UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

A.A., by and through his mother, P.A.; **B.B.**, by and through her mother, P.B.; **C.C.**, by and through her mother, P.C.; **D.D.**, by and through his mother, P.D.; **E.E.**, by and through his mother, P.E.	*	CIVIL ACTION NO.:
	*	JUDGE:
	*	MAGISTRATE:
Plaintiffs,	*	
v.	*	CLASS ACTION
REBEKAH GEE, in her official capacity, as Secretary of the Louisiana Department of Health, and the LOUISIANA DEPARTMENT OF HEALTH	*	
Defendants.	*	

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COMPLAINT

I. INTRODUCTION

1. Plaintiffs A.A., B.B., C.C., D.D., and E.E., are child Medicaid recipients with disabilities who bring this action on behalf of themselves and all other similarly-situated individuals against Defendants, Louisiana Department of Health (LDH), and its Secretary, Dr. Rebekah Gee, for their failure to provide an accessible statewide mental health system of intensive home and community-based services (IHCBS), including: intensive coordination, crisis services, and intensive behavioral services and supports, necessary to correct or ameliorate their mental illnesses or conditions.

2. Decades of research and experience in other states has led to a consensus among mental health practitioners throughout the nation that IHCBS are much more effective and less expensive option than institutionalizing children and youth who have ongoing mental health needs or who experience a psychiatric crisis.

3. Children and youth with mental illnesses or conditions who are left untreated or undertreated have an increased risk of chronic physical conditions and a shorter life

expectancy than those who do not have a mental health condition. These children often experience struggling self-esteems, strained family and peer relationships, languishing in school, and becoming involved with the juvenile-justice system. Therefore, for Plaintiffs and the proposed Class— approximately 47,500 Louisiana Medicaid-eligible children and youth under the age of 21 with a mental illness or condition, a significant number of whom are children and youth with severe emotional disturbances—IHCBS are necessary to lead functioning and productive lives.

4. Unfortunately, rather than provide necessary IHCBS, Defendants have implemented a fragmented, inadequate, and uncoordinated mental health system for Louisiana Medicaid children and youth with gaps in service coverage, availability, and accessibility; a lack of coordination between and among behavioral health provide(a)4(n9outh* nBT04.4iIu0 1 103.58 460.390 G

comprehensive and appropriate specialized behavioral health services." *Access to Comprehensive and Appropriate Specialized Behavioral Health Services,* Louisiana Legislative Auditor (February 14, 2018), https://www.lla.la.gov/PublicReports.nsf/B99F834BF8F4AB908625823400758F9B/$FILE/000179B4.pdf at 7 (last viewed Nov. 6, 2019); and

brings this action by and through her mother, P.C. Due to Defendants' failure to ensure the provision of IHCBS, C.C. has repeatedly cycled in and out of hospitals and psychiatric institutions that are

NCLEJ, NHELP, and the Advocacy Center have extensive experience litigating Rule 23(b)(2) class actions under the Medicaid Act, the ADA, and Section 504.

25. Plaintiffs and the Class further meet Rule 23(b)(2) requirements. First, Plaintiffs and the Class have suffered the same injury: all have been deprived of necessary and timely IHCBS in violation of the Medicaid Act. Due to this failure, they are also at serious risk of unnecessary institutionalization in violation of the ADA and Section 504. Second, neither Plaintiffs nor the Class seek monetary relief; and thus, the question of predominance is inapplicable. Finally, the injunctive relief sought by Plaintiffs and the Class is sufficiently specific and can be achieved with a single order requiring Defendants to provide necessary IHCBS.

V. STATUTORY AND REGULATORY FRAMEWORK FOR DEFENDANTS

A. The Federal Medicaid Act and EPSDT Mandate

26. Medicaid is a cooperative federal and state-funded program authorized and regulated pursuant to the Medicaid Act, which provides medical assistance for certain groups of low-income persons. *See* 42 U.S.C. § 1396, *et seq.*

27. Medicaid's central purpose is to furnish medical assistance, rehabilitation, and other services to help low-income families and individuals attain or retain capability for independence or self-care. *See* 42 U.S.C. § 1396-1.

28. State participation in Medicaid is voluntary; however, states that choose to receive federal funding for a significant portion of the cost of providing Medicaid benefits and administering the program must adhere to the minimum federal requirements set forth in the Medicaid Act, as amended, and its implementing regulations.

29. States participating in the Medicaid program must designate a single state agency that has the non-delegable duty to administer or supervise the administration of the Medicaid program and to ensure that the program complies with all relevant laws and regulations. *See* 42 U.S.C. § 1396a(a)(5); 42 C.F.R. § 431.10.

30. Federal law requires states participating in Medicaid to operate their Medicaid programs pursuant to state Medicaid plans that have been approved by the Secretary of the U.S. Department of Health and Human Services.

31. States must cover certain mandatory services in their state Medicaid plans. 42 U.S.C. §1396a(a)(10)(A), 1396d(a)(1)-(5), (17), (21), and (28)-(29). Mandatory services include EPSDT for children under age 21. 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).

32. EPSDT requires that the services that are coverable under 42 U.S.C. §1396d(a) must be provided if they are "necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate defects and physical and mental illnesses and conditions . . . regardless of whether or not such services are covered" for adults. 42 U.S.C. § 1396d(r)(5). Services must be covered if they correct, compensate for, improve a condition, or prevent a condition from worsening, even if the condition cannot be prevented or cured. *EPSDT: A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents*, U.S. Dep't of Health & Human Servs., Ctrs., (June 2014), https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf (last viewed Nov. 6, 2019 at 10. (EPSDT: A Guide). Specifically, states participating in the Federal Medicaid Program must establish and implement an EPSDT program in their state Medicaid plan that:

37. Even when a particular service or treatment for youth is not included in a state plan, a state must nevertheless provide that service or treatment if it is listed in Section 1396d(a) and necessary to correct or ameliorate the child's condition. 42 U.S.C. § 1396a(a)(43)(C); 42 C.F.R. § 441.57.

B. The Americans With Disabilities Act and Section 504 of the Rehabilitation Act of 1973

38. 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). The ADA acknowledges 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." *Id.* § 12101(a)(2).

39. In enacting the ADA, Congress found that "[i]ndividuals with disabilities continually encounter various forms of discrimination, including . . . segregation. . . ." *Id.* § 12101(a)(5).

40. Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity,CfB 85.584 3}>c9* f/-3(584 3tq0./74.11odn720410312

"equal to" or "as effective as that afforded [or provided] to others." 45 C.F.R. § 84.4 (b)(1)(i)-(iii); *see also* 28 C.F.R. § 41.51 (DOJ regulations describing prohibitions on disability-based discrimination).

51. The implementing regulations of Section 504 further provide that such programs must "afford [individuals with disabilities] equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement, in the most integrated setting appropriate to the person's needs." 45 C.F.R. § 84.4 (b)(2); *see also* 28 C.F.R. § 41.51(d) ("Recipients [of federal financial assistance] shall administer programs and activities in the most integrated setting appropriate to the needs of [qualified individuals with disabilities].")

52. Because they share a similar framework, Title II of the ADA and Section 504 generally "are interpreted *in pari materia*." *Frame v. City of Arlington*, 657 F.3d 215, 223 (5th Cir. 2011).

C. Public Behavioral Health Services for Children and Youth in Louisiana

53. Louisiana has elected to participate in the Medicaid program and receives federal matching funding that is currently set at 65 percent. *Federal Matching Shares for Medicaid and CHIP for Oct. 1, 2018 through Sept. 30, 2019*, 82 Fed. Reg. 55383, 55385 (2019).

54. As required of all states participating in Medicaid, Louisiana has prepared a state plan for medical assistance (State Plan). *See Louisiana Medicaid Program, State Plan, Chapter 3, Section 3.1-A*, http://ldh.la.gov/assets/medicaid/StatePlan/Sec3/Attachment3.1AItem4b.pdf (last accessed Nov. 4, 2019) (State Plan).

55. LDH is the single state agency responsible for administering Louisiana's Medicaid program. La. Rev. Stat. Ann. § 36:251.

56. As of the date of this filing, LDH contracts with five Managed Care Organizations (MCOs) to deliver physical health and mental health services to all Medicaid-eligible beneficiaries, including children and youth. *See Provider and Plan Resources*, Louisiana Department of Health, http://ldh.la.gov/index.cfm/page/1065 (last accessed Nov. 4, 2019).

57. Even though LDH contracts with MCOs to deliver services, LDH remains solely and ultimately responsible for ensuring the fulfillment of all relevant Medicaid requirements, including the mandates of the EPSDT program. 42 U.S.C. § 1396a(a)(5), 42 U.S.C. § 1396u-2; 42 U.S.C § 1396a(a)(43).

VI. DEFENDANTSô UNLAWFUL POLICIES, PRACTICES, AND PROCEDURES

A. Defendantsô failure to fulfill their Federal mandate to implement an accessible, statewide system of IHCBS

58. In 2018, the Legislative Auditor determined that Defendants have failed to implement an accessible system of IHCBS throughout the state. *February 2018 LDH Audit*, at 5, 7. Contributing to Defendants' failure to provide an accessible system of IHCBS is Defendants' failure to ensure coverage of all necessary EPSDT services in their State Plan. The Defendants also acknowledge that their implementation of a public behavioral health system is entirely undermined by, *inter alia*, a "shortage of licensed providers throughout the state." *FY2018-19 Combined Behavioral Health Block Grant Plan*, Louisiana Department of Health, (Sept. 1, 2017), http://ldh.la.gov/assets/csoc/block_grant/FY1819_Block_Grant_Plan_approved_update.pdf at 15 (last viewed November 6, 2019).

59. Yet another critical barrier to the accessibility of public behavioral health services, including IHCBS, as acknowledged by Defendants in their most recent application for federal block grant funding, is the lack of "education on how to navigate behavioral health system and get services." *FY2020 Combined Behavioral Health Block Grant Plan*, Louisiana Department of Health (Sept. 1, 2019), http://ldh.la.gov/assets/csoc/block_grant/FINAL_BG.pdf at 15. Families of children and youth Medicaid beneficiaries who have been diagnosed with a mental illness or condition have difficulty accessing what mental health services there are, in part, because they are unaware that such services exist.

60. Defendants' failure to provide IHCBS, including intensive care coordination, crisis services, and intensive behavioral services and supports, has resulted in tens of thousands of Louisiana children and youth with behavioral and emotional disorders, including Plaintiffs and the Class, to languish or deteriorate in their communities to the point of being at serious risk of unnecessary institutionalization in psychiatric facilities away from their families.

Intensive care coordination

61. Intensive care coordination is a robust form of case management that includes: an assessment and service planning process conducted through a team, assistance accessing and arranging for services, coordinating multiple services, including crisis services, monitoring and follow-up activities, and transition planning.

62. For youth receiving intensive care coordination, a designated care coordinator must work in partnership with the family, conducting a comprehensive home-based assessment and identifying and coordinating a single treatment team (a "child and family team, or "CFT").

The CFT will develop an integrated plan of care which describes the youth's and family's vision, identifies their strengths and needs, and articulates their service goals and preferences. This plan informs and guides the delivery of care in the community across providers and service settings. The CFT can include educational service providers, a collaboration which creates opportunities to coordinate Individual Education Plan (IEP) goals with community treatment planning efforts, and to consult regarding ongoing behavioral health needs.

63. Intensive care coordination is a coverable case management service and rehabilitation service under the Medicaid Act. *See* 42 U.S.C. §§ 1396d(a)(19); 1396n(g)(2); 42 C.F.R. § 440.169(d) (describing the components of case management); 42 U.S.C. §§ 1396d(a)(13); 42 C.F.R. § 440.130(d).

64. Intensive care coordination is necessary to correct or ameliorate the mental health conditions of Plaintiffs and the Class. However, Defendants have failed to ensure that intensive care coordination is covered as a service, as required under Medicaid's EPSDT mandate, and have failed to provide the service or to ensure that the MCOs they contract with to fulfill their EPSDT mandate provide intensive care coordination throughout the state to Louisiana Medicaid beneficiaries who are children and youth with mental illnesses or conditions.

65. The State Plan includes treatment planning as a component of a Medicaid covered rehabilitative service referred to as "community psychiatric support and treatment" or CPST. *See State Plan Chapter 3, Section 3.1-A*, Item 4.b, at 9a. According to the State Plan, treatment planning "includes an agreement with the individual and family members (or other collateral contacts) on the specific strengths and needs, resources, natural

supports, and individual goals and objectives for that person." *Id.* Treatment planning "should also include developing a crisis management plan." *Id.* However, treatment planning, as defined in the State Plan, does not constitute intensive care coordination and is not sufficient to meet the needs of Plaintiffs and the Class. Furthermore, Defendants do not cover necessary intensive care coordination as a separate EPSDT service.

66. To the extent Defendants may argue that intensive care coordination services can be made available through case management provided by the MCOs, the Legislative Auditor concluded otherwise, when it observed that 0.8% of all Medicaid recipients with a behavioral health diagnosis received case management services from the MCOs. *February 2018 LDH Audit*, at 7. Ostensibly, because this figure includes both adults and children, it is safe to assume that a negligible number of Medicaid children with a behavioral health diagnosis receive any case management services.

67. As a result of the Defendants' failure to cover or provide intensive care coordination to Plaintiffs and the Class, these children and youth continue to receive inadequate and uncoordinated services through the existing fragmented mental health system, including receiving inconsistent and at times conflicting diagnoses and medication. As observed by the Legislative Auditor, "we saw examples in the Medicaid data where individuals received a variety of services across the state, including emergency rooms and psychiatric hospitals, and received differing behavioral health diagnoses." *February 2018 LDH Audit*, at 17.

68. Additionally, Plaintiffs and the Class, as a result of Defendants' failure to cover or provide intensive care coordination, are often forced to rely on personnel in other systems (e.g., schools and juvenile-justice) who lack a clinical understanding of the child's mental health

needs, but might be available to assist them with attempting to access mental health services.

69. Further, in the absence of intensive care coordination, the parents of Plaintiffs and members of the Class, who may have other children to rear, income challenges, or their own health issues, are forced to attempt to navigate the state's complex behavioral health system with little to no support from Medicaid authorities.

Crisis services

70. Per the Louisiana State Plan, crisis services consist of crisis intervention (or mobile crisis) and crisis stabilization services. *See State Plan, Chapter 3, Section 3.1-A, Item 4.b*, at 9d(1).

71. According to the State Plan, Defendants define crisis intervention as follows: "Crisis intervention is provided to [sic] children and youth who are experiencing a psychiatric crisis, designed to interrupt and/or ameliorate a crisis experience including a preliminary assessment, immediate crisis resolution and de-escalation, and referral to appropriate community services to avoid more restrictive levels of treatment." *Id.* "Crisis intervention is a face-to-face intervention" that is to be provided "where the child or youth lives, works, attends school, and/or socializes." *Id.*

72. According to the State Plan, Defendants define crisis stabilization as follows: "Crisis stabilization services are short-term and intensive supportive resources for children and youth and their family." *Id.* "The intent of this service is to provide an out-of-home crisis

with the family to prepare for the child’s/youth’s

services a separate and coverable EPSDT service under the State Plan, has rendered necessary peer support services largely inaccessible and unavailable to Plaintiffs and the Class throughout the state.

79. A survey conducted by the Legislative Auditor and issued to 101 hospitals with emergency departments across the state, garnering a total of 36 responses, revealed that "85% of the respondents stated that there are not adequate community-based services, and 76% of the respondents do not believe that appropriate follow-up treatment and care

81. A.A., C.C., and E.E. have unnecessarily cycled in and out of hospitals, emergency rooms, and psychiatric institutions located hundreds of miles away from their families—a form of trauma by itself for the children and their families, and costly for Louisiana's taxpayers—and for B.B. and D.D., the risk of institutionalization is imminent. A.A., C.C., and E.E. have all become juvenile-justice involved as a result of their mental health needs not being adequately addressed, and B.B.'s and D.D.'s mothers fear that they too will soon unnecessarily encounter the juvenile-justice system.

A.A. (East Baton Rouge Parish)

82. A.A. is an 11-year-old Medicaid recipient who lives in Baton Rouge. A.A. loves computers, video games, and aspires to attend college and become an FBI agent. A.A. desperately wants to be liked and to have friends. He currently lives with his mother, a younger brother who has mental health conditions, an older sister, and their cats.

83. A.A. has four different mental health diagnoses. A.A.'s providers first documented his behavioral symptoms in 2012 when he was four years old and they continue to date. During moments of crises, A.A. exhibits outbursts, anger, and engages in fighting. He expresses suicidal ideations, attention-seeking behaviors, and defiance. In light of his behaviors, A.A.'s providers determined that A.A. needs weekly individual, family, or group counseling; monthly medication management; psychiatric reassessments, as needed; care coordination; and IHCBS, including crisis services.

84.

develop and implement his treatment plan. Instead, A.A. and his family are left to navigate the state's complex public behavioral health system alone.

85. Unable to access the IHCBS necessary to address his mental health needs, A.A. has been admitted under physician orders to psychiatric institutions six times over the last three years— in institutions as near as 80 miles from his home, but as far as 240 miles from his home. On average, A.A. spends eight to ten days at these institutions before he is discharged.

86. A.A.'s institutionalizations follow a cyclical pattern: in the absence of IHCBS, including crisis services, A.A.'s mother reluctantly takes her son to the nearest emergency room, where he is then referred by a physician for treatment at psychiatric institutions located hundreds of miles away from home. Upon being discharged, the psychiatric institution provides A.A.'s mother with a discharge plan, advising A.A.'s mother to call 911, a 1-800 suicide hotline, or the psychiatric facility itself if he experiences another psychiatric episode. Despite his mother's requests to his providers for IHCBS, A.A. returns home where he receives basic, inadequate behavioral interventions consisting of the same

as best as she can; however, advocating alone has taken a significant toll on her, A.A., and his siblings.

B.B. (Caddo Parish)

89. B.B. is a 13-year-old Medicaid recipient who lives in Shreveport. B.B. is enrolled in her school's gifted program. Her mother and teachers describe her as an overall pleasant young person. B.B. lives with her mother, stepfather, and her younger twin brothers.

90. B.B. has three different mental health diagnoses, as well as type 2 diabetes. When B.B. was four years old, she began to exhibit aggression, inattentiveness, anxiousness, suspiciousness, and bouts of depression. These behavioral symptoms continue to date.

91. Despite consistently displaying these behavioral symptoms, and despite her mother's request for IHCBS, B.B. has never received IHCBS. In the moments when B.B. experiences a psychiatric crisis, B.B.'s mother must manage the crisis alone, implementing de-escalation procedures that she has researched on her own so that she does not have to call the police on B.B. or have her daughter unnecessarily institutionalized.

92. B.B. has never received intensive care coordination. Instead, B.B.'s mother has to research available and accessible Medicaid services, locate providers, and keep these providers abreast of any changes in B.B.'

that her relationship with her daughter will deteriorate to the point of no return, and that unnecessary institutionalization is imminent.

C.C. (Terrebonne Parish)

94. C.C. is a 13-year-old Medicaid recipient who lives in Houma. C.C. has been an honor student and has an interest in suspense and mystery novels. She lives with her adopted parents, along with their two cats and two dogs.

95. C.C. has eight different mental health diagnoses. C.C.'s behavioral symptoms include violent outbursts, damaging property, and running away from her home.

96. Despite consistently displaying these behavioral symptoms for years, and despite being recommended for IHCBS, C.C. has never received crisis services and other IHCBS necessary to address her mental health conditions.

97. Unable to access IHCBS, C.C. has been admitted under physician orders to psychiatric institutions three times since becoming a Louisiana Medicaid recipient in 2016. These facilities have been as far away as 300 miles from her family, and her most recent institutionalization in late 2018 lasted for over 100 days. Between each institutionalizationnmq0.0s reW* nBT/F2 12 Tf1 0 0 1 43.19 Tm0 G[(s be)3(ha)] TJETQ0.00000912 0 61

99. Not wanting C.C. to be re-institutionalized, C.C.'s family is desperate for her to receive the IHCBS needed to remain at home and function at home and in her community.

D.D. (Rapides Parish)

100. D.D. is a 13-year-old Medicaid recipient who lives in Alexandria. His mother and teachers

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105. Despite this hospitalization and the behavioral symptoms displayed by D.D. that led to his hospitalization, D.D. was not provided necessary crisis services and other IHBCS. In the spring of 2018, D.D. was expelled from school. At the time of his expulsion, D.D. was repeating the 5th grade due to behavioral concerns stemming from his unaddressed mental health needs.

106.

110. Despite consistently displaying these behavioral symptoms and despite being recommended for IHCBS, E.E. has not had access to crisis services and other IHCBS needed to address his mental health conditions. E.E.'s mother has had to attempt to navigate the state's complex public behavioral health system alone, despite having her own health needs to address.

111.

basic interventions of inconsistent counseling sessions, and occasional medication and case management.

115. Lacking access to the necessary IHCBS to address his mental health needs, E.E.'s condition continues to deteriorate. E.E. has repeatedly been suspended and expelled from school. E.E. has also been arrested as a result of his outbursts and behaviors and has become juvenile-justice involved. Further, due to the manifestations of his behavioral symptoms at home, his relationships with his mother and siblings have been severely strained. In the absence of IHCBS, yet another stay at a psychiatric institution for E.E. is imminent.

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diagnostic, and treatment (IHCBS). Plaintiffs and the Class are therefore entitled to relief under 42 U.S.C. § 1983.

COUNT II

Defendant Geeôs Violation of the Reasonable Promptness Provisions of the Medicaid Act

120. Plaintiffs incorporate by reference the foregoing paragraphs of this Complaint as though fully set forth herein.

121. Defendant Gee has engaged in the continuous and ongoing failure to ensure the provision of medically necessary IHCBS with "reasonable promptness" in violation of 42 U.S.C. § 1396a(a)(8).

122. Defendant Gee

mandated IHCBS, in the most integrated setting appropriate to their needs (i.e., at home and in the community). These failures subject Plaintiffs and the Class to unnecessary institutionalization in hospitals and psychiatric facilities, or the serious risk thereof. 42 U.S.C. § 12132; 28 C.F.R. § 35.130(d).

127. Defendant Gee's actions constitute discrimination in violation of Title II of the ADA, 42 U.S.C. § 12132, and its implementing regulations at 28 C.F.R. Part 35, by failing to provide reasonable modifications to programs and services in order to provide or ensure the provision of necessary IHCBS, and to provide these services to qualified individuals, including Plaintiffs and the Class. 28 C.F.R. §35.130(b)(7).

128. Defendant Gee has utilized and adopted criteria and methods of administration that have the effect of subjecting Plaintiffs and the Class to unnecessary institutionalization or serious risk thereof, and therefore discrimination based on their disabilities, in failing to provide, or ensure the provision of IHCBS to qualified individuals, including Plaintiffs and the Class. 28 C.F.R. § 35.130(b)(3).

129. Plaintiffs and the Class are therefore entitled to declaratory and injunctive relief to remedy Defendant Gee's violations of Title II of the ADA.

COUNT IV
Defendants Gee and LDHôs Violation of Section 504 of the Rehabilitation Act

130. Plaintiffs incorporate by reference the foregoing paragraphs of this Complaint as though fully set forth herein.

131. Defendant LDH is a recipient of federal funds and is, therefore, a "program or activity" under Section 504. 29 U.S.C. §794(b)(1).

132. Plaintiffs and the Class are qualified persons with disabilities covered by Title II of the ADA, and they are qualified to participate in or receive LDH's programs, services, and

activities, including necessary IHCBS, under the Medicaid Act's EPSDT provisions. 29 U.S.C. § 705(20) (defining an individual with a disability under Section 504 as "any person who has a disability as defined in . . . the Americans with Disabilities Act"); *see also* 42 U.S.C. §§ 12102, 12131(2).

133. Defendants Gee and LDH have violated Section 504 by administering LDH's Medicaid services in a manner that fails to ensure that Plaintiffs and the Class receive federally-mandated EPSDT services, including IHCBS, in the most integrated setting appropriate to their needs (i.e., at home and in the community). These failures4(pg0919 Tm0 g0 G[(,)] TJETQ0.0000091

VIII. PRAYER FOR RELIEF

137. WHEREFORE, Plaintiffs request that the Court order the following relief and remedies on behalf of themselves and others similarly situated:

a. Certify this case as a class action pursuant to Federal Rule of Civil Procedure 23(a) and Rule 23(b)(2);

b. Issue a declaratory judgment in favor of Plaintiffs and the Class that Defendants have failed to comply with the requirements of the EPSDT provisions and reasonable promptness provisions of the Medicaid Act, the Americans with Disabilities Act, and the Rehabilitation Act;

c.

Respectfully submitted this 7th day of November 2019,

A.A., B.B., C.C., D.D., and E.E.
By and through their parents

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CERTIFICATE OF SERVICE

I hereby certify that on November 7, 2019, a copy of the foregoing was filed electronically with the Clerk of Court using the CM/ECF system. Notice of this filing will be sent to all parties by operation of the Court's electronic filing system.

/s/ Victor M. Jones
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