IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA
Civil Action No. 1:22-CV-1046

TIMOTHY B., by and through his Guardian *ad Litem* Robert Ward; et al.,

Plaintiffs,

v.

DR. DEVDUTTA SANGVAI, in his official capacity as Secretary of the NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES ("DHHS"),

Defendant.

PLAINTIFFS' MEMORANDUM OF LAW IN SUPPORT OF THEIR MOTION FOR CLASS CERTIFICATION

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I. INTRODUCTION

Every day, the North Carolina Department of Health and Human Services ("DHHS") unnecessarily isolates children in foster care with disabilities in institutions known as Psychiatric Residential Treatment Facilities ("PRTFs") when their identified needs can be met in community-based settings. Under the Americans with Disabilities Act ("ADA") and Section 504 of the Rehabilitation Act ("Section 504"), as the state agency that administers North Carolina's child welfare system and its publicly funded mental and behavioral health services, DHHS must serve these children in the most integrated setting appropriate to their needs. 42 U.S.C. §§ 12131, 12132; 29 U.S.C. § 794(a); 28 C.F.R. § 35.130(d); *Olmstead v. L.C.*, 527 U.S. 581, 597-600 (1999). Plaintiffs seek declaratory and injunctive relief requiring DHHS to end this unnecessary segregation.

Because every child with a disability in North Carolina foster care is subject to DHHS's methods of administration, Plaintiffs move to certify the following class:

> (a) children who are or will be in the custody of a North Carolina county department or division of

> social services ("County DSS"), *see* N.C.G.S. § 7B-903(a)(6);[1]
>
> (b) with a mental impairment that substantially limits at least one major life activity, or a record of such an impairment;
>
> (c) who are unnecessarily institutionalized in a PRTF or who are at serious risk of such institutionalization.

Children at serious risk of unnecessary institutionalization are those in County DSS custody who (i) have a qualifying SED/SMI Diagnosis, or a conditional SED/SMI Diagnosis paired with a Qualifying Enhanced Behavioral Health Service, and (ii) within the prior eighteen months experienced two or more Psychiatric Hospitalizations; two or more Behavioral Health Crisis Service episodes; two or more Psychiatric Emergency Department Visits; PRTF-based treatment; or an Intensive Alternative Family Treatment ("IAFT") referral not filled within five business days. *See* Ex. 1, Expert Report of Cross, Ph.D. ("Cross Rep."), 28-31. Each criterion corresponds to a data field DHHS maintains or can access in the ordinary course, and Plaintiffs' expert has applied the criteria to

[1] County DSSs are statutory agents of DHHS, *see* N.C.G.S. § 108A-14(a)(5), and DHHS is responsible for supervising the administration of the foster care system in accordance with federal law. *See* 42 U.S.C. § 671(a)(2)-(3).

identify the class. *See* Ex. 2, Expert Report of Victor, Ph.D. ("Data Rep.") ¶ 25 & tbl. 13.[2]

Further, Plaintiffs request appointment of the Named Plaintiffs as class representatives and Plaintiffs' counsel as class counsel. Fed. R. Civ. P. 23(a)(4), (g).

II. STATEMENT OF FACTS

As the State's Title IV-B and IV-E agency, 42 U.S.C. § 671(a)(2), DHHS acts through its Division of Social Services, which supervises the County DSSs that are responsible for the care and custody of children in foster care and are "authorized to place" them. N.C.G.S. § 7B-903(a)(6). DHHS sets the standards these counties apply, requires corrective action from noncompliant counties, and may assume control of a County DSS when necessary. *Id.* § 108A-74. Because these counties administer child welfare programs, the State's Title IV-E plan is "mandatory upon" them. 42 U.S.C. § 671(a)(3).

[2] Each element is operationalized from DHHS's own code specifications for Tailored Plan eligibility and "High Risk" identification and the five-business-day IAFT fulfillment standard DHHS's contract imposes. *See id.* ¶ 25 (citing Ex. 3, CFSP Ops Copy Through A5 § VII att. E tbl. 3 row 13; VIII apps. B & C tbls. 3-5, 7-9; Ex. 4, DHHS_2026_00023367); *see also* N.C.G.S. § 108D-40(a)(12).

DHHS also licenses and pays for the placements at issue. As the single state Medicaid agency, *id.* § 1396a(a)(5), DHHS determines when NC Medicaid pays for PRTF care through its Division of Health Benefits ("DHB"). Ex. 5, CCP No. 8D-1. It licenses each PRTF, N.C.G.S. § 122C-23, under rules administered by its Division of Mental Health, Developmental Disabilities, and Substance Use Services ("DMH"). 10A NCAC 27G.1900 *et seq*. DHHS contracts with the managed care entities that authorize foster children's behavioral health services - formerly the LME/MCOs, now a single statewide Children and Families Specialty Plan ("CFSP"). *See generally* N.C.G.S. § 108D-62.

North Carolina defines a PRTF as a facility providing care "in a non-acute inpatient setting" to children requiring "supervision and specialized interventions on a 24-hour basis," 10A NCAC 27G.1901(b)-(c); federal law classifies such care as inpatient psychiatric services. *See* 42 C.F.R. § 441.151(b). Medicaid covers a PRTF admission only where the child cannot "remain in the home environment and receive community-based treatment." Ex. 5, § 3.2.1(f).

Children in PRTFs are separated from their families and communities, denied ordinary childhood experiences, and do

not attend school in the community. PRTF-level care is appropriate only where a child's condition both presents an acute risk of serious harm that cannot be safely managed in the community with intensive supports in place and requires near-daily specialized clinical intervention that cannot be delivered at a lower level of care. *See* Cross Rep., 16-17, 36, 39-40; Ex. 6, Expert Report of Gray, Psy.D. ("Gray Rep."), 20-24. DHHS agrees that PRTFs should "[s]erve only those few youth that cannot be safe in the community." Ex. 7, DHHS_2026_00040760, _00040774.

DHHS has committed since December 2021 to expanding the community service array, "thereby reducing the number of children and youth admitted to" PRTFs. Ex. 8, TIMOTHY_B-0013378, -0013420. It repeated that commitment verbatim in April 2024. Ex. 9, DHHS_2026_00016345, _00016372. Yet in January 2026, a DHHS workgroup identified that "PRTFs are increasingly being used as default placements for youth when appropriate alternatives are unavailable." Ex. 10, DHHS_2026_00231466, _00231475. DHHS's data bear that out: PRTF bed days among children in foster care rose from 67,584 in 2023 to 76,751 in 2024 to 83,146 in 2025, accounting for

12%, 13%, and 15% of that group's total annual days in custody. Data Rep. tbls. 72-74.

Named Plaintiffs Colt H., Isabella A., and Juana R. are in County DSS custody; each has a mental impairment that substantially limits one or more major life activities; and each is or has been unnecessarily institutionalized in a PRTF. None opposed community-based treatment, and each could have received clinically appropriate treatment in community settings during periods of confinement. Gray Rep., 73-80, 129-135, 163-171. This Court has already held that the individually named plaintiffs have standing. Mem. Op. & Order at 25-26, ECF No. 72.

Five system-wide failures in DHHS's administration are driving unnecessary institutionalization: assessments and referrals, discharge planning, access to IAFT, kinship engagement and support, and treatment delivered in PRTFs. Each is established below, in connection with the common question it generates. Because every child in foster care with a mental or behavioral health disability is subject to these same policies and practices, and to the same absence of required protections, each is at serious risk of unnecessary institutionalization.

III. ARGUMENT

Class certification is appropriate where the requirements of Federal Rule of Civil Procedure 23(a) and one of Rule 23(b)'s requirements are satisfied by a preponderance of the evidence. *See Cheng v. Liu*, 2024 WL 3579606, at *2 (4th Cir. July 29, 2024) (per curiam) (unpublished). The inquiry requires a "rigorous analysis," *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 351 (2011), but it is not a "free-ranging merits inquiry"; courts consider the merits only "to the extent necessary to verify that Rule 23 has been satisfied." *Brown v. Nucor Corp.*, 785 F.3d 895, 903 (4th Cir. 2015) (citation omitted).

A. The Elements of Rule 23(a) Are Satisfied

1. Numerosity

Rule 23(a)(1) requires that "the class [be] so numerous that joinder of all members is impracticable[.]" Fed. R. Civ. P. 23(a)(1). A "class of 40 or more members raises a presumption of impracticability of joinder based on numbers alone." *In re Zetia (Ezetimibe) Antitrust Litig.*, 7 F.4th 227, 234 (4th Cir. 2021) (citation omitted). Plaintiffs' figures need not be exact; a court may "use available evidence to make commonsense assumptions regarding the number of

putative class members." *Johnson v. Jessup*, 381 F. Supp. 3d 619, 633-34 (M.D.N.C. 2019) (quoting 1 William B. Rubenstein, *Newberg on Class Actions* § 3:13 (5th ed. 2018)).

The class here far exceeds 40 members. As of February 2026, there were at least 198 children in County DSS custody in PRTFs. Ex. 11, DHHS_2026_00085782. Between 2017 and 2025, 1,380 putative class members were treated in PRTFs across 2,396 treatment episodes, and an average of 237 were confined each month from 2022 through 2025. Data Rep. tbls. 14, 24, 30. Class members at serious risk of unnecessary institutionalization are more numerous still: an average of 742 children met the serious-risk criteria each month in 2025. *Id.* tbl. 13.

Joinder is impracticable for other reasons. Every class member is a minor who cannot sue on his or her own behalf, making separate actions "highly unlikely." *Kenneth R. v. Hassan*, 293 F.R.D. 254, 265 (D.N.H. 2013); *see Jonathan R. v. Justice*, 41 F.4th 316, 337 (4th Cir. 2022) ("*Jonathan R. I*") ("Shoring up sufficient evidence to demonstrate the need for systemic relief requires . . . capital most foster children neither have nor can hope to amass through litigation that seeks only declaratory and injunctive relief."). Their

dispersion across North Carolina's 100 counties, custodial status, and segregation from their families and communities further limit their ability to secure counsel and pursue individual relief. And the class is continuously changing. Children enter and leave County DSS custody and PRTFs, and the class includes children not yet in state custody. *Baxley v. Jividen*, 338 F.R.D. 80, 86 (S.D. W. Va. 2020). Numerosity is satisfied.

2. Commonality

Rule 23(a)(2) requires "questions of law or fact common to the class." Fed. R. Civ. P. 23(a)(2). Commonality exists when plaintiffs put forward a "common contention" that "is capable of classwide resolution" such that "determination of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke." *Wal-Mart*, 564 U.S. at 350. "Even a single common question" satisfies Rule 23(a)(2). *Id.* at 359 (cleaned up).

Putative classes seeking injunctive or declaratory relief from a government agency often satisfy commonality by challenging the legality of "a uniformly applied, official policy . . . or an unofficial yet well-defined practice, that drives the alleged [harms]." *G.T. v. Bd. of Educ. of Cnty. of*

Kanawha, 117 F.4th 193, 203 (4th Cir. 2024) (quoting *Parent/Prof'l Advoc. League v. City of Springfield*, 934 F.3d 13, 29 (1st Cir. 2019) ("*PPAL*")). Determination of a policy's validity is a common question for all plaintiffs impacted by the policy, "irrespective of their particular factual circumstances." *Pashby v. Cansler*, 279 F.R.D. 347, 353 (E.D.N.C. 2011) ("*Pashby I*").

Plaintiffs must show "some common driver – the 'glue' holding all [the individual] decisions together in a way that suggests they can productively be litigated all at once." *G.T.*, 117 F.4th at 205 (cleaned up); *Spurlock v. Wexford Health Sources, Inc.*, 175 F.4th 232, 247 (4th Cir. 2026) (affirming commonality where common questions included whether defendant maintained certain policies). The practices challenged here are of that kind: each is a feature of DHHS's own administration – what it requires, ensures, and monitors – and each applies identically to every child in foster care with a mental or behavioral health disability.

The practice "need not be formal or officially-adopted"; an omission may be the practice, and factual differences among class members do not defeat commonality where class members share the same legal theory and have been subjected to the

same policies. *Jonathan R. v. Justice*, 344 F.R.D. 294, 304-05 (S.D. W. Va. 2023) ("*Jonathan R. II*"). Plaintiffs "may identify policies or practices that subject them to an unreasonable *risk* of harm." *Id.* at 305 (emphasis in original). The Fourth Circuit has recognized that "individuals who must enter institutions to obtain Medicaid services for which they qualify may be able to raise successful Title II and Rehabilitation Act claims because they face a risk of institutionalization." *Pashby v. Delia*, 709 F.3d 307, 322 (4th Cir. 2013).

Courts, including district courts in this Circuit, have certified classes alleging systemic *Olmstead* violations, because such claims often turn on the adequacy of a state's service system rather than on any individual's circumstances. *See Jonathan R. II*, 344 F.R.D. at 311-13 (availability of community-based services for foster children with disabilities); *Pashby I*, 279 F.R.D. at 353 (Medicaid policy favoring facility over in-home personal care); *Thorpe v. District of Columbia*, 303 F.R.D. 120, 146-47 (D.D.C. 2014) (deficiencies in a system of transition assistance); *S.R. v. Pa. Dep't of Hum. Servs.*, 325 F.R.D. 103, 109 (M.D. Pa. 2018) (sufficiency of service array for children with mental health

disabilities); *B.D. v. Sununu*, No. 21-cv-4-PB, 2024 WL 4227544, at *16 & n.15 (D.N.H. Sept. 18, 2024) (collecting "the long line of cases finding that [*Olmstead*] claims are appropriate for class treatment precisely because they are susceptible to common proof regarding the aggregate effect and legal sufficiency of identified state practices").

This Court has already observed that Plaintiffs' claims are not about individual placement decisions: "Plaintiffs are not challenging their individual placement decisions or asking this [C]ourt to make findings about what specific services an individual in the child welfare system may require," but rather allege "that children with disabilities are generally eligible to receive community-based services yet are systemically institutionalized" due to "Defendant's systemic failures to provide an adequate supply of community-based services[.]" Mem. Op. & Order at 36, 51, ECF No. 72 (citations omitted). The Fourth Circuit recognizes that piecemeal reform of such deficiencies is unworkable: "[r]eforming foster care case-by-case would be like patching up holes in a sinking ship by tearing off the floorboards." *Jonathan R. I*, 41 F.4th at 336.

(a) Assessments and Referrals

DHHS's failure to require that a child in foster care be assessed and referred in a manner capable of identifying whether the child's needs could be met in a more integrated setting is the first concrete practice driving classwide violations of the ADA and Section 504.

A child cannot be placed in a PRTF without a Comprehensive Clinical Assessment ("CCA"). Ex. 5, § 3.2.1; Ex. 12, Crosbie Dep. 82:24-83:2. The CCA is used to "determine treatment needs, which would lead to determining a level of care," Ex. 13, Freeman 30(b)(6) Dep. 27:4-29:9, but the CCA was not designed for that purpose. Crosbie Dep. 86:17-87:11. DHHS's own analysis lists among the CCA's limitations "[n]o standardized tool," "[l]ack of training," and "not renewed annually." Ex. 14, DHHS_2026_00041326, _00041336. Thus, no validated instrument governs the level-of-care determination. Ex. 15, DHHS_2026_00039834, _00039837 (referring to the CCA process as "currently problematic" and recommending adoption of "one validated, evidence-based assessment instrument"); Gray Rep., 11, 16-20.

Nor does DHHS require that the assessment answer whether the child could be served in a less restrictive setting, or

that anyone document the basis for that conclusion. DHHS policy permits a clinician to complete a CCA without ever meeting the child, Ex. 16, Crosbie 30(b)(6) Dep. 149:3-150:4, and does not require the assessor to be trained in, or have knowledge of, the community-based options available to these children. Freeman 30(b)(6) Dep. 47:11-52:16; Ex. 17, DHHS_2026_00107629.

Nothing requires the assessor to record why a community alternative was rejected. Freeman 30(b)(6) Dep. 96:13-25. No policy prohibits recommending several placements at once with conflicting criteria for admission, Crosbie 30(b)(6) Dep. 18:17-19:5, which predictably happens: 30% of IAFT referrals included simultaneous referrals to a lower level of care, and another 5% to more restrictive levels of care, including PRTFs. Data Rep. tbl. 79. Nothing directs the care manager who requests authorization, or the managed care entity that grants it, who need not even review the assessment, toward the least restrictive service for which the child is eligible. Crosbie 30(b)(6) Dep. 13:6-20; 16:3-17:13, 19:12-20.

Nor does DHHS check the result: DMH has never compared children's assessments against authorizations to determine whether the resulting placements were the most integrated

settings appropriate. DMH performs that quality assurance only for adults. Crosbie Dep. 109:13-110:3; Crosbie 30(b)(6) Dep. 19:22-23:22.

No child should be placed in a PRTF unless a qualified professional who has examined the child has first determined, through a comprehensive individualized assessment employing validated measures, that the child's needs could not be met in a less restrictive setting with community supports. *See* Cross Rep., 86-89, 91, 99; Gray Rep., 10-18. DHHS requires no assessment capable of producing that determination. These failures place children in PRTFs whose needs could be met in the community with appropriate supports, and because no policy requires regular reassessment, nothing identifies the point at which a child no longer requires PRTF care. *See* Cross Rep., 99-100; *see generally* Gray Rep. DHHS has identified "improving clinical assessments to identify the treatments that children need" as a means of reducing unnecessary institutionalization. *See* Ex. 18, DHHS_2026_00016693, _00016718.

None of this turns on the quality of any individual assessment or the judgment of any individual clinician. What is uniform across the class is not the outcome of any

assessment but the absence of any required standard, which is precisely the type of "common direction" or "common mode of exercising discretion" courts have found sufficient under Rule 23(a)(2). *See PPAL*, 934 F.3d at 29-30 (quoting *Wal-Mart*, 564 U.S. at 355-56); *Elisa W. v. City of New York*, 82 F.4th 115, 125 (2d Cir. 2023) (whether the agency "lacks effective criteria for placements" is a common question); *Jonathan R. II*, 344 F.R.D. at 307-08 (lack of quality comprehensive assessment as part of deficient case planning).

Whether DHHS fails to require such an assessment and referral process presents a common question resolvable as to all class members in a single stroke.

(b) Discharge Planning

DHHS's failure to ensure discharge planning for children in foster care is the second concrete practice driving classwide violations.

DHHS has a stated objective of conducting "intentional discharge planning that reduces length of stay and enables youth's successful transition from residential treatment services." Ex. 10, _00231471. But DHHS has never required it. Its PRTF CCP recites two requirements, but only among the criteria for authorizing Medicaid payment for a continued

stay, Ex. 5, § 3.2.2(g), (k), which DHHS's own workgroup found to focus on medical necessity for discharge rather than on planning during the stay, and which do "not define what activities must be included as part of 'active discharge planning.'" Ex. 19, DHHS_2026_00025566, _00025576-77. DHHS requires no standardized discharge plan form, sets no interval at which a plan must be updated, and requires no minimum documentation of the child's clinical progress, anticipated discharge date, or barriers to discharge. Ex. 5, § 3.2.2; Ex. 20, DHHS_2026_00052540, _00052548; Ex. 15, _00039837.

In 2022, DHHS began drafting an administrative rule that would have required discharge planning as a condition of PRTF licensure, including that no child be discharged without needed services in place; it has not adopted the rule and has no timeline to do so. Ex. 21, DHHS_2026_00230532; Ex. 22, DHHS_2026_00230534; Crosbie Dep. 236:6-241:13. Asked whether DMH does anything to ensure discharge planning occurs, DMH Director Crosbie answered: "Not systematically." Crosbie Dep. 218:23-219:7. DHHS's own workgroup recommended implementation of a requirement that the CFSP conduct a case review for children who do not have a discharge placement identified

within six months and/or have a length of stay greater than six months to prevent "unnecessarily prolonged stays" and maintain "clear accountability." Ex. 23, DHHS_2026_00052522, _00052532. This recommendation has not yet been implemented. Crosbie Dep. 249:14-251:6.

Discharge planning for a child in a PRTF should begin at admission and identify an anticipated discharge date, the setting to which the child will return, the receiving caregiver, and the services needed to sustain the child after discharge. Cross Rep., 101-05; Ex. 24, Shusko Dep. 96:19-97:14. Where it does not occur, a child remains confined past the point at which he or she could have been served in the community, because no setting, caregiver, or service array has been identified to receive the child. *See* Cross Rep., 106-07. The consequence is that children "sometimes remain in a PRTF long after a discharge plan is made because there is no identified placement for them." Ex. 25, TIMOTHY_B-0012338, -0012401-02.

This is confirmed by DHHS's own records. DHHS treats a PRTF episode exceeding 180 days as an "extended stay," Ex. 26, DHHS_2026_00025594, _00025597, yet the average episode for putative class members lasts 198 days, and 46% of episodes

exceed 180 days. Data Rep. tbls. 59, 64. Children leaving PRTFs are increasingly not connected to community care: the proportion receiving any outpatient behavioral health service within thirty days of their discharge has declined every year measured, from 31.7% in 2019 to 9.2% in 2025. Ex. 27, DHHS_2026_00058766, _00058863. And discharge is largely not a return to the community: 46.7% of children discharged from a PRTF are in residential care again within ninety days, and 56.1% within twelve months. *Id.* at _00058841.

Deficient planning of this kind is a practice susceptible to classwide proof, and specifically one that drives unnecessary institutionalization. *Thorpe*, 303 F.R.D. at 146-47. The same is true of case planning deficiencies more generally. *See Jonathan R. II*, 344 F.R.D. at 308 ("[C]ommon questions exist regarding whether the deficiencies in case planning subject the . . . class to an unreasonable risk of harm[.]"); *B.D.*, 2024 WL 4227544, at *11 (certifying class of children in foster care alleging that deficient case planning drives unnecessary institutionalization).

Because whether DHHS imposes these requirements is answerable from its own policies rather than from the adequacy of any individual child's discharge plan, whether DHHS fails

to require adequate discharge planning presents a common question resolvable as to all class members in a single stroke.

(c) IAFT

DHHS's failure to ensure access to IAFT is the third concrete practice driving classwide violations.

Because not every child can be served in a traditional foster home, enhanced-support family placements are a necessary component of the placement array. *See* Cross Rep., 15-16, 115. North Carolina's is IAFT. Ex. 18, _00016710, _00016720-21. IAFT's eligibility criteria describe the putative class here: multiple out-of-home placements, disrupted therapeutic foster care placements, "[o]ne or more hospitalizations within the last year," and "[s]ignificant trauma history which manifests in current symptoms and behaviors." Ex. 28, DHHS_2026_00041259, _00041270. DHHS reports that IAFT yields "a 20% reduction in risk for both first time PRTF entry and PRTF recidivism." Ex. 18, _00016710.

IAFT's intensive service requirements are built to serve those children: one child per family, weekly in-person therapy, monthly psychiatric oversight, twenty-four-hour crisis support, and an evidence-based treatment model. Ex.

29, DHHS_SET_0000014-000001, -00087. For many children in foster care with significant mental and behavioral health disabilities, IAFT is the clinically indicated placement. *See* Cross Rep., 117-19. DHHS's official testified that youth with high needs could succeed in IAFT with additional training for the treatment parent and basic safety measures such as door chimes. Ex. 30, Bell Dep. 119:18-120:10.

DHHS's own standard is that an IAFT referral should be filled within five business days. Ex. 3, § VII att. E tbl. 3 row 13. Yet among putative class members referred to IAFT from 2020 to 2025, only 27% received an IAFT placement within 180 days of referral, and the average time to fulfillment among fulfilled referrals was 223 days. Data Rep. tbls. 84, 86. The result is that few foster children with significant emotional and behavioral health needs actually receive IAFT: between 2017 and 2025, only 12% of putative class members were ever treated in IAFT, while 51% were treated in PRTFs. *Id.* tbl. 21.

DHHS knows the supply is short, Bell Dep. 86:18-87:1, and that referrals cannot "be placed because of not having beds available." *Id.* 154:3-10. DHHS's recent $11 million investment in IAFT was "not meant to fulfill every IAFT need

throughout the state," but DHHS has committed no further funds. *Id.* 153:10-16; 159:11-14. Despite being informed that attracting and retaining providers requires a much higher daily rate for IAFT, DHHS has not raised it, Ex. 31, RRFF-000421, and none of its $11 million investment went to rates. Bell Dep. 84:17-25.

Evidence of "systemic deficiencies in the availability of community-based services" creates a common question of whether "the deficiency place[d] foster children with disabilities at risk of unnecessary institutionalization." *Jonathan R. II*, 344 F.R.D. at 313; *B.D.*, 2024 WL 4227544, at *13 ("Because all class members are affected by what the defendants do and do not do to increase the supply of available foster homes, the legal sufficiency of the defendants' efforts raises common questions capable of class-wide resolution.") (collecting similar cases).

None of that turns on any individual child's referral; each question is answered once, from DHHS's own practices reflected in contracts and records. Whether DHHS fails to ensure access to IAFT therefore presents a common question resolvable as to all class members in a single stroke.

(d) Engagement and Support of Kin

DHHS's failure to require the practices that identify and sustain kinship placements is the fourth concrete practice driving classwide violations.

Kinship care is the preferred placement for children in foster care, including children with mental and behavioral health disabilities, and properly supported, it is an alternative to PRTF placement. 42 U.S.C. § 671(a)(19); *see* Cross Rep., 124-27. DHHS agrees: "[w]hen children cannot safely live in the home, relatives are the first choice for placement" and "[m]ore kinship . . . parents will be able to care for children with behavioral health needs if they are provided with financial resources and behavioral health training and supports." Ex. 18, _00016718, _00016696. Kin engagement can also prevent PRTF placement and shorten PRTF stays. Ex. 32, Frisina Dep. 288:18-290:24.

DHHS set its own kinship targets in 2023 to be met by 2028: 50% of Children in Foster Care placed with kin, and 25% placed with licensed kin. Ex. 33, DHHS_2026_00099036, _00099048; Frisina Dep. 80:2-19. As of March 2025, kin placements stood at 31.31%, and DHHS is not on pace to meet the 2028 goal. Ex. 33, _00099048; Frisina Dep. 115:2-23.

Rather than close the gap on licensed kin, DHHS lowered that goal from 25% to 10%. Frisina Dep. 92:14-25; 94:11-95:1. From 2022 to 2025, an average of 0.5% of putative class members were placed with licensed kin annually. Data Rep. tbls. 32, 71-74.

DHHS has not required the practices that identify and sustain kin placements. It articulates a "best practice" of engaging kin while adopting none of the concrete measures, such as using nationally recognized family search and engagement tools, dedicating county staff to finding kin, or requiring training on family search and engagement. Frisina Dep. 114:13-115:1, 138:6-17, 144:11-23. Its manual directs counties to document relative-search efforts at each permanency hearing, but DHHS does not monitor whether that is completed. Ex. 34, Sanders Dep. 209:11-20, 212:9-24.

DHHS also controls the intensive community-based services a child needs to sustain a kinship placement, regardless of caregiver licensure. *See* Cross Rep., 148, 158-59. Those services do not reach children that need them. Of the putative class members placed with kin in the 180 days before a PRTF episode, only half received any intensive community-based services. Data Rep. tbl. 88. A study DHHS

commissioned found that kinship caregivers reported a lack of support and inconsistency across counties, and recommended bolstering resources and training. Ex. 35, DHHS_2026_00025081, _00025085-87. DHHS separately commissioned a kinship navigator feasibility study, completed in 2022, and chose the option that deferred building supports to "a later point in time." Frisina Dep. 294:19-295:18. Four years later, North Carolina has no kinship navigator program and no plans for one. Sanders Dep. 206:5-11, 208:4-6.

A state's failure "to take certain steps to increase the supply of community-based placements" is susceptible to classwide proof, because "all class members are affected by what the defendants do and do not do to increase the supply of available foster homes." *B.D.*, 2024 WL 4227544, at *12-13; *see also Jonathan R. II*, 344 F.R.D. at 311-13 (insufficient placement array presents common question).

None of that turns on any individual child's family or any individual county's efforts; each question is answered once, from DHHS's own policies. Whether DHHS fails to require the practices that identify and sustain kinship placements therefore presents a common question resolvable as to all class members in a single stroke.

(e) Evidence-Based Treatment in PRTFs

DHHS's failure to require evidence-based treatment in PRTFs is the fifth concrete practice driving classwide violations.

A PRTF discharge turns on whether the child's "treatment plan goals and objectives have been substantially met." Ex. 5, § 3.2.3. Treatment is therefore the mechanism by which a child becomes able to discharge and not be readmitted. Shusko Dep. 109:24-110:16. Yet DHHS does not require that any particular treatment be delivered in a PRTF.

For the community-based services it covers, DHHS specifies required service components, staffing, and training. Ex. 36, CCP Nos. 8A, 8A-1. IAFT likewise has minimum service requirements and is evidence-based. Ex. 29. DHHS imposes no comparable requirement on PRTFs. Neither the PRTF coverage policy, the rules governing PRTF licensure, nor the PRTF contracts require a minimum treatment regimen, an evidence-based treatment modality, or an evidence-based milieu model. Crosbie Dep. 191:16-192:1, 197:14-199:23; Crosbie 30(b)(6) Dep. 79:2-81:5, 132:9-21; Shusko Dep. 50:14-17, 51:14-17, 153:16-20.

Payment is untethered from treatment. PRTF rates, which DHHS's managed care contractors negotiate with PRTFs, range from approximately $401 to $1,750 per day, and are not tied to services delivered. DHHS conducts no oversight of what services are delivered for the rate paid. Crosbie Dep. 196:15-197:24; Ex. 37, Dubay 30(b)(6) Dep. 20:8-21:19, 27:14-25, 29:16-21.

What children receive in PRTFs falls far below what a twenty-four-hour treatment setting implies. DHHS's workgroup found that about one hour of services per week is provided "across all residential levels of care." Ex. 38, DHHS_2026_00258958, _00258960. Its own consultant has recommended a minimum of seven hours of therapeutic intervention per week, at least one hour of which must be individual therapy. Ex. 15, DHHS_2026_00039834, _00039843.

Consequently, children remain confined longer than necessary. A child receiving about an hour of therapy a week cannot meet the treatment goals on which discharge depends. *See* Cross Rep., 42-45, 57, 59. On DHHS's own reporting, 25 of approximately 90 children had been confined in a PRTF more than six months with no clinical progress recorded. Crosbie 30(b)(6) Dep. 51:21-52:4; Ex. 39, DHHS_2026_00310481,

_00310485. DHHS requires nothing of the facilities charged with producing that progress.

DHHS has identified the problem and not fixed it, despite receiving $80 million to "transform" its residential services. Crosbie 30(b)(6) Dep. 78:13-16. Its Residential Services Workgroup recommended in January 2026 that DHHS "[d]evelop policies that establish clear minimum standards for milieu-based care models and evidence-based treatment modalities[.]" Ex. 10, _00231491. PRTF rule amendments that DHHS drafted and shelved would have increased required treatment hours and mandated evidence-based models, but they have not been implemented. Crosbie Dep. 241:15-24; Ex. 22, _00230537-38.

Courts have held that a state's failure to require adequate treatment in the institutions it operates or funds is a practice susceptible to classwide proof. *Braggs v. Dunn*, 317 F.R.D. 634, 657-58 (M.D. Ala. 2016) (whether defendant utilized unsupervised and unqualified nursing staff and placed prisoners with serious mental illness in prolonged segregation); *Scott v. Clarke*, 61 F. Supp. 3d 569, 587 (W.D. Va. 2014) (whether the state agency "systematically provides inadequate medical care" in a prison); *Baxley*, 338 F.R.D. at

87-88 (whether defendant fails to oversee the provision of healthcare in regional jails).

Additionally, everything a PRTF delivers can be delivered to a child living with a family. What distinguishes a PRTF from community-based care is only "the intensity and frequency of the" services. Shusko Dep. 51:20-25. Where services are not delivered at greater intensity or frequency than in the community, the placement serves no treatment purpose the community could not serve. *See* Cross Rep., 7, 52, 59, 81-82.

None of that turns on the individual treatment any child received in a PRTF. Whether DHHS fails to require evidence-based treatment in PRTFs, at any defined intensity or frequency, thereby prolonging class members' confinement, therefore presents a common question resolvable as to all class members in a single stroke.

Rule 23(a)(2) is met.

3. Typicality

Rule 23(a)(3) asks whether "the claims or defenses of the representative parties are typical of the claims or defenses of the class." Fed. R. Civ. P. 23(a)(3). This requirement "tends to merge" with commonality, and the named

plaintiffs' claims need not "be perfectly identical or perfectly aligned" with those of the class. *Deiter v. Microsoft Corp.*, 436 F.3d 461, 466-67 (4th Cir. 2006) (citations omitted). "[T]he crux of the typicality requirement is whether the Named Plaintiffs' *claims* are representative of the absent class members' *claims* — not whether their factual circumstances are identical." *Jonathan R. II*, 344 F.R.D. at 314 (emphases in original).

The Named Plaintiffs' claims are typical because they challenge the same conduct under the same legal theory. Like every class member, each is a child in foster care with a qualifying mental or behavioral health disability, entitled to treatment in the most integrated setting appropriate to their needs. None opposed community-based treatment; each could have received clinically appropriate treatment in a community setting during periods of PRTF confinement. Gray Rep., 73-80, 129-135, 163-171. Colt H. and Juana R. are currently in PRTF placements out-of-state.

When not confined, each child remained at serious risk of unnecessary PRTF placement arising from the same five policies and practices that expose the rest of the class to

that risk. *See generally* Gray Rep. Isabella A. currently fits the serious-risk factors enumerated above. *Id.* at 35-36, 73.

Courts routinely find typicality in such cases, where plaintiffs and the class do not have identical disabilities or suffer injury in precisely the same way, because "both the Named Plaintiffs and the absent [class] members share an interest in securing community services sufficient to prevent their continued exposure to such risk." *Jonathan R. II*, 344 F.R.D. at 315.

Because the relief Plaintiffs seek runs to DHHS's policies rather than to any child's placement, the ways in which the Named Plaintiffs' circumstances differ – from one another or absent class members – do not bear on typicality. Rule 23(a)(3) is satisfied.

4. Adequacy of Representation

Rule 23(a)(4) asks whether "the representative parties will fairly and adequately protect the interests of the class." Fed. R. Civ. P. 23(a)(4). The inquiry is whether the named plaintiffs and their counsel have conflicts of interest and whether they will prosecute the action vigorously on the class's behalf. *Jonathan R. II*, 344 F.R.D. at 315. Adequacy "does not require complete identity of claims or interests

between the proposed representative[s] and the class," only "sufficient similarity of interest such that there is no affirmative antagonism." *Sharp Farms v. Speaks*, 917 F.3d 276, 297 (4th Cir. 2019) (cleaned up).

The Named Plaintiffs seek no individualized damages, only declaratory and injunctive relief directed at DHHS's policies and practices. Their interests are the interests every class member holds, and the relief they seek would benefit the class equally. There is accordingly no antagonism between them and the class. Each will prosecute the action vigorously through class counsel. Ex. 40, Decls. of Russell, Holden, and Holtzman.

Plaintiffs' counsel are likewise adequate. Plaintiffs are represented by Disability Rights North Carolina, the North Carolina State Conference of the NAACP, Children's Rights, and Moore & Van Allen PLLC. Each organization is experienced in systemic federal civil rights and class action litigation, and none has any conflict with the class. Ex. 41, Decls. of Stiles, Joyner, Frye, and Lanning; *see generally Jonathan R. II*, 344 F.R.D. at 315-16.

Rule 23(a)(4) is satisfied.[3]

B. Rule 23(b)(2)

Rule 23(b)(2) applies where the defendant has "acted or refused to act on grounds that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole." Fed. R. Civ. P. 23(b)(2). "The key to the (b)(2) class is the indivisible nature of the remedy warranted" and "[c]ivil rights cases against parties charged with unlawful, class-based discrimination are prime examples of what (b)(2) is meant to capture." *Wal-Mart*, 564 U.S. at 360-61 (alteration in original) (citations omitted).

DHHS has acted and refused to act on grounds that apply generally to the class. Each of the five practices set out above is a feature of DHHS's own administration of the systems it operates – what DHHS requires, ensures, and monitors – and each applies to every child in foster care in North Carolina

[3] The Fourth Circuit's ascertainability requirement does not apply to Rule 23(b)(2) classes where plaintiffs seek "only declaratory and injunctive relief from a discriminatory policy." *Kadel v. Folwell*, 100 F.4th 122, 160-61 (4th Cir. 2024) (en banc), *vacated on other grounds sub nom. Folwell v. Kadel*, 145 S. Ct. 2838 (2025) (mem.); *see also Brantmeier v. Nat'l Coll. Athletic Ass'n*, No. 1:24-CV-238, 2025 WL 2108638, at *3 (M.D.N.C. July 28, 2025).

with a mental or behavioral health disability, whether or not the child is confined in a PRTF today. *See supra* § III.A.2; *B.D.*, 2024 WL 4227544, at *18.

Plaintiffs also seek indivisible relief. At the certification stage, all that is required is that an appropriate injunction be "conceivable." *Shook v. Cnty. of El Paso*, 543 F.3d 597, 608 (10th Cir. 2008). That standard has been met: Plaintiffs ask the Court to order DHHS to change what it requires and verifies as to assessments; discharge planning; access to IAFT; kinship placements, and the community-based services that support them; and treatment in PRTFs. None of that can be ordered for one class member and withheld from another. As one court explained in certifying a materially similar class, "at the conclusion of the merits proceedings, the court could only declare unlawful and enjoin the challenged conduct 'as to all of the class members or as to none of them.'" *Jonathan R. II*, 344 F.R.D. at 317 (quoting *Wal-Mart*, 564 U.S. at 360).

Rule 23(b)(2) is satisfied.

Dated October 1, 2026

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Counsel of Record hereby certifies pursuant to Local Rule 7.3(d)(1) that the foregoing memorandum of law contains fewer than 6,250 words. Counsel relies upon the word count feature of word processing software in making this certification.

Date: October 1, 2026 /s/ Lindsey Frye

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