

STATE OF NORTH CAROLINA
WAKE COUNTY

IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION
17 CVS 6357

SAMANTHA R., by her Guardian, TIM R.,)
MARIE K., by her guardian, EMPOWERING)
LIVES GUARDIANSHIP SERVICES, LLC)
CONNIE M., by her guardian CHARLOTTE R.,)
JONATHAN D., by his guardian MICHAEL D.,)
MITCHELL T., by his guardian, BETSY S.,)
MICHAEL A., and)
DISABILITY RIGHTS NORTH CAROLINA,)

Plaintiffs,)

v.)

STATE OF NORTH CAROLINA,)
NORTH CAROLINA DEPARTMENT OF)
HEALTH AND HUMAN SERVICES, and)
MANDY COHEN, in her official capacity as)
Secretary of the North Carolina)
Department of Health and Human Services,)

Defendants.)

**MEMORANDUM IN SUPPORT OF
PLAINTIFFS' MOTION FOR
PARTIAL SUMMARY JUDGMENT**

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Plaintiffs, by and through counsel and pursuant to Rules 5, 7, and 56 of the North Carolina Rules of Civil Procedure, submit this Memorandum in Support of Plaintiffs' Motion for Partial Summary Judgment.

INTRODUCTION

This case is grounded in the Integration Mandate, a fundamental principle underpinning the North Carolina Persons with Disabilities Protection Act, Title II of the Americans with Disabilities Act ("ADA"), and the United States Supreme Court's decision in *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999). Title II of the ADA mandates integration of individuals with disabilities. 42 U.S.C. §12132. Accompanying regulations further require that all public entities administer services and programs "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R § 35.130(d). The Supreme Court applied the ADA's Integration Mandate to the institutionalization of individuals with disabilities, holding that the unjustified institutionalization of an individual who preferred services in the community violated the ADA. *Olmstead*, 527 U.S. at 600. This decision has provided a landmark legal imperative for states to provide behavioral health services in the community and an enforcement mechanism regarding state systems long-biased toward institutionalization.

In response to the *Olmstead* decision, the North Carolina General Assembly incorporated the Integration Mandate into the North Carolina Persons with Disabilities Protection Act. N.C. Gen. Stat. § 168A-7(b); 2002 N.C. Sess. Laws 163, s. 3 (adding subsection (b) containing Integration Mandate provision); *see also*, House Judiciary III, Bill Analysis (Senate Bill 866: Persons with Disabilities Changes) (August 16, 2001) (copy attached) (explaining proposed amendment). The law was amended "to reflect the intent of the U.S. Supreme Court in *Olmstead v. L.C.*" and to specify that the statute is intended "to promote independent living." *Id.*

Notwithstanding the Integration Mandate, North Carolina remains over-reliant on institutions and fails to provide adequate community-based services for people with intellectual and/or developmental disabilities (I/DD). Approximately 5,200 individuals with I/DD remain institutionalized. In addition to those currently institutionalized, thousands more are at risk of institutionalization or segregation. Those at risk include the approximately 12,000 individuals who are on a waiting list for services specifically designed as an alternative to institutionalization, and others who face unnecessary limitations on the services they need to avoid institutionalization. Meanwhile, there is no limit placed on funding of eligible individuals for admissions to institutions.

The record in this case is replete with admissions by Defendants and their key staff that the I/DD service system relies too heavily on institutionalization and that community-based services are lacking in quantity and quality. The record also shows Defendants have long known of the need to address the underlying flaws in the I/DD service system. Yet, twenty years after the *Olmstead* decision, Defendants do not have effective policies or a comprehensive plan to address the systemic drivers of segregation and institutionalization. Consequently, the ongoing violations of the rights of individuals with I/DD require comprehensive, significant remedial action.

STATEMENT OF THE CASE

Plaintiffs initiated this action on May 24, 2017, and filed an Amended Complaint on April 9, 2018, asserting violations of: (1) Chapter 168A of the North Carolina General Statutes, which prohibits disability discrimination, including segregation, in the administration of public services; (2) the procedural due process requirements of the North Carolina Constitution in the

rules applied to Plaintiffs' access to services; and (3) the substantive due process requirements of the North Carolina Constitution affecting Plaintiffs' liberty interests in avoiding segregation.

Plaintiffs now move for partial summary judgment on their First Claim for Relief for violation of Chapter 168A of the North Carolina General Statutes and submit this Memorandum in support thereof.¹ For the reasons below, Plaintiffs ask the Court to enter an Order declaring Defendants in violation of the Integration Mandate codified in N.C. Gen. Stat. § 168A-7(b) and requiring the development and implementation of systems changes to address Defendants' violations.

STATEMENT OF UNDISPUTED FACTS²

1. People with I/DD are capable of living their lives integrated into their communities with community-based supports; they need not be institutionalized. Deposition of John M. Agosta, Ph.D. (Agosta Dep.) p. 89:10-23; Deposition of Deborah Goda (3/20/19) (Goda 3/20/19 Dep.)³ pp. 61:16-62:1; 62:25-63:4; Deposition of Natasha Ashmont as Rule 30(b)(6) designee (Ashmont 30(b)(6) Dep.) p 13:3-8; Deposition of Jeffrey C. Holden, Ph.D. (Holden Dep.) p. 76:17-22; 78:7-11; Deposition of Michael J. Kendrick, Ph.D. (Kendrick Dep.) p. 30:20-25.⁴

¹ The facts underlying Plaintiffs' First Claim for Relief also support Plaintiffs' Third Claim for Relief for violation of the substantive due process provision of the North Carolina Constitution. Plaintiffs' Third Claim for Relief was pled in the alternative to their First Claim for Relief.

² Additional facts are included in the arguments to which they apply. The facts asserted in this Memorandum are derived primarily from Defendants' admissions, discovery responses, depositions of Defendants' key staff and designated experts, and from documents authored by Defendants or their agents. Consistent with Rule 56, Plaintiffs are relying on facts that are not genuinely in dispute.

³ Ms. Goda was deposed on three dates, including as a designated expert witness for Defendants.

⁴ Dr. Agosta and Ms. Goda were designated as experts in this matter by Defendants. Ms. Ashmont was Defendants' Rule 30(b)(6) designee. Drs. Holden and Kendrick have been designated by Plaintiffs as experts. Plaintiffs include an attached Glossary, which lists individuals referenced in this Memorandum and their titles, along with acronyms and selected terminology used. The Glossary contains information about each Plaintiff.

2. There are institutionalized North Carolinians with I/DD who would prefer to live in the community and have needs that could be met in the community. Am. Comp. ¶ 44; Ans. ¶ 44; *see also*, Deposition of David Richard⁵ (Richard Dep.) p. 186:9-29 (agreeing the barrier in addressing the desire for discharge is availability of community-based services).
3. In the absence of appropriate habilitation and ongoing support, individuals with I/DD are vulnerable to needless dependence and institutionalization. Am. Comp. ¶ 25; Ans. ¶ 25.
4. Institutionalization of people with I/DD is neither inevitable nor desirable. Agosta Dep. pp. 23:3-25, 89:10-23; Ashmont 30(b)(6) Dep. pp. 84:21-85:8; Holden Dep. pp. 76:17-22; 78:7-11; Kendrick Dep. p. 36:20-25.
5. People enter and remain in institutions when there is no viable community-based alternative. Agosta Dep. p. 89:10-23; Ashmont 30(b)(6) Dep. p. 100:20-23; Holden Dep. p. 76:17-22; 78:7-11; Kendrick Dep. pp. 37:23-38:9; 51:13-24.
6. Defendants do not have in place adequate community-based services for all individuals with I/DD who prefer a community-based setting to institutionalization. Deposition of Katherine Nichols as Rule 30(b)(6) designee (Nichols 30(b)(6) Dep.) p. 114:4-10.
7. Addressing the gap in community-based services is necessary to curb the flow of admissions to institutions. Ashmont 30(b)(6) Dep. p. 16:8-14.
8. Defendants pay for various types of institutions, including state-operated Developmental Disabilities Centers (DD Centers), private Intermediate Care Facilities (ICFs), and Adult Care Homes (ACHs), to house people with I/DD. Am. Comp. ¶ 34; Ans. ¶ 34.

⁵ Mr. Richard is DHHS Deputy Secretary for Medical Assistance (Medicaid Director), and was formerly Deputy Secretary for Behavioral Health and Intellectual and Developmental Disabilities.

9. There are approximately 5,200 people with I/DD living in institutions in North Carolina:
 - a. Between 2013 and 2016, the number of people with I/DD in public ICFs (DD Centers) and private ICFs (combined) rose from 3,153 to 3,889. Exhibit A⁶: Defs.’ Supp. Resp. to First RFA, pp. 2-3.
 - b. Approximately 1,400 North Carolinians with I/DD live in ACHs as of 2017 (the last year for which data has been provided). Dep. Ex. 37: ACH Data.
10. There are individuals with I/DD currently residing in state-operated DD Centers who have been there since the 1940s. Additional people have entered these facilities each year from 1950 to the present. Ex. F: Developmental Center Census.⁷
11. In 2011, Defendants’ designated expert, Dr. John Agosta, conducted a study which found: “North Carolina relies on Developmental Centers, community ICFs[], [and] nursing homes . . . to serve people with intellectual and other developmental disabilities to an extraordinary extent. As a result, opportunities for individuals to receive services in the most integrated setting are reduced.” Dep. Ex. 9: *Strategic Analysis for Change*, Humans Services Research Institute, 2011, p. 25 (hereinafter *Strategic Analysis*, 2011); *see also*, Agosta Dep. pp. 104:16-105:14 (discussing analysis).
12. Other states have reduced or eliminated their reliance on institutions. Agosta Dep. pp. 49:9-50:10; Richard Dep. p. 185:4-7.

⁶ Discovery material filed with Plaintiffs’ Notice of Filing are designated with letters A-F and abbreviated “Ex.” Deposition exhibits are designated with numbers and abbreviated “Dep. Ex.”

⁷ Plaintiffs requested through discovery the names of the individuals housed in institutions in North Carolina who expressed an interest in discharge and/or were designated as ready for discharge. Based on Defendants’ privacy and confidentiality objections, the parties agreed to the disclosure of data in lieu of names. Ex. B: Defs.’ Supp. Resp. to Pls.’ Second Interrogs. and RPDs, pp. 2-5.

13. About 30 states do not operate institutions or have fewer than 150 people living in state-operated facilities. Agosta Dep. pp. 49:16-50:8.
14. As of 2018, North Carolina’s “current system is too heavily dependent on the most restrictive, facility-based, inpatient and institutional treatment.” Dep. Ex. 29: *Strategic Plan for Improvement of Behavioral Health Services*, (Report to the Joint Legislative Oversight Committee on Health and Human Services, *et al.*), NC Department of Health and Human Services, January 31, 2018, p. 87 (emphasis added) (hereinafter Dep. Ex. 29: “*DHHS Strategic Plan*”). “In the I/DD population, 38% of expenditures are community-based and 63% are facility-based.” Dep. Ex. 29: *DHHS Strategic Plan*, p. 22.
15. The DHHS Strategic Plan “reflects the collective judgment of the department leadership.” Richard Dep. p. 130:18-21.
16. North Carolina’s overall fiscal effort toward I/DD services has decreased since 2009, while the national average has increased. Agosta Dep. pp. 46:7-47:24; Dep. Ex. 114: Agosta Expert Report, p. 3.
17. There remains “an imbalance of community-based services relative to inpatient, residential, and institutional care in North Carolina, even though community-based services are often more cost-effective.” Dep. Ex. 29: *DHHS Strategic Plan*, p. 5.
18. “Because our state lacks robust community-based behavioral healthcare services, more people go into crisis for otherwise manageable conditions.” Dep. Ex. 29: *DHHS Strategic Plan*, p. 5.
19. The lack of availability of Direct Support Professionals (“DSPs”) is a significant barrier for individuals with I/DD in need of community-based support. *DHHS Strategic Plan*, p. 38 (“DSPs play a critical role in the provision of services for individuals with I/DD. However, there

is a shortage of these professionals in North Carolina”); *see also* Deposition of Jason Vogler, Ph.D.⁸ (Vogler Dep.) p. 81:8-20 (“quite honestly, most people know that there’s a shortage. . . . [of] direct support professionals who are really the foundational workforce in I/DD especially who in many of these jobs make less than they could make at Walmart or McDonald’s.”).

20. North Carolina’s primary alternative to institutionalization for people with I/DD is a Medicaid program called the Innovations Waiver. Dep. Ex. 29: *DHHS Strategic Plan*, p. 26.

21. Innovations Waiver services are available to individuals who need the services to avoid institutionalization. Goda (3/20/19) Dep. p. 8:15-16; *see also, Olmstead*, 527 U.S. at 601 (noting federal policy preference for use of Medicaid waivers rather than institutionalization).

22. Approximately 12,888 people are served through the Innovations Waiver. Dep. Ex. 29: *DHHS Strategic Plan*, p. 3.

23. About 12,000 North Carolinians remain on a “Registry of Unmet Need,” a waiting list for services through the Innovations Waiver. Dep. Ex. 29: *DHHS Strategic Plan*, p. 26.

24. North Carolina has the discretion to increase Innovations Waiver slots, subject to the approval of the General Assembly and the Centers for Medicare and Medicaid Services (CMS). Am. Comp. ¶ 122; Ans. ¶ 122.

25. The average cost for community-based Innovations Waiver services is approximately \$66,000 per year. Goda (3/20/19) Dep. p. 27:17-20.

26. The average cost for placement in a private ICF is approximately \$135,000 per year. Ex. D.: Defs.’ Supp. Resp. to Pls.’ Third RPD and Third Interrogs., p. 8.

⁸ Dr. Vogler is a Senior Psychologist and was formerly Senior Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

27. The average cost for placement in a state-operated ICF (DD Center) is \$235,000 per year. Ex. D.: Defs.' Supp. Resp. to Pls.' Third RPD and Third Interrogs., p. 6.

28. The number of people on the Registry of Unmet Need is growing, in part, because “[o]utside of the Innovations Waiver there are few services that are specific to the support needs of individuals with I/DD.” Dep. Ex. 29: *DHHS Strategic Plan*, p. 26.

29. The Innovations Waiver has a \$135,000 cost limit, and a limit on the number of hours of support that a person can receive. Dep. Ex. 3: Innovations Waiver, Bates Nos. 290, 332.

30. Individuals whose needs exceed the limits set in the Innovations Waiver are referred to an ICF. Dep. Ex. 3: Innovations Waiver, Bates Nos. 290-291.

31. Issues surrounding Defendants’ compliance with the Integration Mandate have been studied extensively. Dep. Ex. 27: Email dated 1/15/13, Farnham to Bradley, Re: Materials for Olmstead Group, p. 1.

32. Change to Defendants’ system has been hampered by “[t]urnover and distraction.” Deposition of Patricia Farnham⁹ (Farnham Dep.) p. 48:22-25. There has also been lack of political and executive will. Deposition of Holly Riddle¹⁰ (Riddle Dep.) p. 120:14-25; Farnham Dep. 25:17-19.

33. Defendants do not have a current plan to address reliance on institutions. Ashmont 30(b)(6) Dep. p. 7:15-18; Nichols 30(b)(6) Dep. pp. 51:22-54:8; 74:8-10.

⁹ Ms. Farnham is Associate Director of Special Initiatives and was formerly Project Director for the Money Follows the Person Project.

¹⁰ Ms. Riddle is a Policy Advisor and was formerly Executive Director of the North Carolina Council on Developmental Disabilities.

STANDARD OF REVIEW

Summary judgment is warranted where “the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that any party is entitled to a judgment as a matter of law.” N.C. Gen. Stat. § 1A-1, Rule 56(c). “This is true even if the questions of law are complex.” *Virginia Electric & Power Co. v. Tillett*, 80 N.C. App. 383, 385 (1986); *see also McNair v. Boyette*, 282 N.C. 230, 234 (1972) (noting that, where “plaintiff and defendant . . . are in agreement as to all the factual particulars,” the issue for the court is one of the application of law). Summary judgment may be rendered as to one of several claims, and a partial summary judgment may be granted. N.C. Gen. Stat. § 1A-1, Rule 56 (a) and (c).

ARGUMENT

Summary judgment is appropriate in a case such as this where the salient facts are not in dispute. The record shows that: (1) Defendants continue to institutionalize individuals with I/DD who would prefer access to community-based support services; (2) Defendants have failed to engage in adequate deinstitutionalization efforts – including providing for sufficient alternative supports in the community; and (3) more and more individuals with I/DD are at risk for institutionalization because of the lack of sufficient community-based services and unnecessary limits imposed on the amount of support available. Defendants’ long-term failure to address these issues and their lack of an effective plan for doing so violate the Integration Mandate and warrant injunctive relief.

I. Plaintiffs are Entitled to Summary Judgment Because the Undisputed Facts Show Defendants Have Violated the Integration Mandate

“Unjustified ‘segregation’ of persons with disabilities” is “a ‘form of discrimination.’” *Olmstead*, 527 U.S. at 600; *see also Helen L. v. DeDario*, 46 F. 3d 325, 333 (3d Cir.), *cert.*

denied, 516 U.S. 813 (1995) (holding that unnecessary segregation is a form of illegal discrimination against people with disabilities). The *Olmstead* decision was grounded in the following regulation implementing the ADA’s prohibition on discrimination in public services: “A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.” 28 CFR § 35.130(d).

The North Carolina General Assembly, in response to the *Olmstead* decision, adopted N.C. Gen. Stat. § 168A-7(b) as part of the Persons with Disabilities Protection Act, which provides language mirroring that of the ADA Title II regulations: “A covered governmental entity shall administer its services, programs, and activities in the most integrated setting appropriate to the needs of persons with disabilities.” N.C. Gen. Stat. § 168A-7(b).

Integrated settings are located in mainstream society; offer access to community activities and opportunities *at times, frequencies and with persons of an individual's choosing*; afford individuals choice in their daily life activities; and, provide individuals with disabilities the opportunity to interact with non-disabled persons to the fullest extent possible.

U.S. Dept. of Justice, Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.*, June 20, 2011, (“DOJ Guidance”) p. 3 (emphasis added) (copy attached).

Administration of publicly funded services, including services under the Medicaid program and other services managed by state agencies for individuals with I/DD, violates the Integration Mandate if those services promote unnecessary institutionalization or segregation. *See Pashby v. Delia*, 709 F.3d 307, 322 (4th Cir. 2013) (applying the decision in *Olmstead* to North Carolina’s Medicaid program). Specifically:

a public entity may violate the . . . integration mandate when it: (1) directly or indirectly operates facilities and/or programs that segregate individuals with disabilities; (2) finances the segregation of individuals with disabilities in private facilities; and/or (3) through its planning, service system design, funding choices,

or service implementation practices, promotes or relies upon the segregation of individuals with disabilities in private facilities or programs.

DOJ Guidance, p. 3; *see also* 28 C.F.R. § 35.130(b)(1) (prohibiting discrimination in the provision of services by a public entity).

On an individual level, the Integration Mandate is violated where individuals who could be, and prefer to be, supported in the community are nevertheless confined to segregated settings, or are placed at risk of such segregation. *Olmstead*, 527 U.S. at 601-602; *See Pashby v. Delia*, 709 F.3d 307, 322 (4th Cir. 2013).¹¹ As noted in the DOJ Guidance, violation of the Integration Mandate occurs on the system level when a state’s policies and practices promote segregation. DOJ Guidance, p. 3.

A. Defendants Unnecessarily Institutionalize Thousands of North Carolinians with I/DD in Violation of the Integration Mandate

At one time, institutionalization of people with disabilities seemed inevitable. Agosta Dep. p. 28:3-25. We now know that it is neither inevitable nor desirable. Agosta Dep. p. 89:10-23; Holden Dep. pp. 76:17-22; 78:7-11; Kendrick Dep. p. 36:20-25. Institutionalization “perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life.” *Olmstead*, 527 at 600. Rather than inherent inability or unworthiness, the difference between those who are institutionalized and those who are not is the availability of community-based services as an alternative. *See Goda* (3/20/19) Dep. pp. 61:16-62:1; 62:25-63:4 (noting that individuals in institutions generally have the same level of support needs as those in the community); *see also*, Agosta Dep. p. 89:11-23.

¹¹ North Carolina courts “look to federal decisions for guidance in establishing evidentiary standards and principles of law to be applied in discrimination cases.” *North Carolina Dep’t of Correction v. Gibson*, 308 N.C. 131, 136 (1983).

People live in institutions when there is no viable alternative. Agosta Dep. p. 89:10-23; Ashmont 30(b)(6) Dep. pp. 15:13-15; 23:5-10; 100:20-23; Farnham Dep. pp. 23:15-21, 34:9-12, 41:8-11, 50:19-25; Kendrick Dep. pp. 37:23-38:9; Holden Dep. pp. 76:17-22; 78:7-11. People with I/DD can be served in the community when needed supports are in place. Agosta Dep. p. 89:10-23; Farnham Dep. p. 10:23-11:21; Kendrick Dep. p. 49:13-24; Holden Dep. pp. 76:17-22; 78:7-11. In fact, about 30 states do not operate institutions¹² or have fewer than 150 people living in state-operated facilities, and “you can see the evolution of a national system in this direction.” Agosta Dep. pp. 49:16-50:8. “It was best practice in the United States as it continues to be to either downsize or close developmental centers.” Riddle Dep. p. 62:14-16. Despite this trend, North Carolina has failed to address the long-term¹³ institutionalization of individuals with I/DD, and continues to institutionalize additional people with I/DD every year. *See* Ex. F: Developmental Center Census Data (showing number of individuals, by year of admission, remaining institutionalized in DD Centers).

Because the cost of institutional placement exceeds the cost of community-based support, there is disproportionate funding of institutionalization: “The majority of funding is spent on inpatient, institutional, residential and facility-based treatment as opposed to community-based treatment.” Ex. 29: *DHHS Strategic Plan*, p. 20. “In the I/DD population, 38% of expenditures are community-based and 63% are facility-based. . . . [T]here is agreement that *the current system is too heavily dependent on facility-based treatment and supports.*” *Id.* at 22 (emphasis

¹² Plaintiffs do not seek closure of specific institutional settings in this action. Rather, Plaintiffs seek meaningful access for people with I/DD to community-based supports that obviate involuntary institutionalization.

¹³ The DD Center census data provided by Defendants shows that 8 individuals admitted in the 1940s remain institutionalized more than 70 years later, along with 48 from the 1950s, 315 from the 1960s and 135 from the 1970s. Ex. F: Developmental Center Census Data.

added). This fiscal inefficiency further limits the availability of funds for community-based services. Agosta Dep. pp. 113:13-114:8.

i. Despite a Clear Legal Mandate Requiring Defendants to Foster Integration, Thousands of North Carolinians with I/DD Remain Institutionalized

There are approximately 5,200 people with I/DD living in institutions in North Carolina. Rather than decreasing, North Carolina's reliance on institutionalizing people with I/DD in ICFs has increased. *See* Ex A: Defs.' Supp. Resp. to First RFA, pp. 2-3 (showing census data from 2013 to 2016). In 2013, there were 960 individuals in public ICFs (DD Centers) and 2,193 in private ICFs. *Id.* By 2016, there were 1,124 individuals in public ICFs and 2,765 in private ICFs. *Id.* Approximately 1400 people with I/DD live in ACHs, which are institutional settings. Dep. Ex. 37: ACH Census Data; *Pashby*, 709 F.3d at 323 (noting District Court's determination that North Carolina ACHs are institutions was consistent with U.S. Department of Justice findings to the same effect).

Nationally, more people were discharged from state-operated ICFs than were admitted in fiscal year 2016, the last year such data is available. Agosta Dep. p. 81:6-8; Dep. Ex. 115: Residential Information Systems Project, In-Home and Residential Long-Term Supports and Services for Persons with Intellectual or Developmental Disabilities: Status and Trends Through 2016 (hereinafter "RISP Data"), p. 125. The opposite was true in North Carolina.¹⁴ Agosta Dep.

¹⁴ Losing case management services affected discharge efforts negatively: "There was not . . . always an identified person who spent as much time with the individual or working on behalf of the individual." Deposition of Carol Donin (Donin Dep.) p. 52. Although Defendants' contractors for behavioral health services are required to send someone to discharge planning meetings, the individuals involved do not have the authority to actually approve services. Ashmont 30(b)(6) Dep. p. 24:16-18. Effective discharge planning would require "ability to write the checks" and "authority to actually implement" a plan. Ashmont 30(b)(6) Dep. p. 24:18-23. Case management is critical for

p. 79:15-18; Dep. Ex. 115: RISP Data, p. 125. In North Carolina, more people *died* in DD Centers in 2016 than were discharged. Agosta Dep. p. 80:7-10; Dep. Ex. 115: RISP Data, p. 125. Since May 2017, when this action was filed, more people have entered and remained in state-operated DD Centers. *See* Ex. F: Developmental Center Census Data (showing DD Center census by year of admission; does not reflect individuals admitted and discharged prior to the end of 2018). Among them, Plaintiff Samantha R. was admitted to a DD Center in 2015 and remains institutionalized.¹⁵ Am. Comp. ¶ 201; Ans. ¶ 201.

The fact that individuals with I/DD continue to be institutionalized in North Carolina is not subject to dispute.

ii. *Individuals Currently Institutionalized Prefer to Live in the Community but Remain Institutionalized Due to Lack of Adequate Community-Based Services*

Defendants admit that there are individuals with I/DD who are institutionalized but prefer to be in the community and have needs that could be met in the community with appropriate supports. Am. Comp. ¶¶ 39, 44; Ans. ¶¶ 39, 44.

Through transition lists, Defendants track a set of individuals who should be in the process of leaving state-operated DD Centers. Ashmont 30(b)(6) Dep. pp. 43:1-3, 55:5-14. Defendants identified, on average, about 100 individuals on transition lists for each year from 2014 through 2018. Ex. B: Defs' Supp. Resp. to Pls.' Second Interrogs. and RPDs., pp. 3-4. The data does not indicate whether these figures represent individuals who were on the list for

transitions to the community because of the need to replace the tightly knit set of services in the institution. Farnham Dep. pp. 37:4-16; 38:4-5.

¹⁵ Defendants' designated expert, Dr. Bonny Forrest, did not challenge the desire or ability for Samantha to be served in the community, but stated only that the Defendants are "unlikely" to be able to provide community-based services "given the resource allocation for its programs." Dep. Ex. 124: Forrest Report, p. 9. However, Defendants have offered no factual premise for any inability to serve Samantha in the community. *See* Ex. D: Defs.' Second Supp. Resp. to Pls.' Third RPDs and Third Interrogs., p. 2.

multiple years or whether these are 500 unique individuals, or some figure in between. *See id.*¹⁶ (“The numbers . . . are derived from annual reports and will include the # of individuals on the [list] at year’s end along with any discharged from the FY (as they would have been on the [list] prior to [discharge]”).) As explained below, individuals on a transition list face barriers to discharge based on the availability of services and/or access to needed funding.

Defendants’ DD Center transition lists do not provide for a complete picture, however, because they do not include individuals in other institutional settings (such as private ICFs and ACHs, which collectively house about 4000 people with I/DD), and they do not include individuals who would prefer community placement but whose guardians opt not to include them on the list. *See Nichols* 30(b)(6) Dep. pp. 28:4-31:1 (affirming that “the department doesn’t have numbers and locations for individuals who might want to leave ICFs at this point”) *and* 71:23-72:9 (same as to ACHs); *see also, Ashmont* 30(b)(6) Dep. p. 55:5-19 (noting that Defendants do not track people who prefer to leave facilities unless the guardian has also agreed) *and* p. 31:18-23 (explaining that the inability to assure the availability of community-based services is a deterrent to guardians seeking discharge).

Gaps in community services that cause institutionalization also make discharge more difficult. Defendants acknowledge that individuals with I/DD remain institutionalized or at risk of institutionalization when they do not have access to adequate community-based services. *See Ashmont* 30(b)(6) Dep p. 100:20-24 (“[W]hen you do refer somebody to the [DD] center, you are identifying that you haven’t been able to meet their needs” in the community.) Building

¹⁶ As noted above, Defendants provided the number of individuals on transitions lists in lieu of providing Plaintiffs with the names of those individuals. Ex.B: Defs.’ Supp. Resp. to Pls.’ Second Interrogs. and RPDs, pp. 3-4.

capacity to serve people in the community is a necessary component of enabling discharge from facilities. Ashmont 30(b)(6) Dep. pp. 66:18-67:5. The discharge process depends on Defendants' contractors¹⁷ having or developing community provider capacity to serve people. Donin Dep. p. 40:3-24. Both Natasha Ashmont, director of the DD Centers, and her predecessor noted that gaps in community-based services inhibited the ability of the DD Centers to effectuate discharges. Ashmont 30(b)(6) Dep. p. 100:20-23; Donin Dep. pp. 51:4-52:4. Since an admission to a facility means there were inadequate supports provided by the LME/MCO in the community, the question at discharge regarding the same LME/MCO, according to Ms. Ashmont, is "what's being done differently in the community so that they can go back out and be successful"? Ashmont 30(b)(6) Dep. p. 24:3-5. Ms. Ashmont indicated that LME/MCOs will need to address the missing components of the service system in order for discharge to be possible. *See* Ashmont 30(b)(6) Dep. pp. 100:20-101:4. ("[Y]ou referred her to us because you [the LME/MCO] don't have this component in the community. So what are you going to do to address that component[?]").

Both quantity and quality are lacking with regard to community-based providers of I/DD services. This includes limited availability of psychologists with I/DD expertise. Donin Dep. pp. 54:16-55:4. In addition, "it's really the quality of providers we've discussed quite a bit. We've had what we thought were really great transition plans, and they fall apart sometimes after we're no longer following the individual." Ashmont 30(b)(6) Dep. p. 22:8-13; *see also*, Farnham Dep. p. 25:1-8 (noting "difficulty finding quality community-based . . . residential provider . . . [and that] [i]t is often difficult to access the therapy piece that people may require, and behavioral

¹⁷ Defendants contract with Local Management Entities/Managed Care Organizations (LME/MCOs) for administration of behavioral health services.

health and crisis services were sometimes not as effectively available as they needed to be”). In order to help people transition back to the community, Defendants need providers with expertise in complex needs and to address gaps in resources across the whole menu of services. Donin Dep. p. 53:1-54:5.

Defendants’ designated expert, Dr. John Agosta, agrees that development of community capacity is necessary to address institutionalization and risk of institutionalization, including services for those with the highest needs. Agosta Dep. pp. 85:15-86:15; 88:23-89:23; *see also*, Holden Dep. p. 209:11-14 (“[T]raining makes a huge difference when you’re talking about individuals like . . . the plaintiffs, because they do have complex needs.”). Defendants’ personnel agree that better training of direct service providers, including competency based curricula, is necessary. Riddle Dep. pp. 25:23-26:5.

Defendants’ failure to provide for a community-based service system that allows for individuals to choose to leave institutions violates the Integration Mandate.

iii. Defendants Have Failed to Engage in Adequate Deinstitutionalization Efforts

From 2011 to 2012, Defendants’ designated expert, Dr. John Agosta, was charged with evaluating North Carolina’s reliance on institutions. He wrote at the time: “North Carolina relies on Developmental Centers, community ICFs[], [and] nursing homes . . . to serve people with intellectual and other developmental disabilities to an extraordinary extent.” Dep. Ex. 9: *Strategic Analysis* 2011, p. 25 (emphasis added). “It is apparent that the department, though it seeks to reduce its developmental center census, is having a difficult time doing so. As individuals are discharged, others take their place.” Dep. Ex. 9: *Strategic Analysis* 2011, p. 34; *see also*, Agosta Dep. p. 108:5-8 (discussing same). Dr. Agosta proposed a benchmark of reducing the DD Center population to the national average by 2017 – a benchmark he considered

“a good first crack at it” and “a place to start.” Agosta Dep. p. 139:7-140:6. North Carolina failed to meet that benchmark. Agosta Dep. p. 108:5-14. Faced with the current data, Dr. Agosta testified that “it would seem that North Carolina is still having difficulty.” Agosta Dep. p. 108:13-14.

Although the Integration Mandate requires affirmative steps to address deinstitutionalization, DOJ Guidance at p 4, Defendants’ 30(b)(6) witness as to Defendants’ deinstitutionalization plans, Katherine Nichols, testified that there are none with regard to private ICFs. Nichols Dep. pp. 51:22-54:8. Defendants do not require their contractors to conduct efforts to identify individuals who would prefer to leave institutional settings. Nichols 30(b)(6) Dep. pp. 31:24-32:24. Even if such efforts were undertaken, these contractors have inadequate staff tasked with transitioning people from private facilities. Ashmont 30(b)(6) Dep. pp. 42:11- 43:10. “There’s [sic] only 16 Olmstead liaisons across the state. I mean, I don’t have the current numbers for individuals who are in an ICF setting, but it’s a lot more than 16 can manage.” Ashmont 30(b)(6) Dep. p. 43:7-10.

Recognizing that individuals or their guardians may have previously been dissuaded from pursuing integration, the DOJ directed that “[p]ublic entities must take affirmative steps to remedy this history of segregation and prejudice in order to ensure that individuals have an opportunity to make an informed choice.” DOJ Guidance, p. 4. Defendants have no such efforts in place with regard to private ICFs and ACHs. Nichols 30(b)(6) Dep. p. 50:16-19. It is not enough to ask an individual or their guardian whether they want to leave the facility and move to the community. *Id.*; *see also* Farnham Dep. p. 24:9-21 (describing the utility of more robust in-reach efforts), *and* Vogler Dep. pp. 100:16:23; 120:6-121:25 (“giving people the opportunity to see the community [options] when maybe they haven’t was important to maybe see what ... the

alternatives are. If you're only ever presented with water to drink, you don't know there are other options.”).

Concerns or objections raised by individuals and guardians of individuals living in North Carolina institutions include the fear that necessary services will not be sustainably available in the community. *See* Farnham Dep. pp. 33:3-9; 34:9-12 (describing “family members not [being] comfortable with the idea of supporting the transition . . . [because] [t]he community failed them the first time” and “we’ve heard [about] the lack of coordinated community supports available or concerns about the level of a person’s need in their community”), and pp. 50:19-22; 51:15-18 (identifying family concerns regarding staff turnover, difficulty coordinating care, and keeping providers). Ms. Ashmont, head of the DD Centers, agrees that lack of availability of community services was and is a concern for guardians in considering pursuing discharge. Ashmont 30(b)(6) Dep. pp. 39:9-20; 65:22–66:3.

It’s not realistic to expect the social worker on the [facility] unit to know what the community options are on any given day. It’s unfair when the families ask questions and we can’t answer them. That doesn’t reassure them. So, therefore, they’re like, yeah, we want to stay [in the facility].

Ashmont 30(b)(6) Dep. p. 31:18-23.¹⁸

¹⁸ There is an important distinction between family-member guardians and public guardians with regard to the question of guardian reluctance to approve discharge. Public guardians, carrying out the role of the public entity (usually DSS), are providing services that are subject to the requirements of the Integration Mandate. *See* N.C. Gen. Stat. § 168A-3(1) (defining covered governmental entity to include agencies, including social services). Thus, the public guardian’s preference to maintain an individual in a segregated setting itself violates the Integration Mandate and cannot serve as the basis for denial of discharge. *Id.*; *see also*, Salzman, Leslie, *Rethinking Guardianship (Again): Substituted Decision Making as a Violation of the Integration Mandate of Title II of the Americans with Disabilities Act* (December 14, 2009), Cardozo Legal Studies Research Paper No. 282; University of Colorado Law Review, Vol. 81, p. 157, 201, 2010. Available at SSRN: <https://ssrn.com/abstract=1567132> (describing the application of *Olmstead* principles to the provision of guardianship services as a state service, program, or activity).

Defendants have an affirmative obligation to address barriers to discharge, including those that are related to guardians' reluctance to trust a community service system that they believe was inadequate in the past. This would involve a process of discussion that is not currently built into the discharge planning process. *See* Ashmont 30(b)(6) Dep. p. 72:18 (describing need for more effective process). Developing trust in the community-based system, of course, also entails developing a sufficient and reliable one, including access to quality providers and case management to navigate services within the community-based system. Addressing the issue of guardian concerns includes addressing the other barriers in the system and answering the questions "how do we build the workforce, how do we build the desire to do something different so that there is an option other than just ICF for some individuals?" Vogler Dep. p. 99:4-24.

Defendants continue to house thousands of individuals with I/DD in institutional settings and have failed to engage in adequate efforts toward deinstitutionalization. Because there are no genuine issues of material fact as to liability with regard to Defendants' over-reliance on institutionalization, Plaintiffs are entitled to judgment as a matter of law on their claim for a declaratory judgment that Defendants are in violation of the Integration Mandate contained in the Persons with Disabilities Protection Act, N.C. Gen. Stat. § 168A-7(b).

B. Defendants' Policies Place Thousands of North Carolinians with I/DD at Serious Risk of Institutionalization In Violation of the Integration Mandate

Defendants have created and perpetuated widespread risk of institutionalization by failing to address the persistent growth of the Registry of Unmet Needs, and by imposing policies related to the Innovation Waiver that expressly and unnecessarily limit access to community-based services.

The Integration Mandate protects individuals who are currently institutionalized as well as individuals that are at risk for institutionalization or segregation as a result of a State’s policies or practices. *See Pashby*, 709 F.3d at 322 (“[T]here is nothing in the plain language of the [Integration Mandate] that limits protection to persons who are currently institutionalized.”); *Davis v. Shah*, 821 F.3d 231, 263 (2d Cir. 2016) (holding that “a plaintiff may state a valid claim for disability discrimination by demonstrating that the defendant's actions pose a serious risk of institutionalization for disabled persons”); *Fisher v. Okla. Health Care Auth.*, 335 F.3d 1175, 1181 (10th Cir. 2003) (holding the Integration Mandate “would be meaningless if plaintiffs were required to segregate themselves by entering an institution before they could challenge an allegedly discriminatory law or policy that threatens to force them into segregated isolation”). A plaintiff establishes a "sufficient risk of institutionalization to make out an *Olmstead* violation if a public entity's failure to provide community services . . . will likely cause a decline in health, safety, or welfare that would lead to the individual's eventual placement in an institution." *Davis* at 262-63 (citing DOJ Guidance).

Defendants’ Rule 30(b)(6) designee testified that North Carolina has not “sufficiently eliminated the risk of institutionalization for individuals with I/DD.” Nichols 30(b)(6) Dep. p. 115:23-116:1. Defendants have failed to provide individuals with I/DD with necessary community-based services, thereby placing them at risk for institutionalization. As detailed below, Defendants have about 12,000 people on a waiting list for services needed to avoid institutionalization. For those who are receiving services, unnecessary limitations imposed on the provision of medically necessary services and provider quality deficits create serious risk of institutionalization.

i. *The Waiting List for Defendants' Primary Alternative to Institutionalization is Growing, Leaving Thousands at Risk for Institutionalization*

The estimated prevalence of adult North Carolinians with I/DD in the population is 62,801; 62% of these individuals are in need of, but without, services. Dep. Ex. 29: *DHHS Strategic Plan*, p. 21. A program called the Innovations Waiver is the primary source of community-based support for people with I/DD in North Carolina. Dep. Ex. 29: *DHHS Strategic Plan*, p. 26. Waivers, which are Medicaid-based programs, were conceived as an alternative to institutionalization. Richard Dep. pp. 99:6-100:5. Approximately 12,888 people are served through the Innovations Waiver. Dep. Ex. 29: *DHHS Strategic Plan*, p. 3. “Outside the Innovations Waiver, there are few services that are specific to the support needs for individuals with I/DD.” Dep. Ex. 29: *DHHS Strategic Plan*, p. 26. North Carolina has discretion to increase waiver slots, subject to the approval of the General Assembly and the Centers for Medicare and Medicaid Services (CMS). Am. Comp. ¶ 122; Ans, ¶ 122.

As of January 2018, there were 11,698 individuals on a waiting list called the Innovations Waiver Registry of Unmet Need (Registry). *DHHS Strategic Plan*, p. 26. The Registry does not include individuals in DD Centers, and entry into a private ICF does not automatically put a person on the Registry. Ashmont Dep. pp. 90:15-17; 91:16-19. An individual is eligible for Innovations Waiver services if they would qualify for admission to an ICF based on their level of support needs. Dep. Ex. 3: Innovations Waiver, Bates Nos. 271-272. The Innovations Waiver is limited to “individuals who would otherwise be placed in an institution, in this case an ICF[.]” Goda (3/20/19) Dep. p. 8:15-16. Before being placed on the Registry, individuals are screened for eligibility. Goda (8/23/17) Dep. pp. 67:18-68:20. By definition, individuals who need an ICF level of care are at risk for institutionalization in the absence of adequate community-based

supports. *See* Dep. Ex. 3: Innovations Waiver, Bates No. 274 (providing assurances to CMS that services are needed in lieu of institutionalization). In essence, the approximately 12,000 people with I/DD on the Registry constitute a list of individuals facing the serious risk of institutionalization.¹⁹

Plaintiffs Marie K. and Jonathan D. were on the Registry during the pendency of this case. They have each been approved for emergency Innovations Waiver slots, which are available in very limited quantities where someone “is at significant, imminent risk of serious harm.” Dep. Ex. 3: Innovations Waiver, Bates. No. 294.

The Registry is growing. Goda (8/23/17) Dep. p. 68:21-25. There are 445 people who have been waiting more than ten years for services. Ex. A: Defs.’ Supp. Resp. to Pls’ First RFA, p. 7. Absent additional Innovations Waiver slots, “[t]he number of individuals waiting for Innovations [W]aiver funding will continue to increase without any substantial relief. ICF placements will grow as well as the need to fund these placements, which are more costly than Innovations Waiver slots.” Dep. Ex. 19: NCDHHS 2015-17 Biennium Special Provision Action Form, p. 1.

Maintaining individuals on a waiver waiting list supports a claim for violation of the Integration Mandate. *Guggenberger v. Minnesota*, 198 F. Supp. 3d 973, 1029 (D.C. Minn. 2016). Here, Defendants’ failure to reduce the Registry – and the fact that it continues to grow instead – leaves individuals with I/DD at risk of institutionalization in violation of the Integration Mandate.

¹⁹ Staff legislative funding requests highlight the risk: “Without additional [Innovations Waiver] slots, there will be increased demand for more restrictive, more costly ICF-IID placements as well as demand on State funded services for individuals with IDD.” Dep. Ex. 19: NCDHHS 2015-17 Biennium Special Provision Action Form, p. 4.

ii. *Defendants' Failure to Adequately Prioritize Community-Based Services Has Placed Individuals with I/DD at Risk of Institutionalization*

Access to the Innovations Waiver does not guarantee access to quality services. The availability of Direct Support Professionals (DSPs)²⁰, in particular, is a significant barrier for individuals with I/DD in need of community-based support. Dep. Ex. 29: *DHHS Strategic Plan*, p. 38 (“DSPs play a critical role in the provision of services for individuals with I/DD. However, there is a shortage of these professionals in North Carolina”); *see also* Vogler Dep. p. 81:8-20 (“quite honestly, most people know that there’s a shortage. . . . [including] direct support professionals who are really the foundational workforce in I/DD especially who in many of these jobs make less than they could make at Walmart or McDonald’s”). The rate paid by the Defendants does not allow for recruitment and retention of a quality workforce. Vogler Dep., p. 82:21-83:11; *see also* Richard Dep. p. 72:8-22 (describing difficulty retaining DSPs based on wages); *and* Deposition of Robert Hedrick (Hedrick Dep.) pp. 45:5-46:11 (describing DSP crisis and noting that provider “rates have been downwardly suppressed for at least ten years. . . . for the most part, they have not kept up with inflation”). Defendants are aware that provider rates are too low to create a quality workforce. Richard Dep. pp. 71:19-72:19. Addressing the DSP crisis will take a comprehensive approach, but Defendants do not have an answer for it. Richard Dep. p. 73:1-10.

Defendants’ elimination of most case management services has been another barrier to stability in the community for individuals with I/DD. “A key to ensuring individuals receive

²⁰ DSPs are workers who “provide a wide range of supportive services to individuals with I/DD on a day-to-day basis, including habilitation, health needs, personal care and hygiene, employment, transportation, recreation, and housekeeping and home management-related supports so that these individuals can live and work in their communities and lead self-directed, community and social lives.” Dep. Ex. 29: *DHHS Strategic Plan*, p. 38 (citation and quotation marks omitted).

services that enhance their health and well-being is the presence of a trained cadre of case managers who function independently of the provision of services.” Dep. Ex. 9: *Strategic Analysis* 2011, p. 46. Defendants’ designated expert, Dr. Agosta, explained:

The spear point of . . . any system oftentimes is the person that individuals interact with. That . . . person gives access to the service system. That person has the capacity to ensure that your health and well-being is accounted for, that you're receiving the services that you need, and helps you build those plan of services or support for you.

So in a lot of ways, the case manager is the person that people will interact with to get information about the system, to understand what's available, to try to match up the service response to my needs, and so that person is pretty [key] in any service system.

Agosta Dep. p. 119:6-18.

Defendants recognize that lack of access to case management “has created gaps in service support.” Dep. Ex. 29: *DHHS Strategic Plan*, p. 40. Dr. Agosta noted that case managers are key to ensuring access to the service system, monitoring services for quality, ensuring that there is no abuse or neglect, and advocating for the individual. Agosta Dep. pp. 119:6–120:7; 121:9-14; 112:12-23; 124:10-14. The level of oversight and quality of services affects the level of risk of institutionalization. Holden Dep. p. 80:8-14. Regardless of the services being offered, maintaining quality service is important to avoiding risk of institutionalization. Holden Dep., p. 136:3-8. With regard to the records of the individual Plaintiffs, Plaintiffs’ expert, Dr. Jeffrey Holden, noted a lack of qualitative oversight of the services provided. Holden Dep. p. 211:17-21.

iii. Defendants’ Funding Cap on Waiver Services Creates an Explicit Serious Risk of Institutionalization.

Defendants have chosen to place an individual cost limit on Innovations Waiver services at \$135,000. Dep. Ex.3: *Innovations Waiver*, Bates Nos. 289-290. An individual is not eligible for the Innovations Waiver if their service needs are projected to cost in excess of \$135,000. Goda (8/23/17) Dep. p. 109:18-21. North Carolina “could choose to have a cap or not have a

cap.” Goda (8/23/17) Dep. p. 105:3-6. Its inclusion in the Innovation Waiver is a policy decision based on reasoning that Defendants no longer remember. Goda (8/23/17) Dep. p. 105:12-20 and Goda (3/20/19) Dep. p. 133:25-134:7. It is included in the current Waiver because it existed in the preceding Waivers. Goda (3/20/19) Dep. p. 133:25-134:7.

Individuals who require services costing in excess of the cap are referred to an ICF. Goda (8/23/17) Dep. 111:5-20; Dep. Ex. 3: Innovations Waiver, Bates Nos. 290-291. This policy expressly places individuals at risk of institutionalization. The cap also is a barrier for individuals attempting to leave institutions, and has prevented transitions from DD Centers to the community. Farnham Dep. p. 41:8-11. Some LME/MCOs have elected not to facilitate the deinstitutionalization of individuals using an Innovations Waiver slot because the cost of their services were expected to exceed the \$135,000 cap. Farnham Dep. p. 41:8-11. Defendants could have chosen to have no cap, a higher cap, or to provide designated additional funding for those needing more services to avoid institutionalization. *See* Dep. Ex.3: Innovations Waiver, pp. 289-290 (detailing other options). They did not choose any of those other options. *Id.*

Individuals with needs that require relatively greater funding are entitled to the benefits of the Integration Mandate. *See Radaszewski v. Maram*, 383 F.3d 599, 614 (7th Cir. 2004) (noting that, although “the State would have to substantially increase the level of expenditures . . . in order to continue [plaintiff’s] at-home care[,] [t]hat alone does not defeat his [Integration Mandate] claim”) (citing *Fisher*, 335 F.3d at 1183 (“If every alteration in a program or service that required the outlay of funds were tantamount to a fundamental alteration, the ADA’s integration mandate would be hollow indeed” .)).

The funding cap has, and continues to, negatively impact named Plaintiffs and others with I/DD, and places them at increased risk of institutionalization. Connie M.’s services cost

just under the cap at \$134,738.50. Dep. Ex. 124: Forrest Report, p. 10. The cost of Plaintiff Michael A.'s service needs increased to above the cap due to rate changes that the Defendants made to the Innovations Waiver. Michael A. Dep. pp. 7:17-8:13. Prior to the change in services, Michael A. was able to receive all of his services within the cap. Michael A. Dep. p. 8:9-13.

Another individual, not named as a Plaintiff, Alissa Haley, has likewise been informed of the need for service cuts due to the funding cap. Affidavit of Laurie Haley (Haley Aff.) ¶ 6. Alissa enjoys living with her family and her family home is the best setting for her. Haley Aff ¶ 3. Alissa has Aicardi Syndrome, a profound intellectual disorder, a severe seizure disorder, and other medical complications. She is nonverbal, using gestures to communicate. Haley Aff. ¶ 4. Alissa has had difficulty obtaining and keeping staff to provide her services due to her complicated condition. As a result of her issues with obtaining and retaining staff, Alissa H.'s mother/guardian requested an enhanced reimbursement rate for her providers. Haley Aff. ¶7. The higher rate has helped Alissa keep reliable staff; however, it has also caused her service costs to exceed \$135,000. Haley Aff. ¶¶ 7-10. To keep her service costs below the cap, Alissa's service hours are being cut. Haley Aff. ¶ 13.

There are an additional 70 individuals with I/DD whose services cost in excess of \$120,000 per year. Ex. C.: Defs.' [First] Suppl. Resp. to Pls' Third RPD and Third Interrogs., p. 13. These individuals are currently at serious risk of institutionalization due to the cost cap, with a reasonable expectation that additional individuals will be at risk – or unable to transition from institutional settings – as costs increase.

Defendants' individual cost limit eliminates the ability of many individuals to leave institutions and/or stay in the community, in violation of the Integration Mandate.

iv. *Defendants' Limits on Services and the Requirement that "Exceptional" Services "Fade" Create an Explicit Risk of Segregation.*

Defendants' requirement that individuals reduce medically necessary services and/or move into a group setting to receive medically necessary services violates the Integration Mandate. Defendants limit the number of hours of services Innovations Waiver participants can receive, regardless of their individual needs. Goda (8/23/17) Dep. p. 117:15-20. Services in one's home are limited to 84 hours per week. Goda (8/23/17) Dep. p. 120:18-121:1. This limitation was carried over from the Innovations Waiver pilot of 2005. Goda (8/23/17) Dep. p. 116:5-8. Defendants failed to provide any other rationale for their specific limits on hours of service. If someone needs services in excess of the limit, they would need an alternative such as a group home or other congregate setting. Goda (8/23/17) Dep. p. 122:10-18.

When individuals need services exceeding 12 hours per day (or 84 hours per week), they are deemed to have "exceptional needs." Dep. Ex. 3: Innovations Waiver, Bates No. 332. Waiver participants with "exceptional needs" must "fade" services or transition from community services to "other services." Dep. Ex. 3: Innovations Waiver, Bates No. 332. Those "other services" include congregate settings or institutionalization. Goda (8/23/17) Dep. p. 122:10-18.

Individuals with I/DD, like Plaintiff Connie M., have lifelong needs that are not expected to be significantly reduced or eliminated. Richard Dep. pp. 41:20-42:2; Holden Dep. p. 143:14-21. Both parties' designated experts agree that Connie M. needs 24-hour support. Dep. Ex. 124: Forrest Report, p. 10; Holden Dep. p. 137:15-16. Yet, Connie M. has repeatedly received notifications from Defendants' contractor LME/MCO that she must plan to fade her level of services. Holden Dep. p. 138:13-15. For Connie, the loss of hours would create a serious risk of institutionalization. Holden Dep. p. 146:11-15; *see also* Dep. Ex. 124: Forrest report, p. 10 (basing assessment on current level of in-home support).

Plaintiff Connie M. provides but one example of how Defendants' policies place individuals with I/DD at serious risk of institutionalization. Plaintiffs' expert, Dr. Jeffrey Holden, served on the admissions committee at Murdoch Developmental Center for many years. Holden Dep. p. 147:2-3. Dr. Holden explained that the loss of services was often the reason LME/MCOs sought to institutionalize individuals. Holden Dep. p. 147: 6-8. It was not that the individual changed, "it's that the services had changed supporting them..." Holden Dep. p. 147:8-11; *see also*, Ashmont 30(b)(6) Dep. pp. 15:24-16:14 (noting that admissions were the result of lack of community services).

C. Defendants Have Not and Cannot Prove a Viable Defense for Their Failure to Comply with the Integration Mandate.

Defendants pled a variety of defenses in their Answer. Ans. pp. 29-32. Defendants, however, have not produced any evidence in discovery that support such defenses, or more important, that excuse their violation of the Integration Mandate. For example, Defendants listed an "undue burden" defense in their Answer, but discovery has failed to yield any explanation or factual basis for the defense. Ans., Thirteenth Defense, p. 31. Plaintiffs requested that Defendants explain the basis for the defense, including factual and legal contentions. Defendants, however, offered no factual basis for the defense, and pointed only to Plaintiffs' requests for systemic relief and the statutes and regulations related to the undue hardship defense applicable to requests for accommodations. Ex. D: Defs.' Second Supp. Resp. to Pls.' Third RPD and Third Interrog., p. 2. Requests for accommodations fall under a separate provision than the Integration Mandate. *Cf.* N.C. Gen. Stat. § 168A-(7)(a) (providing for an undue hardship defense to reasonable accommodation request) and (b) (not providing for an undue hardship defense to the Integration Mandate).

Neither Defendants' response to Plaintiffs' inquiry as to the basis for the undue burden defense nor Defendants' unsupported affirmative defenses are sufficient to defeat the instant motion. A non-moving party may not rest upon "denials of his pleading . . . but must set forth specific facts showing that there is a genuine issue for trial." N.C. Gen. Stat. § 1A-1, Rule 56(e). Defendants have failed to produce through discovery any evidence upon which an asserted defense could be based.

II. Systemic Relief is Necessary and Appropriate to Remedy Defendants' Violation of the Integration Mandate

After the decision in *Olmstead v. L.C.*, states sought to develop "Olmstead Plans" to address unnecessary institutionalization and risk of institutionalization. DOJ Guidance, p. 6. The Department of Justice provided guidance on the type of plan a state needs in order to meet the Integration Mandate:

An *Olmstead* plan is a public entity's plan for implementing its obligation to provide individuals with disabilities opportunities to live, work, and be served in integrated settings. ***A comprehensive, effectively working plan must do more than provide vague assurances of future integrated options or describe the entity's general history of increased funding for community services and decreased institutional populations.*** Instead, it must reflect an analysis of the extent to which the public entity is providing services in the most integrated setting and ***must contain concrete and reliable commitments to expand integrated opportunities. The plan must have specific and reasonable timeframes and measurable goals for which the public entity may be held accountable, and there must be funding to support the plan, which may come from reallocating existing service dollars.*** . . . To be effective, the plan must have demonstrated success in actually moving individuals to integrated settings in accordance with the plan.

DOJ Guidance, pp. 6-7 (emphases added). Defendants do not have an *Olmstead* plan in place.

Ashmont 30(b)(6) Dep. pp. 104:25-105:18.

Plaintiffs' expert, Dr. Michael Kendrick,²¹ explained that a detailed, specific, and highly targeted plan is needed to address institutionalization and gaps in community services that leave people at risk. Such a plan must:

create services that are sound enough in the community that the people will not return to the institution. And that needs to be detailed, what those service models look like. How much they would cost. How quickly you could bring them on board. Who might be the parties that would operate them. What some of the quality considerations would be, and so on.

Kendrick Dep. p. 42:4-10. The plan must be carefully created and realistic. Kendrick Dep. p. 42:14-24. Defendants' expert, Dr. Agosta, agrees that community services must be developed in order to phase out over-reliance on legacy systems like institutions, and that such a process entails addressing many questions. Agosta Dep. pp. 85:15-86:15; *see also*, DOJ Guidance, p. 7 (“[T]here must be funding to support the plan, which may come from reallocating existing service dollars.”).

Because of the complexity of the process, there must be leadership with the authority to implement a detailed plan and coordinate efforts to reduced reliance on institutions. Agosta Dep. pp. 131:15-132:25; Kendrick, Dep. p. 43:10-24. Key systems barriers to be remedied, as identified by Defendants' staff and experts, include:

- lack of community-based alternatives,
- institutional bias in funding,
- insufficient discharge and case management support for transitions, and

²¹ Dr. Kendrick has extensive experience over the past 40 years advising entities responsible for I/DD service delivery, including serving as Assistant Commissioner for Program Development in Massachusetts, charged with deinstitutionalization efforts. Kendrick Dep. pp. 10:23-23:2; Dep. Ex. 105; Kendrick CV. Dr. Kendrick's dissertation was on leadership in deinstitutionalization. Kendrick Dep. p. 75:22-23.

- failure to adequately – and credibly - address guardian fears about the reliability of community services.

The barriers that prevent deinstitutionalization also place people in the community at risk of institutionalization, and must be addressed in any plan for change.

A. A Comprehensive Plan is Needed to Address Defendants’ Historic and Continuing Violation of the Integration Mandate

North Carolina has lacked the clear leadership and direction necessary to set policy direction for the I/DD service system. Agosta Dep. pp. 133:14-20; 134:23-135:2; 135:17-20; 136:14-16. “There needs to be political will and executive will to ensure that the resources that are needed are available.” Farnham Dep. p. 25:17-19; *see also*, Riddle Dep. p. 120:14-25 (identifying as “the biggest barriers” to community integration, “lack of political will, urgency at all levels of the system”).²²

As noted below, numerous efforts to convene *Olmstead* planning have not produced results. *See, infra*, pp. 35-38. A member of DHHS leadership suggested that the Department’s *Olmstead* efforts had been “pushed by litigation, not vision.” Vogler Dep. p. 137:8-11; Dep. Ex. 33, Att. 3, p. 2. Defendants have established a pattern of failure to implement the Integration Mandate.

i. Defendants’ Historical Efforts Were Inadequate

In 2000, in the aftermath of the 1999 *Olmstead* decision, the state undertook a process of identifying individuals for discharge which “was probably one of our biggest movements towards downsizing.” Ashmont 30(b)(6) Dep. pp. 27:10–28:6. However, “what happened

²² Defendants previously had a State I/DD office, with a Section Chief who directed the I/DD system. Riddle Dep. p. 68:9-17. That is no longer the case. Riddle Dep. p. 68:18. Holly Riddle, the former head of the NC Council on Development Disabilities, suggested the elimination of the State I/DD office, and shift to regional LME/MCOs, correlated with a decline in rankings regarding the efficacy of the state’s I/DD system. Riddle Dep. pp. 69:21-71:14.

thereafter was there wasn't a lot of movement with the rest of the population." Ashmont Dep. p. 28:6-8. The next effort was to move people from DD Centers to private ICFs – maintaining institutionalization, but premised on the idea that this was a step toward further transition to the community. Ashmont 30(b)(6) Dep. pp. 28:10-17. The intent was to conduct a “bed transfer” from the DD Centers to the private ICFs that would enable people to step down to a smaller setting and then transition to the community. Ashmont 30(b)(6) Dep. pp. 28:10-17. This did not happen as intended. Ashmont 30(b)(6) Dep. pp. 28:18-29:7. Once established, “those beds have kind of not held true to what we had set them up as” and the initiative has “gotten away from its original intention” to promote a process of deinstitutionalization. Ashmont 30(b)(6) Dep. p. 29:4-15. Instead, private ICFs engage in “cherry picking” of residents and do not choose those with higher needs, leaving those individuals in DD Centers. Ashmont 30(b)(6) Dep. pp. 85:22-87:1.²³

The development of time-limited memorandum agreements has been “our biggest, best controls over who comes in.” Ashmont 30(b)(6) Dep. p. 30:18-19. These were instituted in 2011 and entail the individual and their LME/MCO signing a renewable memorandum of understanding that admissions are for one year. Ashmont 30(b)(6) Dep. p. 30:15-17. However, the agreements, because they are renewable, do not actually limit stays to one year: approximately 125 people admitted since 2011 were still in DD Centers at the end of 2018. Ex. F: DD Center Census Data. In addition, almost a thousand others who have been in the DD Centers since before 2011 remain there as well – some for decades. *Id.*

From 2011 to 2012, Defendants' designated expert, Dr. John Agosta, was contracted by the Council on Developmental Disabilities, an entity within DHHS, to develop *Strategic Analysis*

²³ The concept of incrementally stepping people down in the way contemplated by the bed transfer plan has since been discredited because of the “continuum trap” that develops when people do not progress beyond more restrictive settings. Agosta Dep. p. 109:6-25.

reports. Riddle Dep. p. 53:4-20. The *Strategic Analysis* 2012 report proposed a downsizing effort to get North Carolina to the national average with regard to reliance on institutionalization. Dep. Ex. 10: *Strategic Analysis* 2012, p. 21. The *Strategic Analysis* documents were shared with DHHS leadership. Riddle Dep. p. 75:2-7. However, the downsizing effort was not undertaken and North Carolina has slipped further behind. Dep. Ex. 114: Agosta Expert Report, pp. 2-3. The 2012 report was one in a long line of inchoate efforts to address Defendants' *Olmstead* obligations. See Dep. Ex. 27: Email dated 1/15/13, Farnham to Bradley, Re: Materials for *Olmstead* Group, p. 1 (providing *Strategic Analysis* documents and prior studies and noting "NC has been waiting a LONNNNNG time for this discussion and it has been studied EXTENSIVELY")(emphases in original).

In 2016, Ms. Deborah Goda, Behavioral Health Unit Manager, wrote a "Background Briefing" regarding the Registry of Unmet Need. Dep. Ex. 18: Background Briefing. In it, Ms. Goda, who is also designated as an expert for Defendants, referred to litigation in other states "over access and *Olmstead* concerns" regarding waitlists "when access to more restrictive settings (ICF[]) is more readily available, creating an institutional bias. *Id.*

Despite understanding their *Olmstead* and Integration Mandate obligations, Defendants have not complied.

ii. *Defendants Do Not Have a Current Viable Plan for Compliance*

In 2017, after Plaintiffs contacted Defendants about the issues in this case, Defendants convened a series of meetings because leadership of Defendant DHHS "all sort of said, we need an updated *Olmstead* plan." Vogler Dep. p. 129:8-13. A "Preliminary *Olmstead* Regrouping" discussion was begun in the context of "[p]ending . . . legal actions" and "advocate activity" around deinstitutionalization, lack of community services, and funding biases. Dep. Ex. 32, Att.:

NC DHHS Preliminary *Olmstead* Regrouping Agenda, p. 1. Thereafter, “the concerted *Olmstead* planning meeting stopped roundabout the time of [a staff member’s] departure, and then to my knowledge, those were not picked back up before I left earlier [in May 2018].” Vogler Dep. p. 134:17-21.

While there were various efforts to develop *Olmstead* planning over the years, the barriers to carrying out those efforts included “[t]urnover and distraction,” Farnham Dep. p. 48:22-25, as well as “lack of political will.” Riddle Dep. p. 120:18. As of August 2018, there were not even any drafts of an *Olmstead* plan. Ashmont 30(b)(6) Dep. p. 94:9-10. Defendants have not produced an *Olmstead* plan in this case. Even if Defendants were to propose a plan for compliance, history shows that Defendants have lacked the long-term follow-through needed. Moreover, as the DOJ Guidance notes, for a plan to be considered effective, a public entity must show that it has been working. DOJ Guidance p. 7. Defendants cannot show that.

The design and implementation of the state’s I/DD service system generally falls to the legislative and executive branches, which are charged with the obligation to comply with state and federal law, including the Integration Mandate found in both. 28 C.F.R. § 35.130(d); N.C. Gen. Stat. § 168A-7(b). However, where the other branches fail to protect citizens’ rights, “it will then be the duty of the court to enter a judgment granting declaratory relief and such other relief as needed to correct the wrong while minimizing the encroachment upon the other branches.” *Leandro v. State*, 346 N.C. 336, 357 (1997).

North Carolina has failed to effectively initiate necessary changes in its behavioral health care system. This pattern of non-compliance by the Defendants provides the back-drop for Plaintiffs’ request that the Court order injunctive as well as declaratory relief. *See infra*, pp. 41-43.

B. Plaintiffs Should Be Granted Systemic Prospective Relief to Ensure Defendants Comply with the Integration Mandate

Individual Plaintiffs and Plaintiff Disability Rights NC (DRNC) brought this action seeking systemic relief. Am. Comp. ¶¶ 197-199. Plaintiff DRNC is the designated Protection and Advocacy (P&A) system for people with disabilities, charged with advocating for the rights of North Carolinians with disabilities. 42 U.S.C. § 15041; Am. Comp. ¶ 13; Answer ¶ 13; *Wilson v. Thomas*, 43 F. Supp. 3d 628, 632-33 (E.D.N.C. 2014).

Federal law grants Plaintiff DRNC the right and obligation to “pursue legal, administrative, and other appropriate remedies or approaches to ensure the protection of, and advocacy for, the rights of such individuals within the State who are or who may be eligible for treatment, services, or habilitation, or who are being considered for a change in living arrangements.” 42 U.S.C. § 15043(a)(2). The Department of Justice notes that:

P&As have played a central role in ensuring that the rights of individuals with disabilities are protected, including individuals’ rights under title II’s integration mandate. The Department of Justice has supported the standing of P&As to litigate *Olmstead* cases.

DOJ Guidance, pp. 8-9.

Plaintiff DRNC brought this action on behalf of individuals with I/DD who are institutionalized or at risk of institutionalization and therefore has standing to seek systemic relief on behalf of its constituents. *See Warth v. Seldin*, 422 U.S. 490, 515 (1975) (“[W]hether an association has standing to invoke the court’s remedial powers on behalf of its members depends in substantial measure on the nature of the relief sought. If in a proper case the association seeks a declaration, injunction, or some other form of prospective relief, it can reasonably be supposed that the remedy, if granted, will inure to the benefit of those members of the association actually injured.”). The Court has previously denied Defendants’ Motion to Dismiss Plaintiffs’ First

Claim for Relief, which was based in part on standing. *Order Granting in Part and Denying in Part Defendants' Motion to Dismiss*, January 30, 2018.

Courts have routinely held that remedies to systemic violations need not be individually-tailored but rather may include alterations to how government entities administer services. *See, e.g., Dunn v. Dunn*, 219 F. Supp. 3d 1163, 1167 (M.D. Ala. 2016) (acknowledging right of the P&A “to bring claims on behalf of identifiable groups of similarly situated constituents” akin to a class action); *Disability Advocates, Inc. v. Paterson*, 598 F. Supp. 2d 289, 310-11 (E.D.N.Y. 2009) (rejecting argument that NY P&A lacked standing to pursue “system-wide relief” as plaintiff’s *Olmstead* claim alleged and was supported by “evidence of an ongoing, system-wide harm to its constituents that could be redressed by the injunctive relief it seeks”); *and N.B. v. Hamos*, 2013 U.S. Dist. LEXIS 171471, at *27 (N.D. Ill. Dec. 5, 2013) (rejecting defendants’ argument that an *Olmstead* claim can provide “remedies for individual instances of discrimination” but not “a right to ‘programmatic’ relief”).

The individual Plaintiffs in this action do not seek relief for themselves. Rather they seek to remedy the I/DD service system that they rely on, and will continue to rely on for the foreseeable future. Samantha R. remains institutionalized and needs expansion of community-based service options and robust discharge planning to enable her to be deinstitutionalized. Marie K., though she now has Innovations Waiver services, will need access to an adequate supply of skilled providers. Jonathan D., though he now resides closer to his community and is no longer on the Registry, will, like Marie, need access to an appropriate array of quality providers for the rest of his life. The same is true for Mitchell T, who participates in Innovations, but faced service cuts related to his budget. Connie M. and Michael A. will continue to face the risk of losing their

needed services if Defendants do not change their policies requiring that “exceptional” services fade out and imposing a funding cap on services. *See, supra*, pp. 28-32.

Systemic relief is warranted here, as the barriers to integration are systemic, as identified by Defendants and their key staff, and about which there are no genuine issues of material fact.

C. This Matter Warrants Appointment of a Qualified Expert to Implement and Oversee Systems Change

The U.S. Department of Justice has offered guidance on systems issues to be addressed in the context of violations of the Integration Mandate:

A wide range of remedies may be appropriate to address violations of the ADA and *Olmstead*, depending on the nature of the violations. Remedies typically require the public entity to expand the capacity of community-based alternatives by a specific amount, over a set period of time. Remedies should focus on expanding the most integrated alternatives. For example, in cases involving residential segregation in institutions or large congregate facilities, remedies should provide individuals opportunities to live in their own apartments or family homes, with necessary supports. Remedies should also focus on expanding the services and supports necessary for individuals’ successful community tenure. *Olmstead* remedies should include, depending on the population at issue: supported housing, Home and Community Based Services (“HCBS”) waivers, crisis services, Assertive Community Treatment (“ACT”) teams, case management, respite, personal care services, peer support services, and supported employment. In addition, court orders and settlement agreements have typically required public entities to implement a process to ensure that currently segregated individuals are provided information about the alternatives to which they are entitled under the agreement, given opportunities that will allow them to make informed decisions about their options (such as visiting community placements or programs, speaking with community providers, and meeting with peers and other families), and that transition plans are developed and implemented when individuals choose more integrated settings.

DOJ Guidance, p. 8. The implementation of a remedy in this case will necessarily entail detailed analysis about systems needs and in-depth understanding of best practices in the design and delivery of I/DD services. Agosta Dep. pp. 85:15-86:15; Kendrick Dep. 51:13-56:9; Dep. Ex. 106, pp. 2-3; *see also* Richard Dep. pp. 201:4-203:10 (describing need for sustainable systems change and failure of same in a prior context). The solutions to specific needs can only be

determined through a focused effort to identify those who wish to leave the institutional setting and what supports are needed to accomplish that. Similarly, the necessary changes to address community capacity issues can be implemented only after an evaluation of the specific deficits (e.g. geographically) and the development of specific plans. Agosta Dep. pp. 85:15-86:15; Richard Dep. p. 73:1-10; Kendrick Dep. pp. 53:24-55:17.

Plaintiffs propose that one or more appropriate expert(s) be identified and charged with developing and overseeing remedial implementation of an *Olmstead* plan consistent with the DOJ Guidance. The Court has the “inherent authority to manage the cases before it.” *SPX Corp. v. Liberty Mutual Ins. Co.*, 210 N.C. App. 562, 573 (2011). Designation of an expert by the Superior Court is an appropriate means of implementing a remedy. *See Stephenson v. Bartlett*, 355 N.C. 354, 358, n. 8 (2002) (“The trial court should consider whether a court-appointed expert would be of assistance in ensuring compliance with federal law and state constitutional requirements.”) (citing N.C. Gen. Stat. § 8C-1, Rule 706).

Plaintiffs respectfully propose that the Court order as injunctive relief:

- Appointment of one or more experts with the input of the parties;
- Provision of authority to the selected expert(s) to design and implement a process, including stakeholder engagement, for development of a detailed, specific, and highly targeted plan to address:
 - Community-based service capacity
 - Community-based provider quality
 - Transitions processes and in-reach efforts
 - System navigation (discharge planning and case management)
 - Diversion from institutions
 - Funding biases
 - Waiting lists
 - Identification of timelines, resources, personnel, leadership, and sustainability;

- Such other relief as may be needed to effectuate an appropriate remedy; and
- Retention of jurisdiction by the Court.

CONCLUSION

The Integration Mandate provides people with I/DD a right to live in the world. Defendants' violations of the Integration Mandate have had, and continue to have, profound consequences for thousands of North Carolinians.

Defendants have continued to unnecessarily institutionalize individuals with I/DD and have perpetuated widespread risk of institutionalization by failing to address the persistent growth of the Registry of Unmet Need, and by imposing policies that expressly and unnecessarily limit access to community-based services.

Because there are no genuine issues of material fact as to liability with regard to Defendants' unnecessary institutionalization of individuals with I/DD and their creation and perpetuation of serious risk of institutionalization, Plaintiffs are entitled to judgment as a matter of law on their claim for declaratory judgment that Defendants are in violation of the Integration Mandate contained in the Persons with Disabilities Protection Act, N.C. Gen. Stat. § 168A-7(b).

By failing to provide services and supports in the most integrated setting appropriate to the needs of affected individuals with I/DD – and by failing to address the barriers they have identified themselves - Defendants have made it necessary for Plaintiffs to seek injunctive relief and invoke “the duty of the court to enter a judgment granting declaratory relief and such other relief as needed to correct the wrong while minimizing the encroachment upon the other branches.” *Leandro, supra*, at 357.

WHEREFORE, Plaintiffs pray the Court enter summary judgment in favor of Plaintiffs and against Defendants on Plaintiffs' First Claim for Relief, declare Defendants to be in violation of the North Carolina Persons with Disabilities Protection Act, and order the injunctive relief outlined above.

Respectfully submitted, this 15th day of May, 2019.

DISABILITY RIGHTS NORTH CAROLINA



Lisa Grafstein
North Carolina Bar No. 22076
lisa.grafstein@disabilityrightsnc.org



Emma Kinyanjui
North Carolina Bar No. 31450
emma.kinyanjui@disabilityrightsnc.org
3724 National Drive, Suite 100
Raleigh, North Carolina 27612
Telephone: (919) 856-2195
Facsimile: (919) 856-2244

DRINKER BIDDLE & REATH LLP

By: Karen A. Denys
Karen.Denys@db.com
105 College Road East
P.O. Box 627
Princeton, New Jersey 08542-0627

LAW OFFICE OF JERRY HARTMAN

By: Jerry Hartman
JerryHartman12@gmail.com
1500 K Street, N.W., Ste. 1100
Washington, District of Columbia 20005-1209

ATTORNEYS FOR PLAINTIFFS

CERTIFICATE OF SERVICE

This is to certify that the undersigned has served a copy of the foregoing **Memorandum in Support of Plaintiffs' Motion for Summary Judgment** on Defendants by email (by consent) to counsel for the Defendants as follows:

Michael T. Wood
mwood@ncdoj.gov
Neal T. McHenry
nmchenry@ncdoj.gov
N.C. Department of Justice
Post Office Box 629
Raleigh, North Carolina 27602

This 15th day of May, 2019.

DISABILITY RIGHTS NORTH CAROLINA



Lisa Grafstein
North Carolina Bar No. 22076
lisa.grafstein@disabilityrightsncc.org
3724 National Drive, Suite 100
Raleigh, North Carolina 27612
Telephone: (919) 856-2195
Facsimile: (919) 856-2244