IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

UNITED STATES OF AMERICA,

Plaintiff-Appellee

v.

THE STATE OF MISSISSIPPI,

Defendant-Appellant

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI

BRIEF FOR THE UNITED STATES AS PLAINTIFF-APPELLEE

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STATEMENT REGARDING ORAL ARGUMENT

Given the importance of the issues presented, and the lengthy trial record, the United States respectfully requests that this case be set for oral argument.

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INTRODUCTION

In *Olmstead* v. *L.C.*, the Supreme Court held that "[u]njustified isolation * * * is properly regarded as discrimination based on disability." 527 U.S. 581, 597 (1999). Under Title II of the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. 12132, individuals with disabilities are entitled to care in the most integrated setting appropriate to their needs. For years, Mississippi has repeatedly and systematically denied that right to thousands of persons with serious mental illness by forcing them to receive care in state hospitals, rather than in the

communities where they live and work. Following a four-week bench trial in 2019, the district court made factual findings that, although "[o]n paper, Mississippi has a mental health system with an array of appropriate community-based services," it remains the case that "[i]n practice, * * * the mental health system is hospital-centered and has major gaps in its community care." ROA.3896. The court found that Mississippians with serious mental illness "are faced with a recurring cycle of hospitalizations, without adequate community-based services to stop the next commitment." ROA.3910. As the court rightly held, this recurring cycle of avoidable hospitalizations, without adequate access to appropriate community-based care, violates the ADA, 42 U.S.C. 12132. ROA.3945-3948.

This is a solvable problem. The district court correctly found that Mississippi can reasonably modify its existing mental-health system to increase the availability of community-based services and avoid the unnecessary institutionalization of people with serious mental illness. ROA.3933, 3947. Indeed, following the court's liability finding, Mississippi claimed to have addressed the ADA violation and expanded access to its community-based services. The court acted well within its discretion in entering injunctive relief by deferring to the compliance strategies that Mississippi itself selected and incorporating them into the remedial order. The court also acted appropriately in

appointing a Monitor to ensure that the State's expansion of its existing services will not merely be recorded on paper but experienced in practice by Mississippians with serious mental illness who otherwise would be needlessly institutionalized in state hospitals.

STATEMENT OF THE ISSUES

1. Whether the district court correctly concluded that Mississippi violated Title II of the ADA by failing to provide mental-health services to individuals with serious mental illness in the most integrated setting appropriate to their needs.

2. Whether the district court correctly rejected Mississippi's argument that expanding access to the State's existing community-based services would fundamentally alter its mental-health system.

3. Whether the district court properly exercised its discretion in granting injunctive relief and appointing a Monitor to ensure Mississippi's compliance with Title II of the ADA.

STATEMENT OF THE CASE

1. Statutory And Regulatory Framework

a. In enacting the ADA, Congress set out "a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. 12101(b)(1). Congress found that "society has tended to isolate and segregate individuals with disabilities" and that such segregation is a

form of discrimination that continues to be a "serious and pervasive social problem." 42 U.S.C. 12101(a)(2). It further found that such discrimination often exists in areas such as institutionalization, housing, public accommodations, health services, access to public services, and employment. 42 U.S.C. 12101(a)(3). Congress emphasized that "the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals." 42 U.S.C. 12101(a)(7).

Title II of the ADA prohibits discrimination by public entities: "[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. 12132.[1] Title II applies to all services, programs, and activities provided or made available by public entities, including through contractual, licensing, or other arrangements. 28 C.F.R. 35.130(b). A "public entity" includes "any State or local government," as well as any department, agency, or other instrumentality of a State or local government. 42 U.S.C. 12131(1)(A)-(B). Thus,

[1] Individuals with a mental illness that substantially limits one or more major life activities are covered by the ADA. 42 U.S.C. 12102(1)(A).

Title II prohibits Mississippi and its agencies from discriminating in the delivery of mental-health services.

Congress directed the Attorney General to promulgate regulations implementing Title II. 42 U.S.C. 12134. These regulations require public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. 35.130(d) ("the integration mandate"). The "most integrated setting" is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 C.F.R. Pt. 35, App. B, at 711 (2020). The regulations also require public entities to "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." 28 C.F.R. 35.130(b)(7).

b. In *Olmstead* v. *L.C.*, 527 U.S. 581 (1999), the Supreme Court held that, under Title II, "unjustified institutional isolation of persons with disabilities is a form of discrimination." *Id.* at 600. This holding "reflects two evident judgments." *Ibid.* First, "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." *Ibid.*

(citations omitted). Second, "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." *Id.* at 601.

The Court concluded in *Olmstead* that Title II and its regulations require States to provide services to people with disabilities "in the most integrated setting appropriate to [their] needs," unless the State successfully asserts a fundamental-alteration defense. 527 U.S. at 596, 599-600; *id.* at 607 (plurality opinion); see also 42 U.S.C. 12132; 28 C.F.R. 35.130(b)(7)(i) and (d). The Court explained that under Title II's integration mandate, individuals with disabilities are entitled to community-based services when (1) these services are appropriate to the needs of the individual, (2) the affected persons do not oppose community-based treatment, and (3) community-based services can reasonably be provided, taking into account the resources available to the public entity and the needs of other persons with disabilities. *Olmstead*, 527 U.S. at 607 (plurality opinion).

2. Procedural History

In 2011, the United States Department of Justice notified the State of Mississippi that its investigation showed that Mississippi was "unnecessarily institutionalizing persons with mental illness" in violation of the ADA's

integration mandate. ROA.2551-2584. After years of negotiations failed, the United States filed suit in 2016. ROA.49-79.

Fact-discovery ended in December 2018, and in June 2019, the district court presided over a four-week bench trial. The trial record includes: 345 stipulated facts, more than 400 exhibits, live testimony from 33 witnesses, deposition excerpts from 19 additional witnesses, and over 2500 pages of transcript. Based on this record, the court found in September 2019 that "Mississippi's system of care for adults with [serious mental illness] violates the integration mandate of the ADA." ROA.3948.

The district court did not immediately enter a remedial order. Instead, the court appointed a Special Master to assist the court and the parties in attempting to reach an agreed-upon remedy. ROA.4025-4027. No agreement was reached. In September 2021, the district court issued a remedial order and appointed a Monitor. ROA.4310-4320. With no objection from the United States, the district court issued a partial stay pending appeal. ROA.4357.

3. District Court Proceedings—Liability Phase

As the district court found after a bench trial, "[o]n paper" Mississippi has an adequate framework for providing community-based mental-health services to persons with serious mental illness. ROA.3896. But the reality tells an entirely different story.

a. Mississippi's Heavy Reliance On Segregated State Hospitals

The district court found that Mississippi's public mental-health system is "hospital-centered" (ROA.3896), and heavily reliant on four state hospitals, which, as the parties stipulated, "are institutional, segregated settings." ROA.3660 (Stip. ¶ 11). Patients in Mississippi's state hospitals do not voluntarily seek care there but instead are involuntarily committed by the State's chancery courts. ROA.3660 (Stip. ¶ 12); ROA.6930 (Trial). State hospitals are heavily regimented places where individuals cannot make basic choices about their daily activities or associations. ROA.13047. The "routine is determined by other people, and the food is determined by other people, and your privacy level is determined by other people." ROA.3925 (citation and brackets omitted). Numerous state hospital policies highlight the personal freedoms lost upon commitment: in-person visits and telephone calls are tightly controlled; patients wear armbands identifying their privilege levels, must earn back the privilege of wearing their wedding ring or a watch, and must undergo full body searches. ROA.3926; ROA.6013-6014 (Trial); ROA.13048.

While psychiatric inpatient hospitalization can provide necessary support under certain circumstances, these benefits come with significant risks. ROA.13048. Hospitalization can be traumatizing, as patients are involuntarily "[s]egregat[ed] away from [their] family, home, social network, and source of

income." ROA.13049. Patients described their experience of state hospitals as "very scary" with "no independence at all, no privacy" (ROA.3925 (citation omitted)), worse than homelessness (ROA.13051), akin to being in a "prison," and as "the most humiliating experience she had ever had in her life." ROA.5647 (Trial). In addition, as a Mississippian who struggled with mental illness and worked as a peer support counselor testified, being hospitalized can result in "los[ing] a lot of momentum" in your life, including losing an apartment or custody of children. ROA.5013 (Trial); see also ROA.3926 ("It particularly struck this Court that a single hospitalization can result in you losing custody of your children.").

Mississippi is an outlier among States in its degree of reliance on institutional mental-health care. ROA.3924-3925. The district court found that "Mississippi has relatively more hospital beds and a higher hospital bed utilization rate than most states." ROA.3923; see ROA.13063. In 2018, two Mississippi state hospitals added beds, and the director of a third testified that he intends to continue operating the same number of beds. ROA.3924. The State significantly prioritizes spending on institutional care over community-based services: in 2017, after excluding federal Medicaid dollars, only 35.65% of Mississippi's mental-health spending went to community-based services. ROA.3925. The court found that, compared to most States, Mississippi allocates a much larger share of its budget to

institutional care than to community-based services. ROA.3924-3925. The cost of running Mississippi's state hospitals is paid for nearly entirely through state dollars, because, unlike community-based mental-health services, state hospitals are generally ineligible for Medicaid reimbursement. ROA.3940 n.44; ROA.13065.

b. The Unavailability Of Mississippi's Community-Based Mental-Health Services

Mississippi has developed a set of community-based mental-health services that are necessary to prevent hospitalizations and effective in doing so. ROA.13052-13064 (Peet Report). The State offers these services primarily through 14 regional community mental health centers (CMHCs), which Mississippi's Department of Mental Health (DMH) is responsible for certifying, monitoring, and assisting. ROA.3910; ROA.3695 (Stips. ¶¶ 5, 7).

The evidence at trial focused on seven core community-based mental-health services that Mississippi has chosen to establish and which, if available, prevent unnecessary hospitalizations. As described below, however, the district court found that Mississippi has not actually made its community-based services available to many Mississippians with serious mental illness, who instead are needlessly hospitalized as a result. ROA.3910.

i. Programs Of Assertive Community Treatment (PACT)

PACT is Mississippi's most intensive community-based mental-health service for individuals with severe and persistent mental illnesses. ROA.3910-3911; ROA.3665 (Stips. ¶¶ 189-193). PACT teams include a psychiatric nurse practitioner or psychiatrist, nurses, community or peer support specialists, employment and housing specialists, therapists and program coordinators. ROA.3911.

The district court found that PACT was "unavailable and under-enrolled" in Mississippi, years after the State added the service to its Medicaid State Plan in 2012. ROA.3913; see ROA.11401. As of June 2018, PACT services did not exist in 68 of 82 counties, leaving approximately 58% of Mississippi's population without access to the service. ROA.3913; see ROA.13175 (counties without PACT); ROA.14717-14719 (population by county).

The district court further found that even in the 14 counties where PACT exists, "PACT teams are not operating at full capacity." ROA.3916. In 2018, just 384 individuals received PACT in Mississippi. ROA.3915, 3942. Many individuals with multiple state hospital admissions were discharged to counties without PACT or were discharged without being connected to PACT even where it was available. ROA.3913-3917; see ROA.13179, 13181.

ii. Mobile Crisis Teams

Mobile crisis teams provide support to individuals experiencing a mental-health crisis at home or other community locations and promptly connect them to community-based services. ROA.3911; ROA.3666 (Stips. ¶¶ 207-209).

The district court found that these teams are "illusory" in many parts of the State, despite being offered as a Medicaid service in Mississippi since 2012. ROA.3917; see ROA.3666 (Stip. ¶ 211); ROA.11395. Under DMH regulations, mobile crisis response services are required "to be available 24 hours a day, 7 days a week, 365 days a year." ROA.3911 (citation omitted). But there was insufficient capacity to provide timely, face-to-face service to individuals with serious mental illness, which led to avoidable state hospital admissions. See ROA.3917-3918; ROA.5595, 5604, 5611 (Trial); see also ROA.13177, 13182-13184.

iii. Crisis Stabilization Units

Crisis stabilization units are short-term residential services for individuals experiencing acute symptoms of mental illness, which help to stabilize individuals and prevent the need for hospitalization. ROA.3911; ROA.3666 (Stip. ¶ 212). But the district court found these units "are not available" in many parts of the State—a "missed opportunity" to prevent needless institutionalization because data from the State shows that "CSUs successfully divert a patient from a state hospital 91.85% of the time." ROA.3918-3919.

iv. Community Support Services

Community support services are mobile support services, including medication management and in-home supports. ROA.3912.

The evidence at trial showed that Mississippi does not provide community support services with sufficient intensity to help individuals with serious mental illness remain in the community. See, *e.g.*, ROA.21815, 21833-21835; ROA.21459-21461; ROA.21576 (CRT expert reports). Although Medicaid will reimburse up to 100 hours of community-support services per person, per year (ROA.3912), the district court found that there is a "gross underutilization" of these services in Mississippi. ROA.3943 (citing Peet testimony); see also ROA.13198.

v. Peer Support Services

Peer support services are provided by certified specialists who have lived experience with mental illness and can help people develop coping skills. ROA.3912; ROA.3668 (Stips. ¶¶ 251-252). Although the service has been included in Mississippi's Medicaid State Plan since 2012 (ROA.11397), the district court found "no indication that the service is being utilized across the State" and concluded that Medicaid billing for the service was "[s]hockingly" low in certain regions. ROA.3919; see, *e.g.*, ROA.4819 (Trial). In the three most populous

regions, CMHCs billed Medicaid for a *total* of 17 persons receiving peer support services in 2017. ROA.3919.

vi. Supported Employment

Supported employment helps adults with serious mental illness secure and maintain integrated, competitive-wage employment. ROA.3912; ROA.3667 (Stips. ¶¶ 227-228). The district court found that the availability of such services is "miniscule" in Mississippi. ROA.3919. One of the State's own experts admitted that access to supported employment in Mississippi is "quite low." ROA.3919, quoting ROA.6196. While DMH itself recognizes "employment can be an essential part of integration" and maintaining recovery (ROA.13047), only 257 individuals received supported employment services in 2018. ROA.3919; see ROA.6196, 6239 (Trial).

vii. Permanent Supported Housing

Permanent Supported Housing combines housing supports (including assistance locating an affordable, safe apartment and help negotiating with landlords) with access to integrated, affordable housing. ROA.3913; ROA.3667-3668 (Stips. ¶¶ 235-236).

Since 2016, the State has ostensibly provided permanent supported housing through the CHOICE housing program, which targets individuals with serious mental illness transitioning from state hospitals to the community. ROA.3913;

ROA.3667-3668 (Stip. ¶ 236). But the district court found that the CHOICE program is "grossly underutilized," and indeed, that only about 400 individuals have benefited from CHOICE, despite the State's estimate that it would need at least 2500 housing units. ROA.3920; see ROA.3668 (Stip. ¶ 250); ROA.13178.

The availability of supported housing is critical to "maintaining people in the community" and avoiding needless hospitalization. ROA.13056 (Peet Report). But as of 2018, CHOICE was provided in only about half of Mississippi's counties. ROA.13053, 13056; ROA.13178. During 2016-2018, seven CMHC regions each had fewer than five CHOICE enrollees. ROA.3920; ROA.13178. Rather than increasing referrals to CHOICE, state hospitals discharged some individuals to homelessness or homeless shelters. See, *e.g.*, ROA.8776, 8782, 8784.

* * *

Mississippi has chosen to include PACT, mobile crisis services, crisis stabilization, community support services, and peer support in its State Medicaid Plan. ROA.3669 (Stip. ¶ 266). "Federal Medicaid regulations require services available through the Medicaid State Plan to be available statewide." ROA.3669 (Stip. ¶ 265); see also 42 U.S.C. 1396a(a)(1) and (a)(8); 42 C.F.R. 435.930; 42 C.F.R. 431.50. The federal government pays approximately 75% of the cost of Medicaid services for Mississippians. ROA.3669 (Stip. ¶ 264); ROA.13065-13066

(Peet Report).[2] Most individuals admitted to state hospitals in Mississippi are eligible for Medicaid. ROA.3946 n.52.

c. Mississippi's Avoidable Hospitalization Of Individuals With Serious Mental Illness

The district court found that Mississippi systemically fails to provide services to Mississippians with serious mental illness in the most integrated setting appropriate to their needs. ROA.3945-3948; see also ROA.3899 (quoting Title II regulations).

Through a group of six experts (the Clinical Review Team or CRT),[3] the United States conducted a generalizable review of the 3951 individuals who were admitted to state hospitals at least once between October 2015 and October 2017. ROA.3931-3932. The review was generalizable in that its results are statistically representative of the entire population of persons who were hospitalized. ROA.4990. Dr. Todd MacKenzie, the United States' statistics expert, drew a representative sample of 299 individuals from this group for the CRT's use.

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[2] The Medicaid reiumbursement percentage for Mississippi has since risen to 84.5%. See Kaiser Fam. Found., *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier*, https://perma.cc/KBA8-QX8E.

[3] The district court described the CRT's experts at ROA.3931-3932 nn.24-29. Their sealed reports can be found at ROA.21310-21453 (Byrne Report); ROA.21455-21561 (VanderZwaag Report); ROA.21563-21812, 22336 (Baldwin Report); 21814-21938 (Drake Report); ROA.21940-22112 (Burson Report); ROA.22114-22237, 22338 (Bell-Shambley Report).

ROA.3932; ROA.4957-4960, 4970-4979 (Trial); ROA.13002-13004 (MacKenzie Report). Dr. Robert Drake, who led the CRT, created an interview tool that the CRT used to interview 154 of the 299 persons in the sample, in addition to reviewing their hospital and outpatient records and, where possible, interviewing family members and community-service providers. ROA.3932-3933; ROA.4845-4850 (Trial); ROA.21818-21819 (Drake Report). Twenty-eight individuals were in state hospitals when the CRT interviewed them in 2018. ROA.21815; ROA.13005, 13033. The CRT answered four questions for each individual:

> 1. Would this patient have avoided or spent less time in the hospital if reasonable community-based services had been available?
>
> 2. Is this patient at serious risk of further or future hospitalization in a state hospital?
>
> 3. Would this patient be opposed to receiving reasonable community-based services?
>
> 4. What community-based services are appropriate for and would benefit this patient?

ROA.3933; ROA.21814, 21817; see also ROA.4787-4793 (Trial).

First, the Clinical Review Team concluded that all 154 people would have avoided, or spent less time in, a state hospital if they had been provided reasonable community-based services. ROA.3933; ROA.4978 (Trial); ROA.13005 (MacKenzie Report). Second, the CRT found that of the 122 persons who were

not living in an institution during their interview, 103 of them (85%) were at serious risk of re-institutionalization. ROA.3933-3934; ROA.4790 (Trial).

Third, of the 150 persons who were still living, 149 were not opposed to receiving community-based care. ROA.3933; ROA.4790-4791 (Trial); ROA.13005 (MacKenzie Report). Finally, the fourth question solicited a description of the community-based mental-health services that the person would benefit from. ROA.3934; ROA.4792 (Trial). The CRT identified such services for these 154 individuals but found that most had not received community-based mental-health services from the State. ROA.3934-3937; ROA.4786, 4793 (Trial). The district court highlighted a number of representative findings on this question:

> Person 133, interviewed by Ms. Burson, had been admitted to a state hospital 16 times at the time of his interview. He has a work history and supportive family, and because of that support and desire to work, he would benefit from community-based services. Yet, Person 133 had never received community-based services. At the time of his interview, he was appropriate for and would have benefited from PACT, supported employment, peer support, and mobile crisis services. * * *
>
> Person 58, interviewed by Mr. Byrne, had been in and out of state hospitals five times over a two-year span at the time of her interview. Mr. Byrne testified that she was not receiving any community-based services between hospitalizations. At the time of her interview, she would have benefited from PACT and permanent supported housing. * * *
>
> Person 46 was interviewed by Dr. VanderZwaag at the [Mississippi State Hospital]. He had been admitted to the state hospital 18 times in the previous seven years and would have benefited from PACT—but had never received it. At the time of his interview, he was appropriate

> for and would have benefitted from PACT and permanent supported housing. * * *
>
> Person 108, interviewed by Dr. Baldwin, was 27 years old at the time of his interview but had been hospitalized eight times in the past nine years. He would have benefited from crisis services when his symptoms became acute, particularly because he had a good grasp of his own symptoms. Without such a service, he had to rely on hospitals. At the time of his interview he was appropriate for and would have benefitted from PACT, crisis stabilization, and community support services. * * *
>
> Person 132, interviewed by Ms. Burson, has a high school diploma, some college education, and a work history. He had been in state hospitals on three separate occasions. He was not receiving community-based services, but would have benefited from them because of his work history and desire to be active in the community. At the time of his interview, he was appropriate for PACT and supported employment.

ROA.3934-3936 (internal citations omitted) (highlighting additional examples). The court noted that the State's experts "offered no opinions as to why so many of the 154 [people] were without community-based services between hospitalizations." ROA.3937.

Indeed, just under half of the 3951 adults admitted to state hospitals between October 2015 and October 2017 had been admitted at least once *before* that period. ROA.13030 (MacKenzie Report). During the two-year sample period itself, many individuals were repeatedly hospitalized: 514 patients were admitted exactly twice, 147 patients had exactly three admissions, and 82 patients had four or more admissions. ROA.13028. Crediting expert testimony from Dr. Drake, the district

court found that this "process of 'cycling admissions' is 'the hallmark of a failed system.'" ROA.3910 (citation omitted).

d. District Court Findings Regarding Reasonable Modifications

The district court found that Mississippi could feasibly modify its existing system to address the problem of over-institutionalization. ROA.3947. The court credited the testimony of the United States' mental-health systems expert Melodie Peet that Mississippi had identified an adequate framework for community-based care but failed to actually implement that framework with sufficient capacity throughout the State. ROA.3941, 3943. Her testimony was supported by other experts for the United States. For example, these experts concluded that, of the 154 individuals in the clinical review population, 100 individuals were appropriate for and would benefit from PACT, but more than half of those individuals live in a county or region where PACT was not available as of June 30, 2018. ROA.3670 (Stips. ¶¶ 281-286); ROA.13179 (map showing PACT availability).

Beyond geographic unavailability, the district court identified other factors contributing to the low usage of community services to prevent needless institutionalization. For instance, the court found that one contributing reason is the "lack of data-driven management." ROA.3921. DMH executives "admitted that they do not regularly review data on community-services utilization," or even review rates of hospital readmission. ROA.3922. Further exacerbating the

problem, the court found, was the State's failure to engage in appropriate discharge and transition planning. ROA.3926. For example, in most cases state hospitals failed to connect patients with the services they needed upon discharge, instead simply informing people of a future appointment at a CMHC. ROA.3926-3927. In addition, it was common for state hospitals to use the same "formulaic" discharge plan after a patient had been repeatedly hospitalized, even though it was clear that "the discharge plan hadn't worked." ROA.3927 (citation omitted).

The district court found that the United States' experts had proven—and the State's experts did not refute—that "providing community-based services can be reasonably accommodated within Mississippi's existing mental health system," by addressing each of these deficiencies. ROA.3947. In making that finding, the court considered and rejected Mississippi's defense that requiring it to expand access to its existing community-based services would "fundamentally alter" its mental-health system. ROA.3948-3951 (citation omitted). In response to the State's claim that the cost of such an expansion is itself a fundamental alteration, the court noted that the State's own experts had testified that "institutional and community care cost the system the same amount of money." ROA.3947, 3950. Accordingly, the court concluded that when the evidence was considered under *Olmstead*'s standards, the United States had proved that Mississippi violated the ADA's integration mandate. ROA.3947-3948.

4. District Court Proceedings—Remedial Phase

After issuing its liability opinion in September 2019, the district court did not immediately order a remedy. Instead, "[m]indful of the size and 'complexity of this system, the progress that the State has made, and the need for any changes to be done in a patient-centered way that does not create further gaps in services for Mississippians'" (ROA.4024-4025 (citation omitted)), the court appointed a Special Master, Dr. Michael Hogan, to assist the court and parties in crafting a remedy. ROA.4025-4027. Dr. Hogan brought more than 40 years of experience in mental-health services, including 25 years spent leading statewide mental-health systems in Connecticut, Ohio, and New York. In 2002, President Bush appointed Dr. Hogan to chair a presidential commission on mental-health services. ROA.3965-3967. In defining the Special Master's role, "the Court largely adopt[ed] the State's proposed framework," under which no additional discovery would be taken. ROA.4026.

After a period of negotiation, the parties failed to reach an agreement. The district court ordered the parties to submit proposed remedial orders and asked the Special Master to address any points of disagreement, given "his vast experience and knowledge of mental health systems." ROA.4070.

Mississippi filed a report (ROA.4116-4121) describing its "current compliance actions and commitments regarding those matters," and declared that

no further relief was warranted because, as of April 2021, "Mississippi is now in substantial compliance with Title II of the ADA," and had addressed or would imminently address "the violations the United States alleged and the Court believed to exist." ROA.4102. Along with its report, Mississippi submitted a three and one-half page declaration from Wendy Bailey, its new DMH Executive Director, describing improvements that DMH purportedly had made since the district court issued its liability opinion. ROA.4122-4125.

The United States submitted its own proposed remedial plan (ROA.4148-4160), and the Special Master submitted a report addressing the parties' disagreements and recommending a remedial plan. ROA.4236-4258.

As the district court explained, the Special Master "recommend[ed] implementing the State's proposal regarding the services to be delivered, and the United States' proposal for how those services should be monitored." ROA.4277. The court adopted in full Dr. Hogan's recommendations, which it characterized as a "careful and modest proposal for achieving minimum compliance with the ADA." ROA.4278. The court stressed that its remedial order—which in substantial part simply requires the State to take actions it had identified to remedy its violation—"recognizes the primary role of the State in setting the standards to be achieved and then actually achieving them." ROA.4278-4279.

SUMMARY OF ARGUMENT

1. The district court correctly concluded that Mississippi violated Title II of the ADA by failing to provide mental-health services to individuals with serious mental illness in the most integrated setting appropriate to their needs. Through its experts on the Clinical Review Team, the United States showed that reasonable community-based services would have shortened or avoided hospitalization for "the entire population" of the 3951 persons institutionalized during a recent two-year period (ROA.4990; ROA.3931-3933) and that most persons would not oppose receiving such services. ROA.3933.

On appeal, Mississippi does not challenge the district court's repeated factual findings that the State's community-based services are largely unavailable "[i]n practice." ROA.3896, 3913, 3917, 3920. The State's failure to provide these services to the thousands of Mississippians with serious mental illness who need them to avoid unnecessary institutionalization violated Title II. ROA.3947; see *Olmstead* v. *L.C.*, 527 U.S. 581, 599-600 (1999).

To sidestep those findings, Mississippi makes three legal arguments. Each fails.

a. The district court did not improperly "extend[] *Olmstead*, which contemplates individual determinations, not systemwide claims." Br. 21. The court faithfully applied *Olmstead*'s framework, and relied heavily and

appropriately on the highly individualized evidence from the Clinical Review. ROA.3945-3948. The systemwide breakdowns that caused the State to relegate thousands of Mississippians with serious mental illness to avoidable institutionalization without meaningful access to community-based services make the State's violation of Title II more, not less, flagrant.

b. Mississippi contends that viable *Olmstead* claims must involve a determination made by the State's own treatment professionals that community-based care is appropriate. Br. 22-24, 29. But there is no basis for Mississippi's argument in either Title II's text or its regulations; *Olmstead* did not address whether the State's treating physicians are the only professionals who can make that determination; and courts have universally rejected the argument. Insistence on agreement from a State's own treating professionals would void the integration mandate, as the State's own employees would be the unreviewable judges of Title II compliance.

c. Mississippi is wrong in arguing that Title II protects only individuals who are "actual[ly] institutionaliz[ed]" and not also those "at risk" for future institutionalization. Br. 17, 25-29. Every court of appeals to address this issue has held otherwise. But, in any event, this legal argument is misplaced here, and the Court need not reach it. This case is not about the mere risk of institutionalization. The record demonstrates that Mississippi *already* has subjected thousands of

people with serious mental illness to avoidable institutionalization because of its failure to make sufficient community-based services available. ROA.3910-3931.

2. The district court also correctly rejected Mississippi's argument that it would constitute a fundamental alteration of its mental-health system to expand access to certain community-based services (PACT and crisis stabilization services) that the State has already chosen to provide. Following trial, Mississippi filed a declaration and accompanying report describing purported changes it had made (or planned to make) to improve its delivery of community-based services. The court's remedial order defers to the State's choices and simply requires that Mississippi actually do what it promised. Indeed, because Mississippi has for years included PACT and crisis stabilization services in its State Medicaid Plan, it had a pre-existing legal obligation to offer these services statewide.

3. The district court acted within its discretion when it granted injunctive relief and appointed a Monitor—particularly given the State's longstanding non-compliance with the ADA's integration mandate and the harms that its violations have inflicted. Again, the court's remedial order largely adopts as requirements changes that Mississippi volunteered to make after the court found the State liable. Finally, the court's appointment of a Monitor lies well within its discretion, as it ensures that the State's transition to compliance will be prompt and complete.

STANDARDS OF REVIEW

"The standard of review for a bench trial is well established: findings of fact are reviewed for clear error and legal issues are reviewed de novo." *Deloach Marine Servs., L.L.C.* v. *Marquette Transp. Co.*, 974 F.3d 601, 606 (5th Cir. 2020) (citation omitted). This Court "employ[s] a strong presumption that the court's findings must be sustained even though this court might have weighed the evidence differently." *Id.* at 607 (citation omitted). "The credibility determination of witnesses, including experts, is peculiarly within the province of the district court," and this Court "defer[s] to the findings and credibility choices trial courts make with respect to expert testimony." *LULAC #4552* v. *Roscoe Indep. Sch. Dist.*, 123 F.3d 843, 846 (5th Cir. 1997) (citations omitted).

An order granting "[i]njunctive relief is reviewed for an abuse of discretion." *Houston Chronicle Publ. Co.* v. *City League City*, 488 F.3d 613, 621 (5th Cir. 2007).

ARGUMENT

I

MISSISSIPPI VIOLATED TITLE II OF THE ADA

A. The District Court Correctly Found That Mississippi Violated Title II's Integration Mandate By Forcing Mississippians With Serious Mental Illness Into A Cycle Of Avoidable Institutionalizations

In *Olmstead* v. *L.C.*, the Supreme Court held that the "unjustified isolation" of individuals with disabilities in state institutions constitutes discrimination based on disability under Title II of the ADA. 527 U.S. 581, 597 (1999). As the Court observed, such "unjustified institutional isolation" both "perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life" and "severely diminishes [their] everyday life activities." *Id.* at 600-601.

Olmstead explains that, under the ADA, a State must provide community-based care for people with disabilities when (1) "such placement is appropriate," (2) "the affected persons do not oppose such treatment," and (3) "the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with [similar] disabilities." 527 U.S. at 607 (plurality opinion). The district court correctly found that the United States satisfied each of these elements in proving that Mississippi violated Title II.

As to the first element, the district court explained that "the treatment professionals on the CRT determined that the individuals they interviewed would be appropriate for community-based services." ROA.3946. The CRT found that all 154 persons would have avoided or spent less time in a state hospital if the State had provided reasonable community-based services. ROA.3933; ROA.13005 (MacKenzie Report). On appeal, Mississippi does not challenge this finding.

The importance of this finding is hard to overstate. The collective response to each Clinical Review question is "representative of the actual value were the entire population to be interviewed," *i.e.*, as if all 3951 persons hospitalized in the State from October 2015 to October 2017 had also been interviewed. ROA.13005-13006 (MacKenzie Report). As Dr. MacKenzie testified, the CRT showed that reasonable community-based services would have shortened or avoided hospitalization for "the entire population" of persons institutionalized during this time period. ROA.4990.

The United States thus proved, through a reliable, representative sample, that *thousands* of Mississippians committed to state hospitals during this two-year time frame could have shortened or avoided institutionalization had they received reasonable community-based services. ROA.3933; ROA.4982-4983, 4989-4990 (Trial). "[A] State may violate Title II when it refuses to provide an existing benefit to a disabled person that would enable that individual to live in a more

community integrated setting." *Radaszewski ex rel. Radaszewski* v. *Maram*, 383 F.3d 599, 609 (7th Cir. 2004).

The CRT further found that, of the 122 persons who were not hospitalized at the time of their interview, 103 (approximately 85%) were at serious risk of re-institutionalization. ROA.3933-3934; ROA.4982. As Dr. Drake testified, with an "absence of community services, * * * people are just at much greater risk for * * * ending up back in the hospital." ROA.4793; see also ROA.4801.

As to the second element, the district court properly relied on the Clinical Review's finding that 149 out of 150 patients did not oppose receiving services in the community. ROA.3933. And as to the third, the court found that Mississippi has established appropriate community-based services and could fulfill its Title II obligations if it actually provided these services to the thousands of Mississippians with serious mental illness who need them to avoid further unnecessary institutionalizations. ROA.3947.

The district court's *Olmstead* findings, viewed alongside its uncontested findings regarding the insufficient availability of community-based services (ROA.3910-3922), and the lack of data management and appropriate discharge planning (ROA.3921-3922, 3926-3927), amply support the court's determination that Mississippi violated Title II. See, *e.g.*, *Townsend* v. *Quasim*, 328 F.3d 511, 516-517 (9th Cir. 2003) (explaining that a State's "failure to provide Medicaid

services in a community-based setting" may be "a form of discrimination"); *Helen L.* v. *DiDario*, 46 F.3d 325, 337-339 (3d Cir. 1995) (holding that a State violated the integration mandate by not providing state-funded attendant care services in plaintiff's own home, rather than a nursing home).

B. Mississippi Cannot Show Any Legal Or Factual Error In The District Court's Conclusion That The State Violated Title II

Mississippi makes three legal arguments as well as a handful of factual claims, challenging the district court's conclusion that it violated Title II. Mississippi first argues that Title II *Olmstead* claims are limited to individual determinations, "not systemwide claims." Br. 21. Second, it contends that a court cannot find a violation of the integration mandate unless the State's own treating professionals have attested that individuals are being unjustifiably segregated. Br. 22-24. Third, it argues that Title II protects only individuals who are currently institutionalized, and not persons at serious risk of institutionalization. Br. 25-29. Finally, the State takes issue with the factual judgments of the United States' experts regarding the risk of re-institutionalization. Br. 29-31. Each of these arguments fails.

1. The District Court Properly Applied Olmstead*'s Framework*

Mississippi argues that "the district court improperly extended *Olmstead*, which contemplates individual determinations, not systemwide claims." Br. 21. Not so. The court faithfully applied the *Olmstead* framework to the record here.

ROA.3945-3948. In doing so, the court relied heavily and appropriately on the highly individualized evidence from the Clinical Review. That review provided both a person-by-person account—documenting the number of hospitalizations each person had, addressing whether they had received community-based services before or after hospitalization, and assessing which services would be appropriate—as well as a cumulative view of the State's failure to provide care in the most integrated setting appropriate. ROA.3946-3947; see ROA.21317-21441; ROA.21458-21549; ROA.21576-21797; ROA.21833-21835, 21848-21864; ROA.21944-21947, 21949-22100; ROA.22119-22227 (CRT expert reports).

With this evidence from the Clinical Review, the factual record documenting Mississippi's violation of the integration mandate is overwhelming and unmatched among *Olmstead* cases. The Clinical Review shows that thousands of Mississippians with serious mental illness have been repeatedly and avoidably institutionalized with no meaningful access to community-based mental-health services. Again, the CRT found that all 154 individuals interviewed could have avoided or shortened their hospitalizations with reasonable community-based services (ROA.3933; ROA.13005 (MacKenzie Report)); that most of these individuals had not received community-based services before or after their hospitalization (ROA.4786 (Trial)); and that approximately 85% of those living in the community remained at risk of re-institutionalization (ROA.13005). Dr.

MacKenzie explained that these findings are generalizable to the *entire population* of the 3951 people who had been committed to state hospitals between October 2015 and October 2017. ROA.13006 (MacKenzie Report); ROA.4977-4979 (Trial). Each of these individuals suffered an *Olmstead* violation. Mississippi's widespread violation of the integration mandate is incontrovertible. ROA.3926-3927, 3933-3937.

It is no answer to stress, as the State repeatedly does, that the district court acknowledged that "on paper" Mississippi had an adequate array of community-based services. Br. 2, 16, 19-20. The court followed that acknowledgment with repeated findings that Mississippi's community-based services are, in reality, "unavailable and underenrolled," "grossly underutilized," "illusory," and largely unavailable "[i]n practice." ROA.3896, 3913, 3917, 3920. Notably, the State challenges none of the court's extensive factual findings about this actual unavailability.

This case, regarding the repeated and unnecessary institutionalization of persons with serious mental illness, is in the heartland of discrimination prohibited under *Olmstead* and Title II's integration mandate. See *Townsend*, 328 F.3d at 516-517 (explaining that failure to allow the plaintiff to "receive the services for which he is qualified in a community-based, rather than nursing home, setting, * * * can prove that the [State] has violated Title II of the ADA"). "Segregation

from community-based services is not cured by the fact that the community-based services exist." *Steward* v. *Abbott*, 189 F. Supp. 3d 620, 633 (W.D. Tex. 2016).

Finally, the State's argument that it is somehow shielded from liability because this case does not challenge any one "specific policy" is meritless. Br. 26-29. Instead, the evidence shows that the State's systemwide failures have caused a "significant number of persons * * * [to] cycle repeatedly between their communities and hospitals, who could be served less restrictively with community-based services." ROA.3940 n.46. That the State's failings were pervasive makes its violation of the integration mandate *more*, not less, flagrant.

The reason this case does not turn on "one" single practice is that Mississippi's *de facto* policy has been to maintain a mental health system that is adequate on paper, but woefully deficient in practice. The district court correctly identified multiple causes of this "process of cycling admissions." ROA.3910 (citation and internal quotation marks omitted). When individuals are discharged from the hospital, "there is no follow-up or consistent connection to local services." ROA.3926. Moreover, state hospitals often used "the same discharge plan" even after an individual "returned for another commitment"—meaning, the discharge plan had failed. ROA.3927. In addition, "patients did not have access to medication upon discharge, which led to rehospitalization relatively quickly." ROA.3927 (citation and internal quotation marks omitted). Again, the State

contests none of these factual findings. And of course, the district court correctly identified the State's overarching failure: the descriptions of the services the State provides "do not match the reality of service delivery." ROA.3913. Based on the record before it, the court correctly concluded that the State has violated Title II by forcing Mississippians with serious mental illness into avoidable and repeated hospitalizations. ROA.3910.

2. Proof Of A Violation Of The ADA's Integration Mandate Does Not Depend On The Opinions Of The State's Own Treating Professionals

Second, citing the Supreme Court's reference to the "State's" treatment professionals, Mississippi argues that viable *Olmstead* claims must involve a determination made by the State's own treating professionals that community-based care is appropriate with respect to an individual who is currently institutionalized. Br. 22-24, 29 (citing 527 U.S. at 587). The *Olmstead* plaintiffs were two individuals—L.C. and E.W.—who continued to be held in a Georgia state hospital psychiatric unit after their treating physicians, who were employed by the State, had agreed they could receive appropriate services in the community. 527 U.S. at 593. According to Mississippi, the Supreme Court's holding in *Olmstead* is essentially limited to its facts. But courts have repeatedly and correctly rejected such arguments.

There is no basis for Mississippi's argument in the text of Title II or its regulations, neither of which require the testimony of particular kinds of witnesses

to prove a violation of the integration mandate. See 42 U.S.C. 12132; 28 C.F.R. 35.130(d). Mississippi's argument is drawn instead from language in the Supreme Court's decision in *Olmstead* that described the facts of those plaintiffs' situation, not the required elements of an ADA claim. See *Olmstead*, 527 U.S. at 593-594. "[T]he language of an opinion is not always to be parsed as though we were dealing with language of a statute." *Reiter* v. *Sonotone Corp.*, 442 U.S. 330, 341 (1979). *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, which is that unjustified segregation of people with disabilities violates Title II of the ADA. 527 U.S. at 597. This Court should "resist reading" a single qualifying word—namely, *Olmstead*'s reference to the "*State's*" treatment professionals—that was "unnecessary to the decision as having done so much work." *Arkansas Game & Fish Comm'n* v. *United States*, 568 U.S. 23, 35 (2012) ("[G]eneral expressions * * * ought not * * * control the judgment in a subsequent suit when the very point is presented for decision.") (citation omitted).

Indeed, lower courts "have universally rejected" the argument that a violation of Title II's integration mandate depends on the opinions of treatment professionals specifically employed by the State. *Day* v. *District of Columbia*, 894 F. Supp. 2d 1, 23-24 (D.D.C. 2012). Requiring a determination by the State's own treating professionals "would eviscerate the integration mandate" and "condemn

the placements of [individuals with disabilities] to the virtually unreviewable discretion" of the State. *Disability Advocates, Inc*. v. *Paterson*, 653 F. Supp. 2d 184, 258-259 (E.D.N.Y. 2009), vacated on other grounds *sub nom. Disability Advocates, Inc.* v. *New York Coal. for Quality Assisted Living, Inc.*, 675 F.3d 149 (2d Cir. 2012); accord *Long* v. *Benson*, No. 08-cv-0026, 2008 U.S. Dist. LEXIS 10991, at *6 (N.D. Fla. Oct. 14, 2008); *Frederick L.* v. *Department of Pub. Welfare*, 157 F. Supp. 2d 509, 539-540 (E.D. Pa. 2001).

Under Mississippi's logic, simply "by refusing to acknowledge that the individual could receive appropriate care in the community," a State could render the integration mandate "wholly illusory." *United States* v. *Georgia*, 461 F. Supp. 3d 1315, 1324 (N.D. Ga. 2020) (citation omitted). This Court should reject Mississippi's attempt to make its own employees the sole, and unreviewable, judges of the State's compliance with Title II's integration mandate.

3. The Integration Mandate Does Not Protect Only Currently Institutionalized Persons

Mississippi's further argument that Title II imposes liability based only on individuals' "actual institutionalization," and not on the "risk" of future institutionalization, is also meritless. Br. 17, 25-29. Title II's integration mandate is not limited to people who are currently institutionalized, but also protects people with disabilities who are at serious risk of segregation—as every court of appeals to squarely address the issue has decided. See *Davis* v. *Shah*, 821 F.3d 231, 263

(2d Cir. 2016); *Pashby* v. *Delia*, 709 F.3d 307, 321-322 (4th Cir. 2013); *Waskul* v. *Washtenaw Cnty. Cmty. Mental Health*, 979 F.3d 426, 460-461 (6th Cir. 2020); *M.R.* v. *Dreyfus*, 663 F.3d 1100, 1116-1117 (9th Cir. 2011), amended by 697 F.3d 706 (9th Cir. 2012); *Fisher* v. *Oklahoma Health Care Auth.*, 335 F.3d 1175, 1181 (10th Cir. 2003).

a. Here, however, the question whether the integration mandate encompasses risk of institutionalization is not even squarely presented. Each 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. ROA.13005 (MacKenzie Report); ROA.4788 (Trial). Moreover, the Clinical Review included 28 persons who were institutionalized *at the time* of their interview, and who the CRT found could have avoided or shortened their hospitalization if they had received appropriate community-based care before admission. See ROA.21815 (noting hospitalized interviewees); ROA.3933-3934 (noting 122 of 150 living persons not institutionalized when interviewed).

The Clinical Review thus makes clear exactly what the district court found—namely, that "Mississippians with [serious mental illness] are faced with a recurring cycle of hospitalization, without adequate community-based services to

stop the next commitment." ROA.3910. That conclusion is bolstered by the State's pattern of repeated institutionalizations generally. Nearly half of the 3951 persons admitted to state hospitals from October 2015 to October 2017 had already been admitted at least once before that time, and 743 of them were admitted multiple times during the two-year sample period. ROA.13028, 13030 (MacKenzie Report). This case is based on proof of unnecessary segregation that has already occurred, and will continue to occur, until the State's violation of the integration mandate is remedied.

As such, this case is factually distinct from the ones Mississippi cites regarding risk of future harm. See Br. 27-29. This case is not like *Fisher*, where Oklahoma's decision to cap the number of prescriptions for Medicaid participants threatened to force the plaintiffs into nursing care facilities to receive their needed medications. 335 F.3d at 1177-1178. Nor is this case like *M.R.* v. *Dreyfus*, where Washington State's cuts to the hours of personal care services for Medicaid beneficiaries threatened the plaintiffs with institutionalization to receive adequate care. 697 F.3d at 720. To be sure, the courts of appeals have uniformly and correctly held that these plaintiffs all had actionable Title II claims, but the harms here are more concrete and pervasive. We are far past the point of debating "risk." Here, there is certainty. Mississippi *already* has subjected thousands people with

serious mental illness to avoidable institutionalization because of its failure to make sufficient community-based services available. ROA.3910-3931.

b. Notwithstanding these glaring facts, if this Court reaches the question whether risk-of-institutionalization claims can be brought under Title II, the answer is yes.

Mississippi's assertion (Br. 25-29) that the integration mandate applies only to individuals who are currently institutionalized is at odds with the text and purpose of the ADA and its regulations. Title II protects "qualified individual[s] with a disability" from discrimination. 42 U.S.C. 12132. That prohibition contains no textual requirement demanding current institutionalization. Nor does Title II's definition of a "qualified individual with a disability" require institutionalization as a predicate for ADA protection. See 42 U.S.C. 12131(2). Likewise, "there is nothing in the plain language of the regulations that limits protection to persons who are currently institutionalized." *Fisher*, 335 F.3d at 1181. Instead, the integration regulation "simply states that public entities are to provide 'services, programs, and activities in the most integrated setting appropriate' for a qualified person with disabilities." *Ibid.* (quoting 28 C.F.R. 35.130(d)).

It is not surprising that Mississippi's argument is textually baseless. Requiring that individuals with serious mental illness undergo current, on-going institutionalization for the United States to bring a Title II claim would demand

that they suffer the very harm—unnecessary segregation—that the statute prohibits. As the Tenth Circuit has explained, the protections of 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." *Fisher*, 335 F.3d at 1181.

While it is true that the plaintiffs in *Olmstead* itself were institutionalized, "nothing in the *Olmstead* decision supports a conclusion that institutionalization is a prerequisite to enforcement of the ADA's integration requirements." *Fisher*, 335 F.3d at 1181. The Supreme Court stated that unjustified institutionalization constitutes discrimination because:

> In order to receive needed medical services, persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice.

Olmstead, 527 U.S. at 601; see also *Waskul*, 979 F.3d at 460 (recognizing that prohibited discrimination occurs before institutionalization). For these reasons, the Department of Justice issued guidance in 2011 stating that "[i]ndividuals need not wait until the harm of institutionalization or segregation occurs or is imminent" to bring a Title II claim. U.S. Dep't 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., https://www.ada.gov/olmstead/q&a_olmstead.htm (last updated Feb. 25, 2020). See *Olmstead*, 527 U.S. at 597-598 ("Because the Department is the agency directed by Congress to issue Title II regulations, its views warrant respect.").

Mississippi's "current institutionalization" argument is at odds with the text of the statute, the regulations, *Olmstead*, and indeed, the actual facts of this case. This Court should reject it.

4. The District Court Committed No Factual Error

Mississippi's claims that the district court made factual errors undermining its liability determination likewise are meritless. Br. 29-31.

First, contrary to the State's argument that CRT members used no common definition of risk, all team members relied on Dr. Drake's literature review identifying risk factors for hospitalization. ROA.21317; ROA.21457; ROA.21571-21572; ROA.21942; ROA.22117; see ROA.8037-8040 (literature review). Moreover, the team conducted many interviews in pairs or groups, with interviewers sharing ratings, to ensure consistency in the findings. ROA.21819.

Second, the State asks this Court to second-guess determinations of the United States' experts that particular individuals in the Clinical Review were at

serious risk of re-hospitalization.[4] The appropriate time for the State to contest those determinations was at trial. But Mississippi's own experts did not offer opinions as to whether the individuals in the Clinical Review were likely to be re-hospitalized. Instead, as the district court found, they "limited their review to the hospitalizations of the past." ROA.3947. This Court should reject Mississippi's invitation to serve as appellate factfinder.

Finally, Mississippi claims that because a study that Dr. Drake cited shows that PACT reduces hospitalizations by 41%, the United States' experts should have been "constrain[ed] * * * from claiming that community-based services are 100% effective at reducing hospitalization in Mississippi." Br. 31. But the United States' experts never claimed that all hospitalizations could be avoided. Instead, based on individual interviews and review of medical records, the CRT determined that each of the 154 persons could have spent less time *or* avoided hospitalization, and that determination rested not just on PACT but on the use of other reasonable

[4] Compare, *e.g.*, Br. 30 (noting that Person 4 was "living independently in his apartment, was receiving social security benefits, and was managing his own funds"), with ROA.22136-22139 (Bell-Shambley Report) (noting that Person 4 (ROA.21305) has been diagnosed with "schizophrenia-chronic," has been hospitalized at least four times, was "isolated" and "fearful" during the interview, and was not receiving appropriate medication monitoring such that "[n]oncompliance with psychotropic medication is a significant risk factor for re-hospitalization").

community-based services as well. ROA.3946-3947 & n.53; ROA.21823-21828 (Drake Report). That conclusion is well-supported by the evidence.

* * *

Mississippi has failed to show that the district court committed any legal or factual error in concluding that the State violated Title II of the ADA.

II

THE DISTRICT COURT CORRECTLY REJECTED MISSISSIPPI'S ASSERTION OF A FUNDAMENTAL ALTERATION DEFENSE

Mississippi can show neither factual nor legal error either in the district court's assessment that the State can take reasonable steps to make its community-based services actually available or in the court's rejection of the State's fundamental alteration defense. ROA.3947-3951.

A. Mississippi Must Make Reasonable Modifications Unless Doing So Would Result In Inequitable Treatment Of Other People With Disabilities

Under Title II's reasonable modification regulation, "[a] public entity *shall make* reasonable modifications * * * necessary to avoid discrimination on the basis of disability, unless *the public entity can demonstrate* that making the modifications would fundamentally alter the nature of the service, program, or activity." 28 C.F.R. 35.130(b)(7)(i) (emphases added). Under this regulation, a State does not violate the integration mandate if it proves, as an affirmative

defense, that the requested modifications would "fundamentally alter" its service system. 28 C.F.R. 35.130(b)(7)(i).

The Supreme Court has instructed that "[i]n evaluating a State's fundamental-alteration defense," courts must consider, "in view of the resources available to the State, not only the cost of providing community-based care to the litigants, but also the range of services the State provides others with mental disabilities, and the State's obligation to mete out those services equitably." *Olmstead* v. *L.C.*, 527 U.S. 581, 597 (1999). As an affirmative defense, the burden of proof is on the State. *Brown* v. *District of Columbia*, 928 F.3d 1070, 1077 (D.C. Cir. 2019); *Steimel* v. *Wernert*, 823 F.3d 902, 914-916 (7th Cir. 2016); *Townsend* v. *Quasim*, 328 F.3d 511, 517 (9th Cir. 2003).

A plurality of the *Olmstead* Court discussed two ways that a State can establish a fundamental alteration defense. First, a State can show that it has a "comprehensive, effectively working plan for placing qualified persons with * * * disabilities in less restrictive settings." 527 U.S. at 605-606. Where a State demonstrates that it has an effective and comprehensive "*Olmstead* Plan" in place, and that the requested modification would disrupt implementation of that plan, the State has proven the defense. *Frederick L.* v. *Department of Pub. Welfare*, 422 F.3d 151, 157 (3d Cir. 2005). Second, the State can 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 * * * disabilities." *Olmstead*, 527 U.S. at 604. When a State does not have an adequate *Olmstead* Plan in place, it "*must* make" responsive modifications "*unless* the modification would be so costly as to require an unreasonable transfer of the State's limited resources away from other * * * individuals [with disabilities]." *Brown*, 928 F.3d at 1078.

The United States proved at trial that there are three reasonable modifications Mississippi must make to its existing service design and administration to prevent unnecessary hospitalizations: (1) expanding existing community mental-health services that prevent hospitalization to ensure that those services are available statewide; (2) identifying eligible adults with serious mental illness who need community-based services to connect them with those services so they can avoid entering state hospitals; and (3) implementing effective discharge planning and diversion practices to prevent readmissions. The district court analyzed the three modifications taken together and correctly found that they would cause no fundamental alteration. ROA.3947-3951.

B. Mississippi Failed To Establish A Fundamental Alteration Defense

On appeal, Mississippi asserts a fundamental alteration defense as to only part of a single (the first) modification—namely, "the number of PACT teams, and

Crisis Stabilization Units needed." Br. 17, 32. The record establishes that the district court correctly rejected the defense.

1. First, the district court correctly found that Mississippi did not have a comprehensive, effectively working *Olmstead* Plan in place. ROA.3948-3949. In so finding, the court relied on the testimony of a senior DMH official that "he had never seen an *Olmstead* plan at DMH * * * [and] that, even if he had, it would be 'useless.'" ROA.3948-3949 (citation omitted). The court emphasized that a "scattered, ineffective assemblage" of routine budget and planning documents cannot constitute an *Olmstead* Plan for purposes of the affirmative defense. ROA.3950. The court's finding that Mississippi does not have an *Olmstead* Plan is well-supported by the evidence and unchallenged on appeal.

Because Mississippi has no *Olmstead* Plan, it must show that it would be inequitable for other persons with disabilities if the State expanded PACT and crisis stabilization services. *Brown*, 928 F.3d at 1078. But Mississippi does not even attempt to make that showing. Instead, the State argues that it is entitled to this defense simply because it is costly to "drastically expand the services * * * it was offering." Br. 34.

Mississippi's argument is factually rebutted by its own experts, who testified that "institutional and community care cost the system the same amount of money." ROA.3947, 3950. And, in any event, cost alone is not the test for the

defense. "Though clearly relevant, budgetary constraints alone are insufficient to establish a fundamental alteration defense." *Pennsylvania Prot. & Advocacy, Inc.* v. *Pennsylvania Dep't of Pub. Welfare*, 402 F.3d 374, 380 (3d Cir. 2005).

As the Tenth Circuit explained, in "passing the ADA, Congress was clearly aware that 'while the integration of people with disabilities will sometimes involve substantial short-term burdens, both financial and administrative, the long-range effects of integration will benefit society as a whole.'" *Fisher* v. *Oklahoma Health Care Auth.*, 335 F.3d 1175, 1183 (10th Cir. 2003) (alteration omitted) (quoting H.R. Rep. No. 485, 101st Cong., 2d. Sess. pt.3, at 50 (1990)). If every expansion of services "that required the outlay of funds were tantamount to a fundamental alteration, the ADA's integration mandate would be hollow indeed." *Ibid.* Nor can it be the case that the farther away a State is from compliance, the stronger its fundamental alteration defense—simply because more "drastic[]" steps (Br. 34) and costly changes obviously will be required.

Instead, the *Olmstead* plurality instructs that costs should be considered in the context of whether granting relief to 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." 527 U.S. at 604. Justice Kennedy's concurrence likewise emphasizes that because "[n]o State has unlimited resources, and each must make hard decisions on how much [money] to allocate to

treatment" for people with disabilities, it would be unreasonable to read the ADA to require the reduction of services to some people with disabilities to support "the treatment and care of other disabilities." *Id.* at 612.

On appeal, Mississippi does not even attempt to argue that providing community-based services as required under the remedial order will cause "inequitable treatment" of other persons with disabilities. That void is fatal to its fundamental alteration defense.

2. Second, and also fatal, is the fact that the remedial order, as to PACT and crisis stabilization units, simply requires Mississippi to maintain the service expansions it has purportedly made (and, as discussed below, that it had an independent legal obligation under Medicaid to make). Compare ROA.4117-4118 (Mississippi's post-trial actions with respect to PACT and crisis stabilization), with ROA.4311 (remedial order).

After the district court issued its liability opinion, Mississippi made its own decisions about how to expand PACT and crisis stabilization services, and purportedly implemented those changes without awaiting a remedial order. ROA.4122-4125. While the United States had proposed that the State maintain PACT teams and crisis stabilization units in each region, the Special Master deferred to the strategies that Mississippi had purportedly implemented, and the district court adopted his recommendations. ROA.4311.

Strangely, the State frames its fundamental alteration argument primarily in terms of what the United States *proposed*, rather than what the district court actually *ordered*. Contrary to the implication in the State's brief, the district court did *not* require the State to "add 6 new PACT teams to have a PACT in every Region." Br. 33. Instead, the court (like the Special Master) adopted Mississippi's *own* plan (ROA.4117) that it add just two PACT teams to the existing eight teams, and then use two alternative models of providing PACT-type services statewide—mini-PACT teams called ICORTs in smaller communities, and solo, mobile clinicians called Intensive Community Support Specialists (ICSS)—in rural areas. ROA.4240; ROA.4311.

Likewise, the district court did *not* require the State to "add 6 Crisis Stabilization Units to have one in each Region." Br. 33. Instead, as the Special Master recommended, the court adopted the State's plan (ROA.4118) to provide crisis services "in all regions except Region 11 (where the State commits to develop and sustain a program) and Region 15, where the State proposes to provide access to Crisis Residential Services in neighboring Regions." ROA.4243; see ROA.4311.

Courts rightly have found that modifications expanding existing services are reasonable (and not a fundamental alteration), particularly when the modifications align with the jurisdiction's own stated plans and obligations. See, *e.g.*, *Haddad* v.

Arnold, 784 F. Supp. 2d 1284, 1304-1305 (M.D. Fla. 2010) (providing a service already in State's service system to additional individuals is not a fundamental alteration); *Messier* v. *Southbury Training Sch.*, 562 F. Supp. 2d 294, 344-345 (D. Conn. 2008) (requested service expansion, consistent with defendants' publicly stated plans, was reasonable). That the district court adopted and incorporated into its remedial order the changes that the State itself had previously chosen weighs strongly against finding a fundamental alteration.

3. The third reason that Mississippi's fundamental alteration defense fails is that under federal Medicaid requirements, the State was already required to make PACT and crisis stabilization services available statewide. For years, Mississippi included both PACT and crisis stabilization services in its Medicaid State Plan but offered those services in only some parts of the State. ROA.3669 (Stip. ¶ 266). But when a State includes services in its Medicaid State Plan, it must ensure that those services are available with reasonable promptness to all individuals statewide who meet its Medicaid eligibility criteria. See p. 15, *supra*. The expansion of these services required by the remedial order simply ensures that Mississippi complies with existing federal Medicaid requirements, and therefore cannot constitute a fundamental alteration. Cf. *Henrietta D.* v. *Bloomberg*, 331 F.3d 261, 280-281 (2d Cir. 2003) (upholding as a reasonable modification an order requiring an agency to follow existing law and procedures).

4. Finally, Mississippi is wrong to challenge the district court's consideration of cost in its fundamental alteration analysis. Contrary to its argument, the court did not "merely compare the cost of institutionalization against the cost of community-based health services." Br. 35 (citation omitted). To be sure, the court did note that the State's own experts had concluded that hospitalization and community-based services cost approximately the same. ROA.3950. But the court made this point in the course of correctly rejecting an argument by the State's attorneys "that the cost of community-based services is itself a fundamental alteration." ROA.3950; see p. 47, *supra*.

Mississippi's arguments (Br. 33) about the costs of expanding PACT and crisis stabilization are also factually baseless. Its claim that it would cost $600,000 annually, in perpetuity, in state dollars to fund each new PACT team is unfounded. Br. 33. The only support Mississippi provides for this claim is the parties' stipulated fact that DMH has, in the past, provided annual state grant funding in that amount to each PACT team. ROA.3666.

But Mississippi's assertion ignores federal Medicaid funds, which will reimburse more than 75% (now 84.5%) of the PACT costs for each participating beneficiary. ROA.3669 (Stips. ¶¶ 264, 266). The district court found that Mississippi fails to use available federal funds because it underutilizes Medicaid billing. ROA.3943. In 2017, only 163 of the 387 individuals who received PACT

services in Mississippi had those costs reimbursed through Medicaid, even though nearly all individuals receiving PACT are Medicaid-eligible. ROA.3946 n.52; ROA.13187. Thus, the State's claim that it will cost $600,000 annually in state dollars to fund each PACT team wrongly ignores the uncontested evidence that the State leaves untapped the federal Medicaid dollars to which Mississippians are entitled.[5] The same is true for Mississippi's argument about the cost to expand crisis stabilization services (Br. 33), which likewise does not account for the fact that Medicaid funding is available for these services. ROA.3667 (Stip. ¶ 226).

In sum, Mississippi has failed to establish that the district court erred in rejecting its fundamental alteration defense.

III

THE DISTRICT COURT PROPERLY EXERCISED ITS BROAD DISCRETION TO ENTER INJUNCTIVE RELIEF

Finally, Mississippi has failed to show that the district court abused its discretion by awarding injunctive relief and appointing a Monitor, particularly given the State's longstanding non-compliance with the ADA's integration mandate and the harms its failure has inflicted on Mississippians with serious mental illness. Instead, the court's remedial order simply ensures that Mississippi

[5] In addition, the State's argument also ignores the fact that one of its own witnesses testified at trial that PACT teams have not always used all of their annual DMH grant funding. See ROA.6310-6311.

will be bound by the commitments the State purports to have made after the court found liability.

A. The Remedial Order Appropriately Defers To Compliance Choices Made By The State

"It is axiomatic that 'federal courts must vigilantly enforce federal law and must not hesitate in awarding necessary relief.'" *M.D.* v. *Abbott*, 907 F.3d 237, 271 (5th Cir. 2018) (quoting *Horne* v. *Flores*, 557 U.S. 433, 450 (2009)). In ADA cases, this responsibility includes ordering injunctive relief where appropriate. 42 U.S.C. 12133 (incorporating "[t]he remedies, procedures, and rights" of Section 504 of the Rehabilitation Act of 1973). Injunctions must be "narrowly tailored . . . to remedy the specific action which gives rise to the order." *M.D.*, 907 F.3d at 272 (citation and brackets omitted; alteration in original); see also *John Doe #1* v. *Veneman*, 380 F.3d 807, 818 (5th Cir. 2004). Injunctive relief may also appropriately seek to "prevent repetition of the violation * * * by commanding measures that safeguard against recurrence." *Ruiz* v. *Estelle*, 679 F.2d 1115, 1156 (5th Cir. 1982).

Here, the district court was keenly aware of the dangers of inserting the judiciary into the administration of Mississippi's mental-health system and issued an injunction narrowly tailored to addressing the specific causes of the State's Title II violation. ROA.3953. The remedy is structured around commitments that Mississippi chose, which the court then incorporated into its remedial order. The

court deferred as much as possible (indeed, more than the United States thought advisable) to the State's own choices as to how to comply with its ADA obligations. For the reasons discussed below, the State cannot show that the court abused its discretion in crafting the remedy here.

1. The District Court's Exercise Of Discretion In Entering Injunctive Relief Is Amply Supported By The Record

Mississippi argues (Br. 37) that the district court should not have entered any injunctive relief simply because, in April 2021, years after the close of discovery and trial, it submitted to the court a three-and-one-half page declaration (and accompanying report) asserting that it has now actually made community-based mental-health services available statewide. ROA.4116-4125. Of course, the district court's central finding is that "[o]n paper" Mississippi has a mental-health system with an array of appropriate community-based services, but "[i]n practice * * * the mental health system is hospital-centered and has major gaps in community care" that result in a system that "excludes adults with SMI from full integration into the communities in which they live and work, in violation of the [ADA]." ROA.3896-3897. The single post-trial declaration provided by the State does not establish that Mississippi has actually remedied that Title II violation.

Discovery has been closed since December 31, 2018. Indeed, Mississippi specifically urged that "[d]iscovery * * * should not be reopened" for remedial proceedings, and that "[t]he remedy ordered in this case should be based on only

the evidence admitted at trial and subject to the trial evidentiary cutoff." ROA.3993-3994. Mississippi's general assurances of compliance are unsubstantiated by facts tested through the adversarial process and cannot obviate the need for injunctive relief to ensure actual compliance in the face of the State's record of widespread *Olmstead* violations.

As the district court emphasized, curing the violation in this case depends on what happens in practice, not just "[o]n paper." ROA.3896-3897. The State's meager post-trial submission says nothing about whether Mississippians with serious mental illness are actually receiving community-based services. The court's remedial order is entirely appropriate because it defers to Mississippi's chosen models of service delivery and then requires a brief period of monitoring to ensure Mississippi is keeping its promises.

Nor is there merit to Mississippi's claim that the remedial order exceeds the scope of the proven violation. The State points, first, to the remedial order's requirement that it provide peer support services at satellite and main CMCH offices. Br. 41. The evidence at trial showed the effectiveness of peer support services, which Mississippi has chosen to offer. ROA.4818-4819 (Trial); ROA.21827-21828 (Drake Report). It was well within the district court's discretion to order that Mississippi provide those at *all* CMHC offices that are open five days per week to make peer support services available statewide.

Likewise, Mississippi's assertion that the remedial order "exceeds what is required to comply with Title II" because of paragraphs 12-28, which "do not discuss core community-based services," is also incorrect. Br. 41. Paragraphs 12-28 of the remedial order address medication access, diversion from state hospitals, discharge planning, technical assistance, data collection, and monitoring. The court identified problems in each of these areas. ROA.3921-3922, 3937, 3943. With the exception of implementation and monitoring, these paragraphs' requirements are substantially based on the changes that Mississippi reported to the court that it had made or planned to make. The remedial order simply requires Mississippi to do what it has said it will do and to sustain compliance over time.[6]

As the district court reasonably concluded, in a case whose long history shows that the State's "movement toward community-based services has only

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[6] Paragraph 12 of the remedial order (ROA.4313) concerns funding for medication access and is materially similar to paragraph 35 of State's report (ROA.4121), except that the court required funding on an ongoing, rather than two-year, basis. Paragraph 13 (ROA.4314) concerns diversion from state hospitals and is materially similar to paragraphs 28-29 of the State's report (ROA.4119-4120). Paragraph 14 (ROA.4314) concerns connecting the individuals in the United States' Clinical Review to care and is materially similar to paragraphs 30-31 in the State's report (ROA.4120). Paragraphs 15-17 (ROA.4314) concern discharge planning and are materially similar to paragraphs 32-34 of the State's report (ROA.4120-4121). Paragraphs 18-19 (ROA.4315) concern technical assistance to chancery courts and mental-health providers and are materially similar to paragraphs 36-37 of the State's report (ROA.4121). Paragraphs 20-21 (ROA.4315) concern data collection and analysis and are materially similar to paragraphs 38-39 of the State's report (ROA.4121), except that reporting is also required regarding calls to mobile crisis teams.

advanced alongside the United States' investigation and enforcement litigation" (ROA.3953), an appropriately tailored, time-limited, judicially enforceable remedial plan—subject to monitoring by a court-appointed expert—is the only reliable path to ADA compliance.

2. The Remedial Order Does Not Raise Federalism Concerns

The State cannot show that the remedial order "creates serious federalism problems." Br. 42. Courts are required to afford States deference in administering their systems and "the first opportunity to correct [their] own errors," but that deference is not absolute, particularly when, as here, the State has had "ample opportunity to cure the system's deficiencies" and "failed to take meaningful remedial action." *M.D.*, 907 F.3d at 272 (brackets omitted) (quoting *Lewis* v. *Casey*, 518 U.S. 343, 362 (1996)).

The remedial order defers to choices that Mississippi has made regarding its model of services and simply requires the State to follow through in practice. For example, the order does not require (as the United States proposed) that Mississippi offer PACT services on the same model statewide. Instead, it defers to Mississippi's preference to provide these services through ICORT and ICSS in smaller and rural areas. ROA.4311-4312. Even absent evidence in the record demonstrating the effectiveness of those programs as substitutes for PACT, the district court adopted a "trust, but verify" approach in allowing Mississippi to

implement them. ROA.4278 (citation omitted). The court thus demonstrated more than ample deference to the State in crafting the remedial order. See *Katie A., ex rel. Ludin* v. *Los Angeles Cnty.*, 481 F.3d 1150, 1157 (9th Cir. 2007) ("As for the deference accorded to state agencies in their internal affairs, the court appropriately allowed defendants an opportunity jointly to develop the remedial plan needed to implement the injunction.").

3. The Termination Requirements In The Remedial Order Are Reasonable, Clear, And Appropriate

Mississippi contends that the remedial order is not narrowly tailored because it "lacks objective criteria for termination." Br. 45. That claim, too, is baseless. The order is appropriate because it "state[s] its terms specifically and describe[s] in reasonable detail the conduct restrained or required." *Daniels Health Scis., L.L.C.* v. *Vascular Health Scis., L.L.C.*, 710 F.3d 579, 586 (5th Cir. 2013) (citation and internal quotation marks omitted)).

The termination provision states that "[t]his Order shall terminate when the State has attained substantial compliance with each paragraph of this Order and maintained that compliance for one year as determined by this Court." ROA.4316. The order specifically states that "[n]on-compliance with mere technicalities, or temporary failure to comply during a period of otherwise sustained compliance, shall not constitute failure" to comply. ROA.4316. The order further provides that, as the State achieves compliance, it may seek "termination of the Court's

oversight for individual major sections of the Order, *e.g.*, on individual Core Services or Discharge Planning." ROA.4316. The order assures the State that temporary or technical non-compliance is not grounds for continued supervision and further provides that that supervision can be terminated program-by-program, as the State achieves compliance.

Moreover, Mississippi is wrong to complain that there is an absence of objective criteria to measure compliance simply because the State must create and use an instrument ("a fidelity scale") as one way of measuring its performance in delivering core community-based services. Br. 45-46; see, *e.g.*, ROA.4312. The remedial order defines the standards for the operation of each program by incorporating the requirements that *DMH* itself has set. See ROA.4310-4313 (paragraphs 4a, 5a, 6, 7, 8, 9, 10); *e.g.*, ROA.4312 ("The Operational Standards for ICORT for adults are set forth in Rules 32.9-32.13 of DMH's Operational Standards."). The order simply requires the State to develop fidelity scales for new programs such as ICORT as one method of measuring its own performance. That the order allows Mississippi to develop the scale exemplifies again the court's deference to the State.

B. The District Court Did Not Abuse Its Discretion In Appointing A Monitor

The State has also failed to show that the district court abused its discretion in appointing a Monitor. The court possesses broad discretion to appoint a monitor

to ensure "compliance with the court's orders." See *Local 28 of Sheet Metal Workers' Int'l Ass'n* v. *EEOC*, 478 U.S. 421, 481-482 (1986).[7]

Mississippi takes issue with the fact that both the Monitor and the United States "shall have 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. But the next paragraph requires that such access be exercised "in a manner that is reasonable and not unduly burdensome and upon reasonable notice." ROA.4320. These transparency provisions will eliminate needless disputes over facts regarding compliance. The district court had ample discretion to include them.

Moreover, contrary to Mississippi's argument, it is not "under court order to indefinitely comply" with data requests from the United States or the Monitor. Br. 48. All data access obligations end once "full compliance and termination are achieved." ROA.4316. Again, the remedial order requires a showing of only one year of compliance before it will terminate. ROA.4316. That is hardly an indefinite obligation.

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[7] After issuing the remedial order, the court asked the parties to submit recommendations of a person to serve as Monitor, and both the United States and Mississippi recommended Dr. Hogan for this role. ROA.4318.

CONCLUSION

This Court should affirm the judgment below.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on April 6, 2022, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit by using the appellate CM/ECF system. Participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

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CERTIFICATE OF COMPLIANCE

This brief complies with the length limitation of Federal Rule of Appellate Procedure 32(a)(7)(B) because, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(f), this brief contains 12,958 words according to the word processing program used to prepare the brief.

This brief also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because it was prepared using Microsoft Word 2019 in Times New Roman 14-point font, a proportionally spaced typeface.

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USDC No. 3:16-CV-622

Dear Ms. Baldwin and Ms. Robin-Vergeer,

We have determined that your Appellees' brief is deficient (for the reasons cited below) and must be corrected within 14 days. We note that our Quality Control Program advised you of some of these deficiencies when you filed the document.

The time for the Appellant to file a reply brief has not started, in light of the Appellee's brief is in excess of the word count limitation.

The brief exceeds the word count limitation and/or the page limitations. See **FED. R. APP. P.** 32(a)(7). You must modify the brief or file a motion for leave to exceed the word count limitation and/or the page limitations. See **FED. R. APP. P.** 27, **5TH CIR. R.** 27.4 and **5TH CIR. R.** 32.4 for motion requirements.

Record References: Although your brief contains citations to the record, they are not in proper form. Every assertion in briefs regarding matter in the record must be supported by a reference to the page number of the original record, whether in paper or electronic form, where the matter is found, using the record citation form as directed by the Clerk of Court. The use of "id" is not permitted when citing to the record on appeal. (See **5TH**

CIR. R. 28.2.2)**(The citation to the record on page 14 is not formatting properly. The parenthesis before quoting and after ROA.6196 needs to be removed – quoting ROA.6196.)**

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