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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

J.K., a minor by and through R.K., *et al.*, on behalf of themselves and all others similarly situated,

Plaintiffs,

vs.

WILL HUMBLE, in his official capacity as Interim Director of the Arizona Department of Health Services; DR. LAURA NELSON, in her official capacity as Director, Division of Behavioral Health Services, Arizona, Department of Health Services; THOMAS J. BETLACH, in his official capacity as Director, Arizona Health Care Cost Containment System,

Defendants.

No. CIV 91-261 TUC JMR

PLAINTIFFS' MOTION FOR ENFORCEMENT OF SETTLEMENT AGREEMENT

(Honorable John M. Roll)

I. INTRODUCTION

Eight years ago, this Court adopted a judicially enforceable Settlement Agreement to protect the right of Arizona's Medicaid-eligible children to receive necessary mental health and substance abuse services ("behavioral health services"). Settlement Agreement ("Agreement") at 1 (Agreement "legally binding and enforceable by the Court"); Order June 26, 2001 (Agreement "approved and adopted in its entirety").

Federal law requires States to provide Medicaid-eligible children "necessary … services, treatment and other measures … to correct or ameliorate … physical and mental illnesses and conditions." 42 U.S.C. § 1396(d)(a)(4)(B);[1] *Katie A. v. Los Angeles County*, 481 F.3d 1150, 1154 (9th Cir. 2007). In the Settlement Agreement, the Defendants – the directors of the Arizona Department of Health Services ("ADHS"), the Department's Division of Behavioral Health Services ("DBHS"), and the Arizona Health Care Cost Containment System ("AHCCCS") – agreed to meet this obligation by developing and maintaining a service system that meets nationally accepted standards, which are spelled out in what are known as the "*J.K.* Principles." The Agreement also includes specific actions Defendants must take to develop and maintain this system, including: developing the array of intensive community-based services that children with serious conditions need, Agreement at ¶ 23; expanding substance abuse services, *id.* at ¶ 52; developing

[1] The cited statute is commonly referred to as the "EPSDT" program of the Medicaid Act. It requires the State to deliver "early and periodic screening, diagnostic, and treatment services," known as "EPSDT" services, to Medicaid-eligible children and youth under 21. 42 U.S.C. § 1396(d)(a)(4)(B). These services include "necessary health care, diagnostic services, treatment and other measures . . . to correct or ameliorate … physical and mental illnesses and conditions." 42 U.S.C. § 3396d(r). States must provide these services regardless of whether they are specifically covered in the State's Medicaid plan. *Id.*

training program that ensures that staff have necessary knowledge and skills, *id.* at ¶¶ 32-39; and changing the state's quality management ("QM") system so that it measures whether class members are receiving the services required by the Agreement, *id.* at ¶ 55.

When it became clear three years ago that Defendants were not meeting their obligations, the parties agreed to and the Court approved a three-year extension to July 2010 of the term of the Settlement Agreement. Order, January 10, 2007. With this date fast approaching, and Defendants' compliance still incomplete and inadequate, Plaintiffs seek another extension of the term of the Agreement, as well as other relief needed to protect Plaintiffs' federal law entitlement.

A. Supporting Declarations

In support of this Motion, Plaintiffs submit ten Declarations detailing Defendants' non-compliance and its tragic consequences for children and families. The declarants include: two national experts who have examined Defendants' compliance, *see* Declaration of Knute Rotto ("Rotto Dec."), attached as Ex. 1, and Declaration of Bruce Kamradt ("Kamradt Dec."), attached as Ex. 2; a former clinical director of a network of providers serving over 8,000 class members, *see* Declaration of Matthew Pierce ("Pierce Dec."), attached as Ex. 3; a former director of children's behavioral health services for the Maricopa County Regional Behavioral Health Authority, *see* Declaration of Michael Terkeltaub ("Terkeltaub Dec."), attached as Ex. 4; a former deputy director of Arizona's Medicaid program, *see* Declaration of Linda Huff Redman ("Redman Dec."), attached as Ex. 5; an expert whom Defendants consulted concerning their quality management system, *see* Declaration of Eric Bruns ("Bruns Dec."), attached as Ex. 6; and parents of class members, *see* Declaration of Krista Long ("Long Dec."), attached as Ex. 7; Declaration of Carol McDermott ("McDermott Dec."), attached as Ex. 8; Declaration of

Donna Ifill ("Ifill Dec."), attached as Ex. 9; Declaration of Lee Bieber ("Bieber Dec."), attached as Ex. 10.

As these declarations show, Defendants have failed to comply with the Agreement. *See, e.g.*, Rotto Dec. at ¶ 46 ("Arizona is not operating a children's behavioral health system that meets the needs of *J.K.* class members, as required by the Settlement Agreement and Medicaid law"); Kamradt Dec. at ¶ 4; Pierce Dec. at ¶ 3; Terkeltaub Dec. at ¶ 4. Defendants have not created the intensive community-based services that class members with serious conditions require, and as a result, children are being needlessly removed from their homes and placed in out-of-home care. *See infra* at Section III.B.1. Defendants have not ensured that class members get the substance abuse services they need; the behavioral health system fails to identify substance abuse treatment needs and lacks sufficient substance abuse services. *See infra* at Section III.B.2. Defendants have not developed the training program required by the Settlement Agreement, that is, one that ensures that behavioral health staff have the knowledge and skills to provide necessary services and that measures the competencies of staff. *See infra* at Section III.B.3. Class members age 18 to 21 have been denied the benefits of the Settlement Agreement; upon their 18th birthday, they are disenrolled from the children's behavioral health system and enrolled in the adult system, where they are denied medically necessary services to which they are entitled under the Settlement Agreement and federal law. *See infra* at Section III.B.4. Furthermore, Defendants have failed to develop a quality management system that monitors compliance with the Settlement Agreement and that takes corrective action when deficiencies are found. *See* infra at Section III.B.5.

The declarations also show the tragic consequences of Defendants' noncompliance for Arizona's vulnerable children and struggling families. *See, e.g.*, Pierce Dec. at ¶¶ 36-

56 (describing cases of four representative children); *id.* at ¶ 35 ("failures … occur repeatedly in our system, to the great detriment of children and their families"); McDermott Dec. at ¶ 3 (" Families like mine, whose children need, but do not receive, intensive services hang on by our fingernails."); Long Dec. at ¶ 6 ("constant struggle"); Bieber Dec. at ¶ 5 ("behavioral health system not helping [her daughter] get better").

The story of "Brittany" is a case in point. Brittany, now 18 years old, entered foster care at an early age. Although a longtime client of the behavioral health system, she has never received the treatment she needs. By age 12, she had taken more than 50 different medications and been hospitalized on several occasions. Her foster parents were told that intensive community-based services were not available; they felt they had no choice but to place her in out-of home care. She ran away from a group home in an effort to return to her foster family and was moved to a residential treatment center where she stayed for the next two years. She returned home and her foster family and again requested intensive community-based services, but again was told these services were not available. Over the next several years, she had more than a dozen different placements. When Brittany was close to turning 18, she was assigned a case manager to plan for her adulthood. The clinician who evaluated whether she qualified for adult services never met Brittany and refused information from the foster parents. Recently, her foster family was informed that no adult services were available for Brittany. Pierce Dec. at ¶¶ 36-42.

B. Relief

With this Motion, Plaintiffs seek to require Defendants to develop and implement a plan that ensures the commitments Defendants made in the Agreement are met and class members receive the services to which they are entitled under federal law. The last eight years have shown that if Defendants are to comply with the Agreement, they must have a

written plan that reflects a strong commitment, provides meaningful accountability for key participants in the system, and resolves the specific deficiencies described in this Motion. Moreover, Defendants must be accountable to the Court for the plan's implementation.

To ensure that Defendants meet their obligations, Plaintiffs respectfully move the Court to:

- Direct Defendants to develop, and secure the Court's approval, for a plan with specific actions and deadlines for correcting the deficiencies described in this Motion,
- direct Defendants to implement the plan, and
- extend the term of the Settlement Agreement, and the Court's jurisdiction, for the period required to implement the plan, including the resolution of any disputes over implementation.

The parties' Agreement provides that, when a party by motion asserts a breach of the Agreement, the Court "will … as appropriate, receive evidence" and "resolve the matter in a manner consistent with the purposes and goals of the Settlement Agreement."[2] Agreement at ¶¶ 69, 70. Plaintiffs are prepared to prove each of the factual assertions in this Motion. Plaintiffs note, however, that in some instances, proof may require testimony

[2] Under the Agreement, either Plaintiffs or Defendants may complain of a breach. Agreement at ¶ 56. "If mediation does not produce a resolution…, the party may file an appropriate motion with the Court. *Id*. at ¶ 68. Earlier this year, Plaintiffs invoked these provisions. *See* March 6, 2009 Letter from Plaintiffs to Defendants, attached as Ex. 11. Mediation failed to produce a resolution. *See* Report of Mediator to the Court, August 13, 2009.

or information from state officials, Regional Behavioral Health Authorities (known as "RBHAs"),[3] networks, or providers that can be obtained only through the Court's compulsory process.

II. FACTUAL BACKGROUND

A. Pre-Settlement Litigation

Plaintiffs, Medicaid-eligible children with emotional and behavioral disorders, filed this class action lawsuit on May 8, 1991. *See* Complaint, May 8, 1991. Plaintiffs sought to compel Defendants to provide them medically necessary mental health and substance abuse services ("behavioral health services") in compliance with the Medicaid Act, 42 U.S.C. § 1396d(r), *et seq.* *See* Second Amended Complaint, April 26, 1993. The certified Plaintiff class includes "all persons, under the age of twenty-one, who are eligible for Title XIX behavioral health services in the State of Arizona and have been identified as needing behavioral health services."[4] Order at 7-8, June 24, 1993.

The litigation proceeded from 1991 through 1997.[5] In October 1997, the litigation was stayed, following the State's declaration of an emergency in the provision of children's behavioral health services, to allow an independent expert to conduct a

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[3] RBHAs are the managed care entities with whom Defendants contract and who actually operate the system. RBHAs in turn contract with networks of providers ("networks") and/or individual provider agencies ("providers").

[4] "Title XIX" refers to the Medicaid Act. *See infra* at n. 10.

[5] Several cross-motions for summary judgment were resolved in Plaintiffs' favor. *See J.K. v. Dillenger*, 836 F. Supp. 694 (D. Ariz. 1993) (finding Defendants responsible for alleged failures to provide medically necessary services); Order, May 13, 1996 (finding violations of the notice and fair hearing provisions of the Medicaid Act).

comprehensive study. *See* Order Approving Parties' Agreement and Staying Litigation, October 23, 1997. In 1998, the independent expert, Dr. Ivor Groves, submitted his first report, focusing on Maricopa County, which found, *inter alia*, that more than half of class members were receiving inadequate behavioral health services and that the system's performance was not acceptable for any age group. June 1998 Report, filed with Pls' Response to Defs' Motion to Extend Stay, August 21, 2000. Dr. Groves' reviews of services in the rest of the state confirmed that behavioral services were inadequate statewide, and a follow-up review of Maricopa County in April 2000 found that little had changed in two years.[6] June 2000 Report, attached to Pls' Response to Defs' Motion for Extension of Stay, August 21, 2000. Soon thereafter, newly appointed directors of ADHS and AHCCCS announced their intention to settle the case.

B. The Settlement Agreement

The *J.K.* Principles are the foundation of the Settlement Agreement, which was signed in March 2001. Agreement at ¶ 19 ("The Principles … are the foundation of this Settlement Agreement ….). The Principles both reflect and articulate a professional consensus concerning the medically necessary treatment of children with behavioral health disorders, including "partnering with families and children, interagency collaboration, and individualized services aimed at achieving meaningful outcomes for families and

[6] After Dr. Groves filed his first report, Plaintiffs agreed to continue the stay of litigation, provided that Dr. Groves would evaluate behavioral health services in the rest of the state and that Defendants would work with Dr. Groves to address the deficiencies identified in his report. Order at ¶¶ 1-4, 8, 8/10/98.

children." *Id*. at ¶ 1; [7] *see also, e.g.*, Rotto Dec. at ¶ 18 ("the services required by the *J.K.* Settlement Agreement are medically necessary to treat class members"); Kamradt ¶¶ 14-17 (same).

The Principles were designed to address the deficiencies identified by Dr. Groves. Individual clinicians, due to excessive caseloads and other reasons, worked in isolation from the child's family and other service providers addressing the child's condition, including the foster care and juvenile probation systems. Service plans were "cookie-cutter," with too heavy a reliance on office-based counseling. What are referred to as "intensive" community-based services – services provided outside the office and in families' homes and other natural settings – were largely unavailable. As a result, it was common that children, especially children with serious conditions, did not get better.

The Principles required the State to make a "fundamental shift" in the way it treated children and families. *See* Gov. Hull Press Release, March 20, 2001, Ex. F to Pls'

[7] A psychiatric expert urged that the Settlement Agreement "provides the basis for developing and implementing a children's mental health system that provides care at a level at least equivalent to national standards." Affidavit of Dr. John Scialli at ¶ 3, May 29, 2001, Ex. L. to Pls' Pre-Hearing Mem. In Support of Approval of Settlement Agreement (hereinafter "Pls' Pre-Hearing Mem"). The Children's Action Alliance -- a non-profit research, education, and advocacy organization -- wrote that the "*J.K.* Principles are widely accepted principles of good practice." Statement of the Children's Action Alliance at ¶ ¶ 3, 7, 6/4/01, Ex. N. to Pls' Pre-Hearing Mem. Dr. Robert L. Klaehn, a member of the American Academy of Child and Adolescent Psychiatry's Work Group on Community-Based Systems of Care, endorsed the *J.K.* Principles as necessary to the provision of community-based services. Statement of Dr. Robert L. Klaehn at ¶ 5, 6/13/01, Ex. P. to Pls' Pre-Hearing Mem.

Pre-Hearing Mem.[8] The Principles committed the State to delivering treatment through "child and family teams" whose membership included the responsible clinician, other involved providers, other systems serving the child, the child's family, and members of the family's natural support system. Agreement at ¶¶ 20, 22, 27, 29-31. The Principles also required the State to expand services so that behavioral service plans could be tailored to the individualized needs of the child. *Id.* at ¶¶ 23-25, 27-31. Of particular importance was the development of intensive community-based services, including intensive case management, direct supports, and therapeutic foster care, which are medically necessary services for children with serious behavioral health conditions. *See, e.g.*, Pierce Dec. at ¶¶ 4-8; Rotto Dec. at ¶ 27; *Katie A. v. Bonta*, 433 F. Supp. 2d 1065 (C.D. Cal. 2006), *rev'd on other grounds*, *Katie A. ex rel Ludin v. Los Angeles County*, 481 F.3d 1150 (9th Cir. 2007); *Rosie D. v. Romney*, 410 F. Supp.2d 18 (D. Mass. 2006). Without such services, children with serious conditions are unlikely to "achieve success in school, live with their families, avoid delinquency, and become stable and productive adults," the outcomes sought by the Agreement, Agreement at ¶ 21.[9] *Id.*

The Agreement requires Defendants to "move as quickly as is practicable to develop a Title XIX behavioral health system that delivers services according to the *J.K.*

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[8] "If everything in this agreement is implemented, this will be a total system change." Statement of Maria Hoffman, former executive director of the Arizona Council of Human Service Providers, at ¶ 3, Ex. O. to Pls' Pre-Hearing Mem.

[9] *See also* Agreement at ¶¶ 24-25, 28.

Principles"[10] and, "[o]nce developed, … [to] maintain the system in accordance with the Principles for the term of this Agreement." *Id.* Additionally, the Settlement obliged Defendants to "conform all contracts, decisions, practice guidelines and policies related to the delivery of Title XIX behavioral health services to be consistent with and designed to achieve the Principles for class members." *Id.* at ¶ 16. To this end, the Settlement required Defendants, among other things, to implement a statewide training program to "provide front-line staff and supervisors sufficient knowledge and skills to enable them to plan and provide services consistent with the Principles," *id.* at ¶ 35; "develop a plan for the expansion of substance abuse treatment services," *id.* at ¶ 52, and change "the quality management and improvement system" (the system Defendants use to monitor service planning and delivery) so that it "measures" whether services are being provided as required by the Agreement, *id.* at ¶ 55.

Defendants' obligations under the Agreement were to end on July 1, 2007. *Id.* at ¶¶ 79-83. By this time, the required system of services was to have been developed. *Id.* at ¶ 15 ("Once developed, Defendants will maintain the system in accordance with the Principles for the term of this Agreement."). Additional time was provided for resolving disputes concerning implementation. *Id.* at ¶ 80 (through February 1, 2008). [11]

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[10] "Title XIX," as used in the Agreement, refers to the Medicaid Act. Agreement at ¶ 12. The term "Title XIX behavioral health system," as used in the Agreement, refers to the behavioral health system "supervised and administered by Defendants for delivering Title XIX behavioral health services to class members." *Id*. at ¶5.

[11] In 2006, the date was extended to July 1, 2010. Order, January 10, 2007. The date for resolving disputes concerning implementation was extended to February 1, 2011. *Id.*

C. Implementation 2001-2006

Plaintiffs were intimately involved in the implementation of the Settlement Agreement. *See* Pls' Pre-Hearing Memo at 10 (referencing parties' "joint commitment to collaborative action"). Plaintiffs' counsel participated in numerous meetings and working committees with State officials, representatives of the RBHAs, private providers, and parents of class members, as well as official reviews of compliance with the Settlement Agreement.[12] Plaintiffs regularly raised issues of concern with Defendants and met with Defendants to attempt to resolve these issues.[13] However, these efforts by Plaintiffs were unavailing in securing compliance.

In January 2006, Plaintiffs invoked the dispute resolution procedures in the Agreement. Based on an interim agreement reached in mediation, the parties tried to reach agreement on a plan for securing compliance with the Agreement. A team of Defendants' staff met with Plaintiffs and family organizations and agreed on the outline of a plan. *See* June 6, 2006 Planning Meeting, Combined Issues, attached as Ex. 12. Unfortunately, Defendants rejected the plan. Ultimately, the parties agreed on a three-year extension of the Settlement Agreement. *See* Stipulation to Amend the Settlement Agreement, November 21, 2006. The Court ordered the extension on January 10, 2007. Order, January 10, 2007.

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[12] Plaintiffs' counsel also regularly advocated on behalf of individual class members denied needed services.

[13] In all these efforts, Plaintiffs collaborated with two major family advocacy organizations.

D. Events Following the Extension

Although the parties had not reached agreement on a written implementation plan, Defendants began to address some of the deficiencies Plaintiffs had identified as top concerns. These were that:

- Defendants had not created adequate performance expectations for RBHAs or held RBHAs accountable for poor performance.
- Intensive community-based services – required by the 25-35% of class with serious conditions – were in short supply, including intensive case management, direct supports, respite, and therapeutic foster care.
- Substance abuse services were inadequate.
- There was no effective training program.
- Youth 18-21 were systematically denied the benefits of the Agreement. When children turned 18, they were transferred to providers in the adult system unable to meet their needs or, worse, denied services altogether.
- Defendants lacked a reliable method for determining whether RBHAs and providers were delivering services according to the Agreement.

The parties met on a regular basis. Of significant concern during this time was a finding in the third quarter of Fiscal Year 2008 that only 33% of the children in Maricopa County were receiving appropriate services. *Cf.* Redman Dec. at ¶ 18. Plaintiffs wrote a series of letters setting forth their views and confirming their understanding of actions that Defendants planned to take. *See* letters from Plaintiffs to Defendants**,** attached as Ex. 13**.**

Ultimately, the parties were unable to resolve their differences. Defendants asserted that they would be in full compliance with the Settlement Agreement by July 2010, and that no actions in addition to those already planned and being implemented

were necessary for Defendants to meet their obligations. In March 2009, Plaintiffs invoked the dispute resolution provisions of the Settlement Agreement. *See* March 6, 2009 Letter from Plaintiffs to Defendants, attached as Ex. 10.

III. ARGUMENT

A. This Court Has the Power to Enforce the Settlement Agreement and Grant the Relief Requested

The Settlement Agreement, by its terms, is judicially enforceable. *See* Agreement at 1 ("legally binding and enforceable by the Court."). The Court approved and adopted the Agreement in its entirety, maintaining jurisdiction for enforcement purposes. Order, July 5, 2001. Plainly, this Court has the authority, as well as the obligation, to enforce the Agreement. *Frew v. Hawkins*, 540 U.S. 431 (2004); *Rufo v. Inmates of Suffolk County Jail*, 502 U.S. 367 (1992); *cf. Spallone v.United States*, 493 U.S. 265, 276 (1990) (referencing courts' inherent powers).

A court may use its enforcement powers even absent a finding of contempt. *Holland v. N.J. Dept. of Corrections*, 246 F.3d 267, 283 n. 14 (3rd Cir. 2001); *Berger v. Heckler*, 771 F.2d 1556, 1569 (2nd Cir. 1985). A district court "is invested with broad equitable powers and simply should not be compelled to operate in a punishment or nothing atmosphere. Alleviation rather than sanction [is] properly the goal on which the district court concentrate[s] its attention." *Alexander v. Hill*, 707 F.2d 780, 783 (4th Cir. 1983).

A Court may require Defendants to undertake specific corrective actions required for compliance. *See, e.g., David C. v. Leavitt*, 242 F.3d 1206, 1209 (10th Cir. 2001) (affirming order for defendants to implement a detailed remedial plan to remedy non-compliance); *Alexander v. Hill*, 707 F.2d 780, 783 (4th Cir. 1983) (affirming order

directing remedial actions to address defendants non-compliance). Moreover, where as here the Defendants' obligations are time-limited, the Court may extend the term of the obligations to remedy non-compliance. *See, e.g.*, *Thompson v. U.S. Dept. of Housing and Urban Dev.*, 404 F.3d 821, 831 (4th Cir. 2005) (extending term of consent decree to address defendants' non-compliance). This Court has already done so by agreement of the parties. *See* Order, January 10, 2007. It may take the same action upon motion of Plaintiffs when such an extension is required to secure the benefit of the bargain struck with Defendants. "[T]he power to modify in appropriate circumstances is inherent in the equity jurisdiction of the court." *Keith v. Volpe*, 784 F.2d 1457, 1461 (9th Cir. 1986); *accord SEC v. Worthen*, 98 F.3d 480, 482 (9th Cir. 1996) ("inherent power of a court sitting in equity to modify its decrees prospectively to achieve equity"). A failure of compliance with a judicial decree "would justify the decree's extension." *Labor/Community Strategy Center v. Los Angeles Metropolitan Transportation Authority*, 564 F.3d 1115, 1120-21 (9th Cir. 2009).

B. Defendants Are Violating the Settlement Agreement and the Medicaid Act

As demonstrated below, Defendants have not moved "as quickly as practicable" to develop the system of services required by the Agreement. *See e.g.*, Rotto Dec., at ¶ 7 ("Defendants have not … moved as quickly as practicable to develop a behavioral health system that provides services according to the *J.K.* Principles."); Kamradt Dec. at ¶ 4; Pierce Dec. at ¶ 57; Terkeltaub Dec. at ¶ 27. That system is not yet developed and, given what remains to be done, Defendants cannot finish the job by the July 2010 deadline. *See, e.g.*, Rotto Dec. at ¶ 4 (Arizona's behavioral health system "is not operating as required by the *J.K.* Settlement Agreement and thus is not providing the medically necessary services

that class members require."); *id.* at ¶ 45, 46 ("If the State were to develop a good remedial plan and implement it with focused and sustained effort, I expect that the State could address the deficiencies in its current system in three years."); Pierce Dec. at ¶ 3; Terkeltaub Dec. at ¶ 4 Kamradt Dec. at ¶¶ 42, 43; Long Dec. at ¶ 11.

Among other problems, Defendants have never developed a comprehensive plan to implement the Agreement. S*ee, e.g.*, Kamradt Dec. at ¶ 43 (Arizona lacks "the clear implementation plan … necessary for a large system-reform effort…."). Nor have Defendants held the key participants in the system – RBHAs, provider networks, and provider agencies accountable for delivering services according to the Principles. *See, e.g.*, Kamradt Dec. at ¶ 29 ("The State does not have clear expectations for performance and meaningful benchmarks related to the Settlement Agreement…"); Rotto Dec. at ¶ 32 ("There are no consequences for poor practice…"); Pierce Dec. at ¶ 29 ("The State continues to distribute money to the same providers, in the same way, no matter how providers have performed…."). These failures are significant causes of Defendants' non-compliance. *See, e.g.*, Rotto Dec.at ¶ 7.

1. *There are too Few Intensive Community Services for Children with Complex Needs*

Due to poverty, life circumstances, and other causes, a significant proportion of the children in the Plaintiff class have serious conditions and hence complex needs.[14] Defendants have estimated that number to be in the range of 25%. Based on their experience nationally, Plaintiffs' experts believe the number to be in the range of 25%-

[14] As is common in the field of children's mental health, Plaintiffs and their declarants use interchangeably the terms "serious conditions," "complex needs," and "high needs."

35%. *See, e.g.*, Rotto Dec. at ¶ 24. These children require intensive community services for their conditions to improve, especially the intensive community services known as "intensive case management" and "direct supports."[15] *See, e.g.*, Rotto Dec. at ¶ 27 ("essential to serving high needs children"); Pierce Dec. at ¶¶ 5, 8 (same); Kamradt ¶ 19 ("I am not aware of any effective children's mental health system that does not provide intensive case management and an array of intensive community-based services and supports to its high needs children."); DBHS Protocol, *Child and Adolescent Service Intensity Instrument (CASII)* ("CASII Protocol"), at 9, available at www.azdhs.gov/bhs.guidance.casii.pdf; DBHS Practice Protocol, *Support and Rehabilitation Services for Children Adolescents and Young Adults* ("Direct Supports Protocol") at 7, available at www.azdhs.gov/bhs/guidance/ supportrehab.pdf. *Accord Katie A. v. Bonta*, 433 F. Supp. 2d 1065 (C.D. Cal. 2006), *rev'd on other grounds*, *Katie A. ex rel Ludin v. Los Angeles County*, 481 F.3d 1150 (9th Cir. 2007); *Rosie D. v. Romney*, 410 F. Supp.2d 18 (D. Mass. 2006). Other needed services include respite care for their parents and, for those children who cannot be supported in their own homes, therapeutic foster care. *See, e.g.*, Rotto Dec. at ¶ 27; Kamradt Dec. at ¶ 21; Pierce Dec. at ¶ 7 ("Home-based respite is another service that is essential for meeting the needs of complex children and keeping them at home or in family settings. They often need a place to go for a few days to help de-escalate crisis situations that otherwise might lead to their removal from their home."); *id* at ¶ 6 ("Children with high needs who cannot be served in their own home or a regular

[15] In Arizona, direct supports are sometimes referred to as "direct support services" or "support and rehabilitation services," s*ee* Direct Supports Protocol at 2. Nationally, they are part of what is often called "intensive community-based services."

foster home need therapeutic foster care to avoid institutional out-of-home care."); DBHS Practice Protocol, *Home Care Training to Home Care Client Services for Children* ("TFC Protocol"),[16] at 3, available at http://azdhs.gov/bhs/guidance/hctc.pdf ("in the absence of such services the child or youth would be at risk of placement into a restrictive residential setting such as a hospital, psychiatric center, correctional facility, residential treatment program …"). *Accord Katie A. v. Bonta*, 433 F. Supp. 2d 1065 (C.D. Cal. 2006), *rev'd on other grounds*, *Katie A. ex rel Ludin v. Los Angeles County*, 481 F.3d 1150 (9th Cir. 2007) (therapeutic foster care).

If these services are not available, effective treatment plans for these children cannot be designed or implemented, and children will not improve their functioning and "achieve success at school, live with their families, avoid delinquency, and become stable and productive adults," that is, they will not achieve the outcomes sought in the Agreement, Agreement at ¶ 21. *See, e.g.*, Rotto Dec. at ¶ 27; Kamradt Dec. at ¶ 19 Pierce Dec. at ¶¶ 5-6, 8; *cf.* Direct Supports Protocol at 7; TFC Protocol at 11. Additionally, without these services, children cannot be maintained "in the home or community" or in the "most-integrated and home-like setting appropriate to their needs" as required by the Agreement, Agreement at ¶ 25. *See, e.g.*, Terkeltaub Dec. at ¶ 17 ("Many children are still ending up in out-of-home care because there is a lack of intensive community-based services to meet their needs."); Rotto Dec. at ¶ 19 ("the services required by the *J.K.* Settlement Agreement . . . prevent the over-reliance on restrictive placements"); Kamradt Dec. at ¶¶ 15, 21; Direct Supports Protocol at 7 (direct supports "increase [the] number of

[16] In Arizona, the official Medicaid title for the service of therapeutic foster care was recently changed to "Home Care Training to Home Care Client Services for Children."

children …living successfully at home with their families or in the community"); TFC Protocol at 12 (TFC allows "home-based" and "community-based" care).

The need for these services was understood when the Agreement was entered into and implementation began. However, Defendants have failed to develop them. Before the 2006 dispute resolution process, intensive case management, direct supports, and therapeutic foster care were essentially unavailable outside Maricopa County. In Maricopa County, intensive case management that had been developed in early implementation efforts had withered away, and direct supports were unavailable to most children who required them. After the 2006 dispute resolution, Defendants began to address these problems. However, Defendants failed to move with dispatch. *See, e.g.*, Kamradt Dec. at ¶ 20-22; Rotto Dec. at ¶ 27. The result is that intensive case management, direct supports, and respite continue to be in short supply.[17] Rotto Dec. at ¶ 27 ("not enough intensive services for high needs children, and this lack of services continues to stymie the ability of child and family teams to develop and implement effective plans"); Pierce Dec. at ¶ 4; Terkeltaub Dec. at ¶ 17; Kamradt Dec. at ¶ 21. Long Dec. at ¶¶ 12-13; Ifill Dec. at ¶¶ 5-6; McDermott Dec. at ¶ 12, 14-15; Bieber Dec. at

[17] In addition, there are not "enough quality services, including psychiatric and clinical services, for children with less complex needs, with the result that many needlessly become children with high needs." Pierce Dec. at ¶ 4.

¶ 5.[18] There is little therapeutic foster care outside Maricopa County, and much of the therapeutic foster care in Maricopa County is of poor quality, Terkeltaub Dec. at ¶ 18 ("quality of TFC is uneven and services are often not delivered consistent with the *J.K.* Principles"); Pierce Dec. at ¶ 6 (TFC providers lack ability to support children with high needs and manage crisis situations); Ifill Dec. at ¶ 8. This is the case despite Defendants' commitment that "[c]hildren have access to a comprehensive array of behavioral health services" sufficient to ensure needed treatment and that services be adapted or created when they are needed but not available." Agreement at ¶ 23.

It was not until 2007 that Defendants set as a goal that every child with complex needs would have an intensive case manager. It took another year for Defendants to settle on a process for identifying these children and a plan for expanding intensive case management. Defendants have not yet met their goal. Defendants have no plan for developing the requisite amount of direct supports, respite, or therapeutic foster care.

With too few intensive community services for children with complex needs, Defendants continue to needlessly institutionalize children, serving far too many in

[18] *See* McDermott Dec. at ¶ 12 ("Although my [child and family team] agreed that other direct supports … were needed, and those supports were included in my treatment plan…, I was not referred for such services. The case manager could not find a service provider. Instead…we were given catalogues identifying parks and recreation programs in the area and told to try different sports. My grandson tried 5 different sports, but, without needed support from the behavioral health system, he failed at each. In fact, the situation became worse. My grandson was disliked by other kids and parents, was excluded and isolated, and was even bullied.")

expensive and ineffective residential centers.[19] Rotto Dec. at ¶ 28 (State "has not made sufficient efforts to keep high needs children from going into out-of-home care"); Terkeltaub Dec. at ¶ 17 ("The State has never made a serious commitment to move money from congregate care to intensive community based services."); Ifill Dec. at ¶¶ 5-6. ("They did not … provide intensive supports. … It was recommended that we place [my stepson] at Canyon State Academy, a residential school. Because we cannot afford it, Cenpatico suggested that we terminate our parental rights and turn our son over to the state so that they can send him to Canyon State."); Bieber Dec. at ¶ 5 (Daughter was not receiving "adequate services for a high needs child" and was "languishing in group homes").

Although a stated goal of the Agreement is to avoid needless institutionalization, Agreement at ¶¶ 21, 25, the State consistently spends too much money on ineffective institutional care. *See, e.g.*, Terkeltaub Dec. at ¶ 15 ("State still spends an inordinate percentage of its children's mental health budget on these congregate placements"). In addition to the harm done children and their families, this has impeded the behavioral health system's ability to make necessary financial investments in intensive community services.

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[19] "Currently, the State still spends more than $20 million dollars on out-of-home placements. The State could easily set a goal to reduce the number of children in out-of-home placements or to reduce their lengths of stay and reallocate the savings to an expansion of needed community based services." Rotto Dec. at ¶ 28. To do so, the State must address "the financial incentives that lead to many children needlessly ending up in congregate care: that providers are not responsible for congregate care costs, so they have no real financial incentive to serve children with complex needs in the community." Terkletaub Dec. at ¶ 17.

2. *Substance Abuse Services are Inadequate*

Substance abuse services in Arizona have long been inadequate. The Agreement required that, early on, Defendants "develop a plan for the expansion of substance abuse services." Agreement at ¶52; *see also id*. at ¶ 23 ("comprehensive array of behavioral health services").

Defendants have convened committees to conduct research and identify best practices. But little has actually been done to ensure that children get the substance abuse services they need. Substance abuse problems are not identified, there are not enough substance abuse services, and the services that do exist are often inadequate and fail to comply with the *J.K.* Principles. *See, e.g.*, Rotto Dec. at ¶¶ 41-43 ("The substance abuse issues of class members are often not identified, and substance abuse services are inadequate to meet children's needs when issues are identified…. The substance abuse programs that exist are full and have waiting lists, and there are very few aftercare programs. … Also, many of the substance abuse services that exist are not sound.…"); Pierce Dec. at ¶¶ 18-19 ("The number of children in the system with substance abuse issues is high, but very few providers have received training or technical assistance in how to identify and address those needs. … [T]here is rarely an appropriate response when children have significant substance abuse needs. … There are very few substance abuse services available to children, and virtually no community-based programs focused on substance abuse."); Kamradt Dec. at ¶¶39-41; Terkeltaub Dec. at ¶ 22.

3. *Training is Inadequate*

The Agreement reflects the importance the parties placed on having a sound training program in order to secure compliance. It includes detailed requirements for the training program that Defendants must design and implement statewide. Agreement ¶¶

32-39. The training program must be designed to provide front-line staff … and supervisors sufficient knowledge and skills to enable them to plan and provide services consistent with the Principles." *Id*. at ¶ 35. It must have a "sufficient number of qualified trainers," *id*. at ¶ 39, and a "hands-on" component in which "trainers … coach and mentor front-line staff and supervisors in effective techniques and approaches," *id*. at ¶ 36. Moreover, Defendants are required to have "[t]ools to evaluate the ongoing effectiveness of the training program" and a "methodology for measuring core-competencies of front-line staff." *Id.* at ¶ 38. Defendants' training program meets none of these standards.

There are too few qualified trainers, inadequate hands-on training opportunities, and there is no methodology for evaluating either the effectiveness of training or the competencies of staff. *See, e.g.*, Rotto Dec. at ¶¶ 34-37 ("Arizona has not developed a training system that ensures that behavioral health staff practice according to the *J.K.* Principles. … [M]ost of the system's training efforts have focused on classroom training instead of the hands-on coaching and mentoring that is necessary for good practice. … [W]hile there has been extensive training on the *J.K.* Principles themselves, there has been inadequate training for staff on developing the skills necessary to deliver services according to the Principles, as required by the Settlement Agreement. Moreover, the State has failed to develop measures to assess the effectiveness of training. "); Pierce Dec. at ¶¶ 30-32 ("The State has spent a lot of time and money on training but the training has not been effective. Most of the training has been in the classroom and focused on values and a theoretical orientation to the system. Practitioners often leave these trainings excited but they are not subsequently given the hands-on coaching and mentoring they need to learn necessary skills. There has not been enough training for supervisors and agency

leadership, which is essential to ensuring that front-line practitioners deliver services as required by the Principles."); Terkeltaub Dec. at ¶¶ 23-25; Kamradt Dec. at ¶¶ 31-35 .[20]

Given the central role of training, it is not surprising that Defendants have been unable to come into compliance with the Agreement.

4. *Youth Aged 18 to 21 Have Been Denied the Benefits of the Agreement*

Youth aged 18 to 21 are class members, entitled to needed services under both the Agreement and the EPSDT program of Medicaid.[21] Defendants have estimated that there are more than 6,000 class members in this age group. Until recently, Defendants largely ignored their obligations to these class members. The result is that these youth are very poorly served by Defendants.

In most instances, when a youth turns 18, the youth is dismissed, or "disenrolled," from the children's behavioral health system and, if the youth wants to continue to receive mental health or substance abuse services, he or she must enroll in the adult behavioral health system. If the youth has a well-functioning child and family team supervising and planning his care, that team is disbanded. If the youth has been receiving intensive services, such as direct supports or therapeutic foster care, from the children's system, those services are typically discontinued. *See, e.g.*, Rotto Dec. at ¶ 38 ("When class

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[20] The training program is also "hampered by the lack of a working QM [quality management] system on which they can rely for data regarding performance." Terkletaub Dec. at ¶ 25.

[21] *See supra* at note 1. A youth exits the plaintiff class when he or she reaches the age of 21. The parties have consistently referred to the older youth in the plaintiff class as "aged 18 to 21." For this reason, Plaintiffs use the term here.

members turn 18, they are being disenrolled from the children's mental health system. As a result, they lose their child and family teams and whatever intensive community-based services and supports they may be receiving from children's providers. Moreover, when the youth reaches out to the adult system, he or she is likely to find that system ill-equipped to meet his needs.); Terkeltaub Dec. at ¶ 26 ("In my experience, serving 18 to 21 year olds has never been a priority or focus for the State. When class members enter the adult system, they are served badly. … [T]hey are denied needed services by the adult system."); Long Dec. at ¶ 14.

Youth must be determined by the adult system to be "seriously mentally ill" (SMI) in order to get access to meaningful services from the adult system. *See, e.g.,* Rotto Dec. at ¶ 17 (those not found SMI "get few if any of the services they require"); Pierce Dec. at ¶ 15 (those not SMI "get little to no services from the adult system"); Long Dec. at ¶ 14; Bieber Dec. at ¶¶ 9-10. However, a substantial number of class members do not obtain SMI status. Pierce Dec. at ¶ 15 ("The majority of the children in the *J.K.* class do not meet the eligibility criteria for 'seriously mentally ill' in the adult system."). Even youth with serious conditions may be denied an "SMI" determination. *See id*. at ¶ 40-42. Hence, a large number of class members are denied needed services. *See, e.g.*, Rotto Dec. at ¶ 17; Pierce Dec. at ¶ 15; Terkeltaub Dec. at ¶ 26 (describing situation of foster children not deemed SMI). For these class members, reaching the age of majority is tantamount to losing an entitlement to services, despite the contrary mandate in the Settlement Agreement and under federal law. Furthermore, even if a youth obtains an SMI determination, he or she may not receive needed services. Given the focus and history of the adult system, it lacks many of the services required by transition age youth. *See, e.g.,* Rotto Dec. at ¶ 17 ("The 18 year olds who are determined to be "seriously mentally ill"

are enrolled in the adult system but cannot access many of the services they need."); Pierce Dec. at ¶ 15 ("The children who are determined to be SMI get some services from the adult system, but these children are routinely denied services required by the *J.K.* Principles.").

In 2006, Defendants developed policy guidance ("Transition to Adulthood Protocol") to address youth transitioning to the adult system. More recently, Defendants have initiated some pilot projects to address the problems described above. However, these pilots have as of yet had only a small impact. Overall, Defendants have made little progress overall in ensuring that youth aged 18 to 21 are served according to the Principles. *See, e.g.,* Rotto Dec. at ¶ 40 (the State has made "little progress" in serving 18-21 year olds); Kamradt Dec. at ¶ 38 ("Children age 18 to 21 continue to be denied medically necessary services."); Pierce Dec. at ¶ 17 (State's "policy document is good, but the State has done little to ensure that the policy is followed and, for the most part, it is not being followed ….").

5. *Defendants Lack a System for Determining Whether Children are Being Served According to the Settlement Agreement*

Paragraph 55 of the Agreement requires changes to Defendants' "quality management and improvement system." Agreement at ¶ 55. Far from being a technical requirement, this provision goes to the heart of Defendants' responsibilities. The job of a "quality management and improvement system" ("QM system") is to inform leaders how well a behavioral health the system is functioning. *See, e.g.,* Redman Dec. at ¶ 9; Bruns Dec. at ¶ 8; Rotto Dec. at ¶ 30. Information from the QM system is used to correct deficiencies that may be found. *Id*. A sound QM system is essential to the system's developing and maintaining the capacity to meet its clients' needs. *See, e.g.*, Redman

Dec. at ¶ 9 ("A functioning QM system is essential for ensuring that Medicaid-eligible children receive medically necessary behavioral health services."); Rotto Dec. at ¶ 30 ("An effective quality management system is essential to a children's mental health system. A QM system must be able to identify whether good practice and outcomes are being achieved and to collect and analyze data to identify problems and areas of needed improvement. … Successful communities establish their QM systems early in their implementation process and use information from their QM system to drive their decision-making.").[22]

The Agreement requires Defendants to "change their quality management and improvement system so that it measures whether services to class members are consistent with and designed to achieve the Principles." Agreement at ¶ 55. The purpose, understood by all parties, is to ensure that Defendants' QM system generates the information that Defendants need to monitor compliance with the Agreement and to take corrective action when required. To ensure that Defendants have rich information, the Agreement requires that Defendants conduct "an in depth case review of a sample of individual children's cases that includes interviews of relevant individuals in the child's

[22] "To work effectively, a QM system must identify measurements that reflect desired program outcomes and goals. It then must collect and analyze data to identify where established program outcomes and goals are being met and where there are areas of needed improvement. Finally, it must ensure that identified problems are addressed and that improvements are sustained over time." Redman Dec. at ¶ 9. "A QM system must be able to identify whether good practice and outcomes are being achieved and to collect and analyze data to identify problems and areas of needed improvement. Information from the QM system must be used to make informed decisions, including to incentivize good practice and consequence poor practice." Rotto Dec. at ¶ 30; *accord* Terkeltaub Dec. at ¶ 6.

life," *id*., a process that the independent expert Dr. Groves used and on which he had trained stakeholders in the State.

Defendants have not complied with Paragraph 55 of the Agreement. *See, e.g.*, Redman Dec. at ¶ 7 ("[T]there are significant deficiencies in DBHS' QM system, including in monitoring and measuring implementation of the *J.K.* Settlement Agreement. DBHS' lack of leadership, lack of staff with QM expertise, and lack of a culture focused on improvement are serious weaknesses in its QM system.");[23] Terkeltaub Dec. at ¶ 5 ("the State's QM system is one of the biggest failures in its implementation of the Settlement Agreement"); Kamradt Dec. at ¶ 27 ("Arizona has not implemented key components of an effective QM system."). Defendants did not even begin to turn their attention to making changes to their QM system until after the 2006 dispute resolution process.

In 2007, Defendants added to their QM system a review process known as the Wraparound Fidelity Index ("WFI"). Plaintiffs, family organizations, and many in the provider community voiced concerns about the WFI, including questioning whether it measured service delivery according to the Principles.[24] The Maricopa County RBHA

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[23] Dr. Redman notes that "DBHS has not prioritized or assured the reliability of measures it claims evaluate compliance with the Settlement Agreement. …DBHS has not used the data it collects to improve practice. …DBHS is unable to examine data trends over time to identify problems because it has repeatedly changed the measures it collects, the intervals for which it reports the measures, and the QM tools it employs." Redman Dec. at ¶ 7.

[24] The WFI lacks measures of, among other things, whether services are designed and implemented to achieve desired outcomes, Agreement at ¶ 21, whether children have access to a comprehensive array of services, *id.* at ¶ 23, and whether services are provided in the most integrated setting, *id* at. ¶ 25.

had developed its own process for implementing Paragraph 55, known as the "Maricopa County review process." Unlike the WFI, it was specifically designed to focus on service delivery according to the *J.K.* Principles, it included mental health professionals in the review process, and it included an in-depth review of cases. *See* Terkeltaub Dec. at ¶ 8; Pierce Dec. at ¶ 24. Plaintiffs and many stakeholders urged Defendants to adopt a review process similar to the Maricopa County process instead of the WFI; however, Defendants rejected this advice. Terkeltaub Dec. at ¶ 10; Pierce Dec. at ¶ 25. Disturbingly, there is significant evidence that Defendants did so specifically to avoid meaningful reviews of their performance in implementing the Agreement. *See* Terkletaub Dec. at ¶ 10 ("What became clear to me at that time is that leadership in the State was not committed to a meaningful review process. At one point, I was specifically told by the State to stop developing and implementing the Maricopa County practice review. I understand that soon after I had left my job as Director of Children's Behavioral Health Services at [the Maricopa County RBHA], a wide range of stakeholders, including family organizations, Plaintiffs' counsel, and providers, tried to encourage the State to adopt the Maricopa County practice review statewide. Not only did the State refuse to expand this review practice statewide, but it stopped the review process in Maricopa County."); *cf.* Bruns Dec. at ¶ 8 ("The WFI is not designed to measure the adequacy of the behavioral health services in a children's behavioral health system or outcomes for children receiving those services."); Pierce Dec. at ¶ 25 (WFI does not measure "whether children's needs are being adequately identified and met. Providers who went through the 'ritual' of the child and family team process but who nonetheless failed to deliver needed services could do well on the WFI.").

The reviews using the WFI were poorly implemented and, hence, there was little confidence in the results. *See* Pierce Dec. at ¶¶ 25-27. To the extent the reviews generated reliable information, the information was not used for its intended purpose, namely, to identify and correct system deficiencies. *Id.* Moreover, Defendants did not apply the WFI to the class as a whole. Instead, the WFI reviews were limited to "high needs" children. As a result, Defendants lacked a QM process for determining whether the approximately two-thirds of class members identified by Defendants as having "moderate" or "low" needs were receiving services according to the Principles.[25] Recently, the Defendants announced they were abandoning the WFI. Their new review process is not yet being implemented.

Defendants' failure to implement the QM process required by Paragraph 55 has severely limited their ability to monitor and ensure compliance with the Agreement. *See, e.g.*, Rotto Dec. at ¶ 7 (lack of effective QM process has contributed to "Arizona's failures"); Kamradt Dec. at ¶ 27 ("The State … does not appear to have an adequate understanding of the outcomes being achieved or whether services are being delivered according to the *J.K.* Principles."); Terkeltaub Dec. at ¶ 5 ("[T]he State's QM system … is a major barrier to its ability to provide children with the services they need for their mental health conditions to improve."). Defendants lack reliable data on whether children are being served according to the Principles, as well as the rich information that in-depth reviews would provide on root causes of deficiencies in the system. *Id.*

[25] Moreover, it is uncertain whether Defendants' QM system can reliably distinguish between children with "high needs" and those with lower needs.

Defendants themselves appear to recognize these deficiencies. They have never used QM data to hold RBHAs, provider networks, or provider agencies accountable for their performance in serving children according to the Principles. *See* Pierce Dec. at ¶ 29; Terkeltaub Dec. at ¶ 13. It is unlikely that the deficiencies described in this motion will be corrected without Defendants using QM data to promote improved performance and to establish accountability when expectations are not met. *See, e.g.*, Kamradt Dec. at ¶ 44 (To remedy the deficiencies, State must "create accountability, including by using its QM system to drive changes"); Rotto Dec. at ¶ 7 (State must address "lack of accountability and lack of data decision-making" to remedy the failures in its implementation of the Agreement). Terkeltaub Dec. at ¶ 5 ("State's QM system is … a major barrier…")

C. This Court Should Order Defendants to Correct Their Non-Compliance and Extend the Term of the Settlement Agreement

This Court has broad discretion to fashion a remedy for Defendants' non-compliance, including ordering specific remedial steps and extending the term of the Agreement. *See, e.g., Horne v. Flores*, 129 S. Ct. 2579, 2594 (2009) ("It goes without saying that federal courts must vigilantly enforce federal law and must not hesitate in awarding necessary relief."). "Deference to the district court's use of discretion is heightened in a case, like this one, when "complex institutional reform" is at issue. *Jeff D. v. Kempthorne*, 365 F.3d 844, 850 (9th Cir. 2004); *accord Labor/Community Strategy Center*, 564 F.3d at 1121.

Plaintiffs hereby request that the Court:

- Direct Defendants to develop, and secure the Court's approval, for a plan with specific actions and deadlines for correcting the deficiencies described in this motion,

- direct Defendants to implement the plan, and
- extend the term of the Settlement Agreement, and the Court's jurisdiction, for the period required to implement the plan, including the resolution of any disputes over implementation.

Plaintiffs' requested remedy is carefully tailored to bring Defendants into compliance. S*ee Labor/Community Strategy Center*, 564 F.3d at 1120. Moreover, it gives Defendants broad latitude in fashioning a plan, so long as the plan is reasonably calculated to secure compliance. It extends the Settlement Agreement only so long as is required to secure class members the services to which they are entitled under the Agreement and federal law.

This Court has ample power to require and direct Defendants to implement a remedial pan. *See David C.*, 242 F.3d at 1209 (requiring defendants to implement a detailed remedial plan to correct non-compliance with a settlement agreement); *Alexander,* 707 F.2d at 783 (imposing additional obligations on defendants to secure compliance with judicial decree). Moreover, extending the Settlement Agreement is well within the Court's power. Such an extension is "not itself an imposition of additional, material obligations on [the state]," but rather a device "to allow … [the state] to fulfill the very obligations it voluntarily undertook when it entered into the Agreement." *David C.*, 242 F.3d at 1211-12; *see also id*. at 1213 ("it would defy logic for [plaintiffs] to agree to include the four-year Termination Provision in the Agreement if they actually foresaw that [Defendants] would not be in substantial compliance with the terms of the Agreement at the end of the four-year period"); *Thompson*, 404 F.3d at 832 (extension of term of consent decree was "necessary to approximate the positions the parties would have occupied had the Defendants lived up to their obligations); *id.* at 828 ("If the parties had

actually anticipated that the Defendants would be so far behind on their obligations at this stage in the proceedings, the Consent Decree would never have been executed.")

Plaintiffs respectfully submit that the Court should exercise its broad powers to ensure that Defendants live up to the commitments they made in the Settlement Agreement and to their commitments under federal law.

IV. CONCLUSION

For the foregoing reasons, Plaintiffs respectfully request that the Court grant their Motion for Enforcement of the Settlement Agreement and order the relief requested herein.

RESPECTFULLY SUBMITTED this 13th day of November, 2009.

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CERTIFICATE OF SERVICE

I hereby certify that on November 13, 2009, I electronically transmitted the attached Plaintiffs' Motion for Enforcement of Settlement Agreement to the Clerk's Office using the CM/ECF System for filing and transmittal of a Notice of Electronic Filing to the following CM/ECF registrants:

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