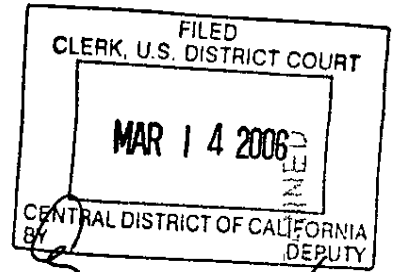


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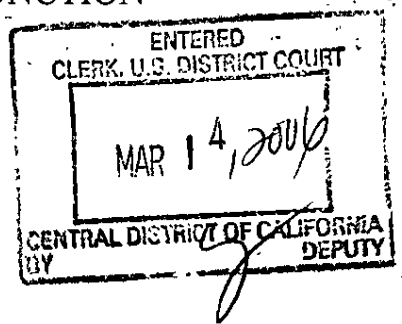


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**UNITED STATES DISTRICT COURT  
CENTRAL DISTRICT OF CALIFORNIA**

KATIE A., *et al.*,  
Plaintiffs,  
v.  
DIANA BONTÁ, *et al.*,  
Defendants.

CASE NO. CV02-5662 AHM (SHx)  
ORDER GRANTING PLAINTIFFS'  
MOTION FOR PRELIMINARY  
INJUNCTION



**I. INTRODUCTION**

Plaintiffs are five troubled children with unmet mental health needs who were, at the time this suit was filed, in the custody of the Los Angeles County Department of Children and Family Services (“DCFS”).

Defendants are Sandra Shewry, the current Director of the California Department of Health Services (“DHS”), and Dennis Boyle, the current Director of the California Department of Social Services (“DSS”) (collectively, the “State Defendants”).<sup>1</sup>

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<sup>1</sup> Shewry’s predecessor was Diana Bontá. Boyle’s predecessor was Rita Saenz.

1 Plaintiffs in their First Amended Complaint (“FAC”) allege that for foster  
2 children with “behavioral, emotional or psychiatric impairment[s],” FAC ¶ 37,  
3 adequate mental health services include, among other things, wraparound services  
4 and therapeutic foster care. Plaintiffs allege, and State Defendants agree, that  
5 virtually all foster children in California receive, or are eligible to receive, their  
6 health care services through Medi-Cal, which is California’s Medicaid program.  
7 *Id.* ¶ 3; Answer ¶ 3. This means, according to Plaintiffs, that virtually all foster  
8 children in California who have “behavioral, emotional or psychiatric  
9 impairments” are entitled to wraparound services and/or therapeutic foster care  
10 where such services are medically appropriate.

11 Over Defendants’ opposition, on June 18, 2003, the Court certified the  
12 following class:

13 [C]hildren in California who (a) are in foster care or are at imminent  
14 risk of foster care placement; and (b) have a mental illness or  
15 condition that has been documented or, had an assessment already  
16 been conducted, would have been documented; and (c) who need  
17 individualized mental health services, including but not limited to  
professionally acceptable assessments, behavioral support and case  
management services, family support, crisis support, therapeutic  
foster care and other necessary services in the home or in a home-like  
setting, to treat or ameliorate their illness or condition.

18 Order Re Class Certification [of Statewide Class].<sup>2</sup>

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21 <sup>2</sup> Plaintiffs’ FAC also named the Los Angeles County DCFS and its Director,  
22 Anita Block, as defendants (collectively, “the County Defendants”). On July 16,  
23 2003, the Court conducted a fairness hearing on a tentative settlement agreement  
24 reached between Plaintiffs and County Defendants on behalf of a subclass of children  
25 who are in the custody of DCFS, or have been referred to or are subject to referral to  
26 DCFS. The Court approved the settlement. *See* Stipulated Order Re Final Approval  
27 of Class Settlement (July 16, 2003) and Stipulation Between Plaintiffs and County  
28 Defendants Regarding Definition of Class Members (Feb. 23, 2004).

26 Although the present motion does not involve the County Defendants directly,  
27 they have expressed their views on the issue by filing a “Statement of Position Re:  
28 Plaintiffs’ Motion for Preliminary Injunction.” In short, the County states that it “is  
committed and able to meet its obligations within the existing Medi-Cal structure but

1           On September 9, 2005, Plaintiffs filed a motion seeking a mandatory  
2 preliminary injunction requiring the State Defendants to provide wraparound  
3 services and therapeutic foster care to all members of the statewide class, within  
4 60 days from the entry of an order granting the motion.<sup>3</sup> The proposed injunction  
5 would require Plaintiffs and the State Defendants to meet and confer to develop an  
6 implementation plan and to submit a joint status report thereafter. The Court  
7 conducted a hearing on October 31, 2005, and requested additional briefing. The  
8 supplemental briefs have helped clarify the issues and very recent decisions have  
9 reinforced the Court's initial view that Plaintiffs have satisfied the necessary  
10 prerequisites for injunctive relief.

11           Given the passage of time and the competing demands of the Court's  
12 caseload, in certain respects this Order necessarily will be streamlined. Thus, for  
13 example, because the parties are fully familiar with their respective contentions,  
14 the Court will not set forth in detail their arguments nor deal with all the  
15 voluminous evidence they proffered. Nevertheless, I am compelled to precede  
16 this analysis of the motion with relevant observations about this case.

17           First, at stake in this lawsuit is the health of thousands of children in  
18 California who are already in, or are likely soon to wind up in, foster care.<sup>4</sup>  
19 "[C]hildren with serious emotional disabilities are among the most fragile  
20 members of our society; their medical needs frequently extend across a spectrum  
21 of service providers and state agencies." *Rosie D. v. Romney*, --- F.Supp.2d ----,

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23 \_\_\_\_\_  
24 would benefit from the changes proposed by Plaintiffs . . . . Should Plaintiffs prevail  
25 . . . the County will be able to meet its obligations more easily and this will necessarily  
26 help to enure to the benefit of the children and family it serves."

26           <sup>3</sup> Defendants do not dispute that currently they are not providing these forms  
27 of assistance, as such, to members of the plaintiff class.

28           <sup>4</sup> As of July 1, 2004, over 85,000 children were in child welfare-supervised  
foster care in California. Pls.' Ex. 106.

1 No. CIV.A.01-30199-MAP, 2006 WL 181393, at \*3 (D. Mass. Jan. 26, 2006).  
2 The class of plaintiffs here, like the emotionally disturbed children in *Rosie D.*,  
3 have “complex needs [and are] particularly vulnerable.” *Id.* at \*33-34. Indeed,  
4 Plaintiffs’ needs are so compelling that Congress afforded them “rights” embodied  
5 in a federal statute. The statute is difficult to apply, however, which has led to this  
6 complex, hard-fought litigation, with the usual attendant delays and diversion of  
7 resources in determining the scope of assistance to which the class members are  
8 entitled. Even though the Government has agreed to provide aid to these children  
9 and has an interest in doing so, the adversary process risks swallowing up and  
10 interfering with both sides’ mutual objectives.

11 In addition to the needs and rights of foster children, also at stake is the  
12 impact on the State of California of complying with requirements of the Medicaid  
13 Act when the State’s budgetary and administrative resources are badly strapped  
14 and the range of Medicaid-mandated services continually become ever-costlier.<sup>5</sup>

15 Finally, also at issue here is the capacity of any court to enforce a decree  
16 entailing the delivery of services to mentally-troubled youngsters caught up in a  
17 complex social welfare system that is, to say the least, beleaguered. In California,  
18 the foster care system has been widely acknowledged to be failing. Can “EPSDT”

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20 <sup>5</sup> Because the Court need not deal directly with the claims asserted under the  
21 Americans with Disabilities Act and Rehabilitation Act, *see infra*, the Court does not  
22 analyze the State Defendants’ arguments that the State’s limited resources militate  
23 against imposing wraparound and therapeutic foster care on a statewide basis. *See*  
24 *Olmstead v. L.C. ex. rel. Zimring*, 527 U.S. 581, 603 (1999). This decision concerns  
25 only the Medicaid Act, and as stated in *Ark. Med. Soc’y, Inc. v. Reynolds*, 6 F.3d 519,  
26 531 (8th Cir. 1993), a state “may take . . . budget factors into consideration when  
27 setting its reimbursement methodology,” but it “may not ignore the Medicaid Act’s  
28 requirements in order to suit budgetary needs.” In any event, there is substantial  
evidence that wraparound services and therapeutic foster care actually save the State  
money, compared to alternatives involving institutionalization. *See, e.g.*, Bruns Decl.  
¶ 22(b)-(c); Kamradt Decl. ¶¶ 16-17; Chamberlain Decl. ¶ 26; Farr Decl. ¶ 20; *see*  
*also* Pls.’ Ex. 135 at 969, Ex. 136 at 971-72, Ex. 137 at 974.

1 (Early and Periodic, Screening, Diagnostic and Treatment Services) for children,  
2 to which Plaintiffs have a right, really provide significant benefits through  
3 wraparound services and therapeutic foster care? Perhaps the Court should not  
4 ponder that question. Perhaps the Court should do nothing more than simply  
5 recognize that these forms of treatment are part of Plaintiffs' EPSDT rights, and  
6 enforce them. From the hard lessons this Court has learned in enforcing the  
7 judgment in *Emily Q. v. Bonta*, 208 F.Supp.2d 1078 (C.D. Cal. 2001), however,  
8 information about just how much the welfare of foster children will improve as a  
9 result of the requested injunction cannot be considered superfluous.

10 **II. DISCUSSION**

11 **A. Legal Standard for Preliminary Injunctions**

12 The parties do not dispute the legal standard for issuance of a preliminary  
13 injunction:

14 To obtain a preliminary injunction in the district court, plaintiffs [must]  
15 demonstrate (1) a strong likelihood of success on the merits, (2) the  
16 possibility of irreparable injury to plaintiffs if preliminary relief is not  
17 granted, (3) a balance of hardships favoring the plaintiffs, and (4)  
18 advancement of the public interest . . . . Alternatively, injunctive relief  
could be granted if the plaintiffs demonstrate[] either a combination of  
probable success on the merits and the possibility of irreparable injury or  
that serious questions are raised and the balance of hardships tips sharply in  
their favor . . . .

19 These two alternatives represent extremes of a single continuum, rather than  
20 two separate tests . . . . As a result, the greater the relative hardship to the  
21 party seeking the preliminary injunction, the less probability of success  
must be established by the party . . . .

22 *Rodde v. Bonta*, 357 F.3d 988, 994 (9th Cir. 2004) (citations, internal quotation  
23 marks, and alterations omitted). In addition, “[m]andatory preliminary relief,  
24 which goes well beyond simply maintaining the status quo Pendente lite, is  
25 particularly disfavored, and should not be issued unless the facts and law clearly  
26 favor the moving party.” *Anderson v. United States*, 612 F.2d 1112, 1114 (9th  
27 Cir. 1979).

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**B. Standing**

As previously noted, Plaintiffs’ substantive claims are based primarily on the Medicaid Act. The key statutory provisions at issue are 42 U.S.C. §§ 1396a(a), 1396d(a) and 1396d(r). As a threshold matter, the State Defendants contend that Plaintiffs do not have a private right of action to bring a suit under 42 U.S.C. § 1983 for violations of these provisions of the Medicaid Act.

The applicable test for standing is set forth in *Blessing v. Freestone*, 520 U.S. 329 (1997). As stated in *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 602 (5th Cir. 2004),

In *Blessing* . . . the Supreme Court reiterated the three factors that it has traditionally considered when determining whether a particular federal statute gives rise to a right enforceable by § 1983: (1) whether Congress intended for the provision to benefit the plaintiff; (2) whether the plaintiff can show that the right in question is not so “vague and amorphous” that its enforcement would “strain judicial competence”; and (3) whether the statute unambiguously imposes a binding obligation on the states.

In *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002), the Supreme Court held that a former university student could not bring a § 1983 suit for alleged violations of the Family Educational Rights and Privacy Act because that statute had an “aggregate focus” and did not contain rights-creating language targeting a specific, identifiable group of individuals:

We . . . reject the notion that our cases permit anything short of an unambiguously conferred right to support a cause of action brought under § 1983. Section 1983 provides a remedy only for the deprivation of “rights, privileges, or immunities secured by the Constitution and laws” of the United States. Accordingly, it is rights, not the broader or vaguer “benefits” or “interests,” that may be enforced under the authority of that section. *Id.* at 283.

[Where a] provision focuse[s] on “the *aggregate services* provided by the State,” *rather than* “the needs of any particular person,” it confer[s] no individual rights and thus could not be enforced by § 1983.

*Id.* at 282 (quoting *Blessing*, 520 U.S. at 343) (emphasis added). Following *Gonzaga*, in deciding whether a statute gives rise to an enforceable right under

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1 § 1983, courts have looked to whether Congress intended that a specific,  
2 identifiable class of individuals benefit from the statute.

3 Some six weeks ago, the Ninth Circuit held that the main subsection of  
4 section 1396a(a) on which Plaintiffs here rely—§ 1396a(a)(10)<sup>6</sup>—“creates an  
5 individual right enforceable under section 1983.” *Watson v. Weeks*, 436 F.3d  
6 1152, 1155 (9th Cir. 2006). The decision in *Watson* contains a useful review of  
7 the “Medicaid Framework” and “of the applicable law for determining whether a  
8 particular federal statute can be enforced through a private right of action under  
9 section 1983.” *Id.* at 1157-62. It is unnecessary to set forth that review here, and  
10 I will not do so. It is sufficient to note that in ruling that § 1396a(a)(10) creates a  
11 private right of action enforceable under § 1983, the Ninth Circuit “join[ed] five  
12 federal circuits that have already so held.” *Id.* at 1159. Also, the court  
13 distinguished *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005), the case on  
14 which the State Defendants mainly rely, by contrasting the Medicaid Act  
15 provision involved in that case (§ 1396a(a)(30)(A)) with the one involved in  
16 *Watson* (and here)—§ 1396a(a)(10)(A). *Id.* at 1161. In short, under *Watson*  
17 Plaintiffs do have standing.

18 **C. Does the Medicaid Act Require That California Provide**  
19 **Wraparound Services and Therapeutic Foster Care to Plaintiffs?**

20 **1. Are They Services?**

21 Defendants do not dispute that by voluntarily participating in Medicaid  
22 through its Medi-Cal program, California is required to “comply with certain  
23 requirements imposed by the Act and regulations promulgated by the Secretary of  
24 Health and Human Services . . . .” *Wilder v. Va. Hosp. Ass’n*, 496 U.S. 498, 502

25 \_\_\_\_\_  
26 <sup>6</sup> The precise provision is 42 U.S.C. § 1396a(a)(10)(A)(I), which in essence  
27 provides that a Medicaid-funded “State plan for medical assistance must . . . provide  
28 Those recipients include “individuals . . . under the age of 21.” 42 U.S.C.  
§ 1396d(a)(4)(B). “Medical assistance” includes payment for EPSDT. *Id.*

1 (1990). Nor do they dispute that the Medicaid Act requires the provision of  
2 EPSDT to Medicaid-eligible children under the age of twenty-one, 42 U.S.C.  
3 § 1396d(a)(4)(B); that EPSDT requires the State to screen eligible children “to  
4 determine the existence of certain physical or mental illnesses or conditions,” 42  
5 U.S.C. § 1396d(r)(1)(A)(ii); and that the Act requires the State “to correct or  
6 ameliorate defects and physical and mental illnesses and conditions discovered by  
7 the screening services, whether or not such services are covered under the State  
8 plan.” 42 U.S.C. § 1396d(r)(5).

9 What the State Defendants do dispute is that “wraparound services” and  
10 “therapeutic foster care” are EPSDT *services* and are “medically necessary.”  
11 They contend that the Medicaid Act only applies to “services” and that  
12 wraparound and therapeutic foster care are not “services” *per se*, but rather  
13 “approaches” or “processes” or “philosophies” regarding the delivery of health  
14 care. *See, e.g.*, Barthels Depo., Vol 1 at 82:14-18; Grayson Depo. at 30:7-14. In a  
15 related vein, the State Defendants also complain that “Plaintiffs have not only  
16 failed to define, but have obstreperously resisted defining, what they mean by the  
17 terms ‘wraparound services’ and ‘therapeutic foster care.’”

18 Throughout much of this litigation this Court has pressed Plaintiffs to  
19 specify, in as concrete a manner possible, the precise forms of assistance that  
20 “wraparound services” and “therapeutic foster care” entail. Plaintiffs now have  
21 done so, at least to the extent necessary to refute the State Defendants’ objections  
22 that they cannot understand what such assistance consists of and should not be  
23 ordered to do something that they cannot understand.

24 As to “wraparound services,” Plaintiffs have provided a statutory reference  
25 point.<sup>7</sup> Plaintiffs also have defined “wraparound” as follows:

26 \_\_\_\_\_  
27 <sup>7</sup> It is California Welfare and Institutions Code § 18251(d), which describes  
28 “community based intervention services that emphasize the strengths of the child and  
family and [that] include[] the delivery of coordinated, highly individualized



1 Providers of wraparound care services: (a) engage in a unique  
2 assessment and treatment planning process that is characterized by  
3 the formation of a child, family, and multi-agency team (b) marshal  
4 community and natural supports through intensive case management  
5 and (c) make available an array of therapeutic interventions, which  
6 may include behavioral support services, crisis planning and  
7 intervention, parent coaching and education, mobile therapy, and  
8 medication monitoring.  
9 McCabe Decl., Ex. D, App. A at 1. In addition, Plaintiffs have provided a nine  
10 page chart breaking down each of the nine identified component services of  
11 wraparound services. For each component service, they presented a detailed  
12 definition of what that service entails, the qualifications of the rendering providers  
13 (e.g., “Staff with BA/BS in MH-related field or with 2 years experience in Mental  
14 Health”), and the specific provision(s) of the Medicaid Act under which, they  
15 contend, California must provide that service. Plaintiffs set forth these detailed  
16 definitions in an “Appendix A” to their answers to interrogatories.

17 As to “therapeutic foster care,” Plaintiffs have described that component of  
18 the requested mandatory injunction as “an intensive, individualized health service  
19 provided to a child in a family setting, utilizing specially trained and intensively  
20 supervised foster parents.” These programs:

21 (a) place a child singly, or at most in pairs, with a foster parent who is  
22 carefully selected, trained, and supervised and matched with the  
23 child’s needs; (b) create, through a team approach, an individualized  
24 treatment plan that builds on the child’s strengths; (c) empower the  
25 therapeutic foster parent to act as a central agent in implementing the  
26 child’s treatment plan; (d) provide intensive oversight of the child’s  
27 treatment, often through daily contact with the foster parent; (e) make  
28 available an array of therapeutic interventions to the child, the child’s  
family, and the foster family (interventions may include behavioral  
support services for the child, crisis planning and intervention,  
coaching and education for the foster parent and the child’s family,  
and medication monitoring); and (f) enable the child to successfully  
transition from therapeutic foster care to placement with the child’s  
family or alternative family placement by continuing to provide  
therapeutic interventions.

McCabe Decl., Ex. D, App. B at 1. In addition, Plaintiffs proffered a seven page  
chart breaking down each of the seven component services of therapeutic foster

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unconditional services to address needs and achieve positive outcomes in their lives.”

1 care, the requisite qualifications of the providers, and the statutory authorization.  
2 *Id.* Plaintiffs specified these aspects of therapeutic foster care as “Appendix B” to  
3 their answers to certain interrogatories.<sup>8</sup>

4 Are Appendices A and B mere words that provide only an illusion of  
5 medically necessary services? Are they highfalutin sentiments devoid of practical  
6 application? Is what Justice Cardozo once wrote applicable: “We seek to find  
7 peace of mind in the word, the formula, the ritual. The hope is an illusion.”  
8 Benjamin N. Cardozo, *The Growth of the Law*, pp. 66-67 (1924). Or do  
9 Appendices A and B merely reflect that “[t]he only tool [that] the lawyer [has] is  
10 words. We have no marvelous pills to prescribe for our patients . . . . Whether we  
11 are trying a case, writing a brief, drafting a contract, or negotiating with an  
12 adversary, words are the only things we have to work with.” Charles Alan  
13 Wright, Book Review, Townes Hall Notes, Spring 1988, at 5.

14 It is perhaps inevitable that in defining and describing these disputed means  
15 of treatment for mentally ill children (“wraparound services” and “therapeutic  
16 foster care”), Plaintiffs included imprecise terms, bordering on jargon.  
17 Nevertheless, I find that the physicians, therapists, social workers, teachers,  
18 counselors, parents and others who are necessary providers of EPSDT surely are  
19 able to convert these words into meaningful services.

20 And services they are. Defendants understandably prefer to characterize  
21 “wraparound” and “therapeutic foster care” as “processes” or “approaches” or  
22 “philosophies,” because those words are not in the Medicaid Act—only “services”  
23 are mandated.<sup>9</sup> But to relegate “wraparound” and “therapeutic foster care” to  
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25 <sup>8</sup> Henceforth, in this opinion the charts **that were** attached as the appendices  
26 to the McCabe Declaration shall be referred to as Appendix A and Appendix B.

27 <sup>9</sup> The State Defendants argue that “[m]ost of Plaintiffs’ declarations do not  
28 state, or even suggest, that ‘wraparound services’ or ‘therapeutic foster care’ are  
Medicaid covered services as such.” Opp’n at 21. Defendants then review several of

1 some realm other than “services,” as the State Defendants seek to do, is akin to  
2 limiting the classification of a criminal defense attorney’s “services” to only his  
3 advice and in-court representation, while excluding his necessary efforts at  
4 coordinating the professional work of others, such as an investigator, jury  
5 consultant or sentencing consultant. Often the client is assisted by a team of  
6 professionals, and a key, necessary “service” of the lawyer is to coordinate these  
7 professionals’ respective services. To extend the analogy further, a criminal  
8 defense attorney will also rely on (and help shape) the participation of the client  
9 himself in his coordinated defense. So, too, in “wraparound” a core element of  
10 that service is “family voice and choice,” *i.e.*, family participation in and  
11 contribution to the array of treatment. *See* Bruns Decl. ¶ 26.<sup>10</sup>

12 \_\_\_\_\_  
13 the declarations submitted by Plaintiffs’ experts—*e.g.*, those of Eric Bruns, Ph.D.; Ira  
14 Lourie, M.D.; Robert Friedman, Ph.D.; Patricia Chamberlain, Ph.D. With respect to  
15 each, Defendants argue that: (1) the expert does not explicitly refer to “wraparound  
16 services” and “therapeutic foster care” as “services” *per se* and (2) the expert has not  
17 claimed that wraparound services and therapeutic foster care are covered by Medicaid.  
18 These arguments are not persuasive.

19 First, that Defendants have combed through these declarations and have been  
20 able to locate instances where the terms “wraparound” or “therapeutic foster care” are  
21 found alongside the words “process,” “program,” or “practice” (instead of the word  
22 “service”) does *not* mean that they are not services. Indeed, such games can be played  
23 with the opposite effect. Plaintiffs have pointed out occasions where the State has  
24 itself referred to wraparound as a “service”—*e.g.*, California’s “Wrap-Around  
25 Services Pilot Project.” Opp’n at 13 (emphasis added). Also, California Welfare and  
26 Institutions Code § 18250(d)—a statute—also refers to “Wrap-around services.”

27 Second, that Plaintiffs’ medical and behavioral experts do not also opine on  
28 whether the EPSDT provisions of the Medicaid Act cover wraparound services and  
29 foster care is of no consequence. Plaintiffs rely on different experts to establish that  
30 point. *See below.*

31 <sup>10</sup> Defendants quote out of context and in a misleading manner this Court’s  
32 observation in *Emily Q.* that “[t]he wraparound process is not a program or a type of  
33 service.” *Emily Q.*, 208 F.Supp.2d at 1091. What the Court actually noted in that  
34 limited portion of a 28 page opinion dealing with Therapeutic Behavioral Services  
35 (“TBS”) was that “TBS is one type of a broad variety of individualized services that

1                   **2. Does EPSDT Require Wraparound and Therapeutic Foster**  
2                   **Care?**

3                   The State Defendants proceed to argue that even if “wraparound” and  
4                   “therapeutic foster care” are services, the Medicaid-mandated provision of EPSDT  
5                   does not encompass them. Section 1396d(r) lists an array of services that states  
6                   are required to provide to children under age twenty-one. Plaintiffs rely primarily  
7                   on § 1396d(r)(5), a catch-all provision, which requires that states render “[s]uch  
8                   other necessary health care, diagnostic services, treatment, and other measures  
9                   described in subsection (a) of this section to correct or ameliorate defects and  
10                  physical and mental illnesses and conditions discovered by the screening services .  
11                  . . .” The State Defendants contend that this language means that such states need  
12                  only provide those services expressly listed in § 1396(d)(a).

13                  The Court disagrees. Section 1396d(a) identifies twenty-eight different  
14                  services, including diagnostic services, psychiatric services, rehabilitative services  
15                  and case management services. To be sure, the statute does not mention  
16                  “wraparound services” and “therapeutic foster care,” but a specific service,  
17                  although not expressly listed in § 1396d(a), may nevertheless fall under one of the  
18                  other twenty-eight categories. *See, e.g., Pediatric Specialty Care, Inc. v. Ark.*  
19                  *Dep’t. of Human Servs.*, 293 F.3d 472, 480-481 (8th Cir. 2002) (“early  
20                  intervention day treatment” required under § 1396d(a)(13) (rehabilitative  
21                  services)); *Collins v. Hamilton*, 349 F.3d 371, 376 (7th Cir. 2003) (“psychiatric

22 \_\_\_\_\_  
23 may be used in a ‘wraparound’ process. The wraparound process is not a program or  
24 a type of service. [It] can include any combination of services and support.”  
25 (emphasis added.) To infer from the middle sentence that something that consists of  
26 a combination of *services* and supports is not in itself a “service” within the meaning  
27 of the Medicaid Act makes no sense. *See* Farr Decl. ¶ 23 n. 1 (“[R]eferring to  
28 Wraparound as a process . . . do[es] not mean . . . that it is not a mental health service.  
Individual and group therapy and case management services, for instance, can all be  
described as processes, but they are unquestionably mental health services. The same  
is true for Wraparound.”)

1 residential treatment facilities” required under § 1396d(a)(16) (inpatient  
2 psychiatric hospital services)); *Emily Q.*, 208 F.Supp.2d at 1090 (“therapeutic  
3 behavioral services” required under EPSDT). “Congress did not grant or allow  
4 states the discretion to define what types of health care and services would be  
5 provided to EPSDT children . . . .” *S.D.*, 391 F.3d at 593. As stated in *Rosie D.*,  
6 *supra*, “the *only* limit placed on the provision of EPSDT services is the  
7 requirement that they be ‘medically necessary’ . . . .” *Rosie D.*, 2006 WL 181393,  
8 at \*5 (emphasis added). “[I]f a licensed clinician finds a particular service to be  
9 medically necessary to help a child improve his or her functional level, this  
10 service must be paid for by a state’s Medicaid plan pursuant to the EPSDT  
11 mandate.” *Id.*

12       Wraparound services has nine component services; therapeutic foster care  
13 has seven. Each component service has numerous subcomponent services. Each  
14 subcomponent may fall under any one or more of the twenty-eight different  
15 categories of § 1396d(a). The three categories Plaintiffs claim to be most  
16 frequently applicable are: “rehabilitative services,” 42 U.S.C. § 1396d(a)(13);  
17 “case management services,” 42 U.S.C. § 1396d(a)(19); and “personal care  
18 services,” 42 U.S.C. § 1396d(a)(24). Plaintiffs’ supplemental interrogatory  
19 responses described above (Appendices A and B) link, in chart form, each  
20 component of wraparound services and therapeutic foster care service to the  
21 corresponding category or categories of § 1396d(a). The declaration of Chris  
22 Koyanagi provides a similar breakdown. Koyanagi Decl. ¶¶ 23-31.<sup>11</sup> The Court  
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25       <sup>11</sup> Ms. Koyanagi is the Policy Director of the Washington, D.C.-based Bazelon  
26 Center for Mental Health Law, which is one of the counsel for Plaintiffs. She works  
27 with the federal Center for Medicare and Medicaid Services and the federal Substance  
28 Abuse and Mental Health Services Administration. She was the primary author of  
“Making Sense of Medicaid for Children with Serious Emotional Disturbance.” *Id.*  
¶ 10 and Ex. 2. That definitive study “demonstrated that wraparound and therapeutic  
foster care can be covered by Medicaid,” *id.* ¶ 22, and that states “regularly” receive

1 finds it likely that virtually all of the corresponding categories of § 1396d(a)  
2 identified by Plaintiffs do, in fact, encompass the linked-to service.<sup>12</sup>

3 The State Defendants do not directly rebut or even challenge Ms.  
4 Koyanagi's categorizations. Instead, they merely point to a June 28, 2005 report  
5 by the federal Government Accountability Office ("G.A.O.") that proposes  
6 numerous legislative reforms to Medicaid, one of which aims to address the use of  
7 categories such as "rehabilitation services" to improperly bill the federal  
8 government for services "that are intrinsic elements of non-Medicaid programs."  
9 See Defs.' Ex. 103 at 168. Even assuming that in principle the G.A.O. report  
10 could be relevant, it is of no help to State Defendants. It does not discuss EPSDT  
11 or wraparound services and therapeutic foster care. Moreover, it confirms that  
12 "Medicaid payments will be available for appropriate rehabilitation services that  
13 are intended for the maximum reduction of physical or mental disability and

14 \_\_\_\_\_  
15 Medicaid funding for such services. *Id.* ¶ 26.

16 <sup>12</sup> For example, the first component service of wraparound services is  
17 "Engagement of the Child and Family." See Appendix A at 2. A subcomponent of  
18 that service is to "organize[] an initial meeting with the child and family [to] explain[]  
19 wraparound care services . . . and encourage[] the participation of additional family  
20 members . . ." *Id.* The Court finds that this likely falls under § 1396d(a)(19) (case  
21 management services). As another example, the second component service of  
22 wraparound services is "Immediate Crisis Stabilization." *Id.* at 2-3. A subcomponent  
23 of that service is "to address safety issues related to medical needs, severe psychiatric  
24 symptoms, behaviors of a child that might place others in jeopardy, or issues related  
25 to a child living in an unsafe environment." *Id.* at 3. The Court finds that, depending  
26 on the circumstances and severity of the crisis, these activities likely fall under  
27 § 1396d(a)(5)(A) (physician services), § 1396d(a)(2)(A) (outpatient hospital  
28 services), § 1396d(a)(9) (clinic services), § 1396d(a)(7) (home health care services),  
or § 1396d(a)(13) (rehabilitative services).

Each component service of therapeutic foster care similarly falls within one or  
more categories of § 1396d(a). For example, "Recruitment and Matching," which  
includes "the recruitment of families to serve as therapeutic foster parents, and then  
matching those families with children in need of a therapeutic foster home," See  
Appendix B at 2, likely falls under § 1396d(a)(19) (case management services).

1 measurable restoration of an individual to the best possible functional level.” *Id.*  
2 (emphasis in original).

3 In short, wraparound services and therapeutic foster care fall within the  
4 EPSDT obligations of Medicaid-participating states. This conclusion is buttressed  
5 by the fact that in other states wraparound services and therapeutic foster care  
6 programs have been funded by Medicaid. For example, Linda Huff Redman,  
7 Ph.D., the former Deputy Director of Arizona’s Medicaid Program, states that  
8 Arizona uses Medicaid funding for EPSDT to pay for almost all of the component  
9 services of therapeutic foster care—the only exclusions being “room and board  
10 expenses and the one-time or occasional goods and/or services needed to support  
11 the child and their family (e.g., refrigerator, clothes).”<sup>13</sup> Redman Decl. ¶¶ 3, 18-  
12 26. Nineteen other states<sup>14</sup> also provide therapeutic foster care as a “mental health  
13 service paid for by Medicaid and billed using codes in the ‘Healthcare Common  
14 Procedure Coding System.” *Id.* ¶ 19. Arizona also funds its wraparound services  
15 program with Medicaid dollars. *Id.* ¶¶ 4, 27-30. The Medicaid-covered  
16 components of Arizona’s therapeutic foster care program includes “group  
17 rehabilitative treatment, individual and family therapy, substance abuse/chemical  
18 dependency therapy, basic living skills redevelopment, social skills redevelopment  
19 and crisis/behavior management.” *Id.* ¶ 25. The Medicaid-covered components  
20 of its wraparound program include the engagement of the child and family;  
21 immediate crisis stabilization; strengths, needs and cultural discovery; formation  
22 of the child and family team; development and implementation of the behavioral  
23 health plan; on-going crisis and safety planning; tracking and adapting; and  
24

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25 <sup>13</sup> These exclusions are not applicable here since Plaintiffs do not seek to  
26 compel California to provide them.

27 <sup>14</sup>Arkansas, Delaware, Florida, Georgia, Kansas, Kentucky, Michigan,  
28 Minnesota, Montana, Nebraska, Nevada, New Mexico, New York, North Carolina,  
North Dakota, Oklahoma, Oregon, South Carolina, and Wyoming. *Id.* ¶ 19 n.2.

1 transition out of the formal wraparound program. *Id.* ¶ 29. Dr. Redman’s detailed  
2 description of Arizona’s state-wide program is corroborated and supplemented by  
3 Timothy Penrod, formerly a State of Arizona Child Protection Services Specialist  
4 and now the CEO of a firm providing those kinds of services to children and  
5 families in Arizona. Penrod Decl. ¶¶ 1-26.

6 Nebraska has used Medicaid funds to provide wraparound services,  
7 Koyanagi Decl. ¶ 27, although the parties debate the extent to which Medicaid  
8 dollars now contribute to that program. Koyanagi Supplemental Decl. ¶ 3b;  
9 Defs.’ Ex. 107.

10 Pennsylvania’s wraparound services are “funded by Pennsylvania’s  
11 Medicaid program, as part of its EPSDT benefit.” Nace Decl. ¶¶ 30-31.

12 In Milwaukee, Wisconsin, Medicaid funding is used for “Wraparound  
13 Milwaukee” to cover “case management, team meetings, mobile crisis  
14 intervention, psychiatric and psychological assessments, crisis stabilization teams,  
15 medical day treatment, medication management, in-home therapy, office-based  
16 therapy, group therapy, substance abuse treatment, and a comprehensive provider  
17 system.” Kamradt Decl. ¶ 18. Only “[n]on-medically necessary services—like  
18 tutors and mentors—are not covered . . . .” *Id.*

19 Even the State Defendants’ own expert, Mary Jean Duckett, of the United  
20 States Department of Health and Human Services, acknowledges that “[s]ome  
21 states have included in their approved state plans, coverage for services under the  
22 label of therapeutic foster care that [the federal Center for Medicare and Medicaid  
23 Services] believed to consist of component parts that are Medicaid-covered care  
24 and services within the scope of the definitions listed in 42 U.S.C. § 1396d(a).”  
25 Duckett Decl. ¶ 5.

26 Not only do wraparound services and therapeutic foster care fall within the  
27 scope of Medicaid-mandated ESPDT services, but they may be “medically  
28 necessary” within the meaning of the statute. The Medicaid Act does not define



1 when a service is “medically necessary.” Rather, the decision “rests with the  
2 individual recipient’s physician and not with clerical personnel or government  
3 officials.” *Pinneke v. Preisser*, 623 F.2d 546, 550 (8th Cir. 1980); *Weaver v.*  
4 *Reagen*, 886 F.2d 194, 200 (8th Cir. 1989) (“The Medicaid statute and regulatory  
5 scheme create a presumption in favor of the medical judgment of the attending  
6 physician in determining the medical necessity of treatment.”). Plaintiffs have  
7 proffered the declarations of numerous behavioral and mental health experts who  
8 attest to the medical necessity of providing these services to foster care children  
9 with emotional disturbances. Thus, Ira Lourie, a former psychiatrist at the  
10 National Institute for Mental Health for over two decades and currently Assistant  
11 Clinical Professor of Child Psychiatry at Georgetown University School of  
12 Medicine, states that “wraparound services are medically necessary for children  
13 with serious mental health needs.” Lourie Decl. ¶ 2. Dr. Lourie adds that  
14 “wraparound programs enable children with behavioral, psychiatric, or emotional  
15 impairments to function as well and as normally as possible.” Lourie Decl. ¶ 13.  
16 Dr. Patricia Chamberlain, an Oregon-based psychologist who developed a  
17 therapeutic foster care program lauded by the federal government, states that “a  
18 children’s mental health system that does not include Therapeutic Foster Care . . .  
19 as an available intervention is incomplete and inadequate because intense mental  
20 health interventions, provided in home-like settings are necessary for many  
21 children with serious behavioral or mental health needs.” Chamberlain Decl. ¶ 3.  
22 Dr. Eric Bruns, a psychologist and Assistant Professor at the University of  
23 Washington School of Medicine, states that “[a]long with therapeutic foster care,  
24 . . . wraparound is generally cited among the most effective integrated community-  
25 based interventions for children with emotional, behavioral, and mental health  
26 disorders. As such, both therapeutic foster care and wraparound are integral parts  
27 of any modern children’s mental health system.” Bruns Decl. ¶ 3. Dr. Charles  
28 Huffine, a psychiatrist who served as President of the American Association of

1 Community Psychiatrists, states that wraparound services “are essential mental  
2 health services and medically necessary for some children with mental health  
3 needs.” Huffine Decl. ¶ 7. Dr. Robert Friedman, the Chair of the Department of  
4 Child and Family Studies at the University of South Florida, states that  
5 “[t]herapeutic foster care is an evidence-based practice, the gold standard in  
6 mental health interventions for youth . . . . [T]here are sufficient findings to  
7 consider wraparound services a research validated evidence-based practice.”  
8 Friedman Decl. ¶ 4. He adds that “a functioning children’s mental health system  
9 would include both therapeutic foster and wraparound care services. Both  
10 services are necessary for some children with serious emotional disturbance, many  
11 of whom are in the foster care system.” *Id.* ¶ 5. Friedman also notes that  
12 “wraparound services and therapeutic foster care are widely thought of as  
13 essential to any modern children’s mental health system . . . .” *Id.* ¶ 31.

14 The State Defendants have not presented any declarations by mental health  
15 experts contesting this evidence that wraparound services and therapeutic foster  
16 care are medically necessary services for foster care children with mental health  
17 care needs.<sup>15</sup>

18 For all the foregoing reasons, the Court concludes that Plaintiffs have  
19 demonstrated a strong likelihood of succeeding on the merits of their substantive  
20 claims concerning the Medicaid Act and EPSDT.

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21  
22 <sup>15</sup> In reference to the wraparound services provided via California’s Title IV-E  
23 Waiver Child Demonstration Project, the State Defendants do contend that “a  
24 federally required independent evaluation of the project showed that the project did  
25 not demonstrate that provision of wraparound services was any more effective than  
26 traditional services.” (citing Treadwell Decl. ¶ 11). This is misleading. Treadwell  
27 went on to state that “[t]he evaluation . . . concluded that one of the likely reasons that  
28 there was no statistically significant positive effect shown for the group of children  
receiving wraparound services was that the [participating] ‘counties were more  
successful at providing Wraparound-like services to the comparison [*i.e.*, control]  
group than the evaluation was able [to] assess, resulting in similar outcomes between  
the groups.” Treadwell Decl. ¶ 11.

1           Plaintiffs contend that the balance of hardships tips in their favor because  
2 absent an order requiring the State of California to provide wraparound services  
3 and therapeutic foster care, those foster children with mental health needs would  
4 likely face unnecessary institutionalization. The State Defendants' one paragraph  
5 opposition on this point argues (1) that Plaintiffs cannot be suffering irreparable  
6 injury given that they waited three years since initiating this suit to file the present  
7 motion and (2) that Plaintiffs have an adequate remedy via the Medicaid appeals  
8 process. As to the first argument, Plaintiffs initially focused much of their efforts  
9 and limited resources on their claims against Los Angeles County, which led to a  
10 pioneering, albeit still problem-laden, settlement. The County agreed to ensure  
11 that members of the countywide subclass "promptly receive necessary,  
12 individualized mental health services in their home . . . or the most homelike  
13 setting appropriate to their needs; receive the care and services needed to prevent  
14 removal from their families . . . ; be afforded stability in their placements . . . ; and  
15 receive care and services consistent with good child welfare and mental health  
16 practice and the requirements of state and federal law." Katie A. Advisory Panel's  
17 Fifth Report to the Court, June 16, 2005, at 3. As to the remaining members of the  
18 statewide class, the unmet mental health needs and the harms of unnecessary  
19 institutionalization are no less grave now than three years ago.

20           Defendants' argument that the Medicaid appeals process undermines the  
21 showing of irreparable injury is also unpersuasive. "[E]xhaustion of state  
22 administrative remedies should not be required as a prerequisite to bringing an  
23 action pursuant to § 1983." *Patsy v. Bd. of Regents of State of Fla.*, 457 U.S. 496,  
24 516 (1982).

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1 **III. CONCLUSION**

2 The Court GRANTS Plaintiffs' motion for preliminary injunction.<sup>16</sup> The  
3 component services of wraparound services and therapeutic foster care identified  
4 in Plaintiffs' supplemental interrogatory responses likely fall within the EPSDT  
5 provisions of the Medicaid Act. Therefore, California must screen members of  
6 the statewide class and provide wraparound services and therapeutic foster care  
7 where medically necessary "to correct or ameliorate defects and physical and  
8 mental illnesses and conditions discovered by the screening services." 42 U.S.C.  
9 § 1396d(r)(5).<sup>17</sup>

10 Accordingly, during the pendency of this lawsuit, Defendant Sandra  
11 Shewry, in her official capacity as Director of the California Department of Health  
12 Services, and Defendant Dennis Boyle, in his official capacity as Director of the  
13 California Department of Social Services, as well as their respective successors in  
14 office, agents, servants, employees, and all others acting in concert with them,  
15 shall provide wraparound services and therapeutic foster care, as defined in  
16 Appendices A and B. Such forms of treatment shall be provided to class members  
17 on a consistent, statewide basis through the Medi-Cal program or other means,

18 \_\_\_\_\_  
19 <sup>16</sup>Docket No. 315.

20 <sup>17</sup> Given this conclusion, it is unnecessary to address Plaintiffs' alternative  
21 claims that they are entitled to the same relief under the Americans with Disabilities  
22 Act and the Rehabilitation Act. Similarly irrelevant is the State Defendants'  
23 contention that Title IV-E of the Social Security Act, which is the primary funding  
24 mechanism for children who have already been placed in foster care, does not permit  
25 payment for social services for the child or the child's family when the child has not  
26 yet been removed from the home. Plaintiffs do not claim that the State of California  
27 must pay for wraparound and therapeutic foster care using Title IV-E funds (although  
28 Title IV-E funds may, indeed, cover certain component services of wraparound  
services and therapeutic foster care). Rather, Plaintiffs claim that the Medicaid Act's  
independent funding provision, namely, Title XIX of the Social Security Act, will  
likely help cover those services. Thus, any restrictions on the use of Title IV-E funds  
are not relevant to Plaintiffs' Medicaid-based argument.

1 beginning not later than 120 days from entry of this Order. (The plan need not  
2 necessarily include *all* of the aspects of wraparound services and therapeutic  
3 foster care specified in Appendices A and B.) In order to effectuate this  
4 requirement, counsel for the State Defendants and for Plaintiffs shall meet and  
5 confer and develop a plan for implementing this preliminary injunction. Among  
6 other things, the plan must identify the responsibilities of the different State  
7 agencies, the need for additional providers, the eligibility criteria for wraparound  
8 services and therapeutic foster care, methods and procedures to inform class  
9 members of the availability of these services, and a timeline for accomplishing  
10 needed tasks. In negotiating the plan, counsel shall diligently and in good faith  
11 take into account and apply this Court's previous rulings and observations in this  
12 case and in *Emily Q.*

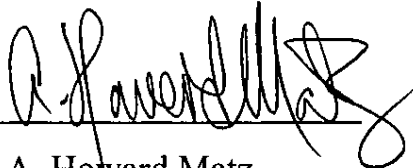
13 Furthermore, the State Defendants and Plaintiffs shall also meet and confer  
14 as to whether the Court should appoint a Special Master. (If the Court does so, the  
15 individual may well be the same person who may be appointed Special Master in  
16 *Emily Q.*)

17 Not later than 70 days from entry of this Order, the State Defendants and  
18 Plaintiffs shall file a joint status report regarding the status of an implementation  
19 plan and the possible appointment of a Special Master.

20 Because this action is brought by a class of indigent Plaintiffs, the Court  
21 chooses to exercise its discretion by not requiring the posting of a bond. *People of*  
22 *State of Cal. ex rel. Van De Kamp v. Tahoe Reg'l Planning Agency*, 766 F.2d  
23 1319, 1325 (9th Cir. 1985).

24  
25 IT IS SO ORDERED.

26  
27 DATE: March 14, 2006

28  
  
A. Howard Matz  
United States District Judge