IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA
WESTERN DIVISION
CIVIL CASE NO. 5:11-cv-354

K.C., a minor child, by his mother and next friend AFRICA H.; ALLISON TAYLOR JOHNS; L.S., a minor child, by his father and next friend RON S.; and D.C., a minor child, by his mother and next friend PENNY C.; on behalf of themselves and all others similarly situated, Plaintiffs, v. LANIER CANSLER, in his official capacity as Secretary of the Department of Health and Human Services, PAMELA SHIPMAN, in her official capacity as Area Director of Piedmont Behavioral Health Care Area Mental Health, Developmental Disabilities, and Substance Abuse Authority, and PIEDMONT BEHAVIORAL HEALTHCARE AREA MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE AUTHORITY doing business as PBH, Defendants.	)	CLASS ACTION COMPLAINT

INTRODUCTION

1. Medicaid recipients with disabling and chronic conditions bring this suit to challenge the lack of basic due process protections for Medicaid recipients when their developmental disability services were reduced or terminated effective July 1, 2011 by the North Carolina Department of Health and Human Services (DHHS), through its Medicaid managed care contractor and agent, Defendant Piedmont Behavioral Healthcare (hereinafter "PBH"), under the direction of its Area Director, Defendant Shipman. Without any change in their underlying health conditions or needs, essential Medicaid services previously authorized for the care of each

named Plaintiff and hundreds of others similarly situated were terminated or reduced effective July 1, 2011 by Defendant PBH. Defendant PBH is using a "Supports Needs Matrix" to terminate the services, but the process uses arbitrary, non-ascertainable standards and the recipients were given no meaningful opportunity to challenge the PBH decisions. This class action seeks to enjoin Defendants from reducing these essential health services without first providing due process to the plaintiffs and others similarly situated. The violations of law and illegal reduction of services suffered by the named plaintiffs are typical of similar violations suffered by hundreds of other North Carolina Medicaid recipients served by PBH. PBH, as Defendant Cansler's agent, has engaged in a uniform policy and practice of reducing these Medicaid developmental disability services in violation of due process.

2. Plaintiffs and all proposed class members have been receiving developmental disability services in the community through the North Carolina "Innovations Waiver," which covers home and community based services for developmentally disabled individuals such as the Plaintiffs and class members and is operated by Defendant Cansler's contractor and agent, Defendant PBH, under the direction of its Area Director and CEO, Defendant Shipman.

3. Prior to July 1, 2011, the Defendants had found the Plaintiffs' services to be medically necessary and were providing coverage for these services through the Medicaid program. Plaintiffs are representative of a class of more than 600 developmentally disabled North Carolina residents who have received services under the PBH Innovations Waiver, but whose coverage was recently reduced, terminated or eliminated by PBH employees. The PBH employees used a tool called the Supports Intensities Scale (hereinafter, "SIS") to assign a score to each Plaintiff based on an assessment of an individual's medical and behavioral support needs and "life activities" in comparison to others with developmental disabilities. Based on the score

obtained from the SIS, Plaintiffs and other proposed class members were assigned by PBH into a category under PBH's new Supports Needs Matrix system. That assignment in turn resulted in a reduction of each class member's services effective July 1, 2011. This reduction in services occurred without adequate written notice of PBH's decisions, without the opportunity for a fair hearing to contest the SIS score's accuracy or to appeal their assignment to a particular category, and without the opportunity to continue receiving services at the prior authorized level pending the outcome of such a fair hearing, all in violation of Plaintiffs' rights under the Medicaid Act and under the Due Process clause of the Fourteenth Amendment.

4. PBH's illegal policies and practices will cause irreparable harm to the Plaintiffs and the Plaintiff class, all of whom are receiving Medicaid-funded services due to their disabling and chronic conditions. Terminating or reducing developmental disability services that have previously been found to be necessary by Plaintiffs' treating providers and by PBH will place the health and safety of Plaintiffs and the Plaintiff class at risk, threatening them with imminent irreparable harm. By depriving them of coverage of essential health services to which they are entitled without due process or statutory authority, Defendants leave many of the most vulnerable disabled children and adults in North Carolina without adequate health care services, even though such services are, and have previously been found by Defendants to be, critical to their health, safety, and development. Some Plaintiffs and class members also will be threatened with placement in institutional settings far from their communities if the services which they need to remain at home are not reinstated. Plaintiffs and class members thus have no adequate remedy at law and are entitled to a declaratory judgment and to temporary, preliminary and permanent injunctive relief to reinstate and continue their previously authorized services until they have been provided with due process.

5. PBH is a Local Management Entity ("LME") contracted by Defendant DHHS to "manage all publicly funded MH/DD/SA [Mental Health, Developmental Disability, and Substance Abuse] services" within its catchment area. Memorandum of Agreement between NCDHHS and PBH effective April 1, 2008, Attachment B (Scope of Work), Section 2.

6. The N.C. Innovations Waiver is a 42 U.S.C. § 1915(c) Home and Community Based Waiver that offers services to individuals with developmental disabilities who would otherwise qualify for services in an Intermediate Care Facility for the Mentally Retarded (ICF-MR).

7. The program is called a waiver because, under the Medicaid Act, the federal Medicaid agency has given North Carolina permission not to comply with certain, otherwise mandatory provisions of the Medicaid Act. Medicaid Act provisions not specifically waived continue to apply in full force and effect for those enrolled in the program. The federal agency did not waive 42 U.S.C. § 1396a(a)(3) as part of the N.C. Innovations Waiver. The federal agency is without authority to waive the Due Process Clause of the U.S. Constitution.

8. Recently, PBH introduced a new system to allocate funding for services amongst waiver participants called the "Supports Needs Matrix." For all plaintiffs and proposed class members, the practical effect of this matrix was a termination or reduction of Medicaid-covered services previously approved for them by PBH effective July 1, 2011.

9. Defendants' actions violate the Medicaid Act and its accompanying regulations, and the Due Process Clause of the Fourteenth Amendment of the U.S. Constitution.

10. Plaintiffs seek declaratory and both preliminary and permanent injunctive relief to halt the implementation of the Supports Needs Matrix system by PBH until the Defendants comply with statutory and constitutional due process requirements.

11. Plaintiffs further seek class relief for all those individuals who are similarly situated, as described infra, at Paragraph 24, in the proposed class definition.

JURISDICTION AND VENUE

12. This is an action for declaratory and injunctive relief for violation of the Social Security Act, 42 U.S.C. §§ 1396-1396w and of the Due Process Clause of the Fourteenth Amendment of the U.S. Constitution.

13. The Court has jurisdiction over Plaintiffs' claims under 28 U.S.C. §§ 1331 and 28 U.S.C. §§ 1343(a)(3), which grant this Court original jurisdiction in all actions authorized by 42 U.S.C. § 1983 to redress the deprivation under color of State law of any rights, privileges, or immunities guaranteed by the United States Constitution and Acts of Congress. Declaratory and injunctive relief is also authorized by 28 U.S.C. §§ 2201 and 2202 and Fed. R. Civ. P. 65.

14. Venue is proper because a substantial part of the events or omissions giving rise to Plaintiffs' claims occurred here and because Defendant Cansler may be found here. 28 U.S.C. § 1391(b)(1).

PARTIES

15. Plaintiff K.C. is a fourteen year old boy who lives in Union County, North Carolina. K.C. has Cerebral Palsy, Moderate Mental Retardation, seizure disorder and incontinence. K.C. does not have a guardian or other duly-appointed representative and appears in this proceeding through his mother and next friend, Africa H. K.C. is unable to obtain necessary and appropriate health services because Defendants illegally reduced coverage of those services. As a result, K.C. is threatened with damage and serious risk to his health, safety, development, and well-being.

16. Plaintiff D.C. is a fourteen year old boy who lives in Union County, North Carolina. D.C. has severe autism and is non-verbal. All twenty-one hours per week of in-home skill building services for D.C. have been terminated by PBH effective July 1, 2011. D.C. does not have a guardian or other duly-appointed representative and appears in this proceeding through his mother and next friend, Penny C. D.C. will be unable to obtain necessary and appropriate health services because Defendants illegally terminated coverage of those services. As a result, D.C. is threatened with damage and serious risk to his health, safety, development, and well-being.

17. Plaintiff Allison Taylor Johns ("Taylor") is an eighteen year old girl who lives in Union County, North Carolina. Taylor has Cerebral Palsy, borderline intellectual functioning, seizure disorder and ADHD. Taylor is unable to obtain necessary and appropriate health services because Defendants illegally reduced coverage of those services. As a result, Taylor is threatened with damage and serious risk to her health, safety, development and well-being.

18. Plaintiff L.S. is a thirteen year old boy who lives in Cabarrus County, North Carolina. L.S. has autism and seizure disorder. L.S. does not have a guardian or other duly-appointed representative and appears in this proceeding through his father and next friend, Ron S. L.S. is unable to obtain necessary and appropriate health services because Defendants illegally reduced coverage of those services. As a result, L.S. is threatened with damage and serious risk to his health, safety, development, and well-being.

19. Defendant Lanier Cansler is the Secretary of the North Carolina Department of Health and Human Services (DHHS). DHHS has been designated as the "single state agency" directly responsible for the administration and supervision of North Carolina's Medicaid program under Title XIX of the Social Security Act. *See* 42 U.S.C. § 1396a(a)(5); N.C. Gen.

Stat. § 108A-54; 42 C.F.R. § 431.10. Defendant Cansler is charged with overall responsibility for the administration of DHHS, which administers the Medicaid program in North Carolina. He is sued in his official capacity.

20. As the director of the single state Medicaid agency, Defendant Cansler is responsible for the supervision and oversight of PBH to make sure that PBH provides Medicaid services in accordance with federal law. *See* N.C.G.S. § 108A-54; 122C-111, *et seq*.

21. Defendant PBH is the Local Management Entity (LME) for Davidson, Rowan, Cabarrus, Union and Stanley counties and a managed care behavioral health organization operating with state and federal Medicaid and other state funds to provide necessary services and supports for individuals with developmental disabilities, substance abuse, and mental health needs.

22. Defendant Pamela Shipman is the area director and chief executive officer of PBH. As such she is responsible for the supervision and oversight of PBH to make sure that PBH provides Medicaid services in accordance with federal law. She is sued in her official capacity.

23. PBH's contract with the State of North Carolina requires PBH's compliance with federal laws and regulations, including those related to the maintenance of a Grievance System under 42 CFR Part 438 Subpart F and meaningful access to the State's Fair Hearing system under 42 CFR Part 431 Subpart E.

CLASS ACTION ALLEGATIONS

24. This action is brought as a statewide class action pursuant to Fed. R. Civ. P. 23(a) and (b)(2) on behalf of:

all current or future N.C. Innovations Waiver participants whose Medicaid services have been or will be denied, reduced, or terminated by Defendant Cansler or Defendant PBH or

any of their employees, contractors, agents or assigns through the implementation of the Supports Intensities Scale (SIS) or Supports Needs Matrix, without first being provided adequate notice and hearing rights as required by the Medicaid Act and Due Process.

25. The class is so numerous that joinder of all members is impracticable. Approximately 675 persons receive services from PBH under the Innovations Waiver and all of them have been assessed and categorized under the SIS and Supports Needs Matrix policies.

26. All individuals served by the PBH Innovations Waiver whose services were denied, reduced, or terminated because of the SIS/Supports Needs Matrix system share a common claim with the Plaintiffs in that their services have been or will be terminated, denied or reduced by PBH or DHHS, directly or through their agents or assigns, without adequate due process protections.

27. There are common questions of law and/or fact as to the permissibility of the Defendants' policies and practices with respect to the procedures for terminating, denying, and reducing Medicaid-covered services that are common to all members of the class. The factual questions common to the entire class include what policies and practices were instituted or permitted by Defendants in the implementation of the SIS/Supports Needs Matrix system and in the resulting denial, termination, and reduction of Medicaid-covered services. The legal questions common to the class include whether Defendants' policies, practices and procedures in the implementation of the SIS/Supports Needs Matrix system fulfill the notice and fair hearing requirements under the Medicaid Act and the U.S. Constitution.

28. The claims of the class representative plaintiffs are typical of the claims of the class. Plaintiffs and other class members all have had Medicaid-covered services reduced or terminated by Defendants under the same challenged PBH policies, practices and procedures. The

implementation of the SIS/Supports Needs Matrix system by Defendants terminate, denies or reduces the Medicaid-covered developmental disability services of each plaintiff and class member without adequate notice or opportunity to first contest that proposed action via the federally-mandated fair hearing system.

29. The Plaintiffs will fairly and adequately represent the interests of all members of the class. Plaintiffs know of no conflicts of interest among themselves or between their interests and those of class members. All are seeking the same relief and none are seeking monetary damages.

30. Prosecution of separate actions by individual class members would create a risk of inconsistent or varying adjudications with respect to individual class members, 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 their ability to protect their interests.

31. Defendant's actions and omissions have affected and will affect the class generally, thereby making appropriate injunctive and declaratory relief with respect to the class as a whole.

FACTUAL BACKGROUND

A. PBH / the N.C. Innovations Waiver

32. The Medicaid Act, Title XIX of the Social Security Act, 42 U.S.C. § 1396-1396w-5, establishes a medical assistance program cooperatively funded by the federal and state governments. Medicaid is designed to ensure that low income people receive necessary medical services. States are required to administer Medicaid "in the best interests of recipients." *Id.* at § 1396a(a)(19).

33. A state's participation in Medicaid is voluntary. Once a state elects to participate, it must adhere to the federal legal requirements, as provided by the United States Constitution, the

Medicaid Act, and the rules promulgated by CMS. North Carolina has elected to participate in the Medicaid program. N.C. Gen. Stat. 108A-54.

34. The Medicaid Act requires participating states and Medicaid participating managed care entities to provide each Medicaid recipient with adequate written notice and an opportunity for an impartial hearing before services are denied, reduced or terminated. 42 U.S.C. § 1396a(a)(3); 42 C.F.R. part 410.200.

35. The Due Process Clause of the U.S. Constitution requires the state Medicaid agency and its agents to provide each Medicaid recipient with adequate written notice and an opportunity for an impartial hearing before services are denied, reduced or terminated. U.S. Const. XIV Amend.

36. The Department of Health and Human Services (DHHS) is designated as the state Medicaid agency responsible for the administration and supervision of North Carolina's Medicaid Program under Title XIX of the Social Security Act. DHHS delegated chief responsibility for administering the federal Medicaid program to its Division of Medical Assistance (DMA).

37. PBH operates under a Memorandum of Agreement with the North Carolina Department of Health and Human Services, Division of Medical Assistance (DMA) under which PBH assumes the task of managing MH/DD/SA services in its catchment area, in exchange for an agreed-upon amount of public funds. However, DHHS retains its oversight responsibilities under state and federal Medicaid law.

38. PBH operates as a Prepaid Inpatient Health Plan ("PIHP"), a type of managed care entity under the Medicaid regulations. *See* 42 C.F.R. § 438.2. PBH internalizes—or conducts all of its own—case management and utilization review functions. PBH employees prepare an

enrollee's plan of care that describes the MH/DD/SA services that the enrollee will receive throughout the year. Other PBH employees are responsible for approving or denying the services contained in the plan submitted for approval.

39. If a PIHP denies, terminates, or reduces the services previously authorized for an enrollee's care, it must provide notice to that enrollee of his/her right to appeal the PIHP's decision. 42 C.F.R. §§ 438.404(b).

40. PIHPs such as PBH may require individuals to exhaust an internal review process before permitting access to the State fair hearing system. 42 C.F.R. §§ 438.402(a). The Memorandum of Understanding between DMA and PBH requires enrollees to complete PBH's internal review process, called a "Reconsideration Review" by PBH, before they may continue their appeal with the State fair hearing system.

41. PIHPs must complete their internal review process within specified time frames established by the State, but under no circumstances may an internal review exceed forty-five (45) days from the date the PIHP receives notice that the enrollee wishes to use the internal review process. 42 C.F.R. §§ 438.408(b)(2). The Memorandum of Agreement between DMA and PBH requires PBH to complete its internal review process within this 45-day timeline.

42. The Medicaid Act authorizes states to obtain Home and Community Based Services waivers (HCBS waivers) upon approval from the Centers for Medicare and Medicaid Services (CMS). *See* 42 U.S.C. § 1396n(c) (also known as Section 1915(c) of the Social Security Act).

43. The N.C. Innovations waiver is a home and community based services waiver in North Carolina. Since 2005, Medicaid-eligible individuals residing in Piedmont Behavioral Healthcare's catchment area—currently consisting of Stanly, Cabarrus, Rowan, Davidson, and Union counties in North Carolina—are eligible to participate in the N.C. Innovations waiver

program. All class members are consumers of services under the N.C. Innovations waiver, which currently has approximately 675 total participants.

44. Under the Innovations waiver, participants meet with a PBH employee called a care coordinator once every twelve months to develop a plan of care for the next twelve month period. The meeting takes place the month before the month in which the participant was born. The plan then takes effect the first day of the participant's month of birth and remains in effect for one year. Under the plan of care, services for the individual for the upcoming year are enumerated, together with providers responsible for the services and funding sources for the services.

B. Supports Needs Matrix

45. In March 2011, PBH issued letters to each individual N.C. Innovations Waiver participant informing them of the implementation of the new Supports Needs Matrix system and of the category to which that participant had been assigned and of the resulting maximum dollar limit on services that could be provided. The letter also included an enclosed pamphlet entitled "2011 Supports Needs Matrix Guide" that purported to explain the new Supports Needs Matrix system to N.C. Innovations Waiver participants and their families. The letter informed each waiver participant that implementation of the individual's new budget limit would be implemented in phases for all participants facing budget reductions beginning in July 2011. The notice did not explain why PBH was implementing the new budget limits for all participants in July 2011, rather than waiting until each participant's current plan of care expires at the beginning of the participant's next birth month. The letter contained no information on how to appeal the decision. PBH care coordinators have routinely informed participants and their providers that their Supports Needs Matrix category could not be appealed.

46. Under the Supports Needs Matrix system, all Innovations waiver participants were placed into one of four different groupings, or "tiers," based on two different factors: (1) whether the participant is a child (defined as "age 21 and under") or an adult (defined as "age 22 or over") and (2) whether the participant lives at home (a/k/a a "non-residential" participant) or in a residential facility (a/k/a a "residential" participant).

47. Within each grouping, there are seven possible categories (Category A-Category G1) to which a participant could be assigned. Each of the seven categories contains a different "Base Budget" dollar maximum for the total amount of most developmental disability services that can be provided over a twelve month period. A participant's "Base Budget" is used to fund particular services that provide regular support and supervision during a participant's day and, therefore, form the core of a waiver participant's plan of care. These services include: Community Networking, Day Supports, Home Supports, Residential Supports, Respite, and Supported Employment.

48. The Base Budget increases by category in ascending order (i.e. Category A contains the lowest cost budget; Category G contains the highest cost budget). PBH assigned participants to one of these seven categories based substantially upon the results of the participant's most recent "Supports Intensity Scale" ("SIS") evaluation.

49. The American Association on Intellectual and Developmental Disabilities created the SIS to "evaluate[] [the] practical support requirements of a person with an intellectual disability through a positive and thorough interview process." Many organizations, including the North Carolina Developmental Disabilities Consortium, oppose the use of the SIS as a means to allocate Medicaid resources because "[t]here is no empirical research to support" its use in this manner.

50. The SIS evaluations that were used to determine individuals' category and Base Budget under the March 2011 Supports Needs Matrix categorizations were performed during 2009, 2010, and 2011. On information and belief, PBH did not consult with the plaintiffs' treating providers as part of the scoring process.

51. At the time these SIS assessments were performed, a copy of a summary of the assessment and score was mailed to each waiver participant. PBH procedure permitted a participant to ask for the SIS assessment to be amended within 90 days of the assessment. However, the notice of the assessment score mailed to participants did not attach a copy or explanation of the scoring system, or explain how the scoring system worked or how the individual's score was arrived at. The notice of the SIS score provided to the participant contained no information on how to contest the score from the SIS assessment or of the deadline for doing so. The notice of the SIS score provided to participants also provided no information on how the SIS score would affect the total amount of services the participant could receive. The notice did not inform the individual that failure to meet the 90-day deadline for requesting an amendment of the score would be used to bar the individual from appealing the reduction in services based on that score in the future. Thus, even if a participant otherwise learned that he or she could contest the assessment score, the participant had no way of knowing why contesting the score was important. Moreover, a participant who did contest the SIS score was not provided with a fair hearing by PBH that meets due process standards. Thus PBH provided no formal means through which the participant could contest in person at a fair hearing consistent with due process the SIS score or the resulting category in the Supports Needs Matrix.

52. The March 2011 notice of the new budget maximum informed participants that they would need to meet with the PBH care manager to write a revised plan of care prior to July 2011

that fits within the budget limit set by the PBH decision. Participants or their guardians were then heavily pressured by the PBH care manager team into signing this new plan of care, which includes statements such as "this plan meets all of [Name of Participant's] needs," to make it appear that the participant/guardian agreed with the budget and the reduced array of services contained therein. One of the ways that this pressure was exerted was to inform participants of PBH's policy that if the new plan were not signed prior to July 1, 2011, *all* waiver services would end on that date.

53. PBH did allow participants who disagreed with their Supports Need Matrix budget limit to request a further review before PBH's "Intensive Review Committee." Such a review might permit the participant to be categorized as an "outlier" within his/her particular category. "Outliers" are eligible for a higher Base Budget than other participants in the same category. However, neither the notices communicating the SIS scores nor the March 2011 letters containing the Supports Needs Matrix category assignments and budget limits contained any information about the Intensive Review process. Rather, the participant had to search through the 2011 Supports Needs Matrix Guide enclosed with the March 2011 notice to find anything about this process. Moreover, the only way to initiate the Intensive Review process was with the agreement and support of the care manager, a PBH employee.

54. PBH has stated that it will not allow more than 7% of all participants to be categorized as an "outlier" within his/her particular category and receive increased funding through the Intensive Review process.

55. PBH care managers have frequently discouraged participants from requesting an Intensive Review. In Plaintiff Taylor Johns' case, her mother was never properly informed that her request for Intensive Review was denied.

56. The Intensive Review Committee makes decisions based entirely upon documentation submitted to it; PBH does not permit individuals to present any information in person to the Intensive Review Committee.

57. According to the documents that waiver participants must complete in order to request an Intensive Review, waiver participants may only request an intensive review of their Medical, Behavioral *or* School needs. Waiver participants may not ask for a review of any combination of these needs through the Intensive Review process.

58. PBH provides no mechanism for appealing the decision of the Intensive Review Committee. The notice of decision provided by the Intensive Review Committee contains no information on appeal rights or about any other steps the individual might take to contest the participant's budget and category assignment beyond the Intensive Review Committee.

59. The "2011 Supports Needs Matrix Guide" appears to require that after the Intensive Review Committee decision, a participant who disagrees must then convince his care manager, who is a PBH employee, to submit a new plan of care to PBH Utilization Management with a budget that exceeds the maximum permitted by the March 2011 Supports Needs Matrix category assignment decision. However, PBH care managers frequently have failed to inform participants of this right or have actively discouraged them from exercising this right.

60. If an individual did succeed in submitting a new plan of care to PBH Utilization Management with a higher budget total than permitted by the Supports Needs Matrix, PBH did provide a written decision to the participant, including appeal rights if the plan was denied. However this notice and its right to a hearing fails to satisfy due process in several respects:

a. The notice was mislabeled as a denial of an initial request for services, even though the decision by PBH was to reduce or terminate existing services that had

been previously approved and even though the reduction or termination took effect prior to the expiration of the participant's previously approved plan of care.

b. The notice fails to provide the right to continuation of the previously approved services pending the outcome of an appeal, as required by federal regulations and due process.

c. The notice fails to adequately explain the reason for the PBH decision to reduce or terminate services.

d. The notice fails to explain that the participant has the right at this point to contest the SIS score or the Supports Needs Matrix categorization. Indeed, PBH care managers have informed some plaintiffs and class members that the SIS score can no longer be contested if it was not challenged within 90 days of the SIS report.

e. PBH care managers also have discouraged appeals by informing participants of PBH policy that if the participant did not sign a new plan of care with a reduced budget under the Supports Needs Matrix prior to July 1, 2011, *all* of the participant's waiver services would end on July 1, 2011, including termination of the services approved in the PBH decision being appealed, even though all of the participant's services were previously approved by PBH under a plan of care that did not expire on July 1, 2011.

61. At least one individual who signed the plan of care under protest, the mother of Taylor Johns, was informed by her PBH care manager on June 30, 2011 that Taylor would lose all services on July 1, 2011 because the plan had been signed under protest.

62. The PBH Supports Needs Matrix system, as implemented by PBH, thus circumvents notice and hearing requirements by enforcing upon participants a budget amount for certain

services which is based upon an individualized factual decision—the participant's level of need according to the SIS assessment—which the participant was never given an opportunity to challenge through the fair hearing process.

C. Plaintiffs

63. Plaintiff K.C. is 14-years-old. Among other diagnoses, he has moderate mental retardation, cerebral palsy, a seizure disorder, and incontinence. Plaintiff K.C. lives in Monroe, Union County, North Carolina.

64. Prior to the adoption of the Supports Needs Matrix, K.C. had a Base Budget amount of $47,936.40 approved by PBH for the plan year October 2010 through September 2011.

65. Using the Supports Needs Matrix system, PBH provided notice to K.C.'s mother in March 2011, assigning K.C. to Supports Needs Matrix Category "Child Non-Residential B" and that his new Base Budget maximum would be $25,476.40.

66. K.C.'s mother, Africa H., requested that PBH reconsider K.C.'s needs through the Intensive Review process. Before K.C.'s needs could be reviewed by the Intensive Review Committee, however, K.C.'s SIS score was re-evaluated.

67. According to K.C.'s mother, the SIS re-evaluation consisted primarily of an interview between herself and the SIS examiner. Also present during this interview was K.C.'s PBH care manager.

68. Based on this new SIS score, PBH changed K.C.'s Supports Needs Matrix Category from "Child Non-Residential B" to "Child Non-Residential D."

69. K.C.'s new Supports Needs Matrix Category carries with it a higher Base Budget than K.C.'s former Supports Needs Matrix category. Nonetheless, it is still approximately $10,000 less than K.C.'s budget in 2010-2011.

70. Because K.C.'s Supports Needs Matrix Category Budget is less than the amount contained in his current plan of care, PBH created a schedule whereby K.C. will be transitioned into his new Supports Needs Matrix Category Budget. In July 2011, K.C.'s individual service plan will be based on an annual Category Budget of $45,550.50 for the period of July 2011 to December 2011. Beginning in January 2012, K.C.'s individual service plan will be based on an annual Category Budget of $36,604.40 for the period of January 2012 to June 2012. The notice did not explain how the reduction was calculated or the basis for the reduction. K.C.'s mother was informed by her PBH care manager that she was required to sign a plan of care prior to July 1, 2011 that does not exceed the newly computed budget limits.

71. K.C.'s health, safety and development are threatened with irreparable harm if his services are not reinstated. Without the medically necessary services that have been eliminated by PBH's actions, he is likely to regress and be at greater risk of institutionalization.

72. K.C.'s SIS score does not accurately reflect his needs. He therefore seeks the right to challenge his Supports Needs Matrix category through the fair hearing process.

73. K.C. was never provided notice or opportunity to challenge his SIS score or Supports Needs Matrix category through the fair hearing process.

74. Plaintiff L.S. is 13-years-old. Among other diagnoses, he has autism and a seizure disorder. Plaintiff L.S. currently lives with his family in Concord, Cabarrus County, North Carolina.

75. Prior to the adoption of the Supports Needs Matrix, L.S. had a Base Budget amount of $55,297.92 approved by PBH for the plan year December 2010 through November 2011.

76. Using the Supports Needs Matrix system, PBH provided notice in March 2011 to L.S.'s parents, assigning L.S. to the Supports Needs Matrix Category Child Non-Residential D

and that his Category Budget amount will be reduced to $36,604.40. The notice stated that beginning in July 2011, L.S.'s individual service plan will be based on an annual Category Budget of $36,604.40. The notice did not explain how the reduction was calculated or the basis for the reduction.

77. Shortly after PBH informed L.S.'s parents of his new budget, L.S.'s parents attended a meeting with his PBH care manager. L.S.'s parents were presented with a new plan of care written by the PBH care manager that would reduce L.S.'s services so that their cost fits within L.S.'s new budget maximum. Although L.S.'s parents were not afforded any input on this draft plan of care, they were told that they had to sign it before they could review the final version of the plan of care.

78. L.S.'s parents then were informed by his PBH care manager that she was no longer an advocate on L.S.'s behalf and that her role was to make sure that "parents don't trump up changes" to their child's plan of care. L.S.'s parents also asked about the possibility of pursuing an Intensive Review, and were informed by the PBH care manager that they could not request an Intensive Review until at least six months after L.S.'s Category Budget took effect.

79. L.S.'s health, safety and development are threatened with irreparable harm if his services are not reinstated. Without the medically necessary services that have been eliminated by PBH's actions, he is likely to regress and be at greater risk of institutionalization.

80. L.S.'s SIS score does not accurately reflect his needs. He therefore seeks the right to challenge his Supports Needs Matrix category through the fair hearing process.

81. L.S. was never provided notice or opportunity to challenge his SIS score or Supports Needs Matrix category through the fair hearing process.

82. Plaintiff Allison Taylor Johns ("Taylor") is 18-years-old. Among other diagnoses, she has Attention Deficit Hyperactivity Disorder, mild mental retardation, hypotonic cerebral palsy, and a seizure disorder. Taylor currently lives in Indian Trail, Union County, North Carolina.

83. Prior to the adoption of the Supports Needs Matrix, Taylor had a Base Budget amount of $45,543.64 approved by PBH for the plan year November 2010 through October 2011.

84. Using the Supports Needs Matrix system, PBH notified Taylor's family in April 2011 that her Supports Needs Matrix category was "Child Non-Residential B," and that her new Base Budget maximum would be $25,476.40. The notice did not explain how the reduction was calculated or the basis for the reduction.

85. Taylor's mother, Linda Johns, then spoke with Taylor's PBH care manager to request an Intensive Review of her needs. The care manager discouraged Taylor's mother from requesting an Intensive Review.

86. Taylor's mother met with Taylor's PBH care manager on May 26, 2011. Although Taylor's mother believed that the purpose of the meeting was to conduct an Intensive Review, it soon became apparent that the PBH care manager's purpose at the meeting was to create a plan of care that would fit within Taylor's new budget.

87. Taylor's mother was asked to have Taylor sign a new plan of care devised by the PBH care manager at the May 26 meeting; she was informed by the PBH care manager that if she did not sign the document, all of Taylor's services would immediately cease. Taylor's mother made handwritten revisions to the document. Taylor initialed these revisions and signed the document under duress.

88. Taylor's mother again asked the PBH care manager about requesting an Intensive Review, and was told by the care manager that she must have an Intensive Review request signed by Taylor's physician and submitted to PBH by the end of the day. Taylor's mother had not previously been informed of these requirements for requesting an Intensive Review.

89. Taylor's mother filed a written request for an Intensive Review on June 23, 2011. To date, she has not yet received any reply from PBH. However, on June 30, 2011, Taylor's mother was informed by PBH that all services for Taylor would cease on July 1, 2011 if she did not sign another plan that removed any objections or reference to signing under protest. Under duress, Taylor signed the plan without indicating any objections in writing, only so that PBH would not terminate all services.

90. Taylor's health, safety and development are threatened with irreparable harm if her services are not reinstated. Without the medically necessary services that have been eliminated by PBH's actions, she is likely to regress and be at greater risk of institutionalization.

91. Taylor's SIS score does not accurately reflect her needs. She therefore seeks the right to challenge her Supports Needs Matrix category through the fair hearing process.

92. Taylor was never provided notice or opportunity to challenge her SIS score or Supports Needs Matrix category through the fair hearing process.

93. Plaintiff D.C. is 14-years-old. Among other diagnoses, he has severe autism and is verbally noncommunicative. Plaintiff D.C. lives in Indian Trail, Union County, North Carolina.

94. Prior to the adoption of the Supports Needs Matrix, D.C. had a Base Budget amount of $43,579.52 approved by PBH for the plan year May 2011 through April 2012.

95. Using the Supports Needs Matrix system, PBH provided notice to D.C.'s parents in March 2011, placing D.C. into Supports Needs Matrix Category "Child Non-Residential A" and

that his new Base Budget maximum would be $18,799.60. The notice did not explain how the reduction was calculated or the basis for the reduction.

96. Because D.C.'s Supports Needs Matrix Category Base Budget is less than the amount contained in his current plan of care, PBH created a schedule whereby D.C. will be transitioned into his new Supports Needs Matrix Category Budget. Beginning July 2011, D.C.'s individual service plan will be based on an annual Category Budget of $28,199.40 for the period of July 2011 to December 2011. Beginning in January 2012, D.C.'s individual service plan will be based on an annual Category Budget of $23,499.50 for the period of January 2012 to June 2012. In July 2012, D.C.'s budget is to be reduced to $18,799.60.

97. D.C.'s Supports Needs Matrix category assignment was based upon an SIS assessment performed in March 2010. This assessment did not accurately reflect D.C.'s actual needs. However, D.C.'s mother, Penny C., did not request that the assessment score be amended at that time for two reasons. First, she was not informed of her right to do so or of the deadline for doing so. Second, she had no way to know that this SIS score would be used to reduce D.C.'s budget over a year later.

98. Despite the March 2011 notice, D.C.'s mother met with his PBH care manager in April 2011 and submitted a Plan of care for the period May 1, 2011 through April 30, 2012 which included an annual base budget of $43,579.52. On April 21, 2011 PBH issued a decision which slightly modified but otherwise approved this plan of care.

99. D.C.'s mother was informed by her PBH care manager that she was required to sign a plan of care prior to July 1, 2011 that does not exceed these reduced budget limits. She was told that if she did not sign a reduced plan, all services would stop on July 1, 2011.

100. In May 2011, D.C.'s mother asked D.C.'s PBH care manager for a new SIS assessment. The care manager informed her that a new assessment would have no effect on D.C.'s services until 2013. On May 21, 2011, D.C.'s mother requested that PBH reconsider D.C.'s needs through the Intensive Review process.

101. On June 7, 2011, PBH faxed to D.C.'s mother the Intensive Review Committee's decision denying her request for a higher budget. The decision contains no reason for the decision, no information about appeal rights, and no information about any other steps that could be taken to contest the PBH decision to reduce D.C.'s services.

102. On June 10, 2011, D.C.'s mother met with her care manager again and submitted a plan of care to PBH Utilization Management which requested PBH to approve continuation of D.C.'s services as approved in the April 2011 Plan of Care.

103. On June 22, PBH issued a notice of decision denying the June 10 plan of care. Further, the decision reduces D.C.'s in home skill building services to zero hours, approving only respite services for him. The decision states that the skills building service is denied as not medically necessary, even though D.C.'s needs have not changed since that service was approved by PBH for the plan year beginning May 2011. The decision makes no reference to the Supports Needs Matrix or SIS assessment as a basis for the termination of this service. The notice is incorrectly labeled a denial of an initial request for services and contains no information about D.C.'s right to continue receiving the terminated service pending appeal.

104. On June 30, 2011 D.C.'s mother again contacted his care manager, and was again informed that all services would end on July 1, 2011 unless she signed a new plan of care for reduced services for D.C. on that day. Under duress, she signed the plan, only so that PBH would not terminate respite services. However, above her signature she indicated the following:

"signed under protest because ISP plan does not meet D.C.'s needs and care coordinator has advised services will end after today if not signed."

105. D.C.'s health, safety and development are threatened with irreparable harm if his services are not reinstated. Without the medically necessary services that have been eliminated by PBH's actions, he is likely to regress and be at greater risk of institutionalization.

106. D.C.'s SIS score does not accurately reflect his needs. He therefore seeks the right to challenge his Supports Needs Matrix category through the fair hearing process.

107. D.C. was never provided notice or opportunity to challenge his SIS score or Supports Needs Matrix category through the fair hearing process.

CLASSWIDE ALLEGATIONS

108. PBH has terminated or reduced each of the Plaintiffs' and class members' Medicaid-covered services effective July 1, 2011 without due process. For each Plaintiff and class member, there was no way to meet the new assigned category and budget limit without reducing or eliminating some of the waiver participant's medically necessary core services in the previously approved annual plan of care.

109. Notwithstanding these forced reductions, Plaintiffs and class members have not been provided with proper written notice or any right to a fair hearing to contest the category to which they were assigned. Moreover, PBH has not provided public information demonstrating ascertainable, non-arbitrary standards and procedures by which PBH has made the decisions upon which the reductions in services are based.

110. Defendant Cansler has failed to adequately supervise PBH in order to assure that PBH complies with federal law in implementing the Supports Needs Matrix system.

111. Defendant Cansler, through his agent PBH, has engaged in numerous practices that violate the Medicaid Act and the Due Process Clause of the U.S. Constitution. Defendants have denied, terminated, and reduced services to hundreds of Medicaid recipients under policies, practices and procedures in clear violation of the law.

112. Defendants have a policy, procedure and practice of instructing waiver participants and providers of waiver services about arbitrary and improper limits on the total cost of core services that may be requested. For example, PBH care managers have informed participants that the plan of care may not request more in services than the Supports Needs Matrix budget allows. Thus, Medicaid services are being denied, reduced, or terminated verbally by Defendants' agent and employee without providing written notice or hearing rights to the recipient.

113. Defendants, through PBH staff, have engaged in a procedure and practice of discouraging requests for services and discouraging appeals of its decisions to reduce or terminate services by improperly threatening participants that all waiver services will end if the plan of care to reduce services is not signed, even though PBH previously authorized the service as medically necessary and the participant's plan of care including those services has not expired.

114. Defendants have engaged in a procedure and practice of insisting or strongly encouraging that waiver participants not file requests for Intensive Review and not file a plan of care in excess of the Supports Needs Matrix budget maximum. Defendants thus have engaged in a practice of verbally denying, reducing, and terminating services without issuing a written notice and without permitting any appeal of the decision.

115. Defendants have engaged in a policy and practice of reducing or terminating services despite the absence of any material change in circumstances or medical improvement since the service was previously approved, without giving an adequate explanation for the change in its decision, even though the period for which services were previously authorized has not expired.

116. Defendants have engaged in a policy and practice of failing to make medical necessity decisions based on the individual facts of the case and controlling law but rather based upon unpromulgated, internal, arbitrary guidelines and procedures that are not readily ascertainable, including but not limited to the failure to publish ascertainable standards for Intensive Review process, and the failure to publish consistent, clear procedures for contesting PBH decisions.

117. Defendants have engaged in a policy and practice of failure to issue timely and adequate written notices when requests for services are denied, reduced or terminated.

118. Defendants have engaged in a policy and practice of failing to provide an adequate explanation of the reasons for their decision in the written notices to Medicaid recipients.

119. Defendants have engaged in a practice of issuing notices that improperly state that services are being initially denied when in fact services are being reduced or terminated and that do not indicate that the Medicaid recipient has a right to continued services pending appeal in that case.

120. After a recipient has appealed a decision by PBH to reduce or terminate services, Defendants have engaged in a policy and practice of failing to provide authorization, with reasonable promptness and for the entire period at issue, for the provider to continue to provide services to recipients pending the outcome of the appeal.

121. Defendants have engaged in arbitrary, secret procedures that deny, reduce, and terminate Medicaid services based on vague, inconsistent, subjective criteria that bear little, if any, relation to the degree of service and support needed by individual waiver participants.

122. Defendant Cansler and his designees have for each allegation herein specifically authorized the illegal policy, procedure or practice of PBH or repeatedly failed to adequately supervise PBH and to timely and effectively take corrective action to require PBH to obey the law.

FIRST CLAIM FOR RELIEF
(Due Process: Lack of Ascertainable Non-Arbitrary Standards)

123. Plaintiffs incorporate and re-allege paragraphs 1 through 122 as if fully set forth herein.

124. In order to comply with due process, a State Medicaid program must use reasonable, ascertainable, non-arbitrary standards and procedures for determining eligibility for and the extent of medical assistance provided.

125. The Supports Needs Matrix system uses vague, subjective, arbitrary and secret criteria and procedures for allocating Medicaid funds amongst waiver participants. Defendants' use of the Supports Needs Matrix system is therefore inconsistent with the Due Process Clause of the Fourteenth Amendment to the U.S. Constitution.

SECOND CLAIM FOR RELIEF
(Medicaid Notice and Hearing Requirements)

126. Plaintiffs incorporate and re-allege paragraphs 1 through 125 as if fully set forth herein.

127. States must provide for granting an opportunity for a hearing to individuals whose claim for medical assistance is denied, reduced, terminated, or not acted upon with reasonable promptness. 42 U.S.C. § 1396a(a)(3).

128. Defendants' practices and procedures, alleged herein, violate the Medicaid Act by failing to grant an opportunity for a fair hearing to individuals whose claims for medical assistance have been denied, reduced, terminated, or not acted upon with reasonable promptness.

129. These violations, which have been repeated and knowing, entitle the Plaintiffs and plaintiffs' class to relief under 42 U.S.C. § 1983 and 42 U.S.C. § 1396a(a)(3) of the Medicaid Act.

THIRD CLAIM FOR RELIEF
(Fourteenth Amendment of the U.S. Constitution)

130. Plaintiffs incorporate and re-allege paragraphs 1 through 129 as if fully set forth herein.

131. The Due Process Clause of the Fourteenth Amendment prohibits states from denying, reducing, or terminating Medicaid services without due process of law. According to the U.S. Supreme Court in *Goldberg v. Kelly*, 397 U.S. 254 (1970), the Constitutional right to due process of law includes the right to meaningful notice prior to the termination of Medicaid benefits, continued benefits pending a pre-termination hearing, and a fair and impartial pre-termination hearing. Following the Court's decision in *Goldberg*, these due process requirements were explicitly integrated into federal Medicaid regulations. *See* 42 CFR § 431.205(d).

132. Defendants have disregarded the requirements set forth in *Goldberg* by, among other things, failing to properly notify Innovations Waiver participants of their right to appeal and, in many cases, by actively discouraging Innovations Waiver participants from pursuing an appeal or requesting an Intensive Review.

133. Defendant's practices and procedures, alleged herein, violate the Due Process clause of the Fourteenth Amendment to the U.S. Constitution by, among other things, denying the Plaintiffs and Plaintiff class adequate, timely notice and a meaningful opportunity for a fair hearing prior to reduction or termination of services previously authorized by Defendants.

134. These violations, which have been repeated and knowing, entitle the Plaintiff and plaintiff class to relief under 42 U.S.C. § 1983 and the Fourteenth Amendment to the United States Constitution.

RELIEF REQUESTED

WHEREFORE, Plaintiffs respectfully request that the Court grant the following relief:

1. Certify this action as a class action pursuant to Fed. R. Civ. P. 23(b)(2).

2. Issue a declaratory judgment pursuant to 28 U.S.C. § 2201 and Fed. R. Civ. P. 57 that Defendants' actions, policies, procedures and practices as alleged herein are in violation of the Medicaid Act and the Fourteenth Amendment of the U.S. Constitution.

3. Grant temporary, preliminary and permanent injunctions enjoining Defendants and their officers, agents, employees, attorneys, and all persons who are in active concert or participation with them from denying, reducing or terminating Medicaid services to plaintiffs and class members based upon the PBH Supports Needs Matrix system until after complying with the Medicaid Act and Due Process, and requiring Defendants to prospectively reinstate services that have been denied, reduced or terminated to plaintiffs and class members whose services are reduced, denied, or terminated by reason of the Supports Needs Matrix system until the violation of law alleged herein are corrected.

4. Waive the requirement for the posting of a bond as security for the entry of temporary and preliminary relief.

5. Retain jurisdiction over this action to insure Defendants' compliance with the mandates of the Court's Orders.

6. Award the Plaintiffs the costs of this action and reasonable attorney's fees pursuant to 42 U.S.C. § 1988.

7. Provide such other and further relief as the Court deems to be just and equitable.

Dated: July1, 2011

Respectfully submitted,

/s/ John R. Rittelmeyer

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