No. 21-60772

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

UNITED STATES OF AMERICA,
Plaintiff – Appellee

VERSUS

THE STATE OF MISSISSIPPI,
Defendant – Appellant

Appeal from the United States District Court
for the Southern District of Mississippi
Civil Action No. 3:16-CV-622-CWR-FKB

REPLY BRIEF OF DEFENDANT-APPELLANT

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INTRODUCTION

This Court should reverse the district court's extraordinary judgment ruling that the State of Mississippi's mental-health system is violating Title II of the Americans with Disabilities Act (ADA) on a systemwide basis and should reject that court's sweeping remedial order. As Mississippi explained in its opening brief: The judgment defies Title II, the integration mandate, and *Olmstead v. L.C.*, 527 U.S. 581 (1999). The liability ruling also cannot stand because it requires a fundamental alteration of the State's mental-health system. And the remedial order improperly inserts the district judge into the day-to-day management of the State's system.

The United States' responses are unavailing. First, the United States argues that the district court's systemwide liability ruling rests on a sound understanding of the law. U.S. Br. 28-44. The United States does not dispute that the ADA, the integration mandate, and *Olmstead* require individualized determinations to decide whether a State has unlawfully discriminated. MS Br. 21-25. The United States insists that it presented such individualized determinations. It did not. It presented a survey of 154 out of 3,951 patients conducted by non-treating experts. Based on this survey, the United States makes the extraordinary claim that Title II was violated *every* time the State hospitalized a patient with serious mental illness between October 2015 and October 2017 because "the entire population" of individuals would have avoided hospitalization or had a shorter stay. U.S. Br. 29. But *Olmstead* does not support such a broad systemwide finding, particularly without systemwide evidence. The United States also defends the district court's view that the risk of hospitalization qualifies as discrimination under Title II, even though that view

defies the statutory text, the regulatory text, and *Olmstead* itself. Each of those authorities speaks to actual discrimination, not the prospect of discrimination. MS Br. 25-29. The United States insists that the State was correctly held liable for hospitalizations that have not occurred (and may never occur), because waiting for such hospitalization "would demand that [patients] suffer the very harm—unnecessary segregation—that the statute prohibits." U.S. Br. 40-41. That argument just underscores that the district court held Mississippi broadly liable without "the very harm ... that the statute prohibits" occurring. U.S. Br. 41.

Second, the United States argues that Mississippi's fundamental-alteration defense failed because the State did not show that providing necessary community-based services would be "inequitable for other persons with disabilities." U.S. Br. 47; *see* U.S. Br. 44-53. But the at-risk-of-institutionalization theory adopted by the district court precluded such comparisons by generating a finding that *all* Mississippians with serious mental illness are at unreasonable risk of hospitalization. Providing deference to state officials managing a mental-health system with limited resources was a key to the Title II analysis in *Olmstead*. But the at-risk theory ignores that central teaching. The federal government also resists the fundamental-alteration defense because—after the district court rejected the defense at the liability stage and before it entered the remedial order—the State voluntarily implemented changes to improve its mental-health system. U.S. Br. 49-51. But the fact that the State made such changes does not alter the reality that they were fundamental alterations.

Last, the United States argues that the remedial order is proper because, even though Mississippi has now substantially implemented the changes deemed

necessary at trial, the State should be monitored to ensure it is "keeping its promises." U.S. Br. 56; *see* U.S. Br. 53-61. But the district court did not question Mississippi's integrity and even acknowledged that "the [state employees] that care for Mississippians suffering from [serious mental illness] should be recognized for their efforts to expand community-based care." ROA.3952. And the federal government largely ignores the federalism problems created by perpetual judicial oversight of an entire state system with no objective, workable criteria for ending that oversight.

ARGUMENT

I. The District Court Committed Reversible Error In Ruling That Mississippi Violated Title II Of The ADA.

The district court reversibly erred in ruling that Mississippi violated Title II. MS Br. 18-32. The court recognized that Mississippi's mental-health system complies with Title II "[o]n paper," ROA.3896.; *see* MS Br. 18-21, but then condemned the system statewide. As the State has explained, that systemwide liability ruling rests on grave legal errors. First, the court wrongly applied *Olmstead v. L.C.*, 527 U.S. 581 (1999)—a test erected to make *individualized* determinations of Title II violations against particular persons—to find a *systemwide* violation of Title II. MS Br. 21-25. Second, the court embraced the legally flawed theory that Title II imposes liability in the absence of actual institutionalization. MS Br. 25-29. And even if that at-risk-of-institutionalization theory were viable, the United States failed to establish liability under it. MS Br. 29-31. The United States' responses, U.S. Br. 28-44, are unavailing.

First, the United States makes several arguments why the district court was right to use *Olmstead*'s test to find systemwide liability. U.S. Br. 31-35; *see also* U.S. Br. 28-31. But that test by its design does not fit a systemwide claim. It is a three-factor test that accounts for the unique needs of *individuals* with serious mental illness ("persons with diverse mental disabilities") and the State's obligation to administer services with an "even hand." *Olmstead*, 527 U.S. at 597. In applying that individual-focused test on a systemwide basis, the district court failed to provide each Mississippian with serious mental illness the unique consideration for placement that the law requires. MS Br. 21-25.

The United States does not dispute that *Olmstead*'s test requires focus on the individual. It contends, however, that "the [district] court relied heavily and appropriately on the highly individualized evidence from the Clinical Review." U.S. Br. 32; *see also* U.S. Br. 29-33. But that review, which focused on only a sample of 154 out of 3,951 patients, ROA.4958-4960., cannot support a systemwide liability finding. The federal government suggests that this is a "representative sample" that is "generalizable" to the "entire population" of 3,951 patients. U.S. Br. 29, 33. But the federal government's need to use a "generalizable" approach—rather than one that actually assesses each person—is at odds with *Olmstead*'s individual-focused test. That test does not contemplate drawing inferences from statistical samples. It requires actual determinations by treatment professionals who are best situated to determine what is appropriate for an individual based on his or her needs. *E.g.*, *Olmstead*, 527 U.S. at 602 ("[T]he State generally may rely on the reasonable assessments of its own professionals in determining whether an individual [can be

placed in] a community-based program. Absent such qualification, it would be inappropriate to remove a patient from the more restrictive setting."). This approach makes sense. A placement that is proper for one individual patient may be detrimental to another.

The United States invokes generalized statements from the district court to argue that Mississippi has "cycle[d]" individuals with serious mental illness between the community and avoidable institutionalization. U.S. Br. 28 (capitalization and italics omitted), 34-35. But those capacious statements are not the individualized findings by treating physicians that *Olmstead* requires. And the federal government must rely on amorphous "cycling" because it failed to establish systemwide discrimination. The same is true of its suggestion that Mississippi has a "*de facto* policy" of "maintain[ing] a mental health system that is adequate on paper, but woefully deficient in practice." U.S. Br. 34. Without making a systemwide showing, the United States' claim fails as a matter of law.

The federal government characterizes the court's decision as "factual findings" of systemwide wrongdoing. U.S. Br. 33. But that does not salvage the judgment below. The liability ruling rests on a legal theory that is unsupportable. Where a "district court's findings rest on an erroneous view of the law, they may be set aside on that basis." *Pullman-Standard v. Swint*, 456 U.S. 273, 287 (1982).

Second, the United States resists (U.S. Br. 35-37) the State's argument that the district court wrongly "relied on non-treating experts hired by the United States" rather than (as *Olmstead* demands) "'the State's treatment professionals'" and their

determinations whether "'community placement is appropriate.'" MS Br. 22-23 (quoting *Olmstead*, 527 U.S. at 587); *see also* MS Br. 22-24, 29. This point fails.

The State's ability to rely on its own treating professionals is central to *Olmstead*. That test accounts not only for the needs of individuals with mental disabilities but also for the needs of the State and its "obligation to administer services with an even hand" to "persons with diverse mental disabilities." *Olmstead*, 527 U.S. at 597. Justice Kennedy recognized too that "[t]he opinion of a responsible treating physician in determining the appropriate conditions for treatment ought to be given the greatest of deference." *Id.* at 610 (Kennedy, J., concurring in judgment). The United States is thus wrong to suggest that "*Olmstead*'s language concerning 'the State's treatment professionals' is based on the particular circumstances of that case and was not central to the Court's holding." U.S. Br. 36 (quoting *Olmstead*, 527 U.S. at 597).

Having recognized that States require leeway to run a mental-health system, the Court explained that, "[c]onsistent with [Title II's] provisions, the State generally may rely on the reasonable assessments of its own professionals in determining whether an individual 'meets the essential eligibility requirements' for habilitation in a community-based program," and that "[a]bsent such qualification, it would be inappropriate to remove a patient from the more restrictive setting." *Olmstead*, 527 U.S. at 602; *see also id.* (citing *School Bd. of Nassau Cty. v. Arline*, 480 U.S. 273, 288 (1987), for the proposition that "courts normally should defer to the reasonable medical judgments of public health officials"). "It would be unreasonable, it would be a tragic event," as Justice Kennedy emphasized, "were the [ADA] to be

interpreted so that States had some incentive, for fear of litigation, to drive those in need of medical care and treatment out of appropriate care and into settings with too little assistance and supervision." *Olmstead*, 597 U.S. at 610 (Kennedy, J., concurring in judgment). Because *Olmstead* emphasized the importance of a State relying on its own treating physicians, the district-court decisions the United States invokes to support its view are wrong too. U.S. Br. 36-37 (citing cases); *cf. Martin v. Taft*, 222 F. Supp. 2d 940, 972 n.25 (S.D. Ohio 2002) (an *Olmstead* claim is adequately pleaded "either by pleading that the state's professionals have determined the plaintiffs are qualified for community-based care, or by pleading facts from which it may be inferred that the determinations of the state's professionals are manifestly unreasonable").

Even if a non-state treating physician's opinion were sufficient under *Olmstead,* the district court failed to abide by even this standard. MS Br. 24. The Clinical Review Team's experts based their determinations about placement on a review of medical records and interviews with the 154 participants in their survey. ROA.4771., ROA.4959-4960. Only two of the Clinical Review Team's members—Dr. Drake and Dr. VanderZwaag—were even physicians, ROA.3931-3932., ROA.4837., and those two physicians reviewed materials from only 35 of the 154 participants. ROA.4850-4851., ROA.5133. As a result, the remaining 119 survey participants did not even have their materials reviewed by any physician. And the vast majority of Mississippians with serious mental illness never met with the Clinical Review Team or indicated whether they welcomed or opposed community placement. ROA.4959-4960. Yet the Team then made sweeping conclusions about

all Mississippians with serious mental illness, despite no treating physician ever opining that an individual was improperly institutionalized. This was error. MS Br. 22-24.

Third, the United States contends that "the integration mandate does not protect only currently institutionalized persons" but extends to "the 'risk' of future institutionalization." U.S. Br. 37 (capitalization and italics omitted); *see also* U.S. Br. 37-42.

The United States makes the threshold claim that "the question whether the integration mandate encompasses risk of institutionalization is not even squarely presented." U.S. Br. 38; *see also* U.S. Br. 38-40. That is so, the United States says, because "[e]ach of the 154 people in the Clinical Review had already been admitted, at least once, to a Mississippi state hospital between October 2015 to October 2017, and 'all 154 would have avoided or spent less time in a state hospital' if they had access to reasonable community services." U.S. Br. 38 (quoting ROA.13005.). The United States suggests that the evidence provided for this sample, combined with the fact that other patients hospitalized during that time period "had already been admitted at least once before" or sometimes "multiple times," shows with "certainty" that "Mississippi *already* has subjected thousands of people with serious mental illness to avoidable institutionalization." U.S. Br. 39-40 (emphasis in original).

The United States failed to make the showing it now claims. It did not bring suit on behalf of the 154 patients from the Clinical Review Team's survey, let alone the remaining 3,797 patients who were hospitalized during the sample period and for whom the federal government produced no evidence of improper hospitalization.

The fact that some of those patients were hospitalized multiple times suggests, if anything, that Mississippi made efforts to incorporate those individuals into the community but that those efforts failed. In any event, the district court adopted the United States' theory about the risk of future institutionalization. *See, e.g.*, ROA.3903. ("The United States claims that ... all Mississippians with SMI are denied the most integrated setting in which to receive services, and are at serious risk of institutionalization."); ROA.3953-3954. ("That discrimination will end only when every Mississippian with SMI has access to a minimum bundle of community-based services that can stop the cycle of hospitalization.").

On the merits, the United States argues that the "at risk" theory is sound and that "Mississippi's argument is textually baseless." U.S. Br. 40; *see also* U.S. Br. 40-42. But Title II prohibits discrimination, not the prospect of discrimination. The statute prohibits individuals with disabilities from being "*excluded* from participation in" or being "*denied* the benefits of" "the services, programs, or activities of a public entity." 42 U.S.C. § 12132 (emphases added). The integration mandate requires a public entity to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d). And *Olmstead* recognizes that "unjustified *segregation* of persons with disabilities" is a form of discrimination. 527 U.S. at 600 (emphasis added; internal quotation marks omitted). It is thus actual "exclu[sion]" (42 U.S.C. § 12132), the actual failure to place someone in the proper "setting" (28 C.F.R. § 35.130(d)), and actual unjustified "segregation" (527 U.S. at 600) that the

law prohibits. The law does not bar the mere *risk* of those things. The at-risk-of-institutionalization theory—central to the judgment below—fails as a matter of law.

And because the statutory and regulatory text is clear, DOJ guidance embracing the at-risk theory (*see* U.S. Br. 41-42) adds nothing. There is no reason "to defer to agency guidance when the text of the ADA and the integration mandate are unambiguous on the point." *Waskul v. Washtenaw Cty. Cmty. Mental Health*, 979 F.3d 426, 469 (6th Cir. 2020) (Readler, J., concurring in part and dissenting in part) (citing *Kisor v. Wilkie*, 139 S. Ct. 2400, 2414 (2010), for the proposition that "the possibility of deference can arise only if a regulation is genuinely ambiguous"). And (as the State explained, MS Br. 27) *Olmstead* afforded deference to a different interpretation by DOJ through its issuance of the integration mandate, an interpretation that is consistent with the statutory text—and with the State's position here: "the Attorney General concluded that unjustified *placement or retention* of persons in institutions ... constitutes a form of discrimination based on disability prohibited by Title II." *Olmstead*, 527 U.S. at 596 (emphasis added).

Even courts that have adopted an at-risk theory have not extended it as the district court did here. The cases invoked by the United States have applied the theory to facial challenges to specific state policies that allegedly placed one or more individuals at risk of institutionalization. U.S. Br. 40-41. As the State has explained, MS Br. 27-28, *Fisher v. Oklahoma Health Care Auth.*, 335 F.3d 1175 (10th Cir. 2003), involved Oklahoma's policy capping prescription medications for participants in a Medicaid waiver program. *Id.* at 1177-78. And *Waskul v. Washtenaw Cty. Cmty. Mental Health* concerned a change in the method through

which the budget for plaintiffs' Community Living Support program was calculated that prevented them from receiving necessary services and support. *Waskul*, 979 F.3d at 436. The United States identifies no case applying the "at risk" theory where the State's policy is sound on its face. Instead, the United States now claims that Mississippi has a "*de facto* policy" of maintaining a "mental health system that is adequate on paper, but woefully deficient in practice." U.S. Br. 34. But that assertion just underscores that the United States' at-risk theory is legally untenable. The theory allows a finding of sweeping liability without any individualized findings that a treating physician's placement determination was overturned and where the overwhelming majority of patients were never consulted.

Fourth, the United States maintains that "the district court committed no factual error" in crediting the at-risk theory in this case. U.S. Br. 42 (capitalization and italics omitted); *see also* U.S. Br. 42-44. But the United States does not seriously dispute Mississippi's factual points. As Mississippi noted, the federal government's experts each had a different understanding of what "at risk" meant. MS Br. 29-30. The United States says that "all team members relied on Dr. Drake's literature review identifying risk factors for hospitalization." U.S. Br. 42. But it does not contest that its experts considered different factors in reaching their conclusions. And the fact that the federal government's own experts could not settle on an objective determination of when an individual is at risk drives home this theory's flaws. "Whether one is in fact institutionalized is a bright-line determination that can be fairly and uniformly applied by those who sit on the federal bench." *Waskul*, 979 F.3d at 470 (Readler, J., concurring in part and dissenting in part). But the at-risk

theory does not rest on "any textually articulated standards." *Id.* It is thus "a surefire recipe for unequal and unpredictable application of the law." *Id.*

Mississippi also explained that some individuals in the study who were found to be at risk of institutionalization were in fact functioning well in the community. MS Br. 30. The federal government says that "[t]he appropriate time for the State to contest those determinations was at trial." U.S. Br. 43. But the evidence at trial, cited in the State's opening brief, showed that the State did. *See* MS Br. 30. The district court also noted in its liability opinion that Mississippi argued that the evidence offered at trial was insufficient to support a conclusion that individuals were unnecessarily hospitalized. *See* ROA.3904. ("[T]he State argues that the United States has not proven that anyone was unnecessarily hospitalized."). And the record evidence shows that, for example, 71.7% of the 3,951 persons in the federal government's sample, had either zero or only one prior hospital admission. ROA.4984-4985.

Nor is the United States correct that "Mississippi's own experts did not offer opinions as to whether the individuals in the Clinical Review were likely to be re-hospitalized." U.S. Br. 43. Ted Lutterman, a state expert, testified that Mississippi has a lower hospital-readmission rate within 30 days of discharge and within 180 days of discharge than other southern States or the U.S. average. ROA.6201-6202. These lower readmission rates are inconsistent with the Clinical Review Team's conclusions regarding "at serious risk of institutionalization." And when people leave the Mississippi State Hospitals, Mr. Lutterman explained, the percentage of

them who remain in the community without readmission for the next six months is higher than elsewhere in the country. ROA.6202.

Finally, Mississippi pointed to Dr. Robert Drake's data showing that Programs of Assertive Community Treatment (PACT)—the expansion of which was the most significant change proposed by the United States—would reduce hospitalizations only 41% of the time. MS Br. 31. The United States does not dispute this evidence. Rather, it suggests that "the CRT determined that each of the 154 persons could have spent less time *or* avoided hospitalization." U.S. Br. 43 (emphasis in original). But again, the failure to point to any objective means to measure when an individual has been improperly institutionalized (or any record evidence showing such specificity for the 154 individuals) shows why *Olmstead's* test is individual-specific and requires determinations by treating physicians. The United States' expansive "could have spent less time or avoided hospitalization" standard is not in Title II, the integration mandate, or *Olmstead*. The *Olmstead* plurality warned against such expansiveness: "The State's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not boundless." 527 U.S. at 603 (plurality opinion).

The United States set out to prove systemwide discrimination. But to do that it advanced two legally untenable theories—that *Olmstead* can be used to show systemwide violations and that the risk of institutionalization is discrimination prohibited by Title II and the integration mandate. Both theories—which are central to the judgment below—fail as a matter of law. The judgment should be reversed.

II. The District Court Committed Reversible Error When It Rejected Mississippi's Fundamental-Alteration Defense.

The fundamental-alteration defense "allow[s] the State to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities." *Olmstead*, 527 U.S. at 604 (plurality opinion). As Mississippi has explained, the changes proposed by the federal government at trial and adopted by the district court required fundamental alterations. They required the State to expand Mississippi's mental-health system and appropriate enormous sums of money to do so. MS Br. 32-36. The district court erred in rejecting the defense. It should not have found the State liable. The federal government defends the district court's fundamental-alteration ruling, U.S. Br. 44-53, but its arguments fail.

First, the federal government contends that "[t]he United States proved at trial that there are three reasonable modifications Mississippi must make" to comply with Title II, yet "Mississippi asserts a fundamental alteration defense as to only part of a single (the first) modification." U.S. Br. 46; *see* U.S. Br. 46-47. That is wrong. The United States cites the liability opinion, ROA.3947-3951., but the district court did not rule (on those or any other pages of its opinion) that the United States proved that "there are three reasonable modifications Mississippi must make." The district court considered and deemed necessary only the first "modification[ ]" identified by the federal government in its brief—an expansion of community services. *See* ROA.3947. ("[T]he United States' experts showed that *providing community-based*

services can be reasonably accommodated within Mississippi's existing mental health system.") (emphasis added). Contrary to the United States' suggestion, the liability opinion did not require Mississippi to identify individuals with serious mental illness to minimize their placement in state hospitals, nor did it require the State to implement discharge policies or procedures to prevent readmission. U.S. Br. 46.

Second, the United States argues that Mississippi failed to show that providing the needed community-based services will be "inequitable for other persons with disabilities." U.S. Br. 47; *see also* U.S. Br. 44-49. But the district court ruled that a systemwide expansion would be needed because *all* Mississippians with serious mental illness were at unjustified risk of institutionalization. ROA.3953-3954. ("[D]iscrimination will end only when every Mississippian with SMI has access to a minimum bundle of community-based services that can stop the cycle of hospitalization."). Applying the fundamental-alteration defense here drives home why it is wrong to apply *Olmstead*'s individualized test on a systemwide basis: that approach fails to account for a State's interests when managing a mental-health system with limited resources. That the State was able to avoid inequitable treatment *and* make the proposed systemwide changes only through legislative appropriation proves this point.

To begin, when speaking of the fundamental-alteration defense, the *Olmstead* plurality makes clear that its ruling and corresponding test weigh *individual* patients' needs against the State's needs in running its mental-health system. 527 U.S. at 604 (plurality opinion). So the question whether "immediate relief" for certain persons

is inequitable depends on the allocation of "available resources" and a State's obligation to care for its full "population of persons with mental disabilities." *Id.* (plurality opinion). But the district court here (at the United States' request) ordered an expansion of the *entire* state system. That foreclosed the individualized determinations and comparisons needed to determine whether community-based treatment of some would come at the expense of others—the same comparisons the federal government now faults the State for "not even attempt[ing]" to show. U.S. Br. 47; *see also* U.S. Br. 49.

But the absence of such comparisons does not preclude the defense. Under the *Olmstead* plurality, the test is whether a State can reasonably accommodate individuals within the mental-health system as it now exists given the State's "allocation of available resources." 527 U.S. at 604 (plurality opinion); *see also id.* at 597 (Court's opinion) (explaining that, when considering a fundamental-alteration defense, the cost of providing community-care must be considered "in view of the resources available to the State"). Justice Kennedy also recognized that States must reasonably accommodate based on existing resources. He explained that "a State may not be forced to create a community-treatment program where none exists." *Id.* at 613 (Kennedy, J., concurring in judgment). Because the changes the district court found necessary required the State to significantly *expand* existing resources, the court was wrong to reject the defense.

Indeed, to implement that expansion, the State's Legislature needed to approve more funding, as the State told the district court would be necessary. ROA.3761-3764. Justice Kennedy cautioned against this in *Olmstead*. He noted: "Of

course, it is a quite different matter to say that a State without a program in place is required to create one. No State has unlimited resources, and each must make hard decisions on how much to allocate to treatment of diseases and disabilities." 527 U.S. at 612 (Kennedy, J., concurring in judgment). Just as it is improper to require a State to create new programs, it is improper to force it to significantly expand existing ones. Here, the district court improperly ruled that Mississippi needed to nearly double its existing PACT teams and Crisis Stabilization Units. MS Br. 33.

Justice Kennedy also cautioned that appropriating more money to treat those with mental illness may come at the expense of "programs directed to the treatment and care of other disabilities"—a "decision" that "may be unfortunate." 527 U.S. at 612 (Kennedy, J., concurring in judgment). And he rightly concluded that such a decision "is a political one and not within the reach of the statute. Grave constitutional concerns are raised when a federal court is given the authority to review the State's choices in basic matters such as establishing or declining to establish new programs." *Id.* at 612-13; *see infra* Part III.2 (discussing federalism concerns with requiring the appropriation of new money). Yet that is what the liability ruling forced on the State.

Third, the federal government suggests, like the district court, that the State's fundamental-alteration defense fails because "institutional and community care cost the system the same amount of money." U.S. Br. 47; *see also* U.S. Br. 47-49. But the *Olmstead* plurality rejected such reductive reasoning. MS Br. 35-36. "[A] comparison so simple overlooks costs the State cannot avoid; most notably, a 'State... may experience increased overall expenses by funding community

placements without being able to take advantage of the savings associated with the closure of institutions.'" 527 U.S. at 604 (plurality opinion) (quoting United States' amicus brief).

Fourth, the federal government argues that it is "fatal" to Mississippi's fundamental-alteration defense that "the remedial order, as to PACT and crisis stabilization units, simply requires Mississippi to maintain the service expansions it has purportedly made." U.S. Br. 49; *see also* U.S. Br. 49-51. That approach punishes the State for expanding its services. The district court rejected the defense at the liability stage before the State had made fundamental changes. ROA.3951. Voluntarily implementing changes deemed necessary does not alter the reality "that such changes required fundamentally altering the State's system, or that the district court was wrong to reject the defense at trial prior to the changes occurring." MS Br. 34. Whatever the remedial order says, it cannot overcome the district court's erroneous rejection of the defense at the liability stage. For the same reason, it is not "strange[ ]" that Mississippi "frames its fundamental alteration argument primarily in terms of what the United States *proposed*, rather than what the district court actually *ordered*." U.S. Br. 50 (emphasis in original); *see also* U.S. Br. 50-51. The district court's remedial order came two years after its liability determination and rejection of Mississippi's fundamental-alteration defense.

Fifth, the United States argues that Mississippi's fundamental-alteration defense fails because "under federal Medicaid requirements, the State was already required to make PACT and crisis stabilization services available statewide." U.S. Br. 51. But the federal government cites no Medicaid regulation, provision of the

State Plan, or other requirement indicating that this is so. It points to regulations requiring State *Plans* to be in operation statewide, U.S. Br. 15, but those regulations say nothing about the quantum of services that must be available in different parts of the State or the source of those services. The United States also cites the parties' stipulation that "Federal Medicaid regulations require services available through the Medicaid State Plan to be available statewide." ROA.3669.; *see* U.S. Br. 15, 51. But the parties' stipulation is best read to mean what that regulation actually says—that the services "will be in operation statewide through a system of local offices" (42 C.F.R. § 431.50(b)(1)), and that "statewide operation" does not mean "that every source of service must furnish the service State-wide" (*id.* § 431.50(c)(1)). Any other reading is clearly erroneous. And "[a] court is not bound by the parties' stipulations of law, particularly when those stipulations are erroneous." *King v. United States*, 641 F.2d 253, 258 (5th Cir. Unit B 1981).

Even accepting the federal government's Medicaid argument at face value, however, it fails. Whether or not Mississippi complied with its Medicaid obligations does not speak to whether drastically expanding its mental-health system is a fundamental alteration. If a State is not complying with Medicaid requirements, the federal government's remedy is to withhold future Medicaid payments until the violation is remedied. *See* 42 U.S.C. § 1396c. The federal government may not, however, force a State to radically alter its existing system, particularly where there has been no Medicaid claim asserted against Mississippi.

Sixth, and finally, the federal government challenges Mississippi's assertions of cost, claiming that the amount of money the State said would be required to make

the requisite changes was "factually baseless" and "unfounded." U.S. Br. 52. But Mississippi pointed to the trial record supporting those costs, MS Br. 33, and the district court did not dispute those numbers in its liability determination. ROA.3950. The federal government suggests that Medicaid reimbursements for individual patients would defray the cost of expanding the State's existing services. U.S. Br. 52-53. But that is speculative and will likely change year-to-year.

The district court erred in rejecting the fundamental-alteration defense.

III. The District Court Abused Its Discretion In Issuing The Remedial Order And Order Appointing A Monitor—Requiring Vacatur Of Both Orders.

If this Court upholds the district court's liability ruling, it should still vacate the district court's remedial order and its order appointing a monitor. MS Br. 36-48. The federal government resists that view, U.S. Br. 53-61, but its arguments fail.

1. The remedial order impermissibly expands the scope of what Mississippi was required to do after the State had implemented the changes to its system that the federal government had proposed and the district court had adopted. MS Br. 37-41. The federal government argues that the district court's injunction is "narrowly tailored," U.S. Br. 54, and "supported by the record," U.S. Br. 55 (capitalization and italics omitted). *See also* U.S. Br. 53-58. But the changes ordered by the district court were sweeping and unnecessary. Indeed, the federal government does not squarely dispute that Mississippi had put in place the additional services that were deemed necessary at trial. Although the United States claims that "[t]he single post-trial declaration provided by the State does not establish that Mississippi has actually remedied [its] Title II violation," U.S. Br. 55, it does not point to any specific state

service previously found necessary that has yet to be implemented. "If a durable remedy has been implemented, continued enforcement of [an] order is not only unnecessary, but improper." *Horne v. Flores*, 557 U.S. 433, 450 (2009).

Nor is the United States in any position to complain about the post-trial declaration now. The United States filed a motion for limited discovery or to strike the declaration, ROA.4132-4134., but then withdrew its motion during a status conference on June 4, 2021. ROA.37. (minute entry).

The federal government says that a judicially monitored state mental-health system is needed because the court must "ensure Mississippi is keeping its promises." U.S. Br. 56; *see also* U.S. Br. 53-54. But the district court did not question Mississippi's integrity and even acknowledged that "the [State employees] that care for Mississippians suffering from SMI should be recognized for their efforts to expand community-based care." ROA.3952. For the same reason, the federal government has it backwards in urging that continued monitoring is appropriate because discovery was closed in 2018 following Mississippi's request that "the remedy ordered in this case should be based on only the evidence admitted at trial and subject to the trial evidentiary cutoff." U.S. Br. 55-56 (cleaned up). As noted, the federal government moved to conduct "limited discovery" on "post-trial-developments," ROA.4132-4134., but withdrew its motion. ROA.37. (minute entry).

Nor does the United States seriously dispute that the district court expanded the scope of what it found at trial was needed to cure the violation. On the new additional Peer Support Services ordered, *see* MS Br. 41, the federal government says that "[i]t was well within the district court's discretion to order that

Mississippi ... make peer support services available statewide." U.S. Br. 56. But the United States does not deny that such a requirement was not deemed necessary at trial. And any expansion of the court's prior finding would be impermissible. *See M.D. by Stukenberg v. Abbott*, 907 F.3d 237, 272 (5th Cir. 2018) (district court may not order relief beyond minimum required to comport with the law).

The federal government's defense of paragraphs 12-28 of the remedial order, which do not even discuss community-based services, is that "[t]he court identified problems in each of [those] areas." U.S. Br. 57. But the district court's ruling spoke only to whether "community-based services can be reasonably accommodated within Mississippi's existing mental health system." ROA.3947. And the suggestion that these additional requirements "are substantially based on the changes that Mississippi reported to the court that it had made or planned to make," U.S. Br. 57, once again tries to hold Mississippi's good actions—which occurred after the liability determination had been made—against it. The suggestion is also inaccurate: the changes that Mississippi reported to the district court do not include the contents of paragraphs 13-28 of the remedial order. ROA.4122-4127.

2. The remedial order defies principles of federalism by usurping management of the State's mental-health system. MS Br. 41-45. The order allows the court (and the federal government) to commandeer Mississippi's system, insert itself into the system's day-to-day management, and impose costs on the State that have required and will continue to require legislative appropriation at the expense of other state services. MS Br. 41-44; *see supra* Part II (discussing the political nature of a court

requiring State appropriation of funds in the context of the fundamental-alteration defense).

The federal government contends that the remedial order does not offend federalism because it "defers to choices that Mississippi has made regarding its model of services and simply requires the State to follow through in practice." U.S. Br. 58. That the remedial order incorporates certain choices Mississippi voluntarily made to improve its system, however, does not cure its defects. Mississippi showed that no remedial relief is warranted. ROA.4122-4127. That Mississippi has significantly improved its system reinforces this point. And the federal government provides no sound response to the core federalism concern the order raises: the ongoing intervention of the district court, monitor, and United States in the daily management of the State's mental-health system. MS Br. 44-45.

3. The remedial order lacks objective criteria for its termination. MS Br. 45-46. It uses vague terms such as "substantial compliance" (without giving that term meaningful content) and requires that this compliance be "maintained ... for one year as determined by [the] Court." ROA.4316. The order also requires the State to invent new "fidelity" systems to measure its own progress, subject to the satisfaction of the monitor and the federal government. MS Br. 45-46. That the measures by which the State's compliance will be judged do not yet exist—even after the entry of the remedial order itself—illustrates that the order lacks objective criteria for termination. The federal government does not dispute these points. Rather, it repeats the order's generic terms, states that "temporary or technical non-compliance is not grounds for continued supervision," and suggests that requiring the State to invent

new fidelity scales "exemplifies ... the court's deference to the State." U.S. Br. 59-60. But despite suggesting that the remedial order's termination requirements are "clear," the federal government acknowledges that the order will only be terminated when "substantial compliance" is "determined by [the] Court." U.S. Br. 59 (capitalization and italics omitted).

4. Finally, the order appointing a monitor exacerbates the remedial order's defects. MS Br. 47-48. Without objective criteria for the remedial order's termination, the monitor and the United States are given indefinite, "full access to persons, employees, residences, facilities, buildings, programs, services, documents, records (including medical and other records in unredacted form), and any other materials necessary to assess the State's compliance with the Remedial Order." ROA.4319-4320.; *see also* MS Br. 47. The federal government suggests that this extraordinary grant of power, which the district court adopted verbatim from the federal government's proposal, ROA.4291., is fine because "such access shall be exercised 'in a manner that is reasonable and not unduly burdensome and upon reasonable notice.'" U.S. Br. 61 (quoting ROA.4320.). But a hollow suggestion that it will not unduly burden the State is cold comfort, particularly when the power is extraordinary.

CONCLUSION

This Court should reverse the judgment below and order judgment for Mississippi or, at the least, vacate the district court's remedial order and order appointing a monitor.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I, Justin L. Matheny, hereby certify that the foregoing brief has been filed with the Clerk of Court using the Court's electronic filing system, which sent notification of such filing to all counsel of record.

Dated: May 13, 2022.

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This brief complies with the word limitations of Fed. R. App. P. 32(a)(7)(B) because, excluding the parts of the document exempted by Fed. R. App. P. 32, it contains 6,460 words. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in proportionally-spaced typeface, including serifs, using Microsoft Word Version 2016, in Times New Roman 14-point font, except for footnotes, which have been prepared the same way except in 12-point font.

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