt. 20) ¶17.

6 This Court apparently discounted much of the evidence concerning actual or imminent
 7 institutionalization based on its finding that the decision to move a beneficiary into a nursing
 8 home is often bound up with the beneficiary and/or provider's financial or living situation. TRO
 9 Order (Dkt. 76) at 11:4-24. But this fails to take into account that the care plans that were
 10 unilaterally "amended" by DSHS to implement these hours cuts specifically rely upon factors
 11 related to the beneficiary and provider's financial and living situations, and providers' agreement
 12 to provide certain numbers of hours toward delineated care tasks (and beneficiaries' agreement
 13 to waive nursing home care) were based on those circumstances. As such, it is foreseeable that
 14 the unilateral "amendment" of the care plans would disrupt the balanced and considered
 15 agreements between providers and beneficiaries, most of whom were already are on the edge and
 16 making due by meeting only the minimal needs of the beneficiaries, and result in some

17 _____
 18 mentally and are very depressed about having to give up their independence, but the nursing home cannot discharge
 19 them because the hours reductions have made it unsafe for them to remain at home. *Id.*

20 ¹⁵ For example, Plaintiff S.J. has muscular dystrophy, cannot move independently, and is totally dependent
 21 on her provider for all activities, including eating, toileting, transfers, and mobility. S.J. Decl. (Dkt. 27) ¶8.
 22 Although Plaintiff S.J.'s live-in provider has agreed to stay on temporarily on an emergency basis and provide the
 23 free care necessitated by the hours reduction in the short term so that no harm comes to S.J., he does not intend to
 24 and cannot provide this free care indefinitely. 2nd Braddock Decl. ¶¶ 4-5, 20. S.J. and her provider contacted a
 25 home care agency to find a replacement provider, but the agency refused the job *because the care plan as written is*
 26 *unsafe and allocates inadequate personal care hours to meet S.J.'s needs and enable her to stay safely at home.* 2nd
 27 Braddock Decl. ¶¶18-19; 2nd S.J. Decl. ¶9. Similarly, Plaintiff J.H. has already been institutionalized because his
 provider was unable to meet the financial burden of providing the excess hours of uncompensated care that would
 have been required for J.H.'s safety under the newly reduced hours allocation. Hayes Decl. (Dkt. 47) ¶8. Although
 the State intimated that there were other disagreements between Plaintiff J.H. and his provider, (12/30/10 TRO Tr.
 29:4-18), this disagreement was precipitated by the hours reduction and the provider's decision that she could no
 longer provide this free care. 2nd Hayes Decl. ¶5, 11-12; Johnson Decl.. Similarly, the live-in provider for M.A.B,
 who suffers from multiple mental illnesses, is seeking to place him into an institution because she cannot afford to
 continue to provide the ever-increasing hours of free care that M.A.B. needs in light of the January 2011 hours
 reductions. Josephsen Decl. ¶¶6-7, 12-15, 18-20. *See also* D.W. Decl. (Dkt. 31) ¶¶22b, 25; C.B. Decl. (Dkt. 29)
 ¶35; K.S. Decl. (Dkt. 36) ¶¶17, 21; Albott Decl. (Dkt. 37) ¶13; Jane B. Decl. (Dkt. 33) 9:26-10:4; Davis Decl. (Dkt.
 30) ¶¶31-32, 36; Dockstader Decl. (Dkt. 42) ¶19; Faatoafe Decl. (Dkt. 56) ¶24; Frederick Decl. (Dkt. 40) ¶¶22-24;
 McIntosh Decl. (Dkt. 32) ¶20-21; Morrow Decl. (Dkt. 38) ¶6.

1 providers' inability or unwillingness to provide even more charity care to fill the gap caused by
 2 the hours cuts. In each and every case presented, the hours cut proximately caused the likely
 3 negative results of institutionalization and irreparable injury. For many years, the State has
 4 laudably allowed seriously disabled individuals to live in their own homes rather than institutions
 5 (saving the State substantial sums) by paying for just enough personal care hours that providers
 6 could also afford to offer many hours of uncompensated care, including 24/7 supervision needed
 7 by many beneficiaries. These last hours reductions have made that impossible for individual and
 8 agency providers alike. *See, e.g.*, Walsh Decl. ¶¶14-15, 17.¹⁶

9 Serious and irreparable harm will befall beneficiaries if the hours reductions are not
 10 enjoined. The hours reductions mean that beneficiaries will receive fewer essential services,¹⁷
 11 receive assistance less frequently,¹⁸ and be left unattended for longer stretches of time.¹⁹

12 The reductions of services necessary to eat, toilet, move, bathe, dress and take medication
 13 likely will lead to injury, illness, health decline, and institutionalization in beneficiaries already
 14 found eligible for round-the-clock nursing home care. For example, a former case manager for
 15 Seattle's Aging and Disability Services who currently directs an agency that supplies providers
 16 to multiple clients predicted that the reductions "will result in hundreds or thousands of cases of
 17 . . . hospitalizations, as well as increases in preventable injury and death." Walsh Decl. (Dkt. 25)
 18 ¶12. Mr. Walsh specifically determined that, at his agency, "approximately 5% of our clients
 19 will likely have *immediate*, serious, adverse outcomes such as hospitalization, emergency room

20 _____
 21 ¹⁶ *See also* Maxson Decl. (Dkt. 26) ¶¶5, 11, 22-26; S.J. Decl. (Dkt. 27) ¶¶24-26, 29; Braddock Decl. (Dkt.
 22 28) ¶¶9,27,30,32; D.W. Decl. (Dkt. 31) ¶21; Hays Decl. (Dkt. 39) ¶¶5-6, 29; Paolino Decl. (Dkt.45) ¶¶14, 24; 2nd
 23 Paolino Decl. ¶¶6-7; Hayes Decl. (Dkt. 47) ¶¶4, 7-8; Allington Decl. (Dkt. 52) ¶¶16-18; Flint Decl. (Dkt. 53) ¶¶12,
 24 16-17; A.H. Decl. (Dkt. 54) ¶12; Guin Decl. (Dkt. 55) ¶¶27-33; Ivonav Decl. (Dkt. 58) ¶¶6, 15, 23-26; 2nd Chatwin
 25 Decl. ¶¶8-10, 12.

26 ¹⁷ C.B. Decl. (Dkt. 29) ¶26; D.W. Decl. (Dkt. 31) ¶22; Jane B. Decl. (Dkt. 33) ¶24; K.S. Decl. (Dkt. 36)
 27 ¶15; ¶18, Dockstader Decl. (Dkt. 42) ¶15; McIntosh Decl. (Dkt. 32) ¶16; Morrow Decl. (Dkt. 38) ¶6; Partridge Decl.
 28 (Dkt. 35) ¶13; Starr Decl. (Dkt. 34) ¶¶25, 26.

29 ¹⁸ A.H. Decl. (Dkt. 54) ¶12; C.B. Decl. (Dkt. 29) ¶26; Ivonav Decl. (Dkt. 58) ¶24; D.W. Decl. (Dkt. 31)
 30 ¶22b; K.S. Decl. (Dkt. 36) ¶15; N.N.A. (Dkt. 57) ¶6; Albott Decl. (Dkt. 37) ¶¶12-13; Davis Decl. (Dkt. 30) ¶26;
 31 Frederick Decl. (Dkt. 40) ¶18; Flint Decl. (Dkt. 53) ¶¶16-17; Guin Decl.(Dkt. 55) ¶29; Hays Decl. (Dkt. 39) ¶25;
 32 McIntosh Decl. (Dkt. 32) ¶16; Morrow Decl. (Dkt. 38) ¶6.

33 ¹⁹ K.S. Decl. (Dkt. 36) ¶15; A.H. Decl. (Dkt. 54) ¶12; C.B. Decl. (Dkt. 29) ¶23; D.V.S. Decl. (Dkt. 59) ¶16;
 34 D.W. Decl. (Dkt. 31) ¶22b; N.N.A. (Dkt. 57) ¶6; Davis Decl. (Dkt. 30) ¶26; Flint (Dkt. 53) ¶16; Guin Decl.(Dkt. 55)
 35 ¶29; Ivonav Decl. (Dkt. 58) ¶24; McIntosh Decl. (Dkt. 32) ¶16; Starr Decl. (Dkt. 34) ¶24.

1 visits, and *imminent* institutionalization.” Walsh Decl. (Dkt. 25) ¶13 (emphasis added).
 2 Plaintiffs respectfully suggest that this Court failed to appreciate the significance of this
 3 testimony, or of Mr. Walsh’s statement that other clients face “several months of slow decline
 4 rather than requiring *immediate* hospitalization or institutionalization.” TRO Order (Dkt. 76) at
 5 10:18-11:2 (emphasis in original). This “slow decline” of health – which may well be
 6 irreversible – is itself an imminent and irreparable injury, even if hospitalization or
 7 institutionalization may not occur for several months.²⁰ *See also* Pritchard Decl. ¶7 (former
 8 director of agency; personal care hours already insufficient to meet many clients’ minimum
 9 needs and “reduction of even 30 minutes a day for individuals who already have just barely
 10 enough services to meet their minimal needs will make a major difference”; caregivers “will now
 11 be unable to finish cooking, obtain needed medications or supervise client self administration of
 12 medications, [or] give clients needed baths”). Uncontroverted expert evidence establishes that
 13 unmet needs in activities of daily living “cannot be tolerated for long” and have “immediate and
 14 serious consequences” such as injury, deterioration of health, and even death. Gardner Decl.
 15 (Dkt 21) ¶¶11-18; LaPlante Decl. (Dkt. 22) ¶¶7, 10.

16 Beneficiaries and their providers described the likely results of the reductions in great
 17 detail: without adequate toileting help or incontinence care, beneficiaries risk skin tearing,
 18 infections and bowel obstructions;²¹ missing necessary medication or taking improper doses;²²
 19 choking or going hungry without sufficient assistance eating;²³ and being unable to maintain the
 20

21 ²⁰ Similarly, former DSHS officials and experts familiar with Washington’s in-home care system predict
 22 that the reductions will place beneficiaries “at immediate risk of serious health deterioration and even death,” Reed
 23 Decl. (Dkt. 18) ¶44, and cause “many” beneficiaries to “experience immediate and substantial harm” including
 24 “more medical emergencies and hospitalizations,” which will cause “serious and irreparable harm to their physical
 25 and mental health condition,” Black Decl. (Dkt. 19) ¶33, because the specific cuts at issue here reduce services to a
 26 level below that required for beneficiaries “to live safely and healthily,” LaPlante Decl. (Dkt. 22) ¶22.

27 ²¹ Flint (Dkt. 53) ¶16 (going to the bathroom without assistance will lead to sitting in “her own mess” and
 potentially “another bladder infection” at which point they may have to remove her kidney), Guin Decl.(Dkt. 55)
 ¶30 (not changing pull-ups regularly will cause infections.), Leamy Decl. (Dkt. 46) ¶4 (improper incontinence care
 can lead to skin infections), A.H. Decl. (Dkt. 54) ¶12; Partridge Decl.(Dkt. 35) ¶13a.

²² McIntosh Decl. (Dkt. 32) ¶16d; D.V.S. Decl. (Dkt. 59) ¶¶7d, 16b; D.W. Decl. (Dkt. 31) ¶¶22a, 22c;
 N.N.A. (Dkt. 57) ¶6; Guin Decl.(Dkt. 55) ¶31; Partridge Decl.(Dkt. 35) ¶13d.

²³ D.W. Decl. (Dkt. 31) ¶13f; S.J. Decl. (Dkt. 27) ¶8e; Braddock Decl. (Dkt. 28) ¶18b; Jane B. Decl. (Dkt.
 33) ¶24a; Dockstader Decl. (Dkt. 42) ¶10b; McIntosh Decl. (Dkt. 32) ¶9c.

1 special diets required to avoid exacerbating their medical conditions.²⁴ Those with mobility
 2 impairments (who will be left alone for longer periods of time) risk falling when unattended,
 3 which can lead to serious injuries, hospitalization, and rapid deterioration.²⁵ Those who cannot
 4 be physically turned as often as needed will suffer bed sores and muscle problems.²⁶

5 Defendants cannot dispute that beneficiaries who already were granted increased hours
 6 due to an Exception To Rules (“ETR”) will suffer irreparable harm as a result of the cuts. The
 7 Department has already determined that they could not live safely at home with the base hours
 8 they were originally allotted and granted additional hours “based on the clinical characteristics
 9 and specific care needs of the participant.” Brenneke Decl. Ex. 7 (Dkt. 13-3) at 113; Leitch Decl.
 10 (Dkt. 67) ¶4. Now the base hours are being cut, reducing the total allocation. Brenneke Decl.
 11 Exs. 1A-1D (Dkts. 12-2 to 12-5). The new hours authorizations will be below their ETR-
 12 assessed minimum need. For example, the Department previously granted an Exception-to-Rule
 13 (“ETR”) to Plaintiff A.R., finding that she needed 323 hours, rather than 157 hours, to live safely
 14 at home. Frederick Decl. Exs. 2, 3 (Dkts. 40-3, 40-4). But now that bare minimum allotment
 15 has been reduced by 14, to 309. *Id.* Ex. 4 (Dkt. 40-5). Although another ETR request for A.R. is
 16 in process, she is currently suffering from the hours reductions. 2nd Frederick Decl. ¶¶5-9.

17 This Court’s original finding that no irreparable harm is likely to result from the hours
 18 reductions was based heavily on Defendants’ assurances that they would use the ETR process to
 19 ensure that beneficiaries who really did need additional hours to live safely at home would
 20 receive those hours. TRO Order (Dkt. 76) at 13:1-22. But beneficiaries were *never notified* that
 21 they could request additional hours through the ETR process, have no right to do so, and have no
 22 current fair hearing right to contest a denial of such hours under Washington law. See *infra* at
 23

24 ²⁴ C.B. Decl. (Dkt. 29) ¶26a; Davis Decl. (Dkt. 30) ¶26a; Guin Decl.(Dkt. 55) ¶30.

25 ²⁵ *E.g.*, Leamy Decl. (Dkt. 46) ¶5 (“I have often seen this situation before: when elderly people are left
 26 alone, they fall, break a bone, catch pneumonia and die.”); K.S. Decl. (Dkt. 36) ¶15; McIntosh Decl. (Dkt. 32)
 27 ¶¶16a-b; A.H. Decl. (Dkt. 54) ¶11; D.V.S. Decl. (Dkt. 59) ¶¶16a; N.N.A. (Dkt. 57) ¶6; Chatwin Decl. (Dkt. 48)
 ¶¶14d, 23; Davis Decl. (Dkt. 30) ¶26a; Guin Decl.(Dkt. 55) ¶¶30-31; Ivonav Decl. (Dkt. 58) ¶24; S.J. Decl. (Dkt.
 27)¶8c; Maxson Decl. (Dkt. 26) ¶¶8g, 26; Portelance Decl. (Dkt. 43) ¶6.

²⁶ Portelance Decl. (Dkt. 43) ¶5; Jane B. Decl. (Dkt. 33) ¶23a; Faatoafe Decl. (Dkt. 56) ¶17-21; Maxson
 Decl. (Dkt. 26) ¶26.

1 25-26 & nn.43-44. As such, the ETR process cannot be relied upon to prevent this irreparable
 2 harm. Even in cases of imminent placement in an adult family home or nursing home,
 3 Defendants neither invoked the ETR process nor notified Plaintiffs of the possibility.²⁷ And
 4 when providers or beneficiaries learned of the ETR process through counsel in this case and
 5 requested an ETR, some case managers refused to initiate the ETR process, many stating that
 6 ETRs are not available with respect to the challenged hours reductions.²⁸ One of the named
 7 Plaintiffs previously requested and now has been granted an ETR, but this followed notice of her
 8 involvement in the case. *See* 2nd Paolino Decl. ¶4.

9 This Court also determined the 2011 reductions would not cause irreparable harm based
 10 on a finding that the 2009 reductions did not cause such harm. TRO Order (Dkt. 76) at 13:24-
 11 14:10. However, the 2009 reductions were much smaller than those at issue here, and were
 12 partially restored in 2010. *See* Emergency Regulations WSR 09-14-046, 10-14-055 (amending
 13 WAC 388-106-0125) (found at <http://www.dshs.wa.gov/msa/rpau/recentlyadoptedrules.html>).
 14 Plus, the effects are cumulative. For example, the E High classification lost 4 base hours in 2009
 15 and will lose 23 more in 2011, while C Medium lost 8 base hours in 2009 and will lose 18 more
 16 in 2011. *See id.* Individual declarations bear out this difference in scale and the cumulative
 17 effect. *Compare, e.g.,* S.J. Decl. (Dkt. 27) ¶21 (S.J. lost 6 hours in 2009), *with id.* ¶17 (lost
 18 another 17 hours in 2011).²⁹ In the *Freeman* case, a Department official filed a declaration
 19 noting that in 2009 the state legislature considered but rejected higher reductions, because four
 20 percent “was thought to [be] small enough to allow in-home care recipients to continue to live in
 21 their own homes while maintaining their health and safety.” 3rd Brenneke Decl. Ex. 4 ¶12.³⁰

22
 23 ²⁷ 2nd K.S. Decl. ¶3; 2nd Paolino Decl. ¶4; 2nd Maxson Decl. ¶17; Ages Decl. ¶4; 2nd Allington Decl. ¶4;
 24 Bergstrom Decl. ¶8; 2nd Guin Decl. ¶4; Anderson-Webb Decl. ¶29; Hayes Decl. (Dkt. 47) ¶8, Maxson Decl. (Dkt.
 25 26) ¶11, S.J. (Dkt. 27) ¶25, Braddock (Dkt. 28) ¶27.

²⁸ 2nd Flint Decl. ¶4; 2nd Allington Decl. ¶4; Perkins Decl. ¶8; 2nd Bowman Decl. ¶3-5; *cf.* Ages Decl. ¶4;
 26 2nd Guin Decl. ¶8, Bergstrom Decl. ¶¶6-8.

²⁹ *See also* Frederick Decl. (Dkt. 40) ¶16 (A.R. lost 3 hours in 2009, 1 of which was restored), *with id.* ¶15
 27 (lost another 14 hours in 2011); Faatoafe Decl. (Dkt. 56) ¶7 (Z.J. lost 8 hours in 2009), *with id.* (lost another 26
 hours in 2011); Braddock Decl. (Dkt. 28) ¶¶8,25; Dockstader (Dkt. 42) ¶6, Allington Decl. (Dkt. 52) ¶6

³⁰ *Freeman* is also distinguishable because there the plaintiffs all made clear that their providers would
 continue to provide the same levels of care; no allegation that the individual beneficiary plaintiffs would be harmed

1 The impact of that much smaller cut can shed little light on what is likely to occur in 2011. 2nd
 2 LaPlante Decl. ¶8 (“In my professional opinion, the difference in the magnitude of these cuts,
 3 and the fact that the 2011 cuts will be in addition to the 2009 cuts, would make any . . .
 4 conclusion [that experience with the 2009 cuts show that the 2011 cuts will cause no harm]
 5 speculative.”) Nor is there any evidence that Defendants tracked the effects of the 2009
 6 reduction upon individuals. In contrast, evidence of the cumulative effect of the 2009 and 2011
 7 cuts demonstrates that beneficiaries are at serious risk of health decline and institutionalization.

8 **2. Current Levels of Personal Care Services Authorizations Are Needed**
 9 **By Beneficiaries.**

10 The Washington Supreme Court has characterized the CARE tool as “assess[ing]”
 11 individual recipients “to require and receive a certain number of care hours.” *Jenkins*, 157 P.3d
 12 at 393 (emphasis added); *see also id.* at 393 (invalidating across-the-board reduction for
 13 beneficiaries who lived with caregivers because “DSHS decided on *individualized*
 14 *determinations* of public assistance benefits” but then “refus[ed] to consider *the[ir] individual*
 15 *needs*”); *ibid.* (“DSHS may use the CARE assessment program to initially classify, rate, and
 16 determine a recipient’s *level of need*”); *ibid.* (recipients are “assessed *an amount needed* for meal
 17 preparation, housekeeping, and shopping”); *id.* at 391 (“initial assessment of each recipient’s
 18 *hours of need*”) (emphasis added in all cases). This Court’s previous conclusion that the State’s
 19 CARE tool “assesses only *relative* need for personal care services,” and that base hours
 20 “correlate with legislative appropriations, as opposed to individual need,” TRO Order (Dkt. 76)
 21 at 8:10-15 (emphasis added), conflicts with that authoritative construction of Washington law,
 22 which Plaintiffs apologize for not pointing out to this Court in the TRO briefing.³¹

23 The State’s Medicaid Plan and waivers also make clear that the CARE tool authorizes
 24 hours based on need. The State Plan provides that a beneficiary’s individualized care plan
 25 “[i]dentifies the State plan HCBS [*home and community based care*] necessary for the

26 _____
 27 or face institutionalization due to a reduction in services was either *made* or *rejected*. Work Decl. Ex. 2 at 19:15-24
 (*Freeman v. DSHS*, No.C09-5616 RJB (Trial Order) (W.D. Wash. Sep. 17, 2010)).

³¹ *Freeman* did not address whether the CARE system authorizes hours based on individual need.

1 *individual*, and furnishes . . . all HCBS *which the individual needs*.” Brenneke Decl. Ex. 6 Part 1
 2 (Dkt. 13-1) Supp. 4 to Att. 3-1A at 11 (emphasis added). State waivers describe the hours
 3 authorization process similarly. *See, e.g., id.* Ex. 7 (Dkt. 13-3) at 3 (individual assessment and
 4 plan of care “tailored to [each applicant’s] individual needs”); *id.* Ex. 7 Part 1 (Dkt. 13-3) at 112
 5 (CARE system identifies needs and develops care plan under process that ensures “the plan
 6 meets [beneficiaries’] needs”); *id.* Ex. 9 Part 3 (Dkt. 14-3) Appendix D at 5, 7 (assessment tool
 7 identifies and measures needs). And a DSHS settlement and order notes that an ISP “is the same
 8 as ‘Plan of Care’ and means the written document which DDD uses to document the health and
 9 welfare needs identified in the comprehensive needs assessment and to identify the services
 10 intended to meet those needs.” 4th Brenneke Decl. Ex. 8 at 2, 3.³² *See also* WAC 388-828-
 11 1020.

12 The declarations of Penny Black and Charles Reed further demonstrate that the CARE
 13 system authorizes the hours needed to permit each individual to remain safely at home, based on
 14 scientific time studies that connect tasks with hours of service and resource allocation
 15 algorithms. Reed Decl. (Dkt 18) ¶¶29-30, 46; Black Decl. (Dkt. 19) ¶¶14, 26, 28; *see also* 4th
 16 Brenneke Decl. Ex. 4 at 23:1-11; Rolf Decl. ¶¶8-13. It is not the case that these experts were
 17 discussing something “outside” the current CARE system, TRO Order (Dkt. 76) at 9:5-19,
 18 simply because the regulations characterize the initial base hours authorization as a “maximum”
 19 that may be reduced when there are other mechanisms for meeting beneficiaries’ needs.³³

20 _____
 21 ³² Federal law requires that state Medicaid plans “provide such methods and procedures relating to the
 22 utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard
 23 against unnecessary utilization of such care and services” 42 U.S.C. §1396a(a)(30)(A). For cases discussing
 24 this provision, *see, e.g., Prestera Center For Mental Health Services, Inc. v. Lawton*, 111 F.Supp.2d 768, 776
 25 (S.D.W.Va. 2000) (discussing legislative history); *Allen v. Mansour*, 681 F.Supp. 1232, 1239 (E.D.Mich. 1986)
 26 (same). Thus, if the State had been authorizing *more* hours than beneficiaries need, it might have been in violation
 27 of this assurance. *See also* 42 U.S.C. §1396a(a)(33)(A) (requiring states to ensure appropriateness of care and
 services); *id.*, §1396a(a)(37) (requiring review of claims); 42 C.F.R. §§ 456.22 (requiring procedures for ongoing
 evaluation of need for and quality and timeliness of services); *id.*, §456.23 (similar). *See also* Ex. 3rd Brenneke
 Decl. Ex. 5 at 9, 23, 33 (CMS instructed State prior to CARE system implementation that it could not limit waiver
 services based on available funding, and that “laws and policies should be implemented recognizing the need to
 fully fund the waiver services CAP participants are assessed to need.”).

³³ The statements in the declaration filed by Penny Black in the instant case that the hours ultimately
 authorized by the CARE system are only those minimally necessary do not conflict with her earlier declaration that
 the “classification results in a baseline determination of the number of hours of in-home care [DSHS] *may be able to*

1 Defendants' argument that the CARE system authorizes hours based on available budget
 2 resources is also undermined by the fact that, as this Court found, the base hours allocations for
 3 acuity categories have remained consistent, other than the addition of three classifications that
 4 more accurately measured acuity or need, until budget-based reductions in 2009 and 2011. TRO
 5 Order (Dkt. 76) at 7:17-19; 3rd Brenneke Decl. Ex. 1; Rolf Decl. ¶¶14-17, 20-24; Logan-von
 6 Wahlde Decl. ¶6; *compare also* 2nd Brenneke Decl. Ex. C (Dkt. 70-3), *with* Brenneke Decl. Ex.
 7 1 (Dkt. 12-1) at 1-2. If Defendants' characterization were correct, then base hours should have
 8 changed each budget year, increasing or decreasing based on the available budgetary resources.³⁴

9 In fact, in defending the CARE system against other challenges, Defendants themselves
 10 have characterized it as evaluating individual "need." *See, e.g.*, 3rd Brenneke Decl. Ex. 3 at 22-
 11 23 ("In contrast [to physicians], the Department regularly assesses the *need* for personal care
 12 services . . . , and it does so using a sophisticated assessment instrument."); *id.* at 24 ("[T]he
 13 Department spent extensive time . . . reviewing Samantha's *specific care needs* related to 19
 14 ADLs and IADLs . . ." and a physician's recommendation need not "alter[] the Department's far
 15 more thorough assessment of Samantha's *needs*." (emphasis added each time); *see also id.* Ex. 2
 16 at 14 (State's *Olmstead* plan; annual assessments "identify the needs of clients"); 4th Brenneke
 17 Decl. Ex. 9 at 18 (reporting that DSHS staff including Defendants' declarants "stated[] the rates

18 _____
 19 *fund.*" TRO Order (Dkt. 76) at 9 n. 4. The next sentence in Ms. Black's prior declaration explains, "Application of
 20 the shared living rule is one of several reductions that may be applied to the baseline determination of hours." Work
 21 Decl. Ex. 1 (Dkt. 71) Black Decl. ¶10. Thus, her statement is consistent with the way the CARE tool works and her
 22 subsequent declarations: the Department only funds the *unmet* needs following adjustments within the CARE tool
 23 itself, and so the Department may fund *fewer* hours than the base if reductions for informal supports or other factors
 24 related to need are appropriate. The other reason why it is appropriate to characterize the system as authorizing
 25 "maximum" hours is because beneficiaries are not required to utilize all of the hours that are authorized.

26 ³⁴ While Defendants have argued that *average* hours have increased over time, Plaintiffs showed that was
 27 attributable to increased acuity and the invalidation of an unlawful services reduction, not changes in base hours.
 2nd Brenneke Decl. Ex. B (Dkt. 70-2) at 7; 2nd LaPlante Decl. ¶¶5-7; *Jenkins*, 157 P.3d at 392. Increasing acuity
 means that people who in the past would have received long-term care services *in nursing homes* are instead now
 receiving those services *at home*. In fact, Defendants' own evidence shows that between 2004 and 2007 acuity
 increased at a higher rate than average hours. *Compare* 2nd Brenneke Decl. Ex. B (Dkt. 70-2) at 7 (showing 8.7%
 increase in ADLs between 2004 and 2007), *with* Def. Resp. TRO Ex. 12 (Dkt. 66-2) (showing 6.9% increase in
 average hours during same time period). Moreover, because authorization of hours prior to 2004 was based on
 individual needs assessments, it is of no moment that the adoption of the CARE system was supposed to be budget
 neutral. The State moved from a more subjective system to a more objective system; some individuals (who had
 been assessed to need too few hours) received more hours as a result, and some (who had been awarded too many
 hours) had their hours reduced.

1 are based on specific personal care needs”); Logan-von Wahlde Decl. ¶4. In contrast to
 2 Defendants’ characterization, the Department’s own description of the purposes of the time study
 3 demonstrates that the CARE system seeks to measure individual needs. *See* 4th Brenneke Decl.
 4 Ex. 4 at 23:1-11 (Deposition testimony of Bea-Alise Rector; purpose of time study was to
 5 determine whether “the classification groups make clinical sense; do the base hours make
 6 clinical sense based on the case manager’s knowledge of trying to meet a client’s needs in the in-
 7 home setting; . . . did the overall calculation [including reductions for informal supports], was it
 8 enough, too much, not enough to meet the client’s needs at the end of that process”); Logan-von
 9 Wahlde Decl. Ex. 3 at 3 (Department’s time study; “The purpose of the time study was to
 10 determine resources use when specific care needs were identified.”); *id.* (“The goal is to develop
 11 a resident classification system that assesses resident care needs and resource use and bases
 12 payments on the degree of use.”); *id.* Ex. 5 (Department publication; “CARE will be more
 13 comprehensive and more objective [than prior system] in measuring client’s care needs. . . .
 14 CARE includes a new client-focused payment system that: Better reflects time and resources
 15 needed to provide care; Considers and accounts for unscheduled task hours, cognitive needs, and
 16 informal support system; and Improves the reliability and consistency of the assessment.”).

17 The Department similarly describes the CARE tool as seeking to assess unmet
 18 individualized needs in the CARE Assessor’s Manual and in documentation regarding CARE
 19 eligibility and rates. *See* Black Decl. Ex. 2 (Dkt. 19-2) at 8 (“The CARE tool assists assessors to
 20 gather definitive information on a client’s . . . needs, which must be addressed in an
 21 individualized care plan.”); *see also id.*, Ex. 1 at 2 (Department rulemaking statement; “Case
 22 managers individually assess each client related to assistance needed as well as any informal
 23 supports available”).³⁵

24 _____
 25 ³⁵ *See also id.* Ex. 2 at 173 (“[T]he hours for in-home care generated by CARE will determine the
 26 maximum payment to meet the client’s care plan needs.”); 4th Brenneke Decl. Ex. 3 at I-1 (CARE “is an automated
 27 system used to collect demographic data, assess functional needs and abilities, health, and medical information,
 determine eligibility for services, develop a care plan, and authorize services for clients on or requesting long-term
 care services”); *id.* at V-3 (as part of CARE, base hours are adjusted “based on a percentage of unmet needs for
 selected ADLs and IADLs”); *id.* at V-2 to V-4 (charts showing how base hours are adjusted based on the presence or
 absence of informal supports tailoring hours allocations to client’s needs).

1 When the Department implemented the CARE tool to assess developmentally disabled
 2 personal care recipients, develop Individual Service Plans (“ISPs”), and manage their care, that
 3 was done based upon the Department’s agreement to engage in individualized assessments and
 4 allocations of hours to meet their individual care needs. *See* 4th Brenneke Decl. Ex. 7 at 2-3
 5 (report prepared on behalf of DDD; “The SIS was designed to directly assess the support needs
 6 of individuals with developmental disabilities across several critical domains of every day
 7 community life and functioning”; other assessment tools “do not measure the level, amount, and
 8 frequency of the supports that are necessary to assist a person day-by-day”).³⁶ The regulations
 9 for the personal care services programs serving individuals with developmental disabilities also
 10 makes clear that hours are authorized to meet clients’ assessed individual needs. *See* WAC 388-
 11 828-1020 (“‘Individual support plan’ or ‘ISP’ is a document that authorizes and identifies the
 12 DDD paid services to meet a client's assessed needs.”).³⁷

13 Finally, even if it *were* the case (which it is not) that the CARE system does not
 14 determine individual need, Defendants have never contested Plaintiffs’ showing that, as a factual
 15 matter, only minimally necessary hours are authorized. In fact, the evidence Defendants
 16 supplied that ETRs increase CARE tool hours authorizations above the maximum in order to
 17 meet minimal needs in exceptional individual circumstances supports the conclusion that
 18 individual beneficiary needs, health and safety drive the authorization standard, and that this
 19 standard is usually met through the CARE assessment and planning process. Defendants
 20 implicitly suggest that the State has been authorizing *more* hours than beneficiaries need – so

21
 22 ³⁶ *See also* 4th Brenneke Decl. Ex. 6 at Federal Medicaid Program 3, Conclusion 3, and Conclusions and
 23 Recommendations 1 (joint legislative committee audit noting that federal government determined state agency was
 24 not meeting Medicaid guidelines and recommending development of assessment process for developmentally
 25 disabled clients); Ex. 8 at 7 (DSHS settlement agreement and order; services “authorized to meet the assessed need
 26 of each HCBS waiver participant” must be documented in ISP).

27 ³⁷ *See also id.*, 388-828-1060 (“The purpose of the DDD assessment is to provide a comprehensive
 assessment process that: . . . (3) Identifies a level of service and/or number of hours that is used to support the
 assessed needs of clients who have been authorized by DDD to receive: (a) Medicaid personal care services or
 DDD HCBS waiver personal care per chapter 388-106 WAC.”); *id.*, 388-828-8000 (“The purpose of the individual
 support plan module is to create a written plan that includes . . . DDD paid services you are authorized to receive: (a) If
 you are enrolled in a DDD waiver, the ISP must address all the health and welfare needs identified in your ICF/MR
 level of care assessment and the supports used to meet your assessed needs; or (b) If you are not enrolled in a DDD
 waiver, DDD is only required to address the DDD paid services you are approved to receive.”).

1 that there is room to cut those hours without inflicting harm – but present no evidence to support
 2 the notion that the State has been authorizing *unnecessary* hours because of available funding
 3 before now.

4 **C. The Balance of Equities and Public Interest Favor Plaintiffs.**

5 The risk of illness and injury to Plaintiffs and other low-income individuals deprived of
 6 home care services outweighs Defendants’ purely fiscal interest in making the reductions:

7 State budgetary concerns cannot . . . be the conclusive factor in decisions regarding
 8 Medicaid. A budget crisis does not excuse ongoing violations of federal law, particularly
 9 when there are no adequate remedies available other than an injunction. . . . State
 10 budgetary considerations do not . . . , in social welfare cases, constitute a critical public
 interest that would be injured by the grant of preliminary relief. In contrast, there is a
 robust public interest in safeguarding access to health care for those eligible for
 Medicaid, whom Congress has recognized as the most needy in the country.

11 *Independent Living Ctr.*, 572 F.3d at 659 (internal quotations omitted); *see also Dominguez v.*
 12 *Schwarzenegger*, 596 F.3d 1087, 1098 (9th Cir. 2010) (“individuals’ interests in sufficient access
 13 to health care trump the State’s interest in balancing its budget”); *California Pharmacists Ass’n*
 14 *v. Maxwell-Jolly*, 563 F.3d at 852-53.³⁸

15 Plaintiffs respectfully suggest that this Court did not correctly apply this Ninth
 16 Circuit authority on the proper weight to be given human and health care needs as
 17 opposed to state fiscal concerns when it held that the balance of equities weighed against
 18 a TRO. TRO Order (Dkt. 76) at 25:9-26:5. That holding was apparently driven by the
 19 Court’s conclusion that the services at issue were not critical and its deference to
 20 Defendants’ decisions regarding how to reduce spending. *Id.* at 25:20-25. Such
 21 deference, however, is not appropriate. In the Ninth Circuit cases concerning California,
 22 cited above, where the budget crisis was certainly no less severe, there were similarly
 23 clients of other health and human service programs.

24 This Court’s conclusion seems to have rested on the erroneous premise that any
 25 delay in implementing the reductions at issue “will result in either greater decreases at a
 26

27 ³⁸ It is doubtful that the reductions will save the State money, given the cost of institutionalization and loss
 of state revenue. Reed Decl. (Dkt. 18) ¶¶20, 23; LaPlante Decl. (Dkt. 22) ¶20; Lucia Decl. (Dkt. 23) ¶¶5, 13.

1 later time to reach the same financial goals or cuts to other programs.” TRO Order (Dkt.
 2 76) at 25:15-17. This is not necessarily the case. Nothing prevents the State from
 3 reducing funding outside of DSHS or raising revenue.³⁹ Even if cuts within DSHS were
 4 necessary, such cuts could be made in ways that would not increase institutionalization.⁴⁰

5 **D. Plaintiffs are Likely to Succeed on the Merits of Their Claims.**

6 **1. Defendants’ Inadequate Notice and Failure To Provide a Hearing**
 7 **Violate the Due Process Clause and the Medicaid Act.**

8 The notices DSHS mailed to inform beneficiaries of the planned hours reductions did not
 9 comply with Due Process or the Medicaid Act because they failed to inform beneficiaries that (1)
 10 additional personal care hours could be awarded through the Exception to Rule (“ETR”) process
 11 if the reduced hours were insufficient to meet their health and safety needs;⁴¹ (2) additional in-
 12 home personal care hours could be awarded through the CARE reassessment process due to
 13 changed circumstances caused by the hours reductions (such as changes in living situations or
 14 provider willingness to provide informal support) or deteriorated health condition; and (3) there
 15 are other Medicaid benefits for which beneficiaries are eligible in lieu of in-home care, including
 16 community-based residential care facilities and nursing homes. *See* Brenneke Decl. Ex. 1A
 17 (Dkt. 12-2) (“Notice”). The Notice also unlawfully told beneficiaries they could not appeal the
 18 reductions and were not entitled to a hearing. *Id.* This Court’s order denying Plaintiffs’ TRO
 19 failed to address deficiencies in the Notice itself (perhaps because the Court mistakenly believed
 20 that the Notices informed beneficiaries of the ETR process when the Notices did not), and found

21 ³⁹ Although RCW 43.88.110(7) requires the governor to make “across-the-board reductions in allotments”
 22 if she “projects a cash deficit in a particular fund or account,” nothing prevents the legislature from adjusting
 23 allocations or raising additional revenue to compensate for a projected deficit and avoid such reductions. In any
 24 event, state law concerning state budgets cannot trump the federal requirements Plaintiffs seek to enforce. *See, e.g.,*
Hutto v. Finney, 437 U.S. 678 (1978) (attorneys’ fees); *Industrial Truck Ass’n, Inc. v. Henry*, 125 F.3d 1305, 1309
 (9th Cir. 1997) (state law must give way “where state law stands as an obstacle to the accomplishment and execution
 of the full purpose and objectives of Congress”).

25 ⁴⁰ *See, e.g.,* 3rd Brenneke Decl. Ex. 6 at 3.9 (unimplemented proposal to close certain DSHS Division of
 26 Developmental Disabilities-run residential habilitation centers and move more clients to home and community-
 based services would have saved State a net total of \$116,138,316 from FY 2010 to FY 2018).

27 ⁴¹ The ETR process “grant[s] additional hours beyond those authorized under the regular assessment
 process” when “the amount of hours for the person’s classification group [is] not ... enough to address the
 individual’s current circumstances.” Leitch Decl. (Dkt. 67) ¶4; WAC 388-440-0001; *see also* WAC 388-106-
 0130(8).

1 that beneficiaries are not entitled to hearings because they cannot not raise factual challenges to
 2 the hours reductions, despite the fact that ETRs and re-assessment require factual determinations.

3 States may not reduce Medicaid services without providing meaningful notice prior to the
 4 reduction, continued benefits pending a pre-reduction hearing, and a fair and impartial hearing.

5 *Goldberg v. Kelly*, 397 U.S. 254, 267-68 (1970); *Perry v. Chen*, 985 F.Supp. 1197 (D. Ariz.
 6 1996) (applying *Goldberg* to reduction in services); *Washington v. DeBeaugrine*, 658 F.Supp.2d
 7 1332, 1335 (N.D. Fla. 2009) (applying *Goldberg* to reduction in optional services). The extent
 8 of the process due is flexible, requiring a balancing of private and government interests.

9 *Matthews v. Eldridge*, 424 U.S. 319, 334-335 (1976). To the extent Medicaid regulations require
 10 notice and hearing,⁴² the government already has agreed that private interests outweigh
 11 governmental interests, *Perry*, 985 F.Supp. at 1204, but due process may require more.

12 Hearings must be provided to recipients who request them to challenge a service reduction as
 13 factually erroneous and services must be maintained at current levels in the interim. 42 C.F.R.
 14 §§431.220, 431.230, 431.241(b). In addition, “free choice” Medicaid rules governing the
 15 personal care services at issue here require that recipients be “(1) Informed of any feasible
 16 alternatives available under the waiver; and (2) Given the choice of either institutional or home
 17 and community based services.” 42 C.F.R. §441.302(d). State agencies must “continue to
 18 furnish Medicaid regularly to all eligible individuals until they are found to be ineligible,” 42
 19 C.F.R. §435.930(b), and Plaintiffs have a right to ongoing and seamless long term care benefits.

20 Under these standards, the Notices are grossly inadequate. First, this Court found that
 21 “even if the decreases in base hours might leave some plaintiffs without sufficient personal care
 22 services to safely remain in their homes,” the ETR procedure could be used to obtain additional
 23 hours. TRO Order (Dkt. 76) at 13:1-22.⁴³ ***But the Notices did not inform beneficiaries that***

24
 25 ⁴² At least ten days prior to the reduction of any Medicaid service, states must mail written notice with (a) a
 26 statement of the State’s intended action; (b) the reasons for the intended action; (c) the specific regulation or law that
 27 supports the change; (d) an explanation of the right to a hearing if one is available; and (e) an explanation of the
 circumstances under which services will be continued pending hearing. 42 C.F.R. §§ 431.201, 431.210, 431.211.

⁴³ State regulations provide no right to request or be considered for an ETR, no standards that apply, no fair
 hearing rights, and no right to continued benefits in the interim. WAC 388-440-0001(3), 388-426-0005. To the

1 **additional hours could be awarded through the ETR process.** This Court's belief that the
 2 Notices advised beneficiaries about the ETR process, TRO Order (Dkt. 76) at 13:6-12, was
 3 mistaken. It is only the *internal* DSHS staff bulletin, *not* the Notice sent to beneficiaries, that
 4 discusses ETR. *Compare* Brenneke Decl. Exs. 1A-1D (Dkts. 12-2 to 12-5); *with* Brenneke Decl.
 5 Ex. 1(Dkt. 12-1); Def. Resp. TRO Ex. 10 (Dkt. 66-2). Instead, beneficiaries were told "[t]here
 6 are no appeal rights for this change" and were advised to contact their case manager only with
 7 "questions or concerns" (not to request additional hours). Brenneke Decl. Ex. 1A-1D (Dkt. 12-2
 8 to 12-5); Chatwin Decl. Ex. 2 (Dkt. 48-2); Allington Decl. Ex. 1(Dkt. 52-1). Case managers
 9 improperly refused to initiate the ETR and some told beneficiaries that the ETR process is not
 10 available to restore these hours reductions. *See supra* at 17 & nn. 27-28.⁴⁴

11 Second, beneficiaries should have been notified that they could request a reassessment if
 12 their circumstances changed as a result of the hours cuts. The CARE tool reduces base hour
 13 allocations when a beneficiary has "informal support[]" (WAC 388-106-0130(b)) such as a live-
 14 in provider who is also able to furnish a certain amount of uncompensated care, and those
 15 informal hours are included in the care plan and counted with specificity. Black Decl. (Dkt. 19)
 16 ¶13 & Ex. 2 (Dkt. 19-2) at 161-163. Reassessments are authorized when there is a change in
 17 informal supports. WAC 388-106-0140; WAC 388-106-0130(2). Many beneficiaries will have
 18 such a change in informal supports as a result of the hours reductions, because their providers
 19 will no longer be willing or able to continue to provide free care.⁴⁵ For example, H.C.'s

20 _____
 21 extent Defendants rely on the ETR procedure to satisfy their substantive legal obligations, the ETR procedure cannot
 22 be discretionary or standardless, and must satisfy due process.

23 ⁴⁴ ETRs are authorized only upon request by DSHS staff (not clients). Black Decl. Ex. 3 (Dkt. 19-3) at 25-
 24 26. Defendants have asserted that "a beneficiary may simply ask a case manager for an ETR," TRO Order (Dkt. 76)
 25 at 13:12-16, but it is impossible for beneficiaries to ask for something of which they have never been notified.
 26 Moreover, Defendants' counsel represented that "any out-of-home placement automatically requires the case
 27 manager to evaluate whether an ETR is appropriate," TRO Order (Dkt. 76) at 13:18-19, but no ETR process has
 been initiated in those cases in which Plaintiffs have been moved into nursing homes or their caregivers have
 notified DSHS that they will need to be moved. Hayes Decl. (Dkt. 47) ¶8; Maxson Decl. (Dkt. 26) ¶11; S.J. Decl.
 (Dkt. 27) ¶25; Braddock Decl. (Dkt. 28) ¶27.

⁴⁵ Plaintiffs have shown numerous examples where this will be true, in cases involving individual and
 agency providers. For example, an agency faced with the cumulative impacts of these cuts will no longer pay for its
 employees to provide additional "'charity' hours" that has been relied upon by their clients, resulting in substantial
 service cuts and increased risk of health deterioration and institutionalization. Walsh Decl. (Dkt. 25) at ¶¶ 14-15. In
 these cases, because the "informal supports" are no longer willing to provide services in the future, the existing

1 provider, who lived with him, was going to be forced to find another job because of the hours
 2 reductions and would have stopped providing uncompensated care. Chatwin Decl. (Dkt. 48)
 3 ¶¶20-21. He had already registered his father for a nursing home. 2nd Chatwin Decl. ¶3, 8.

4 Beneficiaries are entitled to reassessments if their own health condition changes. They
 5 should have been notified of this, as well, at the time the Department unilaterally “amended” the
 6 care plans based upon dated needs assessments. The Department has a duty to ensure the health
 7 and safety of beneficiaries in developing care plans. WAC 388-106-0130 (8). When the
 8 Department unilaterally “amends” the care plans, they cannot escape the duty to ensure the
 9 amended plan provides for the health and safety of the beneficiaries based upon their current
 10 needs for support. Since the Department did not conduct its own reassessments before making
 11 the cuts, beneficiaries at least need to know that they can request a reassessment in such
 12 circumstances. *See, e.g.*, 2nd Maxson Decl. ¶¶4-13, 18 (M.R.’s health condition has deteriorated
 13 since her last assessment but case worker has been unresponsive to requests for assistance; hours
 14 were insufficient even before January 2011 reductions).

15 Third, the vast majority of beneficiaries meet the criteria for admission to a skilled
 16 nursing facility or ICF-MR, which are mandatory Medicaid benefits. 42 U.S.C.
 17 §§1396d(a)(44)(A), 1396a(a)(10)(C)(iv). Beneficiaries’ decision not to receive services in a
 18 nursing home, or to avail themselves of other Medicaid benefits⁴⁶ or alternative community
 19 based residential care options, was made in reliance on a care plan setting forth a specific number
 20 of personal care hours, which the State has now reduced.⁴⁷ Accordingly, beneficiaries should

21 _____
 22 CARE assessment is invalid and a new assessment is required. *See also* Maxson Decl. (Dkt. 26) ¶¶5, 22; Ivonav
 23 Decl. (Dkt. 58) ¶¶15, 23-25; Flint Decl. (Dkt. 53) ¶16; A.H. Decl. (Dkt. 54) ¶12; Guin Decl. (Dkt. 55) ¶¶7, 29-31,
 33, D.V.S. Decl. (Dkt. 59) ¶¶16-18; 2nd Jane B. Decl. ¶¶9-11; 2nd Paolino Decl. ¶7; Perkins Decl. ¶3; Josephsen
 Decl. ¶7-8.

24 ⁴⁶ Other Medicaid services, such as Adult Day Health, nursing care, or Adult Family Home care for which
 25 beneficiaries are eligible, should be provided as alternatives to meet beneficiary needs in light of the hours cuts.
 26 *See, e.g.*, Maxson Decl. (Dkt. 26) (registered nurse who is provider for daughter sought but received no help finding
 27 alternative services such as part-time adult family home placement; despite assessment finding household at “risk”
 and decline in daughter’s health, hours have been reduced).

⁴⁷ Maxson Decl. (Dkt. 26) ¶¶5, 10-11, 13; S.J. Decl. (Dkt. 27) ¶¶10-11; Braddock Decl. (Dkt. 28) ¶¶7, 21-
 22; C.B. Decl. (Dkt. 29) ¶¶3, 13-14, 16; Davis Decl. (Dkt. 30) ¶¶6, 10, 21; D.W. Decl. (Dkt. 31) ¶¶3, 15; McIntosh
 Decl. (Dkt. 32) ¶5; Jane B. Decl. (Dkt. 33) ¶¶4, 7, 14; Starr Decl. (Dkt. 34) ¶¶3, 9, 16; Morrow Decl. (Dkt. 38) ¶5;
 Hays Decl. (Dkt. 39) ¶¶4, 8, 19; Frederick Decl. (Dkt. 40) ¶¶3, 6; Dockstader Decl. (Dkt. 42) ¶5; Paolino Decl. (Dkt.

1 have been notified of their right to choose among available options they previously declined,
 2 including nursing homes and community-based care outside of their homes, *before* their hours
 3 were reduced: a new chance to make a “free choice” is required, based on new circumstances.⁴⁸
 4 *See* 42 C.F.R. §441.302(d).

5 Defendants’ failure to notify beneficiaries of their rights to increased hours through the
 6 ETR process, to reassessment based on changed circumstances (including changed
 7 circumstances caused by the hours reductions), and to choose a nursing home or community-
 8 based residential care facility in light of the hours reduction, violates Due Process and the
 9 Medicaid Act. *See Goldberg*, 397 U.S. at 267-68 (requiring “timely and adequate notice
 10 detailing the reasons for a proposed termination, and an effective opportunity to defend”); 42
 11 C.F.R. §441.302(d) (must be informed of all “feasible alternatives”). In *Rosen v. Goetz*, 410
 12 F.3d 919, 923 (6th Cir. 2005), when a state law eliminated several optional categories of
 13 Medicaid eligibility, the state notified beneficiaries of the planned terminations, informed them
 14 that they could continue to receive Medicaid if they fell within an eligibility category that was
 15 not being eliminated, and allowed them 30 days to supply the information necessary to determine
 16 their eligibility for these other categories. Washington State could and should have done the
 17 same: informed beneficiaries that they could request an ETR to add hours necessary to live
 18 safely at home, a reassessment for changed circumstances (including changed circumstances
 19 caused by the hours reductions), other Medicaid benefits, or nursing home or other residential
 20 placement if no safe plan of care could be arranged. The personal interest at stake (health and
 21 safety) is extremely important; the additional process would be very valuable to beneficiaries;

22 _____
 23 45) ¶¶5, 8, 18; Hayes Decl. (Dkt. 47) ¶¶10-11; Chatwin Decl. (Dkt. 48) ¶¶5, 8, 18; Allington Decl. (Dkt. 52) ¶¶5, 8;
 24 Flint Decl. (Dkt. 53) ¶¶4, 7; A.H. Decl. (Dkt. 54) ¶4; Guin Decl. (Dkt. 55) ¶¶6, 9, 15, 22; Faatoafe Decl. (Dkt. 56)
 25 ¶¶6, 14; N.N.A. Decl. (Dkt. 57) ¶¶4-5; Ivonav Decl. (Dkt. 58) ¶¶5, 8, 18; D.V.S. Decl. (Dkt. 59) ¶¶4, 9-10.
 26 *Compare* Notice, Brenneke Decl. Ex. 1A (Dkt. 12-2); *with* C.B. Decl. Ex. 1B (Dkt. 29-2) at 6 (Service Summary
 27 listing hours to which beneficiary is entitled prior to reductions, with signed acknowledgement: “I am aware of all
 alternatives available to me and I understand that access to 24-hour care is available only in residential settings,
 including community residential settings. I agree with the services outlined in this summary.”)

⁴⁸ The fact that Defendants may have previously informed beneficiaries of their right to nursing home or
 alternate community based services is immaterial; that information must be provided at a meaningful time—in the
 notice of reduction of services. *See Baker v. State of Alaska*, 191 P.3d 1005, 1009-10 (Alaska 2008) (agency may
 not presume that beneficiaries already have certain information, but must provide complete notice).

1 and the burden (mailing a notice) is low.⁴⁹ *See Matthews*, 424 U.S. at 334-335.

2 Beneficiaries are also entitled to a fair hearing and interim benefits pending a final
 3 decision on their request for reassessment or ETR. This Court originally held that hearings were
 4 not required because Medicaid regulations provide that “recipients are not entitled to a hearing if
 5 the sole issue is a state law requiring an automatic change affecting some or all recipients.”
 6 TRO Order (Dkt. 76) at 23:20-24:1 (citing 42 C.F.R. §431.220(b)). As this Court noted, the
 7 “limitation on the hearing requirement arises out of the practical consideration that, absent some
 8 factual dispute about an individual’s right to benefits, a hearing would serve little . . . purpose.”
 9 TRO Order (Dkt. 76) at 24:1-3; *see also Rosen*, 410 F.3d at 926. Here, however, DSHS’s
 10 decision to unilaterally “amend” 45,000 individualized care plans without individualized
 11 reassessments raises myriad factual disputes. Here, the sole issue is not one of a change in state
 12 law: instead, the reassessment and ETR process require factual determinations that may be
 13 challenged in a hearing.⁵⁰ As this Court found, “the right to an exemption for hardship
 14 necessarily raise[s] a factual dispute that g[i]ve[s] rise to a hearing requirement.” TRO Order
 15 (Dkt. 76) at 24:20-21 (citing *Claus v. Smith*, 519 F.Supp. 829, 883 (N.D. Ind. 1981)). The ETR
 16 procedure is an exemption process. Thus, beneficiaries must be notified that they may request
 17 reassessment or ETR, contest the validity of their “amended” care plans at a hearing, and
 18 maintain current hour levels in the interim.

19 In short, the hours reductions will jeopardize the health and safety of some beneficiaries
 20 to the point that they qualify for increased hours through the ETR process, reduce informal
 21 supports available for others such that they are entitled to increased hours under the CARE
 22 assessment tool, and lead others to need alternative community-based or institutional residential

24 ⁴⁹ Any financial burden to the State in actually providing the additional services to which beneficiaries
 25 might be entitled based on reassessment, the ETR process, or nursing home admission is not part of this calculus;
 consistent with Due Process, the State may not balance its budget by hiding from beneficiaries the fact that they are
 eligible for additional or different Medicaid services.

26 ⁵⁰ Washington law recognizes that reassessments give rise to factual disputes requiring a fair hearing.
 27 Beneficiaries have “a right to contest the result of your CARE assessment and/or other eligibility decisions made by
 the department. The department will notify you in writing of the right to contest a decision and provide you with
 information on how to request a hearing.” WAC 388-106-1305. There is no statutory right to appeal ETR denials.

1 placement. Consistent with Due Process and the Medicaid Act, beneficiaries must be notified of
 2 these options, and afforded a hearing (with hours maintained pending the hearing) to contest any
 3 adverse factual determinations. Because the Notices were inadequate in all of these respects, the
 4 cuts must at the very least be immediately enjoined pending mailing of a new, lawful notice and
 5 provision of fair hearing rights with continuing benefits. *See, e.g., Eder v. Beal*, 609 F.2d 695,
 6 701 (3d Cir. 1979) (state must reinstitute terminated Medicaid program until notice consistent
 7 with Due Process and Medicaid Act has been sent).

8 **2. The Reduction in Personal Care Hours Violates the ADA.**

9 Defendants' actions violate the ADA and Rehabilitation Act, which prohibit unjustified
 10 institutionalization and mandate integration of individuals with disabilities into the community to
 11 the greatest extent possible. *See Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999);
 12 *Townsend v. Quasim*, 328 F.3d 511 (9th Cir. 2003); 42 U.S.C. § 12132; 29 U.S.C. § 794(a); 28
 13 C.F.R. §§ 35.130(b)(7) (reasonable accommodation mandate), 35.130(d) (integration mandate).

14 Through Title II of the ADA, 42 U.S.C. § 12132, Congress sought to eliminate the
 15 “unjustified segregation and isolation” of individuals with disabilities. *Townsend*, 328 F.3d at
 16 516. The ADA’s implementing regulations carry out this purpose by requiring public entities to
 17 “administer services, programs, and activities in the most integrated setting appropriate to the
 18 needs of qualified persons with disabilities.” 28 C.F.R. § 35.130(d).⁵¹ In *Olmstead*, the
 19 Supreme Court construed this integration mandate, interpreting discrimination forbidden under
 20 Title II of the ADA to include “unjustified isolation of individuals with disabilities.” 527 U.S. at
 21 597.

22 To establish an *Olmstead* violation, a plaintiff must show (1) the state’s treatment
 23 professionals have determined community-based services are appropriate, (2) the disabled
 24 individual does not oppose such treatment, and (3) provision of community-based services can

25 _____
 26 ⁵¹ “The ‘most integrated setting’ is defined as ‘a setting that enables individuals with disabilities to interact
 27 with non-disabled persons to the fullest extent possible.’” *Brantley* 656 F.Supp.2d at 1170 (citing 28 C.F.R. pt. 35
 app. A; *Olmstead*, 527 U.S. at 592). This mandate “serves one of the principal purposes of Title II of the ADA:
 ending the isolation and segregation of disabled persons.” *Arc of Wash. State, Inc. v. Braddock*, 427 F.3d 615, 618
 (9th Cir. 2005); *see also Brantley*, 656 F.Supp.2d at 1170.

1 be reasonably accommodated, taking into account the resources available to the state and the
 2 needs of other individuals with disabilities. 527 U.S. at 587. The State’s obligation to provide
 3 services in the most integrated setting is excused only when it proves that the relief sought would
 4 require a “fundamental alteration” of its program. *Olmstead*, 527 U.S. at 603-4; *see also*
 5 *Townsend*, 328 F.3d at 517; *Fisher v. Oklahoma Health Care Authority*, 335 F.3d 1175, 1181
 6 (10th Cir. 2003) (integration mandate protects plaintiffs who already reside at home or in
 7 community settings).⁵² Plaintiffs establish an *Olmstead* violation where they present evidence
 8 showing that the State’s actions create “serious risks” of unjustified institutionalization.
 9 *Brantley*, 656 F.Supp.2d at 1171.

10 Plaintiffs satisfy these standards. They are qualified individuals with disabilities who are
 11 able to live at home only because they receive in-home personal care services.⁵³ The reductions
 12 violate the ADA’s integration mandate by requiring them to make do with *less* than they need or
 13 to move out of their homes to obtain full long-term care services in less integrated settings.
 14 Moreover, the relief Plaintiffs seek would not “fundamentally alter” the services at issue; rather,
 15 Plaintiffs seek to maintain current service levels.

16 Plaintiffs have presented substantial evidence showing that the cuts at issue here create
 17 serious risks of institutionalization. DSHS’s own plan admits as much: “[i]n some cases, a safe
 18 in-home plan of care will not be possible and clients may need to go to community residential or
 19 nursing facility settings.” Brenneke Decl. Ex. 4 (Dkt. 12-8) at 6; *see also id.* Ex. 5 (Dkt. 12-9) at
 20 1. That conclusion is reinforced by expert analysis, *see, e.g.*, Black Decl. (Dkt. 19) ¶¶33-34,
 21 Reed Decl. (Dkt. 18) ¶¶46-47, LaPlante Decl. (Dkt. 22) ¶¶21-22, Walsh Decl. (Dkt. 25) ¶¶12-13,
 22 Dapper Decl. (Dkt. 20) ¶17, as well as by many individual declarations establishing a serious and

23
 24 ⁵² ADA regulations require public entities to “make reasonable modifications in policies, practices, or
 25 procedures when the modifications are necessary to avoid discrimination on the basis of disability,” unless they can
 demonstrate that making the modifications “would fundamentally alter the nature of the service, program, or
 activity.” 28 C.F.R. § 35.130(b)(7).

26 ⁵³ DSHS individually assessed and certified that all of the individuals receiving in-home personal care
 27 services under waiver programs qualify for nursing facility or intermediate care facility for the mentally retarded
 (ICFMR) levels of care without in-home services; the vast majority of the MPC beneficiaries have such acute
 disabilities that they, too, meet the functional eligibility criteria entitling them to nursing facility level of care. *See*
 WAC 388-106-0310(4); 388-106-0510(4); *see also* Reed Decl. (Dkt. 18) ¶19.

1 in some cases imminent risk of institutionalization. *See supra* at 12-13 & n. 15.⁵⁴ The risk of
 2 institutionalization has increased in severity and imminence even since this Court denied
 3 Plaintiffs' TRO motion. *See* 2nd Jane B. Decl. ¶14; 2nd Chatwin Decl. ¶¶8, 12
 4 (institutionalization this month as soon as paperwork is completed); 2nd Paolino Decl. ¶¶3, 6-7
 5 (commitment planned once vacancy opens) and 3rd Paolino Decl. ¶¶5-6 (institutionalization now
 6 avoided due to ETR); 2nd Hayes Decl. ¶¶3-12 (beneficiary already institutionalized); Anderson-
 7 Webb Decl. ¶¶7, 30, 32; Bergstrom Decl. ¶7 (in response to concerns about cuts caseworker said
 8 beneficiary should consider institutionalization). *See also* Wujick Decl., pp. 2-3. This risk of
 9 institutionalization will not be mitigated by an ETR process if people don't know about it, have
 10 no right to access it, and no right to challenge its results. *See supra* at 25-26 & nn. 43-44.

11 This Court's previous rejection of Plaintiffs' ADA claims in the context of the TRO
 12 motion was based on erroneous legal standards. Initially, this Court held Plaintiffs had not
 13 shown that the proposed cuts would pose an "immediate threat of mass institutionalization" or
 14 involve a "wholesale denial of benefits to an entire class of disabled individuals." TRO Order
 15 (Dkt. 76) at 22:24-23:1. But as DOJ has explained in other cases involving budget-based
 16 cutbacks to Medicaid in-home services,⁵⁵ a showing that a denial of services would create a
 17 "serious" risk of institutionalization, including a risk of "eventual institutionalization over time,"
 18 establishes an *Olmstead* violation. Brenneke Decl. Ex. 15 (Dkt. 17-5) at 24-26 (emphasis
 19 added). *Olmstead* claims do not require proof that institutionalization is certain or immediate.
 20 *See Fisher*, 335 F.3d at 1181-82, 1184 ("substantial risk" of harm including nursing home entry
 21 posed by cap on prescription medications, which would simply cost some plaintiffs \$25 to \$60

22
 23 ⁵⁴ *See also* Exs. D.W. Decl. (Dkt. 31) ¶¶22b, 25; C.B. Decl. (Dkt. 29) ¶35; K.S. Decl. (Dkt. 36) ¶¶17, 21;
 24 Albott Decl. (Dkt. 37) ¶13; Jane B. Decl. (Dkt. 33) ¶¶22, 25; Davis Decl. (Dkt. 30) ¶¶31-32, 36; Dockstader Decl.
 25 (Dkt. 42) ¶19; Chatwin Decl. (Dkt. 48) ¶¶2, 5-6, 11-14, 20-21, 25; Faatoafe Decl. (Dkt. 56) ¶24; Frederick Decl.
 26 (Dkt. 40) ¶¶22-24; McIntosh Decl. (Dkt. 32) ¶20-21; Morrow Decl. (Dkt. 38) ¶6; Paolino Decl. (Dkt. 45) ¶¶24, 26;
 27 Hayes Decl. (Dkt. 47) ¶8; M.J.B. Decl. (Dkt. 44) ¶5; Hays Decl. (Dkt. 39) ¶31; S.J. Decl. (Dkt. 27) ¶¶25-27;
 Braddock Decl. (Dkt. 28) ¶¶27-31; Maxson Decl. (Dkt. 26) ¶¶25, 31; Walsh Decl. (Dkt. 25) ¶¶14-17 (agency director
 discussion of "likely" hospitalization and institutionalization in individual cases).

⁵⁵ The DOJ is entitled to deference in interpreting the integration mandate, which is set forth in its own
 regulation (28 C.F.R. § 35.130(d)). *See Olmstead*, 527 U.S. at 597-98; *see also Federal Express Corp v. Holowecki*,
 552 U.S. 389, 397 (2008); *Zurich American v. Whittier Properties*, 356 F.3d 1132, 1137 & nn. 25-27 (9th Cir.
 2004); *Barden v. City of Sacramento*, 292 F.3d 1073, 1077 (9th Cir. 2002).

1 per month, could establish *Olmstead* violation); Brenneke Decl. Ex. 15 (Dkt. 17-5) at 26 (DOJ
 2 brief; no immediate institutionalization was threatened in *Fisher*, but “the evidence showed that
 3 many of plaintiffs would remain in their homes ‘until their health ha[d] deteriorated’ and would
 4 ‘eventually end up in a nursing home’”) (quoting *Fisher*, 335 F.3d at 1185 (emphasis added by
 5 DOJ)).⁵⁶ Plaintiffs have shown such a serious risk here. *See supra* at 12-13 & n. 15.

6 Plaintiffs respectfully submit that there also is no requirement that “mass
 7 institutionalization” be shown. TRO Order (Dkt. 76) at 22:25. *Olmstead* itself and numerous
 8 other cases involve individual plaintiff claims; the integration mandate protects *individuals* from
 9 unnecessary institutionalization. 42 U.S.C. §12132; *Fisher*, 335 F.3d at 1181-82, 84; *Marlo M.*
 10 *ex rel. Parris*, 679 F.Supp.2d at 638; *Brantley*, 656 F.Supp.2d at 1171-72.

11 Nor must Plaintiffs show a “wholesale” denial of benefits. TRO Order (Dkt. 76) at
 12 22:25-23:1. *Fisher*, for example, found a risk of institutionalization due to a cap on prescription
 13 drug benefits for recipients of benefits in community-based programs, 335 F.3d at 1181-82—not
 14 at all a situation where the state completely terminated benefits to a group of recipients.

15 The two decisions on which this Court previously relied are inapposite, because they
 16 rejected efforts to compel the state to *drastically change* existing programs on the ground that
 17 they were demanding fundamental alterations of the programs at issue. In *Sanchez v. Johnson*,
 18 416 F.3d 1051, 1063, 1066-68 (9th Cir. 2005), the court rejected on fundamental alteration
 19 grounds the plaintiffs’ claim seeking “a forty percent increase in the State’s budget for
 20 developmentally disabled services.” Similarly, in *Arc of Wash.*, 427 F.3d at 617-18, the court
 21 rejected on fundamental alteration grounds the plaintiffs’ argument that a state must make a
 22

23 ⁵⁶ *See also Marlo M. ex rel. Parris v. Cansler*, 679 F.Supp.2d 635, 638 (E.D.N.C. 2010) (“substantial risk
 24 of institutionalization”); *G. v. Hawaii*, 676 F.Supp.2d 1046, 1057 (D. Haw. 2009) (“will likely force beneficiaries
 25 from an integrated environment into institutional care”); *V.L.*, 669 F.Supp.2d at 1119 (“severe risk of
 26 institutionalization”); *Ball v. Rodgers*, No. CV 00-67-TUC-EHC, 2009 WL 1395423, at *5 (D. Ariz. Apr. 24, 2009)
 27 (“threatened Plaintiffs with institutionalization”); *Mental Disability Law Clinic v. Hogan*, Civ. No. 06-6320, 2008
 WL 4104460, at *15 (E.D.N.Y. Aug. 28, 2008) (“risk of unjustified segregation”); *Nelson v. Milwaukee County*,
 Civ. No. 04-193, 2006 WL 290510, at *7 (E.D. Wis. Feb. 7, 2006) (“substantially increase[d] the probability” of
 institutionalization); *M.A.C. v. Betit*, 284 F.Supp.2d 1298, 1309 (D. Utah 2003) (“threaten[ed]” institutionalization);
Makin ex rel. Russell v. Hawaii, 114 F.Supp.2d 1017, 1034 (D. Haw. 1999) (“could potentially force Plaintiffs into
 institutions”).

1 home and community-based waiver program available to every eligible developmentally
2 disabled person rather than capping the participants.

3 Unlike *Sanchez* and *Arc of Washington*, Plaintiffs here do not ask this Court to order the
4 State to expand its home care program or create a new one; rather, Plaintiffs request maintenance
5 of the status quo, and that the State be enjoined from cutting needed services it already provides.
6 A request to retain an existing program is not a “fundamental alteration,” since the plaintiff is
7 “not demanding a separate service or one not already provided.” *Fisher*, 335 F.3d at 1183.
8 Moreover, fiscal burdens alone cannot justify failing to implement the integration mandate. *See*
9 *id.*; *Pennsylvania Prot. & Advocacy, Inc. v. Pa. Dep’t of Pub. Welfare*, 402 F.3d 374, 380 (3d
10 Cir. 2005); *Townsend*, 328 F.3d at 520. Plaintiffs are likely to succeed on their ADA claims.

11 **3. Plaintiffs Are Likely To Succeed on Their Medicaid Claims.**

12 Medicaid is a cooperative federal-state program that allows states to receive federal
13 financial assistance for medical assistance to low-income individuals. 42 U.S.C. § 1396 *et seq.*
14 Participating states must comply with the Medicaid Act and its implementing regulations. 42
15 U.S.C. § 1396; *Alexander v. Choate*, 469 U.S. 287, 289 n.1 (1985); *see also Lankford v.*
16 *Sherman*, 451 F.3d 496, 510 (8th Cir. 2006).

17 **a. Reasonable Standards**

18 The Medicaid Act requires that participating states employ “reasonable standards ... for
19 determining ... the extent of medical assistance under the plan which ... are consistent with the
20 objectives of this subchapter.” 42 U.S.C. § 1396a(a)(17). The primary objectives of Medicaid
21 are to provide medical assistance to individuals who cannot afford the costs of necessary medical
22 services and to furnish “rehabilitation and other services to help such ... individuals attain and
23 retain capability for independence or self care.” 42 U.S.C. § 1396-1.

24 When state Medicaid rules deny or reduce services based on factors other than a
25 reasonable measure of need, courts invalidate them as contrary to the reasonable standards
26 requirement. *See Lankford*, 451 F.3d at 511-13 (optional medical equipment benefit); *Weaver v.*
27 *Reagan*, 886 F.2d 194, 196-200 (8th Cir. 1989) (AZT coverage based on FDA approved uses);

1 *Allen*, 681 F.Supp. at 1233-34, 1238 (state medical necessity criteria arbitrary when unsupported
2 by expert opinion or scientific data); *see also Hern v. Beye*, 57 F.3d 906, 910-11 (10th Cir.
3 1995); *Preterm, Inc., v. Dukakis*, 591 F.2d 121, 131 (1st Cir. 1979); *White v. Beal*, 555 F.2d
4 1146, 1150-51 & n.3 (3d Cir. 1977).

5 Courts have enjoined budget-driven cuts to services like those at issue here as in violation
6 of reasonable standards. *See V.L.*, 669 F.Supp.2d at 1117 (reduction of Medicaid home care
7 services based on beneficiaries' numerical scores "not designed as a measure of eligibility or
8 need for [home care] services"); *Cota v. Maxwell-Jolly*, 688 F.Supp.2d 980, 992 (N.D. Cal.
9 2010) (modification of qualifying impairments for adult day services, without explanation of
10 "how these changes are linked to the individual's circumstances, particular need for ADHC
11 services or their risk of institutionalization").

12 The reduced services authorizations that will result from the ten percent cut, driven by
13 budgetary needs and without consideration of individual circumstances, will not fulfill the
14 requirement that reasonable standards determine the extent of services. Washington's budget-
15 based reduction of home care hours without any reassessment or change in circumstances
16 undercuts the integrity of the CARE system's scientific, individualized assessments, care plans
17 and hours authorizations. *See supra* at 3-6; *see also* Reed Decl. (Dkt. 18) ¶42 (resulting hours
18 allocations will be "arbitrary" and without "any logic or reasoning"); Black Decl. (Dkt. 19) ¶¶30-
19 31 (will guarantee gap between need and services); Dapper Decl. (Dkt. 20) ¶13 (will separate
20 hours authorization from needs assessment).

21 This Court's previous determination that Plaintiffs were unlikely to succeed on this claim
22 rested in part on the Court's conclusion that the reduction would not cause services to fall below
23 minimum personal care service needs. TRO Order (Dkt. 76) at 15:19-24. That finding was
24 erroneous, *see supra* at 18-23, but in any event, this claim does not depend on whether services
25 will fall below the minimum, but whether a budget-driven reduction is a reasonable manner to
26 determine authorized hours.

27 Finally, no authority supports construing 42 U.S.C. § 1396a(a)(17), which requires

1 reasonable standards to determine the “extent” of Medicaid services, as applying only to the
 2 elimination of programs or eligibility. TRO Order (Dkt. 76) at 16 n. 7. *Lankford* invalidated a
 3 State’s authorization of some optional medical equipment but not other equipment – equivalent
 4 to Washington’s decision to reduce the “extent” of services authorized by reducing hours. 451
 5 F.3d at 501, 511-13. And *V.L.* addressed not only an eligibility change but *also* the reduction of
 6 in-home care hours for recipients who maintained eligibility. 669 F.Supp.2d at 1112, 1117-18.⁵⁷

7 **b. Sufficiency**

8 Medicaid’s “sufficiency” requirement mandates that “[e]ach service must be sufficient in
 9 amount, duration, and scope to reasonably achieve its purpose.” 42 C.F.R. § 440.230(b). While
 10 States do enjoy discretion over the amount of Medicaid services, when the level of service is
 11 insufficient to achieve a specific Medicaid program’s purposes, it is invalid. *Curtis v. Taylor*,
 12 625 F.2d 645, 651 (5th Cir. 1980) (to determine whether service is sufficient, courts consider
 13 whether level of service achieves specific program’s purposes); *Mitchell v. Johnson*, 701 F.2d
 14 337, 347-51 (5th Cir. 1983) (reduction of services and frequency of dental checkups violated
 15 sufficiency requirement); *Lankford*, 451 F.3d at 511-13 (providing some respiratory and other
 16 equipment but denying coverage of other related equipment violated sufficiency); *see also*
 17 *Weaver*, 886 F.2d at 197-200 (failure to cover AZT prescription); *Charpentier v. Belshe*, 1994
 18 WL 792591, at *5 (E.D. Cal. Dec. 21, 1994) (limiting reimbursement to no more than 20% of
 19 Medicare’s reasonable charge).⁵⁸

20 Here, the reduced in-home hours will force some beneficiaries from their homes, while
 21 putting those who stay at home at increased health risk, such that they will no longer be
 22

23 ⁵⁷ This Court also based its conclusion on the availability of the ETR process. TRO Order (Dkt. 76) at 16
 24 n. 7. For reasons previously explained, that process does not provide adequate protections to beneficiaries. *See*
 25 *supra* at 25-26 & nn. 43-44.

26 ⁵⁸ Thus, this Court’s reliance upon *Alexander v. Choate*, 469 U.S. 287, 303 (1985), which explains that
 27 States have flexibility in determining the amount of benefits to cover, was misplaced. TRO Order (Dkt. 76) at 17:5-
 15. States’ flexibility is subject to the requirement of sufficiency set forth in 42 C.F.R. §440.230(b). Moreover,
Alexander explicitly did not decide whether the government action at issue in that case violated the Medicaid Act;
 the Supreme Court used the language quoted by this Court in the course of deciding whether disabled individuals
 had been deprived of required access to services in violation of the Rehabilitation Act, not the Medicaid Act. 469
 U.S. at 303-04 & n.23.

1 sufficient to fulfill the purpose of the State’s in-home personal care services programs: to enable
 2 individuals to remain safely in their homes, rather than be forced into less integrated settings.
 3 *See, e.g.*, RCW 74.39.005(2), (3), (4), 74.39A.007; Brenneke Decl. Ex. 14 (Dkt. 17-4) at 7;
 4 Brenneke Decl. Ex. 7 (Dkt. 13-3) at 3. Reduction of hours to “well below” those previously
 5 authorized “will mean that the Washington in-home personal care services programs will no
 6 longer fulfill the fundamental purpose of home and community-based care, because the
 7 authorized hours will not be sufficient to permit consumers to remain safely in their homes.”
 8 Reed Decl. (Dkt. 18) ¶¶44-45; *see also* Black Decl. (Dkt. 19) ¶32 (reduction will “undercut[] the
 9 very purpose of the system”); *compare V.L.*, 669 F.Supp.2d at 118 (elimination of authorized
 10 services “will likely leave affected individuals without a level of service sufficient to achieve the
 11 purpose of the program”). Department officials have previously stated that the CARE system is
 12 not “designed to provide all the paid hours of personal care services that might be optimally
 13 beneficial for individuals,” but that “the Department has determined that the hours generated by
 14 CARE tool methodology are sufficient to address health and safety requirements.” 3rd Brenneke
 15 Decl. Ex. 4 ¶9. A ten percent *reduction* in services that were just “sufficient” rather than
 16 desirable to address health and safety requirements does not satisfy the sufficiency mandate.

17 This Court found it persuasive that Washington’s hours are more generous than some
 18 other states’. TRO Order (Dkt. 76) at 17:17-18:2 & n. 8. However, Washington spends a higher
 19 percentage of its long-term care spending on home and community-based services, *as opposed to*
 20 *nursing homes*, than any other state. 2nd LaPlante Decl. ¶3. That means that Washington is
 21 serving individuals with very serious disabilities in their own homes, which is not true in much
 22 of the rest of the country. *Id.* As Professor LaPlante points out, that difference in acuity or
 23 disability must be taken into account, and without consideration of that difference, the fact that
 24 Washington has higher averages or caps on personal care hours does not mean it is any more
 25 generous in relation to a particular beneficiary’s needs than other states. *Id.* ¶4.⁵⁹

26
 27 ⁵⁹ *Freeman’s* rejection of a sufficiency claim merits no weight here. The *Freeman* plaintiffs, who did not
 seek to represent a class, challenged much smaller cuts than those at issue here and testified that they would not

1 **c. Free Choice**

2 DSHS provides personal care services through COPES and other Medicaid programs
 3 under Section 1915(c) and/or Section 1915(d) waivers, which are conditioned upon DSHS
 4 assurances that individuals likely to require the level of care provided in a nursing facility or
 5 other specified institution “are informed of the feasible alternatives” to institutional care and
 6 have individual choice. 42 U.S.C. §§1396n(c)(2)(C), 1396n(d)(2)(C); *see also id.*,
 7 §§1396n(c)(1), 1396n(d)(2)(A). Regulations require “the recipient or his or her legal
 8 representative will be—(1) Informed of any feasible alternatives available under the waiver; and
 9 (2) Given the choice of either institutional or home and community based services.” 42 C.F.R.
 10 §441.302(d); *see also* 42 C.F.R. §§441.353(d), 303(d).

11 These “free choice” requirements are “constructed in such a way as to stress . . . two
 12 explicitly identified rights - (a) the right to be informed of alternatives to traditional, long-term
 13 institutional care, and (b) the right to choose among those alternatives.” *Ball v. Rodgers*, 492
 14 F.3d 1094, 1107 (9th Cir. 2007) (emphasis omitted). They “mandat[e] that participating states
 15 keep each eligible Medicaid recipient apprised of these non-institutional care options and afford
 16 each the opportunity to choose how to live.” *Id.* at 1111 (emphasis omitted). “Recipients must
 17 not be forced to choose between adequate health care and institutionalization.” *Ball v. Biedess*,
 18 2004 WL 2566262, at *6-7; (D. Ariz. Aug. 13, 2004). Home-based services that are inadequate
 19 to meet recipients’ needs do not constitute a “feasible alternative” to institutionalization, and so
 20 violate the free choice provisions. *See Ball*, 492 F.3d at 1100 (low wages caused provider
 21 shortage, decreased quality of care, state failed to avoid service gaps); *Ball*, 2009 WL 1395423,
 22 at *6 (requiring specific steps to prevent gaps in service so recipients would have “actual choice
 23 between in-home and institutional care”); *Cramer v. Chiles*, 33 F. Supp.2d 1342 (S.D. Fla. 1999)
 24 (“no real choice” when beneficiary must choose between home-based option that may not meet
 25

26 _____
 27 actually lose any personal care services as a result of the cuts. Def. Resp. TRO Ex. 13 (Dkt 66-2) at 17-19; *see also supra* at 17-18 & n. 29.

1 needs or uncertain placement in institution).⁶⁰

2 This Court correctly concluded that, if alternatives to institutional care are not feasible,
3 that violates the Medicaid free choice provision. TRO Order (Dkt. 76) at 19:13-20:1. However,
4 it wrongly rejected the claim based on its conclusion that services would remain adequate. For
5 the reasons previously discussed, *see supra* at 9-18, the reduced services will force many
6 beneficiaries to leave their homes or face unsafe circumstances, and so will be inadequate to
7 constitute a feasible alternative to nursing home care.

8 **d. Approval of Plan Amendment**

9 When a State makes material changes in its operation of the Medicaid program, it must
10 submit a plan amendment to CMS for determination of compliance with federal requirements,
11 and may not implement that plan amendment until CMS approves it. 42 CFR §§ 430.12, 430.20,
12 447.256. Similar obligations apply as conditions of Medicaid waiver programs. Brenneke Decl.
13 Exs. 7-13 (Dkts. 13-3 to 17-3) (Medicaid waiver applications, at Section 8). Implementation of a
14 plan amendment without CMS approval is unlawful, and should be enjoined. *See Oregon Ass'n*
15 *of Homes for the Aging, Inc. v. Oregon*, 5 F.3d 1239, 1241, 1244 (9th Cir. 1993); *Exeter*
16 *Memorial Hosp. Ass'n v. Belshe*, 145 F.3d 1106, 1108-09 (9th Cir. 1998); *California Ass'n of*
17 *Rural Health Clinics v. Maxwell-Jolly*, ___ F.Supp.2d ___, 2010 WL 4069467, at *12-14 (E.D.
18 Cal, Oct. 18, 2010). So should implementation of unapproved waiver amendments.

19 Plaintiffs have pointed to specific provisions of the State's Medicaid plan and waivers
20 that state that personal care services hours are awarded based on individual need as determined
21 by the CARE assessment system. *See Brenneke Decl. Ex. 6 Part 1* (Dkt. 13-1), Supp. 4 to Att.
22 3.1-A at 11 (DSHS will establish and follow "individualized plan of care" for personal care
23 services based on "independent assessment . . . developed by a person-centered process in

25 ⁶⁰ Under the free choice mandate, "the feasibility of alternatives should not be determined by budgetary
26 constraints. Feasibility must be determined by the recipient's needs and treatment plan, and not solely by the funds
27 available to service that plan." *Benjamin H*, 1999 WL 34783552, *14. Indeed, federal "legislators were adamant
that the determination of which long-term care options are feasible in a particular instance should be based on *an*
individual's needs, as determined by an evaluation, *and not short-term costs savings.*" *Ball*, 492 F.3d at 1114
(internal quotation marks and brackets omitted).

1 consultation with the individual” and “other appropriate individuals,” and this plan of care
 2 “[i]dentifies the State plan HCBS necessary for the individual, and furnishes . . . all HCBS which
 3 the individual needs”); Brenneke Decl. Ex. 7 (Dkt. 13-3) at 171-72 (“CARE . . . assigns base
 4 hours”); Brenneke Decl. Ex. 8 (Dkt. 13-4) at 101 (same). Thus, this Court was wrong to
 5 conclude that the State’s Medicaid plan “does not describe a minimum number of personal care
 6 service hours or, for that matter, a method of calculating personal care service hours.” TRO
 7 Order (Dkt. 76) at 20:12-15.⁶¹ Plaintiffs have shown a likelihood of success on this claim.

8 VI. CONCLUSION

9 Plaintiffs request that this Court issue a preliminary injunction, enjoining Defendants
 10 from implementing emergency regulation WSR 11-02-041 pending trial on the merits.

11
 12 DATED this 21st day of January, 2011.

13 MacDONALD HOAGUE & BAYLESS

ALTSHULER BERZON

14
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 26 ⁶¹ The *Freeman* decision’s holding that no plan amendment was required was based on the *Freeman*
 27 plaintiffs’ failure to identify the relevant plan and waiver provisions. See Def. Resp. TRO Ex. 13 (Dkt 66-2) at
 13:16-16:18 (reviewing plan and waiver provisions cited by plaintiffs and determining that they do not “set[] forth
 the way in which the number of personal care service hours is determined”).

CERTIFICATE OF SERVICE

I hereby certify that on January 21, 2011, I electronically filed the foregoing to the Clerk of the Court using the CM/ECF system which will send notification of such filing to the following:

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