THOMAS E. PEREZ, Assistant Attorney General
EVE HILL, Senior Counselor to the Assistant Attorney General
ALLISON J. NICHOL, Chief
SHEILA FORAN, Special Legal Counsel
KATHLEEN R. WOLFE, Acting Special Legal Counsel
RENEE M. WOHLENHAUS, Deputy Chief
TRAVIS W. ENGLAND, Trial Attorney, NY SBN 4805693
Travis.England@usdoj.gov
U.S. Department of Justice
950 Pennsylvania Avenue, N.W. - NYA
Washington, D.C. 20530
Telephone: (202) 307-0663
Facsimile: (202) 307-1197
ANDRÉ BIROTTE JR.
United States Attorney
LEON W. WEIDMAN
Assistant United States Attorney
Chief, Civil Division
ROBYN-MARIE LYON MONTELEONE
Assistant United States Attorney
Assistant Division Chief,
Civil Rights Unit Chief, Civil Division
California Bar Number: 130005
Robby.Monteleone@usdoj.gov
Room 7516 Federal Building
300 North Los Angeles Street
Los Angeles, California 90012
Telephone: (213) 894-2458
Facsimile: (213) 894-7819
ATTORNEYS FOR UNITED STATES

IN THE UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

KATIE A. by and through her next friend Michael Ludin; MARY B. by and through her next friend Robert Jacobs; JANET C. by and through her next friend Dolores Johnson; HENRY D. by and through his next friend Gillian Brown; AND GARY E. by and through his next friend Michael Ludin; individually and behalf of others similarly situated,
Plaintiffs,

v.

TOBY DOUGLAS, Director of California Department of Health Care Services; LOS ANGELES COUNTY; LOS ANGELES COUNTY DEPARTMENT OF

CASE NO. CV-02-05662 AHM (SHX)
CLASS ACTION
COMMENTS OF THE UNITED STATES IN SUPPORT OF FINAL APPROVAL OF THE PROPOSED SETTLEMENT AGREEMENT

Hearing Date: **Dec. 1, 2011**
Time: 2:00 p.m.
Courtroom: 14
Judge: A. Howard Matz

CHILDREN AND FAMILY SERVICES; ANITA BLOCK,

Director of the Los Angeles County Department of Children and Family Services; WILL LIGHTBOURNE, Director of the California Department of Social Services, and DOES 1 through 100, Inclusive.

Defendants.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Other Authorities

Regulations

The United States respectfully submits these Comments in support of final approval of the Proposed Settlement Agreement (hereinafter, the "Agreement"). The United States has a strong interest in the resolution of this matter because it advances the important public interest of compliance with title II of the Americans with Disabilities Act, 42 U.S.C. § 12131 et seq., and the Early and Periodic Screening, Diagnostic and Treatment ("EPSDT") provisions of Title XIX of the Social Security Act ("Medicaid Act"), 42 U.S.C. § 1396 et seq., including the prevention of segregation, isolation, and unnecessary institutionalization of individuals with disabilities. *See Olmstead v. L.C.*, 527 U.S. 581, 607, 119 S.Ct. 2176, 2190 (1999). The Agreement between Plaintiffs and the State defendants is "fair and reasonable," *see In re Bluetooth Headset Products Liability Litigation*, 654 F.3d 935, 946 (9th Cir. 2011) (*citing Churchill Vill., L.L.C. v. Gen. Elec.*, 361 F.3d 566, 575 (9th Cir. 2004)), and addresses Plaintiffs' allegations that Defendants violate federal law by failing to provide needed community-based mental health services to children in or at imminent risk of placement in the State's foster care system.[1] Accordingly, the United States respectfully urges this Court to grant final approval of the Agreement.

[1] The United States recognizes that the Agreement advances the objective of facilitating the delivery of an array of medically necessary mental health services in a coordinated, comprehensive, and community-based fashion to full-benefit Medi-Cal eligible class members. (*See* Settl. Agr. ¶¶ 20(a)-(g),(i)). As discussed more fully below, pp. 9 to 11, the EPSDT requirements of the Medicaid Act mandate Defendants to ensure the provision of mental health services that are within the permissible scope of the traditional Medicaid benefit to all full-benefit Medi-Cal-eligible children for whom such services are medically necessary. *See* 42 U.S.C. §§ 1396d(a)(4)(B); 1396d(r)(5); 1396a(a)(10)(A); and 1396a(a)(43)(C).

BACKGROUND

Plaintiffs represent a statewide class of children in California that this Court earlier certified, who:

> (a) are in foster care or are at imminent risk of foster care placement,[2] and
>
> (b) have a mental illness or condition that has been documented or, had an assessment already been conducted, would have been documented, and
>
> (c) need individualized mental health services, including but not limited to professionally acceptable assessments, behavioral support and case management services, family support, therapeutic foster care, and other medically necessary services in the home or in a home-like setting, to treat or ameliorate their illness or condition.

(Settl. Agr. ¶ 3; *see also* Order Re Class Cert., ECF No. 92, at 21-22.) This lawsuit alleges that Toby Douglas, current director of the California Department of Health Care Services ("DHCS"), and Will Lightbourne, current Director of the California Department of Social Services ("CDSS") (together, the "Defendants") fail to provide Plaintiffs and members of the Class with necessary community-based mental health services, and instead rely on services provided in restrictive,

[2] The Parties have stipulated that "imminent risk of foster care placement" means that

> within the last 180 days a child has been participating in voluntary family maintenance or voluntary family reunification placements and/or has been the subject of either a telephone call to the Child Protective Services hotline or some other documented communication made to a local Child Protective Services agency regarding suspicions of abuse, neglect or abandonment.

(Settl. Agr. ¶ 3; *see also* Proposed Stip. J. Pursuant to Class Action Settl. Agr., Appx. A. to Settl. Agr. ECF No. 755, ¶ 2(c).)

congregate, and institutional placements, in violation of the Medicaid Act and the ADA. (Pls.' First Am. Compl. ("Compl."), ECF. No. 33, ¶¶ 47, 76, 80-87.)[3]

THE PARTIES' SETTLEMENT AGREEMENT

The Agreement expresses four objectives: (a) to "[f]acilitate the provision of an array of services delivered in a coordinated, comprehensive, community-based fashion that combines service access, planning, delivery, and training into a coherent and all-inclusive approach;" (b) to "[s]upport the development and delivery of a service structure and a fiscal system that supports a core practices and services model, as described in (a);" (c) to "[s]upport an effective and sustainable solution that will involve standards and methods to achieve quality-based oversight, along with training and education that support the practice and fiscal models;" and (d) to "[a]ddress the need for certain class members with more intensive needs … to receive medically necessary mental health services in their own home, a family setting or the most homelike setting appropriate to their needs, in order to facilitate reunification, and to meet their needs for safety, permanence, and well-being." (Settl. Agr. ¶ 19.)

In furtherance of these objectives, the Agreement requires Defendants to, among other things, support the development and delivery of an array of coordinated, community-based mental health services and develop a process "to identify class members and link them firmly to services." (*See id*. ¶¶ 20(a)-(g), (i)). Defendants must develop and disseminate a Medi-Cal Specialty Mental Health documentation manual ("Documentation Manual") designed to inform and instruct

[3] Plaintiffs also allege that Defendants' actions violate their rights under the Due Process clauses of the United States and California Constitutions. (*See* Compl. ¶¶ 77-79, 88-90.)

providers on the provision of Intensive Care Coordination ("ICC")[4] and Intensive Home Based Services ("IHBS")[5] consistent with Core Practice Model Principles and Components ("Core Practice Model"),[6] and to submit to the Centers for Medicare and Medicaid Services ("CMS") amendments to the California State Medicaid Plan to include ICC and IHBS consistent with this approach (Settl. Agr. ¶¶ 20(a)(1), (b)1, (c)). Defendants must also specifically facilitate the provision

[4] The Agreement defines ICC as a service "responsible for facilitating assessment, care planning, and coordination of services." (Appx. E to Settl. Agr..) The components of ICC include a "strengths-based, needs driven comprehensive assessment," development of an Individual Care Plan ("ICP"), referral, monitoring and related activities to meet the needs identified in the ICP, and development of a transition plan when the individual has achieved the goals outlined in the ICP. (*Id*.)

[5] The Agreement defines IHBS as services that are "individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child's functioning." (Appx. D to Settl. Agr..) The interventions are designed to help the child "build skills necessary for successful functioning in the home and community and improving the child's family's ability to help the youth successfully function in the home and community." (*Id*.) Services are designed to educate and train the child's family in managing the child's disorder, to provide medically-necessary skill-based remediation of disorders, to improve the child's self-care, self-management of symptoms, and social decorum, and to support the development and maintenance of social support networks, employment and educational, and independent living objectives. (*Id*.)

[6] The Core Practice Model, defined in Appendix "B" to the Agreement, is designed, among other things, to facilitate the provision of a full array of necessary mental health services to class members, and to ensure that services are individualized, delivered through a multi-agency collaborative approach, and provided in the child and family's community. (*See* Appx. B to Settl. Agr.) The Documentation Manual must outline that ICC and IHBS are to be provided utilizing a Child and Family Team, as defined in Appendix "C" to the Agreement. (*See* Settl. Agr. ¶ 20(b)(1)).

of ICC and IHBS to a Subclass of plaintiffs.[7] (*See Id.* ¶ 19(d)(1); Special Master's Rept. Pursuant to Agr. ("Special Master's Rept."), ECF No. 751, at 8.) The Agreement further requires Defendants to include in the Documentation Manual instructions to providers regarding the provision of Therapeutic Foster Care ("TFC") services, as defined in *Katie A. v. Bonta*, 433 F. Supp. 2d 1065, 1072 (C.D. Cal. 2006). (*See* Settl. Agr. ¶ 20(a)(2).) The Agreement stipulates that TFC services:

> (a) place a child singly, or at most in pairs, with a foster parent who is carefully selected, trained, and supervised and matched with the child's needs;
>
> (b) create, through a team approach, an individualized treatment plan that builds on the child's strengths;
>
> (c) empower the therapeutic foster parent to act as a central agent in implementing the child's treatment plan;
>
> (d) provide intensive oversight of the child's treatment, often through daily contact with the foster parent;
>
> (e) make available an array of therapeutic interventions to the child, the child's family, and the foster family (including behavioral support services, crisis planning and intervention, coaching and

[7] The Agreement defines Subclass members as children and youth who are full-scope Medi-Cal eligible, meet medical necessity, have an open child welfare services case, and either: (a) are currently in or being considered for wraparound, therapeutic foster care or other intensive services, therapeutic behavioral services, specialized care rate due to behavioral health needs or crisis stabilization/ intervention; or (b) are in or being considered for a group home (RCL 10 or above), a psychiatric hospital or 24 hours mental health treatment facility, or has experienced [3] or more placements within 24 months due to behavioral health needs. (Settl. Agr. ¶ 19(d)(1).)

education for the foster parent and 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 placement by continuing to provide therapeutic interventions.

(*See* Settl. Agr. ¶ 20(a)(2)) (referring to the definition of TFC in *Katie A.*, 433 F. Supp. 2d at 1072).[8]

STATUTORY AND REGULATORY BACKGROUND

A. The ADA and the Integration Mandate

Congress enacted the ADA in 1990 "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. § 12101(b)(1). Congress found that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem." 42 U.S.C. § 12101(a)(2). For those reasons, Congress prohibited discrimination against individuals with disabilities by public entities:

> [N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

[8] The Agreement stipulates that, to the extent that "activities and/or components of TFC services" are covered under the Medicaid Act, "the State Plan needs to be amended to cover TFC services that are covered under the Medicaid Act but are not covered in the State Plan." (Settl. Agr. ¶ 20(a)(2)(A)(3).) Any amendment to the State Plan must first be submitted to CMS for approval.

42 U.S.C. § 12132.

As directed by Congress, the Attorney General issued regulations implementing title II, which are based on regulations issued under Section 504 of the Rehabilitation Act.[9] *See* 42 U.S.C. § 12134(a); 28 C.F.R. § 35.190(a); Exec. Order 12250, 45 Fed. Reg. 72995 (1980), *reprinted in* 42 U.S.C. § 2000d-1. The title II regulations require public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d). The preamble discussion of the "integration regulation" explains that "the most integrated setting" is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible…." 28 C.F.R. Pt. 35, App. B at 673 (2011).

Twelve years ago, the Supreme Court applied these authorities and held that title II prohibits the unjustified segregation of individuals with disabilities. *Olmstead*, 527 U.S. at 596. There, the Court held that public entities are required to provide community-based services to persons with disabilities when (a) such services are appropriate; (b) the affected persons do not oppose community-based

---

[9] Section 504, like title II, prohibits disability-based discrimination. 29 U.S.C. § 794(a) ("No otherwise qualified individual with a disability . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance . . . ."). In all ways relevant to this discussion, the ADA and Section 504 of the Rehabilitation Act are generally construed to impose similar requirements. *See Sanchez v. Johnson*, 416 F.3d 1051, 1062 (9th Cir. 2005); *Zukle v. Regents of Univ. of California*, 166 F.3d 1041, 1045 n.11 (9th Cir. 1999). This principle follows from the similar language employed in the two acts. It also derives from the Congressional directive that implementation and interpretation of the two acts "be coordinated to prevent[ ] imposition of inconsistent or conflicting standards for the same requirements under the two statutes." *Baird ex rel. Baird v. Rose*, 192 F.3d 462, 468-69 (4th Cir. 1999) (citing 42 U.S.C. § 12117(b)) (alteration in original).

treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of others who are receiving disability services from the entity. *Id.* at 607.

To comply with the ADA's integration requirement, a state must reasonably modify its policies, procedures, or practices when necessary to avoid discrimination. 28 C.F.R. § 35.130(b)(7). The obligation to make reasonable modifications may be excused only where a state demonstrates that the requested modifications would "fundamentally alter" the programs or services at issue. *Id.*; *see also Olmstead*, 527 U.S. at 604-07.

B. The EPSDT Requirements of the Medicaid Act

Under the EPSDT provisions of the Medicaid Act, participating states must provide coverage to categorically Medicaid-eligible individuals under the age of twenty-one for all medically necessary treatment services described in the Medicaid Act at 42 U.S.C. § 1396d(a), which sets forth the scope of the traditional Medicaid benefits package. 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § 1396d(a)(4); 42 U.S.C. § 1396d(r)(1)-(5). Such treatment services must be covered for EPSDT-eligible children and youth, even if the State has not otherwise elected to provide such coverage for other populations. 42 U.S.C. § 1396d(r)(5).

The EPSDT mandate requires states to effectively inform EPSDT-eligible individuals "of the availability of [EPSDT] services," 42 U.S.C. § 1396a(a)(43)(A), and to provide or arrange for "screening services in all cases where they are requested," 42 U.S.C. § 1396a(a)(43)(B). Thus, a State must make available comprehensive assessments of EPSDT-eligible children who have behavioral, emotional or psychiatric impairments. 42 U.S.C. § 1396a(a)(43)(B); *see also Rosie D. v. Romney*, 410 F. Supp. 2d 18, 52-53 (D. Mass. 2006) ("[T]he

EPSDT provisions of the Medicaid statute require, by their very language, comprehensive assessments of children with [serious emotional disturbance].").

The State must also arrange for (either directly or through referral to other agencies) corrective treatment, the need for which is discovered by the screening. 42 U.S.C. § 1396a(a)(43)(C). The scope of the treatment to be provided for is defined by 42 U.S.C. § 1396d(r) and includes dental, hearing and vision services, and "[s]uch other necessary health care, diagnostic services, treatment, and other measures described in [42 U.S.C. § 1396d(a)]. . . to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are [otherwise] covered under the state plan . . . ." 42 U.S.C. §§ 1396d(r)(1)-(5); *see also* 42 C.F.R. § 440.130.

Thus, under § 1396d(r)(5), states must "cover every type of health care or service necessary for EPSDT corrective or ameliorative purposes that is allowable under § 1396d(a)." *Katie A., ex rel. Ludin v. Los Angeles Cty.*, 481 F.3d 1150, 1154 (9th Cir. 2007); (*citing S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 590 (5th Cir. 2004); *Collins v. Hamilton*, 349 F.3d 371, 376 n.8 (7th Cir. 2003); *Pediatric Speciality Care, Inc. v. Ark. Dep't of Human Servs*., 293 F.3d 472, 480-81 (8th Cir. 2002); *Pittman v. Sec'y, Fla. Dep't of Health & Rehab.*, 998 F.2d 887, 891-92 (11th Cir. 1993); *Pereira v. Kozlowski*, 996 F.2d 723, 725-26 (4th Cir. 1993)). A service must be covered by the EPSDT program if it can properly be described as one of the services listed in the Medicaid Act, 42 U.S.C. § 1396d(a). *See, e.g.*, *Dickson*, 391 F.3d at 594-97 (finding that incontinence supplies were within the scope of home health services described in § 1396d(a) and that the state violated EPSDT provisions by denying Medicaid-eligible children such services); *Parents' League for Eff. Autism Serv. v. Jones-Kelley*, 339 Fed. Appx. 542, 546 (6th Cir.

2009) (affirming preliminary injunction enjoining state from restricting rehabilitative services for Medicaid-eligible children with autism).

States must provide all component services required under § 1396d(a), and they must provide those services effectively. *Katie A.*, 481 F.3d at 1159 ("States also must ensure that the EPSDT services provided are reasonably effective.") Where necessary to meet the needs of children with serious emotional or behavioral disorders, the services must be provided in a coordinated fashion. *Id*. at 1161. Many children will need all services for the effective treatment of their condition, and the delivery of all services in a coordinated fashion will be necessary to avoid unnecessary and harmful institutionalization.

COMMENTS IN SUPPORT OF THE AGREEMENT

The denial of community-based mental health services results in significant harm to Plaintiffs and class members, including the exacerbation of their conditions in inappropriate foster placements, deterioration to the point of crisis, and unnecessary institutionalization in violation of the ADA. (*See* Compl. ¶¶ 4-7; 47); *see also Katie A. v. Bonta*, 433 F. Supp. 2d at 1078 (noting grave harm of unnecessary institutionalization), *reversed and remanded on other grounds*, *Katie A.*, 481 F.3d at 1156-57. The United States recommends that this Court grant final approval of the Agreement because it represents a "fundamentally fair, reasonable, and adequate" resolution of this litigation that addresses the significant harms identified in the Complaint. Fed. R. Civ. P. 23(e)(2); *see also In re Mego Fin. Corp. Sec. Litig.*, 213 F.3d 454, 458 (9th Cir. 2000).[10] Further, the Agreement

[10] To determine whether a settlement is "fair reasonable and adequate," a court generally looks to the following factors: (1) the strength of Plaintiffs' case, (2) the risk, expense, complexity, and likely duration of litigation, (3) the risk of maintaining a class action status throughout the trial, (4) the amount offered in settlement, (5) the extent of discovery completed and the stage of proceedings, (6)

advances the public interest in moving Defendants towards compliance with federal law.

A. The Agreement is Likely to Reduce Institutional Placements and further the State's Compliance with the Integration Mandate of title II of the ADA.

Plaintiffs brought this action seeking declaratory and injunctive relief, in part, under the ADA and the Medicaid Act. (*See* Compl. ¶¶ 55-63, 76, 80-87.) By failing to offer services at home, and in home-like and other community-based settings, and instead requiring Plaintiffs to enter restrictive, institutional settings to receive services, Defendants fail to provide services in the most integrated setting appropriate to Plaintiffs' needs, in violation of the ADA and Section 504 of the Rehabilitation Act and their implementing regulations. (*See* Compl. ¶¶ 7, 18, 23, 27, 29, 40, 52, 80-87); 42 U.S.C. § 12132; 29 U.S.C. § 794; 28 C.F.R. §§ 35.130(d), 41.51(d); *Olmstead*, 527 U.S. at 600-01; *see also Katie A.*, 481 F.3d at 1160 ("[t]he district court, however, did describe plaintiffs' vulnerability, complex needs, and ongoing 'unmet mental health needs and the *harms of unnecessary institutionalization*.'") (emphasis added). The Agreement reflects the strength of Plaintiffs' claims by requiring Defendants to expand community-based services within the State's foster care and mental health systems to reduce the systems'

---

the experience and views of counsel; (7) the presence of a governmental participant; and (8) the reaction of class members to the settlement. *In re Bluetooth Headset Products Liability Litigation*, 654 F.3d at 946 (*citing Churchill Vill., L.L.C. v. Gen. Elec.*, 361 F.3d 566, 575 (9th Cir. 2004); *Torrisi v. Tucson Elec. Power Co.*, 8 F.3d 1370, 1375 (9th Cir. 1993)). The United States addresses only the first factor – the strength of Plaintiffs' case and the degree to which it is reflected by the Agreement – but concurs that the weight of these factors warrants final approval of the Agreement.

reliance on institutional placements. *See Disability Advocates, Inc. v. Paterson*, 598 F. Supp. 2d 289, 316-19 (E.D.N.Y. 2009), *appeal docketed*, 10-235-CV(L) (2d Cir. 2010) (holding that the defendants' planning, funding, and administration of a service system reliant on institutional placements is sufficient to support an *Olmstead* claim). The Agreement contains legally binding commitments from the Defendants to ensure the expansion of intensive mental health services available to foster children and youth with intensive mental health needs, and to reform the manner in which mental health services are provided. (*See* Settl. Agr. ¶¶ 20(a)-(g), (i).) The expansion of these services promotes the important aim of title II's integration mandate to reduce reliance on costly, inappropriate, and unnecessary institutional placements. *See Olmstead*, 527 U.S. at 607.

B. The Agreement is Consistent with the State's Obligation to Provide Medically Necessary Services Under the EPSDT Requirements of the Medicaid Act.

Plaintiffs' Medicaid Act claims arise from the Act's EPSDT provisions, which, as discussed above, pp. 9 to 11, require states participating in Medicaid to ensure the provision of all Medicaid-coverable services to EPSDT-eligible individuals for whom the services are medically necessary. 42 U.S.C. §§ 1396d(a)(4)(B); 1396d(r)(5); 1396a(a)(10)(A); and 1396a(a)(43)(C). Plaintiffs assert that by depriving Medicaid-eligible children in foster care medically necessary mental health services, Defendants violate the EPSDT requirements of the Medicaid Act. (Compl. ¶¶ 55-63, 76). The Agreement defines certain expanded community-based mental health services, to include ICC, IHBS, and TFC, and to facilitate the provision of medically necessary services to EPSDT-

eligible individuals who are members of the Subclass.[11] Under the Medicaid Act, a state is permitted to cover many of the various components of ICC, IHBS and TFC outlined in the Agreement as "diagnostic, screening, preventative, and rehabilitative services . . . ."[12] *See* 42 U.S.C. § 1396d(a)(13). Other Medicaid authorities may also be available for the coverage of these services. CMS has, in other States, approved coverage of intensive mental health services similar to those outlined within the Agreement. *See, e.g. Massachusetts State Plan for Medical Assistance*, *State Plan Amendment* # 08-004, effective Apr. 1, 2009 (relevant excerpts attached as Exhibit 1) (covering EPSDT services under Rehabilitation Services); *Oregon State Plan for Medical Assistance* § 3.1a, pp. 6-f—6-f.2 (relevant excerpts attached as Exhibit 2) (covering EPSDT services as Behavioral Rehabilitation Services); *Nevada State Plan for Medical Assistance*, (relevant excerpts attached as Exhibit 3) (covering EPSDT services under Rehabilitation Services). This Court and the Ninth Circuit Court of Appeals found that the Plaintiffs presented persuasive evidence that the intensive mental health services outlined within the Agreement are likely covered services under the Medicaid Act. *See Katie A.*, 481 F.3d at 1156 (stating that "the District Court cited those [other] states' practices as support for its conclusion that wraparound and TFC are

[11] As noted *supra*, n. 1, the United States recognizes that the Defendants' obligations under the Agreement are narrower than what is required under the EPSDT requirements of the Medicaid Act, which requires Defendants to ensure the provision of medically necessary service to all EPSDT-eligible individuals.

[12] Section 1396d(a)(13) defines as covered medical services any "diagnostic, screening, preventative, and rehabilitative services, including any medical or remedial services . . . for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level." 42 U.S.C. § 1396d(a)(13).

Medicaid-covered services. Evidence in the record supports the Court's findings, and defendants have not presented any strong evidence to the contrary."); *Katie A.*, 433 F. Supp. 2d at 1075 (stating that "[t]he Court finds it likely that virtually all of the corresponding categories of § 1396d(a) identified by Plaintiffs do, in fact, encompass the linked-to service [described in Plaintiff's declaration].").

If such EPSDT services are medically necessary to correct or ameliorate a mental health condition, the statute requires the State to provide coverage for them. *See Dickson*, 391 F.3d at 595-96 ("CMS's approval of state plans affording coverage for [the services sought by plaintiff] demonstrates that the agency construes [the Medicaid Act] as encompassing that type of medical care or service" and therefore required to be covered under EPSDT). If medically necessary, it is the State's obligation to provide the type of EPSDT required services that are included in therapies like ICC, IHBS, and TFC services *effectively* to eligible children. *Katie A.*, 481 F.3d at 1160 (discussing a prior case in which a Massachusetts district court concluded that adequate in-home behavioral support services was a required EPSDT service which the state had failed to provide); *Rosie D.*, 410 F. Supp. 2d at 52-53 (state violated EPSDT provisions by failing to provide to children with serious emotional disorders adequate and *effective* comprehensive assessments, ongoing case management and monitoring, and in-home behavioral support services). Thus, by expanding the availability of medically necessary services for EPSDT-eligible children and youth with significant behavioral health needs, the Agreement advances the important goal of furthering the State's compliance with the EPSDT requirements of the Medicaid Act.

CONCLUSION

For the foregoing reasons, the United States respectfully urges this Court to grant final approval of the Agreement.

DATED: November 18, 2011

Respectfully submitted,

ANDRÉ BIROTTE
United States Attorney
Central District of California

LEON W. WEIDMAN
Assistant United States Attorney
Chief, Civil Division

THOMAS E. PEREZ
Assistant Attorney General

EVE HILL
Senior Counselor to the Assistant Attorney General

_____

ROBYN-MARIE LYON MONTELEONE,
California Bar Number 130005
Assistant United States Attorney
Assistant Division Chief, Civil Rights
Unit Chief, Civil Division

/s/

ALLISON J. NICHOL,
Chief
KATHLEEN R. WOLFE,
Acting Special Legal Counsel
SHEILA FORAN,
Special Legal Counsel
RENEE M. WOHLENHAUS,
Deputy Chief
TRAVIS W. ENGLAND,
New York SBN 4805693
Trial Attorney
Civil Rights Division
Disability Rights Section

U.S. Department of Justice
950 Pennsylvania Avenue, N.W. - NYA
Washington, D.C. 20530
Telephone: (202) 307-8987
Facsimile: (202) 307-1197
travis.england@usdoj.gov