IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No. 21-cv-2381-RMR-STV

Center for Legal Advocacy, d/b/a Disability Law Colorado; and **A.A.** by and through his grandmother, G.A.,[1]
C.C. by and through her mother, P.C., and
D.D. by and through her mother, P.D.,
individually and on behalf of a class,

Plaintiffs,

vs.

KIM BIMESTEFER, in her official capacity, Executive Director of the Colorado Department of Health Care Policy and Financing,

Defendant.

AMENDED COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

Now come the Plaintiffs, by and through their attorneys, Robert H. Farley, Jr., Ltd., the National Health Law Program, and Disability Law Colorado, and file the following amended complaint against the Defendant.

I. INTRODUCTION

1. This case concerns Colorado Medicaid coverage of Intensive Behavioral Health Services (IBHS) for children and youth with serious emotional disturbances. IBHS addresses ongoing acute and intensive behavioral health (mental health and substance use disorder) needs

[1] B.B., a 16-year-old Medicaid recipient residing in Castle Rock, Colorado and a named plaintiff in the Complaint for Injunctive and Declaratory Relief filed on September 3, 2021, ECF No. 1, passed away on December 23, 2022.

of the child and their family/caregiver to enable the child to reside at home and avoid unnecessary institutionalization. IBHS includes intensive care coordination, family and youth support services, intensive in-home therapy, mobile crisis response, and other crisis intervention services. *See* Ctrs. for Medicare & Medicaid Servs. (CMS) and Substance Abuse & Mental Health Servs. Admin. (SAMHSA), I*nformational Bulletin*, *Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions* 3-5 (CMS/SAMHSA, *Coverage of Behavioral Health Services for Children*) (May 7, 2013), https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf.

2. Plaintiff Disability Law Colorado (DLC) is Colorado's Protection & Advocacy system for people with disabilities. DLC is empowered and charged by federal law to protect the rights of Colorado residents with mental health disabilities, including Medicaid-eligible Coloradans under age 21 who need IBHS to treat their serious emotional disorders. In the context of this action, DLC's activities concern Medicaid-eligible children and their families who are not receiving necessary IBHS and, as a result, are confined to unnecessarily restrictive settings or are at serious risk of avoidable segregation in such settings. It is on behalf of these children that DLC proceeds and collectively refers to as the "DLC Constituents."

3. Plaintiffs A.A., C.C., and D.D. (Plaintiff Children) and Class are Medicaid-eligible children with behavioral or emotional disorders who need IBHS. The Plaintiff Children and Class are entitled to receive these medically necessary services in the community under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) provisions of the Medicaid Act, the Americans with Disabilities Act (ADA), and the Rehabilitation Act (RA).

4. The DLC Constituents, Plaintiff Children, and the Class have experienced unnecessary institutionalizations and other serious harms as a result of the Defendant's failure to

provide or arrange for medically necessary behavioral health services as required under EPSDT, ADA, and RA.

5. Defendant's policies, practices, procedures, acts, failures, and omissions cause DLC Constituents, Plaintiff Children, and the Class to be unnecessarily institutionalized or at serious risk of institutionalization for treatment of their behavioral or emotional disorders.

6. The Defendant is well aware that children and youth with severe mental illnesses or severe emotional disorders are not receiving medically necessary IBHS and, as a result, require treatment in restrictive institutional settings.

7. In 2019, the Colorado General Assembly found that "[t]he behavioral health system and child- and youth-serving agencies are often constrained by resource capacity and systemic barriers that can create difficulties in providing appropriate and cost-effective interventions and services for children and youth," Colo. Rev. Stat. § 25.5-5-801(1)(b), and "Colorado must implement a model of comprehensive system of care for families of children and youth with behavioral health challenges." Colo. Rev. Stat. § 25.5-5-801(2).

8. Colorado identified 27,352 children (up to the age of 21) who had a severe emotional disturbance (SED) served by the "state mental health authority" in state fiscal year 2021. SAMHSA, *2021 Uniform Reporting Summary Output Table* 7, https://www.samhsa.gov/data/sites/default/files/reports/rpt39385/Colorado.pdf.

The Colorado Behavioral Health Administration reported that, in FY 2022, 271 children who had been diagnosed as having a mental health disorder and found to be at risk of out-of-home placement received intensive home and community-based services (residential and in-home services), with 43 children receiving residential treatment and 237 children receiving community-based treatment services through the Children and Youth Mental Health Treatment

Act (CYMHTA). Colo. Behav. Health Admin., *Children and Youth Mental Health Treatment Act Annual Rpt. July 1, 2021 – June 30, 2022* at 10-11 (Dec. 30, 2022), https://bha.colorado.gov/sites/bha/files/documents/CYMHTA%20SFY22%20Annual%20Report.pdff. One of the requirements for CYMHTA coverage is that the child or youth "[i]sn't eligible for Medicaid." https://cdhs.colorado.gov/behavioral-health/cymhta.

9. Residential intensive community-based services were provided to 242 children in the "Children's Habilitation Residential Program" as of March 2023. This program is limited to children who have an intellectual or developmental disability as opposed to a child with just a mental health condition or diagnosis. Dep't of Health Care Pol'y & Fin'g, *FY 2022–Medicaid Premiums Expenditure and Caseload Report* at 13 (Mar. 2023), https://hcpf.colorado.gov/sites/hcpf/files/2023%20March%2C%20Joint%20Budget%20Committee%20Monthly%20Premiums%20Report%20%28Clean%20Version%29.pdf.

10. Intensive Community-Based Services were provided to 2,652 children in the "Children's Extensive Support Waiver." This program is also limited to children with an intellectual or developmental disability and not provided to children with just a mental health condition or diagnosis. *Id.*; *see also* Dep't of Health Care Pol'y & Fin'g, *Children's Extensive Support Waiver (CES)*, https://hcpf.colorado.gov/childrens-extensive-support-waiver-ces (last accessed Feb. 17, 2024).

11. The Colorado Department of Human Services Office of Behavioral Health stated in 2020, "Stakeholders described both rising anxiety and substance use among adolescents in the state with concerns about access to the full continuum of care needed to meet adolescent needs. Acute care crisis and residential services were frequently mentioned as gaps in the current system." Colo. Dep't of Human Servs., *2020 Statewide Behavioral Health Needs Assessment:*

Children and Youth with Complex Needs at 2 (2020), https://drive.google.com/file/d/1-RPGkZCoIxJsmzZjc9tniSlYcnGxUYrg/view. "In the surveys disseminated as part of the needs assessment, Colorado's communities and providers identified children and youth as a population who is least likely to get the behavioral health services and supports needed." *Id.* at 4. "Numerous reports indicate that parents encounter challenges accessing appropriate care and this is across payors (public and commercial)." *Id.* at 5. "More options for services in schools, inpatient bed capacity, respite and long-term residential services for both mental health and substance use are indicated as a high need within the state. Intensive home and community-based services are another element of the continuum that could support children and youth while reducing the need for inpatient or acute care services." *Id.* at 7.

12. In 2022, a statutorily created behavioral health task force that included Defendant Bimestefer found that

> [f]or decades, our fractured and too often ineffective behavioral health system has left the most vulnerable without needed support. As a result, Colorado ranks at or near the bottom of states in meeting our behavioral health challenges. Too many Coloradans are left untreated, resulting in high rate of suicide, harmful substance use, and depression. Children are sent out of state to treat serious behavioral health challenges and suicide rates among young people have gone up over *51% during the last decade in Colorado*.

Behavioral Health Transformational Task Force and Subpanel, *Behavioral Health Transformational Task Force Recommendations Rpt.* at II (Jan. 2022), https://leg.colorado.gov/sites/default/files/images/committees/2017/bhttf_final_report.pdf (citing Colo. Rev. Stat. § 24-75-230 (4)(b)).

13. On May 25, 2021, Children's Hospital Colorado declared a "State of Emergency" in youth mental health as the hospital is "seeing [their] pediatric emergency departments and inpatient units overrun with kids attempting suicide and suffering from other forms of major

mental health illness." Children's Hosp. Colo., *Children's Hospital Colorado Declares a 'State of Emergency' for Youth Mental Health* (May 26, 2021), https://www.childrenscolorado.org/about/news/2021/may-2021/youth-mental-health-state-of-emergency. The hospital further stated:

> We've had several of our team members working diligently, every day, every hour, looking for placement for these children. The reality is that there are limited resources available in our community and in our state. . . . At a time when we are seeing volumes increase, severity increase and overall need, the system that is meant to be in place to serve these kids does not only not exist, but those who are attempting to do this work are currently underwater.

14. In May 2022, Children's Hospital Colorado announced the State of Emergency had worsened in the past year. "There has been a 23% increase in patients visiting the hospital's emergency departments for behavioral health concerns when compared to the first quarter of 2021 and a 103% increase above the first quarter of 2019, before the pandemic began." Children's Hosp. Colo., *One Year Later: Mental Health Crisis Worsens* (May 4, 2022), https://www.childrenscolorado.org/about/news/2022/may-2022/mental-health-er-visits-up/.

15. A 2023 HCPF Concept Paper noted feedback about concerns regarding delays in access to care, especially for children, and identified policy options for a "new children's intensive case management program, including independent assessments for medical necessity" and "the use of standardized assessments for authorizing residential care and intensive outpatient care." HCPF, Accountable Care Collaborative Phase III Concept Paper 13 (Aug. 2023), https://hcpf.colorado.gov/sites/hcpf/files/2023%20ACC%20Phase%20III%20Concept%20Paper%209-7-23.pdf.

16. As a result of the Defendant's continued over-reliance on institutions, hundreds of children with behavioral and emotional disorders cycle through in-state and out-of-state

hospitals, emergency rooms, and other acute care and residential facilities without obtaining any long-term relief. The State of Colorado's system of mental health care for children is so weak and uncoordinated that most children are released from facilities with little or ineffective follow-up community mental health care. The services offered after discharge from an institutional setting consist of little more than minimal medication management and limited outpatient counseling, which is inadequate for a child with significant behavioral and emotional problems. Many children and families find themselves thrown back into a crisis, forced to repeat the cycle of institutionalization.

17. Despite widespread agreement among mental health experts that children with significant emotional or behavioral disorders need IBHS, the Plaintiff Children and DLC Constituents have not received such services as they require.

18. Plaintiffs cannot wait any longer for the Defendant to fulfill her legal mandate to provide for the IBHS that they desperately need. Accordingly, Plaintiffs seek prospective injunctive relief ordering the Defendant to provide necessary IBHS and to make the reasonable accommodations necessary to prevent their unnecessary institutionalization and serious risk of such institutionalization.

II. JURISDICTION & VENUE

19. This Court has jurisdiction pursuant to 28 U.S.C. §§ 1331 (federal question jurisdiction) and 1343 (civil rights jurisdiction) to hear Plaintiffs' claims arising under the Medicaid Act, Title II of the ADA, and Section 504 of the RA.

20. This Court has jurisdiction to order the declaratory and injunctive relief sought in this action, as well as other relief that is "further necessary and proper," under 42 U.S.C. § 1983, 42

U.S.C. § 12133, and 29 U.S.C. § 794a. Plaintiffs' claims are authorized under 28 U.S.C. §§ 2201-2202 and Rules 57 and 65 of the Federal Rules of Civil Procedure.

21. Venue is proper in this district under 28 U.S.C. § 1391(b) because a substantial part of the events or omissions giving rise to Plaintiffs' claims occurred in this District and because Defendant Bimestefer may be found here.

III. PARTIES

A. Plaintiff Disability Law Colorado

22. Plaintiff Center for Legal Advocacy d/b/a Disability Law Colorado (DLC) is a federally funded nonprofit corporation, organized under the laws of the State of Colorado, with an office in Denver. DLC's mission is to protect and promote the rights of people with disabilities and older people in Colorado through direct legal representation, advocacy, education, and legislative analysis.

23. In 1977, Governor Richard D. Lamm designated DLC to serve as Colorado's Protection and Advocacy (P&A) system for individuals with disabilities, pursuant to the Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. §§ 15041 *et seq*., the Protection and Advocacy for Individuals with Mental Illness Act (PAIMI), 42 U.S.C. §§ 10801 *et seq*., and the Protection and Advocacy of Individual Rights Act, § 29 U.S.C. § 794(e).

24. PAIMI provides for the establishment and funding of P&A systems, including DLC, to investigate the abuse and neglect of people with mental health disabilities, to engage in protection and advocacy "to ensure that the rights of individuals with mental illness are protected," and "to ensure the enforcement of the Constitution and Federal and State statutes" on behalf of people with mental health disabilities. 42 U.S.C. §§ 10801(b)(1), 10801(b)(2)(A). As Colorado's P&A system, DLC is authorized to "pursue administrative, legal, and other

appropriate remedies to ensure the protection of individuals with mental illness who are receiving care or treatment in the State." 42 U.S.C. § 10805(a)(1)(B).

25. DLC has associational standing to bring this action. DLC is the functional equivalent of a voluntary membership organization created by Congress to protect and advocate for its Colorado constituents, which include children under 21 with mental health disabilities.

26. Individuals with serious mental health disabilities have representation in DLC and influence its activities. DLC is governed by a board of directors comprised predominantly of people with disabilities and their families. DLC's board is advised by a PAIMI advisory council, the majority of whom are individuals who have received mental health services or have family members who do. The PAIMI advisory council has significant input in setting DLC's goals and objectives. DLC uses surveys and meetings with interested members of the public to collect input from people with disabilities and also uses that input to set its goals and objectives.

27. DLC maintains a grievance procedure for constituents to ensure people with disabilities have full access to and input into DLC's advocacy, services, and areas of work.

28. DLC fulfills its federal mandate under PAIMI by providing an array of protection and advocacy services to people with mental health disabilities across Colorado, including children and youth under age 21 who have been unnecessarily institutionalized or who are at risk of such institutionalization.

29. As a result of DLC's organizational structure, leadership, allocation of resources and outreach, connections with constituents in the disability community, and involvement in disability rights advocacy, people with disabilities have a strong voice in and direct influence on the work of DLC.

B. The Named Plaintiff Children

30. Plaintiff A.A. is a 15-year-old Medicaid recipient residing in Northglenn, Colorado, who has been diagnosed with multiple mental illnesses and conditions. Due to Defendant's failure to ensure the provision of IBHS, A.A. cycles in and out of hospital/institutional settings. Pursuant to Fed.R.Civ.P.17(c), A.A. brings this action through his grandmother/guardian and next friend, G.A.

31. Plaintiff C.C. is a 16-year-old Medicaid recipient residing in Aurora, Colorado, who has been diagnosed with multiple mental illnesses and conditions. Due to Defendant's failure to ensure the provision of IBHS, C.C. has been unnecessarily hospitalized/institutionalized. Pursuant to Fed.R.Civ.P.17(c), C.C. brings this action through her mother and next friend, P.C.

32. Plaintiff D.D. is an 18-year-old Medicaid recipient residing in Brighton, Colorado, who has been diagnosed with multiple mental illnesses and conditions. Due to Defendant's failure to ensure the provision of IBHS, D.D. has been unnecessarily hospitalized/ institutionalized. Pursuant to Fed.R.Civ.P.17(c), D.D. brings this action through her mother and next friend, P.D.

C. The Defendant

33. The Defendant, Kim Bimestefer, is the Executive Director of the Colorado Department of Health Care Policy and Financing (HCPF). As such she is responsible for the supervision and oversight of HCPF medical programs and contractual arrangements. Her responsibilities in this role include the responsibility to ensure compliance with federal law. She is being sued in her official capacity.

IV. CLASS ACTION ALLEGATIONS

34. Plaintiffs A.A., C.C., and D.D. bring this statewide action pursuant to Federal Rules of Civil Procedure 23(a) and 23(b)(2) on behalf of a class defined as:

> All Medicaid-enrolled children and youth under the age of 21 in the State of Colorado who have a mental health or behavioral disorder, and for whom a licensed practitioner of the healing arts recommends Intensive Home and Community-based Behavioral Health Services, *i.e.* Intensive Care Coordination, Intensive In-Home Services, and Mobile Crisis Services.

35. The Class is so numerous that joinder of all persons is impracticable. Medicaid covers three out of ten children in Colorado, including all children involved in the foster care system. Kaiser Fam. Found., *Medicaid in Colorado* (Oct. 2022), https://files.kff.org/attachment/fact-sheet-medicaid-state-CO. Between 2018 and 2021, the number of Colorado children under age 18 enrolled in Medicaid ranged from 572,747 (2018) to 617,920 (2021). The Annie E. Casey Found. Kids Count Data Ctr., *Children from birth to 18 enrolled in Medicaid in Colorado*, https://datacenter.kidscount.org/data/tables/463-children-from-birth-to-18-enrolled-in-medicaid#detailed/2/any/false/2048,574,1729,37,871,870,573,869,36,868/any/14567,1140. As described, *supra*, there are tens of thousands of children with a serious behavioral or emotional disorder in Colorado. Most conservatively, the Class is composed of more than a thousand children.

36. The Plaintiffs A.A., C.C., and D.D. and Class have limited financial resources, and as Medicaid recipients, are unlikely to institute individual actions.

37. The claims of the Plaintiff Children and Class members raise common questions of law and fact and include:

(a) Whether the Defendant is providing necessary and timely IBHS to the Plaintiff Children and the Class consistent with the EPSDT requirements of the Medicaid Act pursuant to 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(4)(B), 1396a(a)(43)(C), 1396d(r)(5);

(b) Whether the Defendant is failing to provide Plaintiff Children and the Class with services in the most integrated setting appropriate to their needs, thereby resulting in unnecessary institutionalization or serious risk of institutionalization of Plaintiff Children and the Class;

(c) Whether the Defendant violated the ADA and/or RA Act by failing to make reasonable modifications which would result in the availability of IBHS for the Plaintiff Children and Class;

(d) Whether the Defendant utilizes criteria or methods of administration in the Medicaid program that otherwise have the effect of discriminating against Plaintiff Children and members of the Class on the basis of their disabilities;

(e) Whether the Defendant's policies and practices result in disparate treatment of comparably situated disabled persons under the ADA by providing IBHS to a group of disabled children (up to the age of 21) who have an intellectual or developmental disability as opposed to a group of disabled children with just a mental health condition or mental health diagnosis; and

(f) Whether the Defendant's policies and practices result in disparate treatment of comparably situated disabled persons under the ADA by providing IBHS to a group of disabled children (up to the age of 21) who have a mental health condition or a mental health diagnosis and who are not eligible for Medicaid as

opposed to a group of children who have a mental health condition or a mental health diagnosis and who are eligible for Medicaid.

38. The claims and remedies asserted by Plaintiffs A.A., C.C., and D.D. are typical of the claims and remedies asserted by the Class. Plaintiffs A.A., C.C., and D.D. and the Class are all Medicaid-enrolled children under the age of 21 who have been diagnosed with a serious mental health or behavioral disorder, and who require IBHS to correct or ameliorate their mental illness or behavioral condition. The remedies sought by Plaintiffs A.A., C.C., and D.D. are the same remedies that would benefit the Class: an injunction requiring Defendant to take affirmative actions to provide or arrange for necessary IBHS for all individual Plaintiffs A.A., C.C., and D.D. and the Class to correct or ameliorate their significant mental health conditions.

39. The Plaintiff Children are adequate representatives of the Class because they suffer from deprivations identical to those of the Class members and have been denied the same federal rights that they seek to enforce on behalf of the other Class members. The Plaintiff Children will fairly and adequately represent the interest of the Class members, many of whom are unable to pursue claims on their own behalf as the result of their disabilities. Plaintiff Children's interest in obtaining injunctive relief for the violations of rights and privileges is consistent with and not antagonistic to those of any person within the Class.

40. Plaintiffs' counsel are qualified, experienced, and able to conduct the proposed litigation. Plaintiffs' counsel have extensive experience litigating Rule 23(b)(2) class actions under the Medicaid Act, the ADA, and RA.

41. Prosecution of separate actions by individual Class members would create a risk of inconsistent or varying adjudication, which would establish incompatible standards of conduct

for the party opposing the Class or could be dispositive of the interests of the other members or substantially impair or impede the ability to protect their interests.

42. A class action is superior to other available methods for the fair and efficient adjudication of the controversy in that: (a) A multiplicity of suits with consequent burden on the courts and defendants should be avoided, and (b) It would be virtually impossible for all class members to intervene as parties-plaintiffs in this action. 42. The Defendant has, with knowledge of the requirements of the Medicaid EPSDT mandate, the ADA, the RA and implementing regulations, has acted or refused to act, and continues to act or refuse to act, on grounds applicable to the Class, thereby making appropriate final injunctive and declaratory relief with respect to the Class as a whole.

V. STATUTORY AND REGULATORY FRAMEWORK

A. The Federal Medicaid Act and EPSDT Mandate

43. Medicaid is a cooperative federal- and state-funded program authorized and regulated pursuant to the Medicaid Act, which provides medical assistance for certain groups of low-income persons. 42 U.S.C. §§ 1396-1396w-7.

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

45. The U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS) is the federal agency charged with oversight of the Medicaid Act. CMS promulgates regulations and issues guidance documents to implement the Medicaid Act.

46. State participation in Medicaid is voluntary; however, States that choose to participate receive federal funding for a significant portion of the cost of providing Medicaid

benefits and administering the program must adhere to the minimum federal requirements set forth in the Medicaid Act and its implementing regulations.

47. Each State participating in the Medicaid program must submit a Medicaid plan to the Secretary of Health and Human Services (HHS) for approval. The State plan describes the administration of the program and identifies the services the State will provide to eligible beneficiaries. 42 U.S.C. § 1396a(a).

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

49. Colorado participates in the Medicaid program. In Colorado, HCPF is the single state agency responsible for administering the Medicaid program.

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

51. Federal law requires States to fully implement the Medicaid Act EPSDT provisions.

52. The purpose of ESPDT is to ascertain children's physical and mental health conditions and ensure children receive needed services "to correct or ameliorate defects and physical and mental illnesses and conditions." 42 U.S.C. § 1396d(r)(5). Under EPSDT, States are required to provide screening services to identify health and mental health conditions and illness. *Id.* § 1396d(r)(1). Needed services must be provided if they are among those listed in section 1396d(a) of the Medicaid Act, whether or not those services are covered for adults. *Id.* § 1396d(r)(5).

53. States must "provide for . . . providing or arranging for the provision of . . . screening services in all cases where they are requested[.]" *Id.* § 1396a(a)(43)(B).

54. States must "provide for . . . arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services." *Id.* § 1396a(a)(43)(C).

55. EPSDT services must be covered when they are needed to correct, compensate for, improve a condition, or prevent a condition from worsening, even if the condition cannot be prevented or cured. U.S. Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *EPSDT: A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents*, hereinafter "*EPSDT Guide*" at 10 (June 2014), https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf.

56. Specifically, participating States must establish and implement an EPSDT program that:

(a) informs all persons in the State who are under the age of 21 and eligible for medical assistance of the availability of EPSDT as described in 42 U.S.C. § 1396d(r);

(b) provides or arranges for the provision of screening services in all cases where they are requested (42 U.S.C. § 1396a(a)(43)); and

(c) provides or arranges for corrective treatment, the need for which is disclosed by such child health screening services. *Id.*

57. EPSDT screening includes services at pre-set intervals, sometimes called periodic screens. EPSDT screening also includes services at other intervals as needed to determine the existence of a physical or mental health condition, sometimes called inter-periodic screens. *Id.* at § 1396d(r)(1)(A).

58. According to CMS: "Any qualified provider operating within the scope of his or her practice, as defined by state law, can provide a screening service. The screening *need not be* conducted by a Medicaid provider in order to trigger EPSDT coverage for follow up diagnostic services and medically necessary treatment by a qualified Medicaid provider. . . . The family or beneficiary need not formally request an EPSDT screening in order to receive the benefits of EPSDT. Rather, any visit or contact with a qualified medical professional is sufficient to satisfy EPSDT's screening requirement, and states should consider a beneficiary who is receiving services to be participating in EPSDT, whether the beneficiary requested screening services directly from the state or the health care provider." CMS, *EPSDT Guide* at 6; CMS, State Medicaid Manual § 5310.

59. States "must set standards for the timely provision of EPSDT services which meet reasonable standards of medical and dental practice . . . and must employ processes to ensure timely initiation of treatment, if required, generally within an outer limit of six months after the request for screening services." 42 C.F.R. § 441.56(e).

60. States must "make available a variety of individual and group providers qualified and willing to provide EPSDT services." 42 C.F.R. § 441.61(b).

B. Intensive Behavioral Health Services

61. For children with significant emotional and behavioral disorders, IBHS are medically necessary to treat and ameliorate their conditions.

62. Physician services ((§ 1396d(5)), medical and other remedial care from licensed practitioners (§ 1396d(6)), rehabilitative services (§ 1396d(a)(13)), and case management services (§§ 1396d(a)(19), 1396n(g)) are among the services listed in 42 U.S.C. § 1396d(a) that encompass IBHS. These services must be provided by the State under the EPSDT mandate.

63. Rehabilitative services are defined to include:

> Any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level. 42 U.S.C. § 1396d(a)(13); 42 C.F.R. § 440.130(d).

64. Services that fit within Medicaid's definition of Rehabilitative Services include:

(a) Community-Based Crisis Services, such as Mobile Crisis Teams, and Intensive Outpatient Services;

(b) Individualized mental health and substance use treatment services, including in non-traditional settings such as a school, a workplace or at home;

(c) Medication management;

(d) Counseling and Therapy, including to eliminate psychological barriers that would impede development of community living skills.

CMS, *EPSDT Guide* at 11.

65. Case management services are services which will "assist individuals . . . in gaining access to needed medical, social, education, and other services" and include assessment, care planning, referral, and monitoring. 42 U.S.C. § 1396n(g)(2).

66. CMS and the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) issued a joint informational bulletin on May 7, 2013 and stated as follows:

> This Informational Bulletin is intended to assist states to design a benefit that will meet the needs of children, youth, and young adults with significant mental health conditions. Children with significant emotional, behavioral and mental health needs can successfully live in their own homes and community with the support of the mental health services described in this document. These services enable children with complex mental health needs–many of whom have traditionally been served in restrictive settings like residential treatment centers, group homes and psychiatric hospitals–to live in community settings and participate fully in family and community life.

> The information in this Bulletin is based on evidence from major U.S. Department of Health and Human Services (HHS) initiatives that show that these services are not only clinically effective but cost effective as well. The Bulletin also identifies resources that are available to states to facilitate their work in designing and implementing a benefit package for this vulnerable population. Developing these services will help states comply with their obligations under the Americans with Disabilities Act (ADA) and to Medicaid's Early Periodic Screening, Diagnostic and Treatment (EPSDT) requirements, specifically with respect to mental health and substance use disorder services.

CMS/SAMHSA, *Coverage of Behavioral Health Services for Children* at 1 (footnote omitted), https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf.

67. "While the core benefit package for children and youth with significant mental health conditions . . . include[s] traditional services, such as individual therapy, family therapy, and medication management, . . . a number of other home and community-based services significantly enhance[] the positive outcomes for children and youth. These services include intensive care coordination (often called wraparound service planning/facilitation), family and youth peer support services, intensive in-home services, respite care, mobile crisis response and stabilization, and flex funds." *Id.* at 3. CMS/SAMHSA have defined these services for States, as follows:

1. Intensive Care Coordination

68. "Intensive care coordination includes assessment and service planning, accessing and arranging for services, coordinating multiple services, including access to crisis services. Assisting the child and family to meet basic needs, advocating for the child and family, and monitoring progress are also included." *Id.* at 3.

69. The Wraparound Approach is a "form of intensive care coordination for children with significant mental health conditions. It is a team-based, collaborative process for developing and implementing individualized care plans for children and youth with complex needs and their

families . . . The wraparound 'facilitator' is the intensive care coordinator who organizes, convenes, and coordinates this process. The wraparound approach is done by a child and family team for each youth that includes the child, family members, involved providers, and key members of the child's formal and informal support network, including members from the child serving agencies. The child and family team develops, implements, and monitors the service plan." *Id.* at 3.

2. Intensive In-Home Services

70. "Intensive in-home services are therapeutic interventions delivered to children and families in their homes and other community settings to improve youth and family functioning and prevent out-of-home placement in inpatient or PRTF [psychiatric residential treatment facility] settings. The services are typically developed by a team that can offer a combination of therapy from a licensed clinician and skills training and support from a paraprofessional. The components of intensive in-home services include individual and family therapy, skills training and behavioral interventions. Typically, staff providing intensive in-home services have small caseloads to allow them to work with the child and family intensively, gradually transitioning them to other formal and informal services and supports, as indicated. *Id.*

33. Mobile Crisis Services

71. "Mobile crisis response and stabilization services are instrumental in defusing and de-escalating difficult mental health situations and preventing unnecessary out-of-home placements, particularly hospitalizations. Mobile crisis services are available 24/7 and can be provided in the home or any setting where a crisis may be occurring." *Id.* at 5.

4. Peer Services: Parent and Youth Support Services

72. Family supports are also integral to the continuum of care. "Parent and youth support services include developing and linking with formal and informal supports; instilling confidence; assisting in the development of goals; serving as an advocate, mentor, or facilitator for resolution of issues; and teaching skills necessary to improve coping abilities." *Id.* at 4.

73. Under Colorado policy, IBHS include, but are not limited to:

(a) Individual Therapy and Family Therapy;

(b) Therapeutic Services and/or Behavioral Support Services;

(c) Wraparound Services, Wraparound Plan and Wraparound Monitoring;

(d) Transition Support Services;

(e) Life skills training;

(f) Peer Mentorship;

(g) Applied Behavioral Analysis, therapeutic services;

(h) Case Management Services; and

(i) Residential (Habilitation) Services and Supports.

74. The State of Colorado does not make IBHS available on a consistent, statewide basis for children for who have been diagnosed with a mental health or behavioral disorder.

75. The Medicaid Act also provides authority for states to operate Home and Community Based waiver programs. 42 U.S.C. § 1396n(c). The federal Medicaid agency may grant States the authority to waive certain Medicaid requirements to enable them to provide Home and Community-Based Services to individuals with developmental disabilities (which are conditions separate from mental illness) who would otherwise need the level of care provided in an institutional setting. *Id.* Unlike traditional Medicaid, States may limit enrollment in these waiver

programs and offer services that are not otherwise authorized under Medicaid. 42 U.S.C. §§ 1396n(c)(3), 1396n(c)(4)(B).

C. The American with Disabilities Act and Section 504 of the Rehabilitation Act

76. Congress enacted the ADA in 1990 "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. § 12101(b)(1). The ADA acknowledges that "historically, society has tended to isolate and segregate individuals with disabilities, and despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem." *Id.* § 12101(a)(2).

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

78. Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." *Id.* § 12132.

79. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 597 (1999), emphasizes that "[u]njustified isolation" is "properly regarded as discrimination based on disability." The *Olmstead* Court found that states need to integrate people with disabilities into the community, addressing "two evident judgments" with this integration mandate: institutional placement of those who can be in the community "perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life," and institutional

placement "severely diminishes the everyday life activities of individuals, including family relations, social contacts, . . . educational advancement, and cultural enrichment." *Id*. at 600-01.

80. CMS has long encouraged states to provide services in home and community settings, particularly for children, not only because of *Olmstead*, but because community-based care is considered a best practice for supporting children with disabilities and chronic conditions.

81. Community-based services are also generally more cost-effective. *See, e.g.*, CMS, *EPSDT Guide* at 21-22; CMS/SAMHSA, *Coverage of Behavioral Health Services for Children* (May 7, 2013). National data demonstrate that community-based services cost 25% of what residential treatment will cost, producing an average annual savings of $40,000 per child served in the community. CMS/SAMHSA, *Coverage of Behavioral Health Services for Children* at 2.

82. The DLC Constituents, Plaintiff Children, and the Class are "qualified individuals with a disability," meaning they are each an "individual with a disability, who with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity." 42 U.S.C. § 12131(2).

83. Defendant Bimestefer administers HCPF, which is a "public entity" subject to the nondiscrimination requirements of Title II of the ADA. *Id.* § 12131.

84. Regulations implementing the requirements of Title II of the ADA provide that "[a] public entity shall 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 most integrated setting appropriate to the needs of a qualified individual with a disability means

"a setting that enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 C.F.R. pt. 35, App. B.

85. The U.S. Department of Justice issued a statement on enforcement of the integration mandate, describing those settings as follows:

> Integrated settings are those that provide individuals with disabilities opportunities to live, work, and receive services in the greater community, like individuals with disabilities. Integrated settings are located in mainstream society; offer access to community activities and opportunities at times, frequencies and with persons of an individual's choosing; afford individuals the opportunity to interact with non-disabled persons to the fullest extent possible.

U.S. Dep't of Justice, Civil Rights Division, *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.* 3 (June 22, 2011), http://www.ada.gov/olmstead/q&a_olmstead.htm. The integration mandate is applicable to situations "where a public entity administers its programs in a manner that results in unjustified segregation of persons with disabilities." *Id.* "Individuals need not wait until the harm of institutionalization or segregation occurs or is imminent." *Id*. at 5.

86. In December 2022, the Department of Justice again found that "[c]ommunity-centered behavioral health programs have had success in preventing institutionalization and producing better outcomes for children and families. With access to timely and appropriate services, even children with intensive behavioral health needs and a history of congregate facility placement are able to return to or remain in family homes where they are more likely to have improved clinical and functional outcomes, better school attendance and performance, and increased behavioral and emotional strengths compared to children receiving care in institutions." U.S. Dep't of Justice, *Report, Investigation of the State of Alaska's Behavioral*

Health System for Children 10 (Dec. 14, 2022), https://www.justice.gov/opa/press-release/file/1558151/download.

87. The ADA's implementing regulations further prohibit public entities from utilizing "criteria or methods of administration" that have the effect of subjecting qualified individuals with disabilities to discrimination or "[t]hat have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the entity's program with respect to individuals with disabilities. . . ." 28 C.F.R. § 35.130(b)(3)(ii). The regulation also provides, "A public entity shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any service, program, or activity, unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered." *Id.* § 35.130(b)(8).

88. The implementing regulations of Title II of the ADA 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." *Id.* § 35.130(b)(7).

89. Section 504 of the RA states that "[n]o otherwise qualified individual with a disability . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." 29 U.S.C. § 794(a).

90. Under Section 504, "program or activity" means "all of the operations of a department, agency, special purpose district, or other instrumentality of a State or of a local government." *Id.* § 794(b)(1).

91. Section 504 defines an "individual with a disability" as "any person who has a disability as defined in . . . the Americans with Disabilities Act." *Id.* § 705(20)(B).

92. Regulations implementing Section 504 provide that programs or activities that receive federal funding may not deny or otherwise "afford a qualified [individual with a disability] an opportunity to participate in or benefit from the aid, benefit, or service" that is not "equal to" or "as effective as that afforded [or provided] to others." 45 C.F.R. §. 84.4 (b)(1)(i)-(iii); *see also* 28 C.F.R. § 41.51 (DOJ regulations describing prohibitions on disability-based discrimination).

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

94. Because the language of Title II of the ADA and Section 504 of the RA "is substantially the same, we apply the same analysis to both." *Cohon ex rel. Bass v. New Mexico Dep't of Health*, 646 F.3d 717, 726 (10th Cir. 2011).

95. The Defendant discriminates against the DLC Constituents and Plaintiff Children and the Class by failing to provide them services in the most integrated setting appropriate to their needs. An integrated setting is one that allows individuals to live in their home or a home-like setting with natural family supports and opportunity to attend school and participate in their communities with non-disabled peers.

96. The Defendant offers fragmented and negligible amounts of IBHS. The Defendant is choosing instead to serve children in needlessly segregated settings.

97. Hospitals, Psychiatric Residential Treatment Facilities (PRTFs), Residential Child Care Facilities (RCCFs) and Qualified Residential Treatment Programs (QRTPs) are restrictive settings that severely limit a child from interacting with his or her family, school, peers, and community.

98. Out-of-home placements exacerbate many children's behavioral and emotional problems by severing these important connections. By failing to provide adequate home-based and community-based mental health/behavioral services, the Defendant has and continues to discriminate against DLC's Constituents, the Plaintiff Children, and the Class by unnecessarily segregating them in violation of the ADA and RA.

99. The Defendant discriminates against the DLC's Constituents, Plaintiff Children, and the Class by failing to provide them IBHS while the Defendant provides IBHS to other persons with other disabilities.

100. The Defendant provides greater Medicaid benefits to children (up to the age of 21) with an intellectual or developmental disability than to children with a mental health or behavioral disorder.

101. The Defendant provides greater benefits to children (up to the age of 21) who have a mental health diagnosis and are at risk of out of home placement and *who are not eligible for Medicaid* than to children who are eligible for Medicaid and who have a mental health diagnosis and are at risk of out of home placement.

D. Colorado's Medicaid Program Locks Out Needed Services For Children Under Age 21 with a Mental Health or Behavioral Disorder.

102. Home and community-based (HCBS) waiver services provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted population groups, such as persons with intellectual or developmental disabilities, physical disabilities, and/or mental illness. *See* https://www.medicaid.gov/medicaid/home-community-based-services/index.html.

Home and Community-Based Services Waiver Programs

103. Colorado operates 11 HCBS Waivers (6 Adult Waivers and 5 Children Waivers), for certain groups of persons with disabilities. HCBS services which would benefit Medicaid-eligible children up to age 21 in Colorado with a mental health or behavioral disorder are denied access to medically needed HCBS services as they are excluded under the Colorado's HCBS program rules.

Community Mental Health Supports Waiver (CMHS)

104. Colorado's Community Mental Health Supports Waiver, which provides services to persons experiencing severe and persistent mental health needs, is limited to persons age 18 and older and thus excludes children with mental health needs under the age of 18. Some of the services which are provided this program include:

(i) Alternative Care Facilities;

(ii) Life Skills Training;

(iii) Peer mentorship;

(iv) Personal care;

(v) Personal emergency response system; and

(vi) Transition set up.

See Colo. Dep't of Health Care Pol'y & Fin'g, *Community Mental Health Supports Waiver (CMHS)*, https://hcpf.colorado.gov/community-mental-health-supports-waiver-cmhs.

Children Habilitation Residential Program (CHRP)

105. Colorado's CHRP, which serves children with intensive behavioral or medical support needs through age 20, is limited to children with an intellectual or developmental disability and thus excludes children with a mental health or behavioral disorder who do not have an intellectual or developmental disability. Some of the services which are provided in this program include:

(i) Habilitation Services – Residential 24-Hour Support;

(ii) Intensive Support Services which include Wraparound Facilitator and Wraparound Plan, Prevention/Monitoring, Child & Youth Mentorship;

(iii) Transition Support Services which include Wraparound Facilitator and Wraparound Plan, Prevention/Monitoring, Child & Youth Mentorship;

(iv) Respite Services; and

(iv) Community Connector Services.

See https://hcpf.colorado.gov/childrens-habilitation-residential-program-waiver-chrp.

Children's Extensive Support Waiver

106. Colorado's Children's Extensive Support Waiver, which serves children with intensive behavioral or medical needs through age 17, is limited to children with a developmental disability and thus excludes children with a mental health or behavioral disorder

who do not have a developmental disability. *See* https://hcpf.colorado.gov/childrens-extensive-support-waiver-ces.

Developmental Disabilities (DD) Waiver

107. Colorado's DD Waiver, which serves individuals age 18 and older who are in need of services and supports 24 hours a day that will allow them to live safely and participate in the community, is limited to persons with developmental disabilities and thus excludes children with a mental health or behavioral disorder who do not have a developmental disability. Some of the IBHS services provided in this program include:

(i) Behavioral Services;

(ii) Day habilitation;

(iii) Peer mentorship;

(iv) Residential Habilitation (24-hour individual or group);

(v) Supported Employment; and

(vi) Transition Set Up.

See https://hcpf.colorado.gov/developmental-disabilities-waiver-dd.

Brain Injury (BI) Waiver

108. Colorado's BI Waiver, which serves persons age 16 and older, is limited to persons with a brain injury and thus excludes children with a mental health or behavioral disorder who do not have a brain injury. Some of the services provided in this program include:

(i) Behavioral Management;

(ii) Day Treatment;

(iii) Independent Living Skills Training;

(iv) Mental Health Counseling;

(v) Peer Mentorship;

(vi) Personal Care,

(vii) Personalized Emergency Response System;

(viii) Supported Living Program;

(ix) Transition Set Up; and

(x) Transitional Living Program.

See https://hcpf.colorado.gov/brain-injury-waiver-bi.

E. Colorado's Non-Medicaid Program Locks Out Needed Services For Medicaid-Eligible Children Under Age 21 with a Mental Health or Behavioral Disorder.

The Children and Youth Mental Health Treatment Act (CYMHTA)

109. The CYMHTA of Colorado provides for mental health services for children who are not eligible for Medicaid (Colo. Rev. Stat. § 27-67-101 *et. seq.*). To be eligible for the CYMHTA, a child or youth:

(i) Must have a mental health diagnosis

(ii) Must be at risk of out of home placement

(iii) Isn't eligible for Medicaid

(iv) Accesses the program prior to their 18th birthday and may continue to remain eligible for services unto their 21st birthday.

(v) Doesn't have a pending or current dependence and neglect action with child welfare

See https://cdhs.colorado.gov/behavioral-health/cymhta.

110. Some of the services provided in the CYMHTA program include:

(i) Care Management

(ii) Community-Based Services which include,

- Individual and Family Therapy

- Therapeutic Foster Care

- Intensive In-Home Services

- Intensive Case Management

- Applied Behavioral Analysis

- Day Treatment

(iii) Plan of Care

(iv) Residential Treatment

111. In FY2020, the CYMHTA did not have a waitlist for children and youth who were at risk of out of home placement to begin receiving services. Off. of Behav. Health, *CYMHTA Annual Rpt.* 2 (Dec. 30, 2022), https://bha.colorado.gov/sites/bha/files/documents/CYMHTA%20SFY22%20Annual%20Report.pdff.

112. In FY2020, CYMHTA program expanded its network of providers which will help ensure there are no gaps in the service coverage areas and help to increase the consistency of the CYMHTA statewide.

113. CYMHTA implemented use of the Child and Adolescent Needs and Strengths (CANS) assessment tool for evaluation of a child or youth for eligibility as outlined in Colo. Rev. Stat. 27-67-104(1)(a) on November 1, 2019. The CANS is required at the initial CYMTHA assessment, 6-month assessment updates, and discharge from the CYMHTA program.

114. Once a child and family are approved for CYMHTA funding, the Mental Health Agency's CYMHTA liaison will help the parents choose an appropriate service provider. The

CYMHTA liaison notifies the family, both orally and in writing, of the clinical recommendations and potential providers for CYMHTA funding.

115. In FY 2022, 43 children and youth received residential treatment and 237 children and youth received community-based treatment services in the CYMHTA program. The median length of stay in residential treatment for FY22 under CYMTHA funding was five months. The median length of stay in community-based services under CYMTHA funding was eight months. *Id.* at 10-11.

VI. THE PLAINTIFF CHILDREN

A. The Plaintiff Children's Experiences with Colorado's Medicaid

116. Plaintiffs A.A., C.C, and D.D. are child Medicaid recipients residing across Colorado who have been diagnosed with a serious mental illness or condition. During encounters with health care professionals, each child has been prescribed IBHS. Each Plaintiff, as well as the members of the Class and DLC Constituents, share a common and vital thread: all have experienced harm, including unnecessary segregation and risk of such segregation, resulting from Defendant's failure to arrange for the provision of necessary IBHS.

117. On information and belief, health care providers who are serving Medicaid-enrolled children under age 21 who need IBHS are not seeking Medicaid coverage of such services based on their understanding and previous experience that HCPF will not approve and/or arrange for them, in part because of the inadequacy of the behavioral health network.

118. Defendant's longstanding failure to ensure an adequate mental and behavioral health system is particularly harmful for Medicaid-eligible children with a serious emotional disturbance, such as the Children here. Because necessary IBHS are not available, Plaintiffs experience or are at risk of experiencing deterioration of their mental and behavioral health,

resulting in escalating treatment needs, mental and behavioral health crises, hospitalizations, avoidable institutionalization in psychiatric facilities, and an overall decline socially, academically, and in their daily lives.

119. DLC Constituents and Plaintiff Children, including A.A., C.C., and D.D., are unnecessarily cycling in and out of institutional, segregated settings—hospitals, emergency rooms, and psychiatric institutions—due to the failure of the Defendant to arrange for medically necessary IBHS that the Children need.

Plaintiff A.A.

120. Plaintiff A.A. is a 15-year-old boy who is lives in Northglenn, Colorado.

121. A.A. has diagnoses of Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder, Obsessive-Compulsive Disorder, Depressive Disorder, Reactive Attachment Disorder, Unspecified Anxiety Disorder, and some symptoms of Autism Spectrum Disorder. His psychiatric condition is further complicated by early maternal drug abuse with likely early trauma and possible prenatal drug exposure. Due to his significant disabilities, A.A. has been enrolled in the Colorado Medicaid program since birth.

122. A.A. has a significant history of aggressive and assaultive behavior towards his family, as well as staff and peers at his school. A.A. has had multiple incidents for extreme and disruptive and dangerous behavior, property destruction, self-injurious behavior including head-banging and slapping, and repeated and specific threats to harm and kill others.

123. Many intensive assessment and treatment services have been provided to A.A., typically when he is institutionalized, including during extended inpatient psychiatric hospitalizations.

124. A.A. has also received community-based services; however, these services have been limited in nature, fragmented, uncoordinated, and sporadic. They include individual therapy with multiple providers; group therapy; family therapy; multiple education plans, including self-contained affective needs education; occupational therapy and speech therapy; psychological assessments; applied behavior analysis therapy; medication evaluations and medication interventions targeting a wide range of mood, impulse control, and sleep disorder symptoms beginning at the age of 2; and in-home therapy.

125. Over the years, A.A. has cycled in-and-out of institutional settings due to the lack of comprehensive, consistent, and coordinated IBHS. Most recently, he was discharged home from Third Way Center where he was confined from September 21, 2021 to January 27, 2023.

126. After being discharged from Third Way Center, A.A. attended Community Reach Center Day Treatment (CRC) five days a week, from 8:00AM to 2:30PM until the end of May 2023. He was supposed to receive one mental health therapy session per week of approximately 30 minutes to discuss how he is feeling and coping, as recommended by Elysia Robbins, LPCC/therapist, a licensed practitioner of the healing arts. A.A. did not receive weekly mental health therapy sessions at CRC. From the end of May until August, 2023, A.A., received only one therapy session per month consisting of approximately 10 to 15 minutes per session.

127. In August 2023, A.A. began attending Thornton High School. A.A. is receiving only sporadic services from CRC and only receives minimal in-home support services which are not at the level as recommended by Maren Cabley, MA, and Brianna Harris, licensed practitioners of the healing arts at CRC. These practitioners have recommended that A.A. receive In-Home Support Services, to be provided in A.A.'s home and outside of school, specifically two sessions per week with each session lasting approximately 45-60 minutes, to include

comprehensive assessment of trauma and behavior concerns or impacts; individual and family therapy; safety-focused treatment, including plans for preventing or coping with crisis; coaching and skills building. A.A. is not receiving IBHS while living at home.

128. Examples of A.A.'s cycling in and out of institutional settings include the following: A.A. was institutionalized at Cedar Springs Hospital from February 22, 2021-March 2, 2021, when he returned home. On his return there, he did not receive IBHS. A.A. deteriorated and was again institutionalized on March 9, 2021, this time at Children's Hospital Colorado. A.A.'s providers determined he no longer needed acute care and clinically discharged him on March 31 2021.

129. On July 2, 2021, Dr. Kimberley Stasia recommended that A.A. receive residential treatment.

130. On July 8, 2021, Neil Sorokin, Ph.D., Licensed Psychologist, recommended that A.A. receive residential treatment and other services, to be followed by IBHS:

> [A.A.] is in need of residential treatment in order to: (1) more closely evaluate his mental health condition including his dramatic mood swings and poorly controlled behavior; (2) provide him with a medication regimen that is optimal for his complex mental health condition while monitoring his behavior, symptoms, and side effects; (3) provide a safe and structured milieu to minimize the likelihood of further dangerous behavior with respect to himself and others; and (4) provide him with intensive individual, group and graduated family therapy to .reintegrate with his family. After a successful course of residential treatment is concluded, intensive community-based services such as in-home individual and family therapy should be provided. If despite such efforts he cannot be safely returned to his grandparents' care, DHS should be involved to provide an appropriate community placement.

131. A.A. was in Children's Hospital on September 3, 2021, the day this case was filed, and was not discharged to Third Way Center until September 21, 2021. The extended and

unnecessary institutional stay at Children's Hospital was due to the inability and refusal of the Defendant to arrange or provide for the IBHS that A.A. needed.

132. A.A.'s. request for IBHS is known by the Defendant and/or her agents. However, A.A. is not receiving the IBHS he needs. Due to the failure and refusal of the Defendant to arrange or provide for IBHS to A.A., he is a serious risk for otherwise avoidable institutionalization.

133. A.A. is a qualified individual with a disability under the ADA and RA. The Defendant has regarded Plaintiff A.A. as having a disability within the meaning of the ADA and RA.

Plaintiff C.C.

134. Plaintiff C.C. is a 16-year-old girl. who is currently residing at home.

135. C.C. has diagnoses of Major Depression-Reoccurring, Generalized Anxiety Disorder, Depressive Disorder Unspecified, Insomnia Disorder, BiPolar Disorder, and Trauma Related Disorder.

136. C.C. needs IBHS to correct or ameliorate her mental and behavioral conditions. C.C. needs IBHS for the maximum reduction of her mental disability and for the restoration of her to the best functional level. C.C. needs coordinated, consistent IBHS to avoid cycling in an out of institutional settings.

137. Since March 22, 2021, C.C. has been psychiatrically hospitalized three times and has received five in-patient mental health placements.

138. C.C. is not receiving the coordinated, consistent IBHS that her licensed practitioners recommend for her.

139. On August 17, 2021, Sarah Taylor, PA-C (Physician Assistant), a licensed practitioner of the hearing arts, stated that it is medically necessary for C.C to receive IBHS 7 days a week, 16.5 hours per week. The treatment milieu must have experts trained in working with children diagnosed with psychiatric and behavioral illnesses. Sarah Taylor, PA-C, recommended that C.C. receive the following IBHS:

- A multi-disciplinary assessment.
- Development and implementation of a multidisciplinary treatment plan listing clear goals, objectives, and interventions for treatment.
- 14 hours per week in the home of [C.C] (2 hours per day, Monday through Sunday) with a Licensed Professional Counselor that is trained in Adolescent Counseling.
- 1.5 hours per week with a Licensed Marriage and Family Counselor to meet with C.C. and her family members.
- 1 hour per week with a Licensed Child and Adolescent Psychologist.

C.C. still requires IBHS as recommended by Sarah Taylor, PA-C, but she is not receiving the level of recommended services.

140. C.C. requires the care of an adolescent psychiatrist as stated in the letter of medical necessity, dated August17, 2021. However, her current psychiatric care is through a Psychiatric Nurse Practitioner who is not adolescent-specific and is not a psychiatrist. The failure of the Defendant to arrange for such care for C.C. results in denial of this coverage.

141. According to Sarah Taylor, C.C. requires community-based treatment from an adolescent therapist. The Defendant has not arranged for such care. The only therapy she receives is two 50-minute sessions with a mental health counselor who is not trained in adolescent therapy. The failure of the Defendant to arrange for such care for C.C. results in denial of this coverage.

142. According to Sarah Taylor, C.C. requires in-home family therapy services. C.C. is not currently receiving and has never received 1.5 hours per week with a licensed marriage and family counselor to meet with her and her family members. The failure of the Defendant to arrange for such care for C.C. is a denial of coverage.

143. Unless C.C. receives the medically necessary IBHS she needs, she will be at risk for many more hospitalizations/institutionalizations, and she is at risk of increased harm to self and others.

144. C.C. is a qualified individual with a disability under the ADA and RA. The Defendant has regarded Plaintiff C.C. as disabled within the meaning of the ADA and RA.

Plaintiff D.D.

145. Plaintiff D.D. is an 18-year-old girl who is living at home since May 2023. She is receiving insufficient support services to treat her mental disorders. Since D.D. has been living at home, the insufficient once a week mental health support services of one hour provided by Community Reach Center has been reduced to only once a month due to the lack of staff at the Center. The IBHS are not being provided to D.D. at the level recommended by her licensed practitioner of the healing arts.

146. D.D. demonstrates the symptoms of delusions, mania, hallucinations, and disorganized behavior. D.D. has diagnoses of Bipolar I Disorder, Severe with psychotic features, and her Mental Status is disorganized and delusional. D.D. has a significant history of manic and delusional behaviors, including her believing that her mother has Munchhausen Syndrome by proxy. D.D. exhibits maladaptive behaviors that interfere with her ability to interact effectively with peers and family. There is risk of serious harm to self or others.

147. D.D. has been hospitalized approximately 14 times in the past 2½ years, with the last hospitalization being at Children's Hospital Colorado from December 24, 2022 thru April, 2023. These hospitalizations are due to the failure of the Defendant to arrange for the IBHS she needs.

148. On January 26, 2023, Mary Bobye, PMHCNS-BC (Psychiatric Mental Health Clinical Nurse Specialist), a licensed practitioner of the hearing arts, recommended that D.D. receive IBHS, including Intensive Care Coordination, Intensive In-Home Services and, as needed, Mobile Crisis Services. This includes therapy, one hour per day, Monday thru Friday, with a Licensed Professional Counselor who is trained in Adolescent Counseling in the home of D.D.; one hour per week with a Licensed Marriage and Family Counselor to provide family therapy to D.D. and family members; and one hour per week with a Licensed Child and Adolescent Psychologist.

149. The Defendant has failed to arrange for the services that D.D. needs, and D.D. is not receiving IBHS as recommended by Mary Bobye, PMHCNS-BC.

150. Unless D.D. receives the medically necessary IBHS, she will be at risk for recurring, cyclical hospitalizations/institutionalizations, and she is at risk of increased harm to self and others.

151. D.D.is a qualified individual with a disability under the ADA and RA. The Defendant has regarded the Plaintiff D.D. as having a disability within the meaning of the ADA and RA.

B. Defendant Discriminates Against DLC's Constituents, the Plaintiff Children and Class by Failing to Provide Them IBHS While the Defendant Provides IBHS to Other Persons With Other Disabilities.

152. The Defendant provides greater Medicaid benefits to children (up to the age of 21) with an intellectual or developmental disability than to children with a mental health or behavioral disorder. For children with an intellectual or developmental disability, the Defendant provides the following IBHS and denies these same services to children with a mental health or behavioral disorder:

(a) Intensive Care Coordination: Intensive Support Services which include Wraparound Facilitator and Wraparound Plan, Prevention/Monitoring, Child & Youth and Youth Mentorship;

(b) Peer Services: Parent and Youth Support Services;

(c) Intensive In-Home Services;

(d) Respite Services;

(e) Transition Support Services which include Wraparound Facilitator and Wraparound Plan, Prevention Monitoring, Child & Youth Mentorship;

(f) Behavioral Services;

(g) Peer Mentorship; and

(h) Mobile Crisis Response Services.

153. The Defendant provides greater benefits to children (up to the age of 21) through "The Children and Youth Mental Health Treatment Act" (CYMHTA) of Colorado who have a mental health diagnosis and are at risk of out of home placement and who are not eligible for Medicaid than to children who are eligible for Medicaid and who have a mental health diagnosis

and are at risk of out of home placement. The Defendant provides IBHS through CYMHTA and denies these same services to the Plaintiffs and Class.

VII. CAUSES OF ACTION

COUNT I
VIOLATION OF MEDICAID ACT
EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT

154. The Plaintiffs incorporate and re-allege paragraphs 1 through 153 as if fully set forth herein.

155. In violation of the Medicaid EPSDT provisions, 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(4)(B), 1396a(a)(43), and 1396d(r), the Defendant, while acting under the color of law, has failed to provide DLC Constituents, the Plaintiffs and Class with IBHS when such services are medically necessary to treat or ameliorate their conditions.

156. In violation of the EPSDT provisions of the Medicaid Act, the Defendant, while acting under the color of law, has failed to "arrange for (directly or through referral to appropriate agencies, organizations, or individuals) corrective [IBHS] treatment" for DLC Constituents, the Plaintiffs and Class pursuant to 42 U.S.C. § 1396a(a)(43)(C).

157. The Defendant's violations, which have been repeated and knowing, entitle the Plaintiffs and Class to relief under 42 U.S.C. § 1983.

COUNT II

VIOLATION OF MEDICAID ACT
REASONABLE PROMPTNESS

158. The Plaintiffs incorporates and re-alleges paragraphs 1through 157 as if fully set forth herein.

159. The named Plaintiffs and the Class they seek to represent are all Medicaid-eligible children with disabilities residing in Colorado.

160. The Defendant is engaged in the repeated, ongoing failure to arrange for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment of medically necessary Intensive Home and Community-Based Services (IHCBS) with "reasonable promptness" in violation of 42 U.S.C. Sec. 1396a(a)(8) of the Federal Medicaid Act.

161. The Defendant's violations, which have been repeated and knowing, entitle the Plaintiffs and Class to relief under 42 U.S.C. § 1983.

COUNT III
VIOLATION OF AMERICANS WITH DISABILITIES ACT

162. The Plaintiffs incorporate and re-allege paragraphs 1 through 161 as if fully set forth herein.

163. Title II of the ADA provides that no qualified person with a disability shall be subjected to discrimination by a public entity. 42 U.S.C. §§ 12131-32. The ADA's implementing regulations further state that a public entity shall 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). Policies and practices that have the effect of unjustifiably segregating persons with disabilities constitute prohibited discrimination under the ADA.

164. HCPF, of which Defendant Bimestefer is Director, is a "public entity" within the meaning of Title II of the ADA.

165. DLC Constituents, the Plaintiffs and Class are qualified individuals with disabilities within the meaning of Title II of the ADA, and they are qualified to participate in or receive

HCPF's programs, services, and activities, including necessary IBHS under the Medicaid Act's EPSDT provisions. 42 U.S.C. §§ 12102, 12131(2).

166. The Defendant's policies and practices have the effects of: (1) impermissibly segregating some Plaintiffs, Class members, and DLC Constituents in institutions; and (2) placing other Plaintiffs, Class members, and DLC Constituents at serious risk of institutionalization.

167. Defendant violates Title II of the ADA and its implementing regulations by excluding DLC Constituents, Plaintiffs and the Class from participating in HCPF's Medicaid services, programs, and activities, and by failing to provide DLC Constituents, Plaintiffs and the Class with services in the most integrated setting appropriate to their needs for the following reasons:

a. DLC Constituents, Plaintiffs and the Class mental health or behavioral disorders can be treated at home and in their communities with IBHS.

b. Defendant fails to provide, or ensure the provision of IBHSIBHS to DLC Constituents, Plaintiffs and the Class in the administration of HCPF's programs, activities, and services, including Medicaid.

c. DLC Constituents, Plaintiffs and the Class suffer unnecessary institutionalization in hospitals and psychiatric facilities, or are subjected to the serious risk of institutionalization, because Defendant fails to provide, or ensure the provision of IBHSIBHS to DLC Constituents, Plaintiffs and the Class.

d. DLC Constituents, Plaintiffs and the Class would prefer to receive IBHSIBHS for the treatment of the mental health or behavioral disorder and to live at home and remain in their communities.

168. The actions by HCPF constitute unlawful discrimination under the ADA and violate the integration mandate of the implementing regulations.

169. Defendant's actions constitute discrimination in violation of Title II of the ADA and its implementing regulations by failing to make reasonable modifications to programs and services that would enable DLC Constituents, Plaintiffs and the Class to fully and equally participate in Defendant's public services, programs, and activities, for the following reasons:

a. Defendant has failed to modify HCPF's policies, practices, and procedures in order to provide, or ensure the provision of, necessary IBHSIBHS to qualified individuals, including DLC Constituents, Plaintiffs and the Class.

b. The modification of HCPF's programs, services, and activities by Defendant in order to ensure that HCPF provide DLC Constituents, Plaintiffs and the Class with IBHSIBHS would neither be unreasonable, nor would it constitute a fundamental alteration. HCPF is already required by federal law to provide IBHS to DLC Constituents, Plaintiffs and the Class under the EPSDT provisions of the Medicaid Act. Accordingly, complying with the ADA does not impose additional burdens or costs on HCPF.

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

171. Policies and practices which result in disparate treatment of comparably situated disabled persons constitutes prohibited discrimination under the ADA.

172. The Defendant's disparate treatment of the DLC Constituents, Plaintiffs and Class who have been diagnosed with a mental health or behavioral disorder in contrast to those persons who have been diagnosed with an intellectual or developmental disability constitute unlawful discrimination under 42 U.S.C. § 12132 as they are being treated worse than persons with other disabilities. The Defendant permits children with intensive behavioral needs with an intellectual or developmental disability to receive IBHS in the Colorado's Children Habilitation Residential Program, in the Colorado's Children Extensive Support Waiver, and in the Colorado's Developmental Disabilities Waiver but does not permit IBHS to children (up to the age of 21) who are Medicaid enrolled and who have been diagnosed with a mental health or behavioral disorder. The Defendant permits children who are not eligible for Medicaid and who have a mental health diagnosis under the CYMHTA to receive IBHS, in contrast to the DLC Constituents, Plaintiffs and Class who are Medicaid enrolled, have a mental health diagnosis, and need IBHS.

173. Defendant provides greater Medicaid and non-Medicaid IBHS benefits to other persons with disabilities in contrast to the DLC Constituents, Plaintiffs and Class, despite the fact that the Plaintiffs have similar and comparable needs for IBHS.

174. The Defendant has intentionally discriminated against the DLC Constituents, Plaintiffs and Class as they are being treated worse than persons with other disabilities.

175. The Defendant has intentionally discriminated against the DLC Constituents, Plaintiffs and Class as they receive disparate treatment of comparably situated persons.

176. The Defendant has intentionally discriminated against the DLC Constituents, Plaintiffs and Class by establishing a system which requires them to become institutionalized in

order to receive or access IBHS, while other persons with disabilities are able to access IBHS without having to become institutionalized.

177. DLC Constituents, Plaintiffs and the Class are therefore entitled to declaratory and injunctive relief to remedy Defendant's violations of Title II of the ADA.

COUNT IIII
VIOLATION OF REHABILITATION ACT

178. The Plaintiffs incorporate and re-allege paragraphs 1 through 177 as if fully set forth herein.

179. The Rehabilitation Act, 29 U.S.C. § 794, prohibits public entities and recipients of federal funds from discriminating against any individual by reason of disability. The implementing regulation requires that public and federally funded entities provide programs and activities "in the most integrated setting appropriate to the needs of the qualified individual with a disability." 28 C.F.R. § 41.51(d). Policies and practices that have the effect of unjustifiably segregating persons with disabilities in institutions constitute prohibited RA discrimination.

180. The Colorado HCPF is a recipient of federal funds and is, therefore, a "program or activity" under Section 504 of the RA. 29 U.S.C. § 794(b)(1).

181. The DLC Constituents, Plaintiff Children, and Class are qualified individuals with a disability under Section 504 of the RA.

182. The actions by HCFS and Defendant Bimestefer herein constitute unlawful discrimination under 29 U.S.C. § 794(a) and violate the integration mandate of the regulations implementing this statutory prohibition. 28 C.F.R. § 41.51(d).

183. Defendant has violated Section 504 of the RA, 29 U.S.C. § 794; 45 C.F.R. § 84.4 (b)(1) (i)-(iii), (b)(2); and 28 C.F.R. § 41.51(d), by administering Medicaid services in a manner

that fails to ensure that DLC Constituents, Plaintiff Children, and the Class receive federally mandated IBHS in the most integrated setting appropriate to their needs for the following reasons:

a. DLC Constituents', Plaintiffs' and the Class's mental health or behavioral disorders can be treated at home and in their communities with IBHS.

b. Defendant fails to provide, or ensure the provision of, IBHS to DLC Constituents, Plaintiffs and the Class in the administration of HCPF's programs, activities, and services, including Medicaid.

c. DLC Constituents, Plaintiffs and the Class suffer unnecessary institutionalization in hospitals and psychiatric facilities, or are subjected to the serious risk of institutionalization, because Defendant fails to provide, or ensure the provision of IBHS to DLC Constituents, Plaintiffs and the Class.

d. DLC Constituents, Plaintiffs and the Class would prefer to receive IBHS for the treatment of the mental health or behavioral disorder and to live at home and remain in their communities.

184. Defendant's actions constitute discrimination in violation of Section 504 by failing to make reasonable modifications to programs and services that would enable DLC Constituents, Plaintiffs and the Class to fully and equally participate in Defendant's public services, programs, and activities, for the following reasons:

a. Defendant has failed to modify HCPF's policies, practices, and procedures in order to provide, or ensure the provision of, necessary IBHS to qualified individuals, including DLC Constituents, Plaintiffs and the Class.

b. The modification of HCPF's programs, services, and activities by Defendant in order to ensure that HCPF provides DLC Constituents, Plaintiffs and the Class with IBHS would neither be unreasonable, nor would it constitute a fundamental alteration. HCPF is already required by federal law to provide IBHS to DLC Constituents, Plaintiffs and the Class under the EPSDT provisions of the Medicaid Act. Accordingly, complying with the RA does not impose any additional burdens or costs on HCPF.

185. Defendant has utilized and adopted criteria and methods of administration that have the effect of subjecting DLC Constituents, Plaintiffs and the Class to unnecessary institutionalization or serious risk thereof, and therefore discrimination based on their disabilities, in failing to provide, or ensure the provision of IBHS to qualified individuals, including DLC Constituents, Plaintiffs and the Class. 28 C.F.R. § 41.51(b)(3); 45 C.F.R. § 84.4.

186. DLC Constituents, Plaintiffs and the Class are therefore entitled to declaratory and injunctive relief to remedy violations of Section 504 of the RA by Defendant.

VIII. REQUEST FOR RELIEF

WHEREFORE, the Plaintiffs respectfully request that this Court:

1. Assert subject matter jurisdiction over this action;

2. Certify this case to proceed as a class action pursuant to Federal Rule of Civil Procedure 23(a) and Rule 23(b)(2) and appoint the undersigned as class counsel pursuant to Rule 23(g) of the Federal Rules of Civil Procedure;

3. Issue a Declaratory Judgment in favor of the Plaintiffs and the Class that Defendant has failed to comply with the EPSDT provisions of the Medicaid Act, the Americans with Disabilities Act, and the Rehabilitation Act;

4. Issue Preliminary Injunctive and Permanent Injunctive relief requiring the Defendant to take immediate and affirmative steps to arrange directly or through referral to appropriate agencies, organizations, or individuals, corrective treatment of IBHS for the DLC Constituents, Plaintiff Children, and Class, as required by the Medicaid Act, the Americans with Disabilities Act, and the Rehabilitation Act;

5. Issue Preliminary Injunctive and Permanent Injunctive relief requiring the Defendant to treat the DLC Constituents, Plaintiff Children, and Class in a similar manner as the Defendant treats other persons with disabilities.

6. Preliminary Injunctive and Permanent Injunctive relief requiring the Defendant to:

(A) Establish and implement policies, procedures, and practices to ensure the provision of IBHS to DLC Constituents, Plaintiff Children, and the Class;

(B) Establish and implement policies, procedures, and practices to ensure that Defendants do not discriminate against DLC Constituents, Plaintiff Children, and the Class; and

(C) Arrange for the services DLC Constituents, Plaintiff Children, and the Class are eligible for in the most integrated setting appropriate to their needs.

7. Retain jurisdiction until such time as the Court is satisfied that Defendant's unlawful policies, practices, and acts complained of herein will not reoccur;

8. Award Plaintiffs and the Class the costs of this action, including reasonable attorney's' fees, pursuant to 42 U.S.C. § 12205; Section 504 of the Rehabilitation Act, and 42 U.S.C. § 1988; and

9. Award such other relief as the Court deems just and appropriate.

Dated: February 23, 2024

Respectfully submitted,

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