IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

MICHAEL T., a person with diminished capacity;
ERIC D., by his guardian CONNIE D.;
SARA F., by her guardians REBECCA F. and DAVID F.;
JEREMY C., by his guardian, JO C.; and
TARA R., by her guardian HARV CHRISTIAN R.;

ON THEIR OWN BEHALF AND ON BEHALF OF ALL OTHERS SIMILARLY SITUATED,

Plaintiffs,

v.

KAREN BOWLING, in her official capacity as Secretary of the WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES,

Defendant.

Case No. 2:15-cv-09655

CLASS ACTION

DEMAND FOR PRELIMINARY RELIEF

FIRST AMENDED COMPLAINT FOR INJUNCTIVE AND DECLARATORY RELIEF

PRELIMINARY STATEMENT

1. Plaintiffs hereby amend their initial complaint by right within twenty-one days of the defendant's filing of her F.R.C.P. 12(b)(6) motion, pursuant to F.R.C.P. 15(a)(1)(B).

2. The amended complaint relates back to the filing of the original complaint and supplants it for all purposes. As a result, the defendant's motion to dismiss the original complaint is moot.

3. This is an action on behalf of West Virginia residents with intellectual and developmental disabilities dependent on West Virginia's Intellectual/Developmental Disabilities Home and Community Based Services Waiver program (I/DD Waiver Program). On behalf of themselves and all others similarly situated, plaintiffs seek to preserve pre-existing benefits and

benefit allocation processes so they may continue to receive the same needed services the state provides to others like them who are institutionalized, and so they may remain in the current, more integrated settings they have enjoyed for many years.

4. Since the 1980s, the State of West Virginia has operated a Medicaid home and community-based care program under a special Medicaid waiver plan allowing a limited number of persons with intellectual and developmental disabilities to receive ICF/IID-level services while living at home or in home-like settings.

5. Individuals with intellectual and developmental disabilities who qualify to receive home and community-based services receive an annual amount of waiver benefits represented by a budget for waiver services. The allotment of waiver benefits by law must (i) be based on that person's individual need for care according to the local care provider team most familiar with the individual's needs, and (ii) be sufficient to maintain the recipient in a safe, healthy, and humane condition within an integrated community and home-like setting.

6. In contrast, each year defendant's waiver administrator, Innovative Resource Group d/b/a APS Healthcare, Inc. (APS), allocates benefit amounts arbitrarily through a secret and proprietary computer algorithm that does not apply reasonable standards, give appropriate weight to individual recipient needs, to the amount of waiver benefits and needed services for which the individual recipient was eligible and authorized for in prior years, or to the services the state would provide if that recipient were institutionalized.

7. In past years, the illegal and discriminatory effects of that allocation process were avoidable because APS would routinely reinstate needed benefits and services at previously authorized levels upon submission of individualized evidence showing that a recipient's

circumstances had not significantly improved from prior years, and that the level of benefits and services authorized in the past budget year were still needed to maintain his or her safe, healthy, and humane care in an integrated community and home-like setting.

8. However, defendant has now eliminated that process and provides no reasonable mechanism through which recipients can seek reasonable accommodation between the particular needs of their disabilities and APS's computer-assessed budget.

9. Plaintiffs seek class-wide relief for themselves and similarly-situated West Virginia I/DD waiver program recipients who have had the waiver benefits and services they need to live in an integrated setting unjustifiably reduced or terminated, or who are imminently threatened with such reductions or terminations, even though those same levels and types of services would be available to them were they to choose institutionalization.

10. Those terminations and reductions result from an unpublished, unfiled, and unlawful policy eliminating any method of obtaining reasonable accommodation, as implemented beginning in late 2014 by defendant Secretary Bowling in her capacity as the executive head of the West Virginia Department of Health and Human Resources (DHHR).

11. Pursuant to the challenged policy, DHHR eliminated this avenue for obtaining reasonable accommodation of individual needs by directing APS to deny every request for necessary services over and above the arbitrarily-calculated APS budget "regardless of the situation or setting."

12. That directive meant individual recipients had to apply for reinstatement of prior levels of benefits and services to defendant's Bureau of Medical Services (BMS). However, pursuant to defendant's new policy, BMS customarily denied all such applications because the

request exceeded that recipient's APS initially-assigned budget, without consideration of the recipient's actual need for services, the level and amount of services the state would provide that recipient if institutionalized, and other relevant factors.

13. To further enforce its new policy, DHHR instructed the local care provider teams which coordinate and manage an individual recipient's waiver services not to request the amounts and types services previously authorized, even if the recipient has been receiving and continues to need those services, if doing so would exceed the budget arbitrarily assigned that individual by APS.

14. Moreover, Hearing Officers of the West Virginia Board of Review are routinely denying fair hearing appeals contesting these reductions or terminations, despite proof of continuing need for previously authorized services and the requirements of controlling law.

15. In some cases, the Hearing Officer has simply dismissed appeals of benefit level reductions as being outside the jurisdiction of the Board of Review.

16. Other cases have upheld the benefit and service reductions or terminations, despite recipient's proof of need and the lack of any change in recipient circumstances, on various theories. These range from DHHR "has been directed to operate within budgetary guidelines while providing services . . . [so] individual program budgets cannot be exceeded" to DHHR's official position that I/DD waiver is an "optional" Medicaid program, and the level of benefits and services provided recipients is therefore an unreviewable policy decision solely within DHHR's discretion.

17. The challenged policy, which has not been approved by either the West Virginia Legislature or federal Medicaid officials, and which defendant lacked legal authority to

implement, was instituted solely because of alleged budgetary shortfalls in the I/DD waiver portion of the state's overall Medicaid budget.

18. A recent press report questions whether DHHR is inflating alleged budget problems by including non-waiver Medicaid expenditures in the waiver program expenses.

19. Moreover, any shortfalls have been caused or exacerbated by DHHR's politically-motivated refusal to ask the West Virginia Legislature for additional funding for the waiver program at any time over the last several state budget cycles, even though the state's *Olmstead* plan requires them to push for new funding.

20. Through general application of this challenged policy, over the past few months DHHR has greatly reduced the waiver benefits and services of hundreds of waiver recipients from levels they need to maintain safe, healthy, and humane care in an integrated community setting.

21. DHHR has implemented these massive reductions and terminations of the waiver benefits and services needed by plaintiffs and the class unjustifiably, arbitrarily, and unlawfully, including in that:

- in most or all cases, the level of benefits and amounts and types of services cut would be provided to that same recipient if he or she were institutionalized, and/or would be provided, but at greater expense, if the recipient was moved to a less-integrated setting;
- benefits and services were reduced or terminated despite the lack of any meaningful change in an individual's actual need for services and without DHHR first proving a change in the recipient's circumstances or need for services;

- benefits and services were reduced or terminated without providing adequate prior notice and a meaningful, impartial hearing at which a decision is reached based on the controlling law and regulations, as required by the Constitution and the fair hearing provisions of the federal Medicaid regulations.

22. As a result of DDHR's actions and elimination of the process by which they could to seek and obtain reasonable accommodation of the program to their individual needs, plaintiffs and the absent members of the plaintiff class are suffering loss of the waiver benefits and services needed for safe, healthy, and humane residence in current integrated living arrangements, and/or face imminent peril of such losses as soon as 2015 budgets are implemented for them.

23. In consequence, the named plaintiffs and all others similarly situated are suffering from loss of the type and amount of waiver benefits and services actually needed to maintain them humanely, in safety and health, in the settings which provide them the most integrated community and home-like living arrangements available.

24. As a result of the loss of the benefits and services required to live in safety and health in their current settings, the named plaintiffs and all others similarly situated face a heightened and serious risk of being forced from their long-term home and community living arrangements into segregated, institutionalized settings, denying their right to freedom of choice and violating federal anti-discrimination laws.

25. Because of the loss of the benefits and services resulting from the challenged policy, plaintiff Tara R. has already been forced from the family home in which she has lived all her life. Moreover, because defendant does not provide her the same level and amount of

benefits and services it provides to those who are institutionalized, Tara R. faces imminent risk that she will not even be able to remain at her current placement.

26. Plaintiffs and the absent members of the plaintiff class therefore are suffering or imminently face irreparable harm for which they have no adequate remedy at law

27. Plaintiffs seek class-wide preliminary and permanent declaratory and injunctive relief to remedy DHHR's continuing violation of due process, Medicaid requirements, the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

JURISDICTION

28. This action arises under the Civil Rights Act, 42 U.S.C. §1983; Title II of the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. § 12131, *et seq*.; and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794.

29. This Court has jurisdiction over plaintiffs' claims pursuant to 28 U.S.C. §1343(a)(3) - (4) and 28 U.S.C. § 1331.

30. Declaratory and injunctive relief are authorized pursuant to 28 U.S.C. § 2201 and §2202, and Federal Rules of Civil Procedure 57 and 65.

31. Venue is proper because a substantial part of the acts and omissions of which Plaintiffs complain occurred in this District. *See* 28 U.S.C. § 1391(b).

PARTIES

A. Defendant

32. Karen Bowling is the Secretary of the West Virginia Department of Health and Human Resources (DHHR). In that capacity, Ms. Bowling has full executive authority and responsibility for the operation, control, and administration of the DHHR in West Virginia,

including the West Virginia Bureau of Medical Services (BMS), a subdivision of DHHR. BMS oversees the general administration and operation of the state's I/DD waiver program.

33. Ms. Bowling is sued only in her official capacity as the governmental official with overall executive authority and responsibility over DHHR and its various bureaus and contracting agencies, such as BMS and Innovative Resources Group LLC, d/b/a APS Healthcare, Inc. (APS). No claims are asserted personally against Secretary Bowling. For that reason, this complaint will refer to the defendant generically as "DHHR."

34. West Virginia has designated DHHR as the "single state agency" with direct responsibility for administration of all aspects of the state's Medicaid plan, including all Medicaid Waiver programs. *See* 42 U.S.C. § 1396a (a)(5); W. Va. Code § 29-15-6.

35. DHHR is a recipient of federal funding used to operate and administer all aspects of West Virginia's Medicaid program, including the I/DD Waiver program. The I/DD Waiver program in West Virginia is therefore a "program or activity" subject to the requirements and prohibitions of Section 504 of the Rehabilitation Act of 1973. *See* 29 U.S.C. §794(b).

36. In exchange for that federal funding, DHHR and contracting agencies such as APS must operate all programs in compliance with the statutes and regulations governing the Medicaid program, and with federal laws prohibiting discrimination in the operation of federally-funded programs.

37. Since DHHR is a governmental department of the state of West Virginia, it is a "public entity" as defined by 42 U.S.C. §12131 (1) of Title II of the ADA.

B. Plaintiff Michael T.

38. Plaintiff Michael T. is a 55 year old man living in Poca, Putnam County, West

Virginia, in an Intensively Supported Setting (ISS) residential group home. Michael T. shares this home with another adult who also needs intensive care services.

39. Michael T. has cerebral palsy, a moderate intellectual disability, a seizure disorder, and a vision impairment. In addition, Michael has been diagnosed with a mood disorder and many medical conditions. He is non-ambulatory, incontinent, and requires assistance with virtually all tasks of daily living.

40. Michael's most recent adaptive behavior assessment places his overall functioning at an age equivalent of one year, two months.

41. That same assessment, dated March 13, 2015, shows that not only has Michael's functioning not improved, it has somewhat decreased from the prior year, indicating marginally greater service needs than in previous years.

42. Michael T. does not have a legal guardian, nor does he have living relatives involved in his care.

43. DHHR has assigned a Health Care Surrogate solely to make decisions for Michael T. about his medical care. The Health Care Surrogate is now a representative from the Kanawha County Office of Adult Protective Services. Adult Protective Services is a division of the DHHR, run by waiver program administrator APS. Michael T.'s Health Surrogate is therefore defendant's employee.

44. Michael T.'s waiver benefits and services have been substantially reduced through application of DHHR's challenged policy.

45. However, his Health Surrogate has taken no action to contest that reduction nor sought restoration of the services he needs, even though restoring the benefit level previously

received is crucial to protecting and maintaining Michael T.'s ability to avoid institutionalization.

46. No court has yet determined Michael T. to be incompetent. However, Michael T. is of greatly diminished capacity and requires the immediate appointment of a guardian ad litem.

47. Michael T. has no understanding of the waiver program, DHHR's reduction of his waiver benefits, or the nature of a lawsuit. Michael T. understands only that he will have to leave his home, although he wants to stay where he is.

48. Michael has received services through the I/DD waiver program for approximately twenty years.

49. As is typical of many adult I/DD waiver recipients, Michael's levels of functioning and ability have not improved to any meaningful degree since he was a teenager.

50. The continuing receipt of necessary waiver services throughout the last twenty years has allowed Michael to live in the community in home-like residences such as his current ISS residential group home, rather than in an institution.

51. Continuing to live in this more-integrated setting is medically appropriate for Michael, so long as DHHR does not reduce or terminate the level of community-based waiver benefits and services he needs to reside there in health and safety.

52. Michael T. is a qualified individual with a disability as defined by 42 U.S.C. §12131(2) of Title II of the ADA.

53. Michael T. is entitled to continue to receive waiver benefits at levels previously authorized as necessary to meet his needs unless his circumstances change, as those benefits provide the services needed for him to live safely and in health in the most integrated setting appropriate to his needs.

54. Beginning at least in 2013, APS's proprietary computer algorithm generated a yearly waiver budget for Michael allocating him approximately $170,000 to $174,000 in waiver benefits, regardless of the amount of waiver benefits that had been authorized or needed to meet Michael's actual care needs in the previous year.

55. Upon receipt of that computer-allocated budget, pursuant to the reasonable accommodation process then available, Michael's service coordinator would each year communicate to APS about Michael's individual circumstances, his past history of authorized benefits and services, and his individual health and maintenance needs, explaining why the algorithm-generated budget was not sufficient to provide all the services he needed to maintain his health, his safety, and prevent an increased risk of institutionalization.

56. Prior to 2015, in each year that process resulted in APS authorizing an additional $39,000 to $70,000 in benefits, so as to continue the services necessary to meet his actual needs in the community setting in which he lives.

57. In past years, Michael therefore was authorized to and received waiver benefits totaling in the range of $209,000 - $243,000, and the types and amounts of care and support services he actually needed.

58. Those additional authorizations gave reasonable accommodation to Michael's individual needs within DHHR's general program practices, and resulted in DHHR providing Michael the same level and types of benefits and services it would provide Michael T. if he were institutionalized, but at less cost.

59. For the 2015 budget year, APS's algorithm assigned Michael a benefit level of about $174,000, well below the amount of waiver benefits he previously received.

60. Michael's Health Surrogate was told of that allocation through a standardized form letter DHHR and APS routinely uses to announce the results of the algorithm calculation to every West Virginia waiver recipient. True, redacted exemplars of the letter form customarily employed are compiled in Exhibit 1 to this complaint and incorporated here by reference.

61. When no action DHHR's Adult Protective Services Office took no action for Michael, his provider agency stepped in, as in years past, to help Michael continue to receive the amount of waiver benefits and services he needed and had previously received.

62. Michael's service coordinator therefore submitted to APS a request to reinstate his benefits to the previous year's authorized level so as to maintain the services necessary to meet Michael's actual needs.

63. As in years past, that request was supported by documentation of Michael's circumstances, his service needs, and a review of the type, amount, and cost of services APS had authorized previously as necessary to meet Michael's needs and avoid increasing his risk of institutionalization.

64. However, pursuant to the challenged policy and DHHR's elimination of the mechanism for seeking reasonable accommodation, APS rejected Michael's submission because reinstating the benefits and service levels authorized and received in the prior year would mean exceeding Michael's 2015 algorithm-generated budget.

65. As a result, Michael T. was no longer authorized to receive 24 hours of daily care services as provided under his previously-authorized benefit level. The algorithm-assigned budget required reduction of his available hours of care by 25%, to 18 hours each day.

66. Michael T.'s need for 24 hour care has not changed. He cannot care for himself.

67. Michael lives in an ISS home. He has no family or friends to provide "informal" support to "supplement" the care the waiver program provides. Without 24 hour care, he cannot remain in safety and health where he now lives.

68. DHHR will provide Michael with the 24 hour care services he received last year if he is institutionalized at a higher cost to the state.

69. To continue to get the services Michael T. needs, and which the I/DD waiver program has historically provided him, plaintiff Michael T. will have to move to a less integrated, institutional setting, in which DHHR will provide those services, but at higher cost to the state.

70. Michael is therefore at serious risk of being institutionalized as a direct result of the Medicaid waiver benefit and service reductions imposed on him by the challenged policy.

C. Plaintiff Eric D.

71. Plaintiff Eric D. is a 28 year old man living in Mason, Mason County, West Virginia, with his parents. Eric D. is represented in this suit by his mother and legal guardian, Connie D.

72. Eric D. has a moderate to severe intellectual disability, a seizure disorder, agenesis of the corpus callosum, Crohn's disease, and Hirschsprung's disease. He is non-verbal, incontinent, and requires assistance with all tasks of daily living.

73. Eric's most recent adaptive behavior assessment places his overall functioning at an age equivalent of one year, four months. This same report, dated January 30, 2015, shows no meaningful change in his care needs from the prior year.

74. Eric's levels of functioning and ability have not improved to any meaningful

degree since he was a teenager.

75. Eric has received services through the I/DD waiver program for approximately twelve years.

76. The continuing receipt of necessary waiver services throughout this period has allowed Eric D. to live his entire life with his parents, who both work fulltime.

77. Continuing to live in that integrated setting is medically appropriate for Eric, so long as the DHHR does not reduce or terminate the community-based waiver benefits he needs to reside there in health and safety.

78. Eric wants to remain in his family home, and his parents want him to continue to live there.

79. Eric D. is a qualified individual with a disability as defined by 42 U.S.C. §12131(2) of Title II of the ADA.

80. Eric D. is entitled to continue to receive waiver benefits at levels previously authorized as necessary to meet his needs unless his circumstances change, as those benefits provide the services needed for him to live in the most integrated setting appropriate to his needs.

81. Beginning at least in 2013, APS's computer algorithm has generated a yearly waiver budget for Eric of approximately $64,000 to $65,500, regardless of the amount of waiver benefits authorized and expended to meet Eric's actual care needs in the previous year.

82. Upon receipt of that computer-allocated budget, pursuant to the accommodation process previously available, Eric's service coordinator would each year communicate to APS about his individual circumstances, past history of authorized benefits and services, and his individual health and maintenance needs, explaining why the algorithm-generated budget was

not sufficient to provide all the services Eric needed to maintain his health, his safety, and prevent an increased risk of institutionalization.

83. Prior to 2015, in each year that communication resulted in APS authorizing an additional $17,000 to $19,000 of benefits each year, so as to provide Eric the waiver benefits and services necessary to meet his actual needs.

84. In past years, Eric therefore was authorized to and received waiver benefits and services totaling in the range of $82,000 - $84,000.

85. Those additional authorizations gave reasonable accommodation to Eric's individual needs within DHHR's general program practices, and resulted in DHHR providing him the same level and types of benefits and services it would provide if he were institutionalized, but at less cost.

86. For the 2015 budget year, APS's algorithm assigned Eric a benefit level of about $65,900, well below the amount of waiver benefits and services he previously received. *See* Eric D. notice in Exhibit 1.

87. As in the past, Eric's service coordinator provided APS with a request to reinstate his benefits and services to the previous year's level, as necessary to meet Eric's actual needs. As in years past, that request was supported by documentation of Eric's circumstances, his service needs, and a review of the type, amount, and cost of services APS had authorized in 2014 as necessary to meet Eric's needs and avoid increasing his risk of institutionalization.

88. However, pursuant to the challenged policy and DHHR's elimination of the mechanism for seeking reasonable accommodation, APS rejected Eric's submission because reinstating the benefits and service levels authorized and received in the prior year would mean

exceeding his 2015 algorithm-generated budget.

89. In common with other class members seeking relief from benefit and service reductions or terminations resulting from the policy at issue, Eric's legal guardian, Connie D. asked BMS to review APS's reduction of Eric's previously received waiver benefits and the resulting termination of needed care services.

90. BMS denied Eric D.'s request to restore his previously authorized benefits, despite Eric's continued need for those benefits and the absence of any change in Eric's circumstances, simply because restoring the lost benefits would cause Eric to exceed his algorithm-assigned budget, without consideration of Eric's actual need for services, the level and amount of services the state would provide him if institutionalized, or any other relevant factors. *See* true, redacted exemplars of BMS second level decisions as to named plaintiffs or absent class members, attached as Exhibit 2 and incorporated here by reference.

91. Eric's mother further appealed the reduction in previously authorized benefits and termination of needed waiver services on Eric's behalf, knowing that without the same level of waiver benefits and services Eric had received in previous years, she and her husband could not provide the "informal" support needed to maintain Eric in the only living situation he has ever known.

92. Initially, the family was not provided continuing benefits at the previously authorized level pending appeal, even though the appeal was filed within the necessary time frame.

93. As a result, Eric D.'s services were greatly reduced.

94. Eric's negative behaviors, including hitting, pulling hair, and pinching (many of

which are directed towards himself), became worse when his services were cut.

95. The reduction in plaintiff Eric D.'s waiver benefits level required a reduction of personal-care services by approximately ten hours per week.

96. DHHR denied a request to restore those benefits just enough to allow a caregiver to remain with Eric until his parents arrived home from work each evening.

97. The reduction in personal care services now threatens his parents' ability to continue working full-time.

98. In addition, Eric's respite care services have been drastically reduced.

99. "Respite" care is "specifically designed to provide temporary substitute care normally provided by a family member" . . . "to be used for relief of the primary care-giver(s) to help prevent the breakdown of the primary care-giver(s) due to the physical burden and emotional stress of providing continuous support and care to the dependent member." *West Virginia Title XIX I/DD Waiver Home and Community-Based Services Program Operations Manual* (I/DD Op. Man.) at Chapter 513.9.1.10.1.

100. Loss of respite services means Eric's parents are the sole source of care for Eric – day in, day out, every weekend, holiday, and days of personal illness - whenever the waiver-paid personal care hours have been exhausted.

101. Because of their ages and employment demands, Eric's parents are unable to replace the level and amount of benefits and services Eric has lost with their own efforts for any period beyond a limited one.

102. Eric's care needs have not changed. He cannot care for himself for even a short time. Without the level of benefits and the services the I/DD waiver has historically provided

him, Eric faces care gaps which will adversely affect his safety, health, comfort, and emotional well-being in ways that will not allow him to continue living at home.

103. To get the same level and type of needed benefits and services the I/DD program has previously provided him, plaintiff Eric D. would have to move to a less integrated, more institutionalized setting, at which DHHR will provide all needed services, but at higher cost to the state.

104. Eric therefore is at serious risk of being institutionalized as a direct result of the Medicaid waiver benefit and service reductions imposed on him by the challenged policy.

D. Plaintiff Sara F.

105. Plaintiff Sara F. is a 32 year old woman who lives in Lewisburg, Greenbrier County, West Virginia, with her parents. Sara F. is represented in this suit by her parents and legal guardians, Rebecca F. and David F.

106. Sara F. has intellectual and physical disabilities as the result of a traumatic brain injury; these include a moderate intellectual disability, scoliosis, a seizure disorder, partial left-side paralysis, dementia, anxiety, and a severe vision impairment. Sara is non-ambulatory, incontinent, and requires assistance with all tasks of daily living.

107. Sara's most recent adaptive behavior assessment places her overall functioning at an age equivalent of eleven months. This same report, dated October 14, 2014, shows no meaningful change in her overall service needs from the prior year.

108. Sara's levels of functioning and ability have not improved to any meaningful degree since she was a teenager.

109. Sara has received services through the I/DD waiver program for approximately 30

years. The continuing receipt of necessary waiver services throughout this period has allowed her to live her entire life with her parents.

110. Continuing to live in that integrated setting is medically appropriate for Sara, so long as the DHHR does not reduce or terminate the community-based waiver benefits she needs to reside there in health and safety.

111. Sara F. wants to remain in her family home, and her parents want her to continue to live there.

112. Sara is a qualified individual with a disability as defined by 42 U.S.C. §12131(2) of Title II of the ADA.

113. Sara F. is entitled to continue to receive waiver benefits at levels previously authorized as necessary to meet her needs unless her circumstances change, as those benefits provide the services needed for her to live in the most integrated setting appropriate to her needs.

114. Beginning at least in 2013, APS's computer algorithm has generated a yearly waiver budget for Sara of approximately $71,000 to $73,000, regardless of the amount of waiver benefits authorized and expended to meet Sara's actual care needs in the previous year.

115. Upon receipt of that computer-allocated budget, pursuant to the accommodation process previously available, Sara's service coordinator would each year communicate to APS about her individual circumstances, her past history of authorized benefits and services, and her individual health and maintenance needs, explaining why the algorithm-generated budget was not sufficient to provide all the services she needed to maintain her health, her safety, and prevent an increased risk of institutionalization..

116. Prior to 2015, in each year that communication resulted in APS authorizing an

additional $35,000 or so of benefits, so as to continue the services necessary to meet Sara's actual needs in the community setting in which she resides.

117. In these past years, Sara received authorized waiver benefits in amounts totaling $100,000 - $107,000, which provided the amounts and types of services necessary to meet her health and safety needs.

118. Those additional authorizations gave reasonable accommodation to Sara's individual needs within DHHR's general program practices, and resulted in DHHR providing her the same level and types of benefits and services it would provide if she were institutionalized, but at less cost.

119. For the 2015 budget year, APS's algorithm assigned Sara a benefit level of $72,000, well below the amount of waiver benefits previously received. *See* Sara F. notice in Exhibit 1.

120. As in the past, Sara's service coordinator provided APS with a request to reinstate benefits and services to the previous year's level as necessary to meet Sara's actual needs. As in years past, that request was supported by documentation of Sara's circumstances, her service needs, and a review of the type, amount, and cost of services APS had authorized in 2014 as necessary to meet Sara's needs and avoid increasing her risk of institutionalization.

121. However, pursuant to the challenged policy and DHHR's elimination of the mechanism for seeking reasonable accommodation, APS rejected Sara's submission because reinstating the benefits and service levels authorized and received in the prior year would mean exceeding her 2015 algorithm-generated budget.

122. In common with other class members seeking relief from benefit and service

reductions or terminations resulting from the policy at issue, Sara's mother and legal guardian, Rebecca F., requested a second level review, asking BMS to restore the previously authorized level of benefits and services for Sara.

123. BMS refused to do so, despite Sara's continued need for those benefits and the absence of any change in her circumstances, simply because restoring her lost benefits and services would cause her to exceed the algorithm-assigned budget, without consideration of Sara's actual need for services, the level and amount of services the state would provide her if institutionalized, or other relevant factors. *See* Sara F. BMS decision in Exhibit 2 stating only "[r]equest denied as approval would exceed or has exceeded the member's Individualized Waiver Budget."

124. Sara's mother then sought on Sara's behalf a Medicaid fair hearing to contest the benefit and service reduction, knowing that without the same level of waiver benefits and services Sara had received in prior years, she and Sara's father would be unable to continue to maintain Sara in the only living situation she has ever known.

125. In her request for a hearing, Sara's mother stated "Sara requires this [previously authorized] level of service need and has so for many years. Precedence was set by the States approval in prior years."

126. At Sara's Medicaid fair hearing before a Hearing Officer of the West Virginia State Board of Review, DHHR argued pursuant to the policy at issue that "due to budgetary restraints, all participants of the I/DD waiver program must stay within their respective budget amounts, unless there was a change in the individual's assessed needs."

127. The focus of the case presented by Sara's parents in the fair hearing was that

Sara's needs were exactly the same as in previous years when APS had authorized waiver benefits up to approximately $107,000.

128. DHHR did not dispute the testimony that Sara continues to need the same level of benefits and services, nor did it present any evidence that Sara's circumstances had changed to any significant degree since 2014.

129. Nonetheless, the Hearing Officer affirmed DHHR's refusal to restore Sara's benefits, finding that because Sara's needs had *not* significantly changed, the Hearing Officer could not approve benefits beyond the algorithm-calculated figure. *See* April 1, 2015 Hearing Decision, Action No. 15-BOR-1114, a true but redacted copy of which is attached as Exhibit 3, incorporated by reference.

130. Sara F.'s care services have been greatly reduced, even though her care needs have not changed. She is unable to care for herself for even a short time. Without 24 hour care, she cannot remain in safety and health in the home in which she has always lived.

131. As a result of the approximately $35,000 reduction in Sara's waiver benefits, her parents have been able to hire only one care provider for Sara. That person provides care for eight hours each day, five days each week. Previously, Sara had two to three care staff working various schedules to cover her needs most of her waking day and weekends.

132. Sara's parents are now the sole source of care to make up the lost benefits and services for sixteen hours each workday, and every hour of the weekends.

133. But Sara's parents, who are each in their sixties, lack the physical ability to care for Sara at this level continuously for a long term.

134. For example, Sara's caregivers must transfer Sara, who weighs approximately 160

pounds, in and out of her bed and wheelchair a minimum of twelve times each day.

135. Manual transfers have taken a physical toll on both of her parents in the past. Sara's father has required surgery for a hernia and requires regular injections in both knees as a result of strain from transferring Sara.

136. Sara's mother requires regular chiropractic care to help with back pain. They simply lack the physical ability to transfer and move Sara safely.

137. Sara therefore lacks the level of "informal" support needed to allow her to remain in safety, health, and comfort over the longer term without the services she has lost.

138. To continue to receive the services Sara needs and which the I/DD waiver program has provided her, Sara F. will have to move to a less integrated, institutional setting, where DHHR will provide the services she has lost, but at a higher cost to the state.

139. Sara F. therefore is at serious risk of being institutionalized as a direct result of the Medicaid waiver benefit and service reductions imposed on her by the challenged policy.

E. Plaintiff Jeremy C.

140. Plaintiff Jeremy C. is a 32 year-old man who lives in Charleston, Kanawha County, West Virginia, with his parents. Jeremy C. is represented in this suit by his mother and legal guardian, Jo C.

141. Jeremy C. has had intellectual and physical disabilities since birth. These include severe cerebral palsy, chronic joint arthrosis, chronic muscle spasms in upper and lower extremities, severe muscle spasticity, moderate autism, severe anxiety disorder with cycles of depression, oppositional defiant behavioral disorder, rage reaction seizure disorder, complex partial seizure disorder, ataxia, poor gross motor ability, and non-functional fine motor skills.

142. Jeremy is non-verbal, non-ambulatory, and requires that all daily living tasks be performed for him.

143. Jeremy's most recent adaptive behavior assessment places his overall functioning at an age equivalent of seven months. This same report, dated January 2, 2015, shows a worsening of his medical condition and an increase in his overall service needs, inasmuch as his ICAP Service Score was determined to be 1 (the lowest possible score), while in 2014 it was 11.

144. Jeremy's levels of functioning and ability otherwise have not changed to any meaningful degree since he was a teenager.

145. Jeremy has received services through the I/DD waiver program since April 29, 1996.

146. The continuing receipt of necessary waiver services throughout this period has allowed Jeremy to live with his parents, Jo C. and Todd C., despite their increasing age and their own health problems.

147. Continuing to live in that integrated setting is medically appropriate for Jeremy, so long as the DHHR does not reduce or terminate the community-based waiver benefits he needs to reside there in health and safety.

148. Jeremy wants to remain in his family home, and his parents want him to continue to live there with them.

149. Jeremy C. is a qualified individual with a disability as defined by 42 U.S.C. §12131(2) of Title II of the ADA.

150. Jeremy C. is entitled to continue to receive waiver benefits at levels previously authorized as necessary to meet his needs unless his circumstances change, as those benefits

provide the services needed for him to live in the most integrated setting appropriate to his needs.

151. Beginning at least in 2012, APS's computer algorithm has generated a yearly waiver budget for Jeremy ranging from approximately $69,000 to $92,000, regardless of the amount of waiver benefits authorized and expended to meet Jeremy's actual care needs in the previous year.

152. Upon receipt of that computer-allocated benefit allocation, pursuant to the accommodation process previously available, Jeremy's service coordinator would each year communicate to APS about his individual circumstances, past history of authorized benefits and services, and his individual health and maintenance needs, explaining why the algorithm-generated budget was not sufficient to provide all the services Jeremy needed to maintain his health, his safety, and prevent an increased risk of institutionalization.

153. In budget years 2012, 2013 and 2014, that communication resulted in APS authorizing additional benefits of approximately $28,000 each year, so as to provide Jeremy the services necessary actually to meet his needs.

154. In these three years, Jeremy received authorized waiver benefits in amounts totaling $98,000 - $111,000.

155. DHHR's Patricia S. Nesbit, currently the Director of DHHR's Home and Community Based Services Unit, and one of the main executors of the challenged policy, personally authorized providing waiver benefits to Jeremy at these levels in 2012 and 2013 when she was DHHR's Program Manager for the I/DD Waiver Program.

156. Those additional authorizations gave reasonable accommodation to Jeremy's individual needs within DHHR's general program practices, and resulted in DHHR providing her

the same level and types of benefits and services it would provide if she were institutionalized, but at less cost.

157. For the 2015 budget year, APS's algorithm assigned Jeremy a benefit level well below the amount of waiver benefits previously received, setting his budget at approximately $92,000. *See* Jeremy C. notice in Exhibit 1.

158. As in the past, Jeremy's service coordinator asked APS to reinstate benefits and services at the level of prior years, as necessary to meet Jeremy's actual, on-going, health, safety, and care needs. As in years past, that request was supported by documentation of Jeremy's circumstances, his service needs, and a review of the type, amount, and cost of services APS had authorized in 2014 as necessary to meet Jeremy's needs and avoid increasing his risk of institutionalization.

159. However, pursuant to the challenged policy and DHHR's elimination of the mechanism for seeking reasonable accommodation, APS rejected Jeremy's submission because reinstating the benefits and service levels authorized and received in the prior year would mean exceeding his 2015 algorithm-generated budget.

160. Jeremy's mother and legal guardian, Jo C., asked BMS to restore Jeremy's reduced waiver benefits so as to prevent termination of necessary services.

161. BMS refused to do so, despite his continued need for those benefits and the absence of any change in his circumstances, simply because restoring Jeremy's lost benefits and services would cause him to exceed the algorithm-assigned budget, without consideration of his actual need for services, the level and amount of services the state would provide him if institutionalized, and other relevant factors. *See* Jeremy C. decision in Exhibit 2 stating that

"[y]our assessed annual budget would have been exceeded or has been exceeded and therefore this request is denied."

162. Jeremy's mother then appealed the benefit reduction on Jeremy's behalf, knowing that without the same level of waiver benefits Jeremy had received previously, he could not remain at home safely and in health over more than a short period, and that she and her husband would eventually be unable to continue to maintain Jeremy in the only living situation he has ever known.

163. The family was not allowed to continue to receive waiver benefits at the previously authorized level pending hearing even though the appeal was timely filed.

164. On June 17, 2015, before a State Hearing Officer of the West Virginia State Board of Review, DHHR's lead witness, Patricia S. Nesbit, conceded that the sole reason for reducing Jeremy's waiver benefits below the amount authorized in prior years was DHHR's budgetary concerns. Ms. Nesbit admitted there had been no substantial improvement in Jeremy's circumstances or reduction in his service needs.

165. Pursuant to the challenged policy, DHHR and Ms. Nesbit maintained during the fair hearing that although Jeremy's needs had *not* changed from prior years, DHHR could nonetheless reduce Jeremy's waiver benefits from the authorized levels he had received in prior years to the level set by APS's algorithm-generated budget solely due to DHHR's budget concerns.

166. The Board of Review Hearing Office adopted that contention and overruled Jeremy's appeal.

167. As a result, Jeremy C.'s benefits have been greatly reduced, even though his need

for 24 hour care has not changed.

168. Jeremy cannot care for himself for even a short time. His parents, who are aging and have their own serious health issues, lack the physical ability to provide care at the intense level Jeremy needs now that his benefits and services have been reduced.

169. For example, Jeremy has a very irregular sleep pattern and is awake often throughout the night. His parents have previously utilized respite services during the night so that they can get much-needed and necessary sleep to ready themselves for the care and other demands of regular daily life.

170. DHHR's wrongful reduction of Jeremy's waiver benefits means Jeremy's parents now have to care for him during the nighttime as well, denying them the sleep needed to maintain their own health and energy.

171. Without restoration of the services DHHR has reduced or terminated, Jeremy cannot long remain living with his family in safety and health.

172. To continue to receive the services Jeremy needs and which the I/DD program has been providing, Jeremy will have to move to a less integrated, institutionalized setting, in which DHHR will provide the services he has lost, but at a higher cost to the state.

173. Jeremy is therefore at serious risk of being institutionalized as a direct result of the Medicaid waiver benefit and service reductions resulting from the challenged policy.

F. Plaintiff Tara R.

174. Plaintiff Tara R. is a 27 year old woman living in Parkersburg, Wood County, West Virginia. Tara R. is represented in this suit by her father and legal guardian, Harv Christian R.

175. Tara R. has cerebral palsy, a severe intellectual disability, and limited hand functioning. She is non-verbal, non-ambulatory, and incontinent. Tara R. requires assistance with all tasks of daily living.

176. Tara's most recent adaptive behavior assessment places her overall functioning at an age equivalent of nine months. This same report, dated September 29, 2014, shows no meaningful change in her overall service needs from prior years.

177. In fact, Tara's levels of functioning and ability have not changed to any meaningful degree since she reached adulthood.

178. For approximately fifteen years, the I/DD waiver program provided Tara with the waiver benefits she needed to live with her father.

179. Because those benefits were provided at a level that met her actual needs, Tara R. was able throughout this period to live in a family home with her father, who works fulltime, and her step-mother, who has significant physical disabilities.

180. Continuing to live in that integrated setting remains medically appropriate for Tara, so long as the DHHR provides the community-based waiver benefits and services she needs to reside there in health and safety.

181. Tara wanted to remain in her family home, and her father wanted her to continue to live there.

182. Tara R. is a qualified individual with a disability as defined by 42 U.S.C. §12131(2) of Title II of the ADA.

183. Tara R. is entitled to continue to receive waiver benefits at levels previously authorized as necessary to meet her needs unless her circumstances change, as those benefits

provide the services needed for her to live in the most integrated setting appropriate to her needs.

184. Beginning at least in 2013, APS's computer algorithm has generated a yearly waiver budget for Tara of approximately $58,000 to $62,000, regardless of the amount of waiver benefits authorized and expended to meet Tara's actual care needs in the previous year.

185. Upon receipt of that computer-allocated budget, pursuant to the accommodation process previously available, Tara's service coordinator would each year communicate to APS about her individual circumstances, past history of authorized benefits and services, and her individual health and maintenance needs, explaining why the algorithm-generated budget was not sufficient to provide all the services Tara needed to maintain her health, safety, and prevent an increased risk of institutionalization.

186. Prior to 2015, in each year that communication resulted in APS authorizing $70,000 to $71,000 in additional benefits, so as to provide Tara the waiver benefits and services necessary to meet her actual needs.

187. In these past years, Tara received authorized waiver benefits and services in amounts totaling $130,000 - $133,000.

188. For the 2015 budget year, APS's algorithm assigned Tara a benefit amount of about $72,000, well below the benefit and service levels previously authorized as necessary to meet her needs.

189. As in the past, Tara's service coordinator asked APS to reinstate benefits and services at the level of prior years, as necessary to meet her actual, on-going, health, safety, and care needs.

190. As in years past, that request was supported by documentation of Tara's

circumstances, service needs, and a review of the type, amount, and cost of services APS had authorized in 2014 as necessary to meet those needs and avoid increasing her risk of institutionalization.

191. However, pursuant to the challenged policy and DHHR's elimination of the mechanism for seeking reasonable accommodation, APS rejected Tara's submission because reinstating the benefits and service levels authorized and received in the prior year would mean exceeding his 2015 algorithm-generated budget.

192. Tara's legal guardian appealed the reduction on Tara's behalf, knowing that without the same level of benefits and care services Tara had received in prior years, he would be unable to maintain Tara in the only living situation she had ever known.

193. Tara's Medicaid fair hearing was conducted on March 4, 2014. At that hearing, Tara's representative gave evidence that her needs had not changed since the prior year and that she needed the same waiver benefits and services she had received previously if she was to remain in her home.

194. Nonetheless, the Hearing Officer denied Tara's appeal for restoration of DHHR's reduction in her waiver benefits, finding that DHHR

> ". . . acknowledged that the Claimant received the requested amount of combined units of PCS-Agency and Respite in the previous year, but noted that the Claimant exceeded her individualized budget . . . by $71,430.89. Moreover, the IDD Waiver program as a whole exceeded its budget by more than fifty ($50) million in the previous year, and because Respondent has been directed to operate within budgetary guidelines while providing services to 4,364 recipients, individualized program budgets cannot be exceeded."

See March 9, 2014 Hearing Decision, Action No. 15-BOR-1083, a true but redacted copy of which is attached as Exhibit 4, incorporated here by reference.

195. DHHR's reduction of Tara's waiver benefits by approximately $60,000 was upheld although DHHR offered no evidence that Tara's circumstances had changed such that she no longer needed the same level of waiver benefits she had previously received, without consideration of her actual needs, the level and amount of services the state would provide her if institutionalized, or other relevant factors.

196. DHHR's wrongful reduction in plaintiff Tara R.'s waiver benefits through application of the challenged policy meant she no longer had available the care services needed to keep her safe, healthy, and well-cared for in the family home.

197. After the hearing, Tara was moved to an emergency care facility while her service provider sought a more permanent home.

198. Tara R. now shares an ISS group home with an elderly married couple, both of whom require the use of wheelchairs and require intensive services. DHHR has currently assigned Tara approximately $126,000 in waiver benefits to provide services in the ISS facility.

199. That level of benefits is significantly more than the amount of benefits and services assigned Tara by APS's secret algorithm in 2015 for her service needs at her father's house.

200. Had DHHR at least reinstated Tara's benefits to the $126,000 amount now authorized for her group home care, it might have been some time before Tara would have had to leave her family home for the less-integrated ISS facility.

201. Tara's service coordinator reports that the move has had a negative impact on Tara; where she was previously a very happy individual, she is now lethargic and unwilling to engage with others. In addition, Tara's roommates are not quiet during the night, and Tara is not

getting enough sleep on a regular basis.

202. Moreover, Tara's care needs have not changed. She cannot care for herself for even a short period. Without an appropriate level of 24 hour care, Tara cannot live in health and safety even in her current ISS setting.

203. Tara's service coordinator reports Tara no longer receives the same level of care and support she previously received and the amount of direct care services authorized for Tara under the ISS waiver benefit allotment is insufficient to fully meet all of Tara's care needs this year.

204. As a result, Tara spends significantly less time in the community than she did previously. Moreover, the termination of one to one staff services places Tara and her ISS housemates at a heightened risk of danger.

205. The authorized waiver benefit level is sufficient only to provide **one** staff person in the ISS home during some hours, even though the facility actually houses three severely disabled waiver recipients.

206. The available staff is not sufficient to properly care for all three, and is not sufficient to provide all three the individual assistance they would need to escape in the event of a fire or other emergency.

207. As a result, Tara's ISS placement does not provide the waiver benefits necessary to meet her needs. She has no family or friends at the ISS home to provide any "informal" support to supplement the care which I/DD provides.

208. Consequently, Tara will have to move to a less integrated, institutional setting, in which DHHR would provide those services to her, but at a higher cost to the state.

209. Tara is therefore at serious risk of being institutionalized as a direct result of the Medicaid waiver benefit and service reductions resulting from the challenged policy.

CLASS ALLEGATIONS

210. Plaintiffs bring this action on their own behalf and on behalf of all others similarly situated, pursuant to Fed. R. Civ. P. 23(a) and (b)(2).

211. The class includes all persons who were at any time on or after October 1, 2014, or who will be, qualified individuals with disabilities resident in West Virginia who are eligible recipients of I/DD Home and Community-Based Waiver program services and are subject to a benefit and service eligibility process utilizing APS' proprietary budget-calculation algorithm.

212. The class is so numerous that joinder of all members is impracticable. DHHR's recently filed motion to dismiss represents that West Virginia's program currently serves 4,534 individuals, with another 1100 eligible persons waiting for service. As the program is currently operated, APS's algorithm will be used to determine the level of benefits and services for each of those individuals.

213. Moreover, class members are geographically dispersed throughout the length and breadth of the state, and membership is fluid as individual recipients are admitted to and leave the waiver program.

214. There are questions of law or fact common to the class.

215. Common questions of fact include the precise nature and operation of the algorithm and the challenged policy built around it, and the circumstances of the illegal and discriminatory manner in which these practices and customs have been adopted and implemented.

216. Common questions of law include whether DHHR has thereby violated (i) the due process clause of the United States Constitution, (ii) Medicaid requirements, (iii) Title II of the Americans with Disabilities Act, (iv) Section 504 of the Rehabilitation Act, and/or otherwise illegally discriminated against plaintiffs and the absent class members under *Olmstead v. L.C.*, 527 U.S. 581 (1999), subsequent federal cases applying *Olmstead*, and the federal regulations implementing the federal Medicaid and ADA/Rehabilitation Act statutes.

217. The claims of the named plaintiffs are typical of the claims of the class as a whole. They have been subjected to and suffered injury as the result of the same policy, practices, and algorithm challenged for absent class members.

218. The named plaintiffs will fairly and adequately represent and advance the interests of the class. By filing this action, the named plaintiffs, through their guardians or next friend, displayed a strong interest in vindicating the rights of all who have been similarly harmed by DHHR's arbitrary and illegal actions. Plaintiffs must prevail if they are to maintain an integrated, community-based quality of life and avoid segregated institutionalization. By doing so, the named plaintiffs will also be advancing and proving the claims and rights of absent class members.

219. There are no antagonistic interests between plaintiffs and the absent members of the class, and the equitable relief sought by the named plaintiffs will benefit the class generally.

220. Furthermore, the named plaintiffs are represented by Mountain State Justice, Inc., a non-profit, public interest legal services firm with long and substantial expertise in class litigation on behalf of low-income West Virginians. Counsel for the putative class are knowledgeable about the Medicaid program, and are skilled in conducting civil rights litigation

in the federal courts, including the prosecution and management of class action litigation.

221. DHHR has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final equitable relief with respect to the class as a whole.

STATEMENT OF FACTS

A. General Program Framework

222. The Medicaid program, established by Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq., is a cooperative federal-state program to enable the states to furnish medical assistance to individuals who are unable to meet the cost of necessary medical services. Costs of the program are shared by the federal and state governments, with the federal government contributing approximately 75% of the cost of services in West Virginia.

223. States are not obligated to participate in the Medicaid program. If a state chooses to participate, however, it must operate its program in compliance with federal statutory and regulatory requirements.

224. West Virginia has chosen to participate in the Medicaid Program.

225. Medicaid identifies certain core services that are mandatory for any participating state. In addition, states may choose to cover federally recognized/optional services, including intermediate care level services for individuals with intellectual/developmental disabilities (ICF/IID). Once a state chooses to provide an "optional" Medicaid service, compliance with all federal requirements for that service is *not* "optional."

B. The ICF/IID Medicaid Option

226. The ICF/IID Program is an optional Medicaid service authorized by Title XIX of the Social Security Act, 42 U.S.C. § 1396d (a)(15). ICF/IID provides residential, health, and

rehabilitative services for individuals with intellectual and developmental disabilities. *See* 42 U.S.C. § 1396d (d).

227. West Virginia has chosen to include ICF/IID services in its Medicaid state plan.

228. Since August 1989, there has been a moratorium on the development of any additional ICF/IID institutional beds in West Virginia. *See* W. Va. Code §16-2D-5(h). There are approximately 509 total ICF/IID beds in West Virginia and no large-scale institutions for those with intellectual disabilities.

229. Both the ICF/IID program and the Home and Community-Based Waiver program are "public services" subject to Title II of the Americans with Disabilities Act, 42 U.S.C. §§ 12161-12165.

C. The Home and Community-Based Waiver Program

230. The Home and Community-Based Waiver program (waiver program) was established by Congress so that individuals who would otherwise require care in the segregated environment of a nursing home or ICF/IID facility could exercise "freedom of choice" to receive the same level of care and services in their own homes and/or in home-like settings. *See* 42 U.S.C. § 1396n; Senate Report No. 97-139 and House Conference Report No. 97-208, 1981 *U.S. Code Cong. & Admin. News* 396.

231. Waiver program regulations provide that "the Act permits states to offer, under a waiver of statutory requirements, an array of home and community based services that an individual needs to avoid institutionalization." 42 C.F.R. § 441.300.

232. West Virginia's waiver program is now known as the Intellectual Disabilities and Developmental Disabilities Waiver Program (I/DD Waiver Program).

233. The I/DD Waiver Program "reimburses for services to instruct, train, support, supervise, and assist individuals who have intellectual and/or developmental disabilities in achieving the highest level of independence and self-sufficiency possible. . .The I/DD Waiver Program provides services in natural settings, homes and communities where the member resides, works and shops." *West Virginia Title XIX I/DD Waiver Home and Community-Based Services Program Operations Manual* (I/DD Op. Man.) at Chapter 513.2 (Jan. 1, 2013).

234. DHHR is not covered by West Virginia's Administrative Procedures Act. Legislative and procedural "rulemaking" by DHHR occurs through issuance and filing of new rules in the state register which are promulgated within its policy manual. At all relevant times, DHHR's actions herein have been governed by and subject to the 2013 version of that manual.

235. I/DD Waiver Program funds may not be used for services to individuals who reside in hospitals, nursing homes, or ICF/IIDs. *See* 42 C.F.R. § 441.301(b)(1)(ii), 42 U.S.C. §1396n. These are all considered to be institutional settings.

236. Federal law caps the state-wide average per person cost for community-based waiver services at the average per person cost for the same level of services provided in facilities or institutions. 42 U.S.C. § 1396n(c)(2)(D).

237. According to DHHR, the 2014 state-wide average cost of providing needed health and care services to an individual in a segregated ICF/IID institution in West Virginia was $173,000 per year. The 2014 average state-wide cost of providing all needed health and care services to a waiver recipient in an integrated community-setting was no more than $85,000 per year.

238. Currently, West Virginia's I/DD Waiver Program provides 4,534 I/DD program

"slots" for West Virginians who are eligible for and receiving community-based services.

239. That figure has remained stagnant since 2011. During that period, the waiting list of medically-eligible West Virginians awaiting a "slot" so they may actually begin receiving waiver benefits and services has grown to more than 1100.

D. Waiver Program Renewal Process

240. West Virginia must submit an I/DD Waiver Program renewal proposal to the federal Center for Medicare and Medicaid Services (CMS) every five years.

241. West Virginia's current waiver State Plan was approved in 2011 as an amendment to a prior plan. At all times relevant, DHHR's lawful operation of the I/DD program remains subject to and governed by the terms, conditions, and provisions of the 2011 plan, with which DHHR must comply as a matter of law.

242. Under the 2011 plan, the named plaintiffs and the absent members of the plaintiff class are entitled to the same level of care and services the state would provide them in an ICF/IID, but have the right to receive that care and those services in a community-based, integrated setting instead, through West Virginia's Home and Community-Based Waiver Program.

243. While DHHR has applied for a new waiver that would enact caps on certain services provided under the I/DD program, that waiver remains unapproved.

244. Publically, DHHR has sought to justify program cuts on the basis that the current cost of HCBS waiver services exceeds that portion of the overall Medicaid budget which DHHR wants to allocate for such services.

245. Despite complaints of budget shortfalls, for political reasons, DHHR has chosen

not to request that the West Virginia Legislature appropriate additional funds for the I/DD Waiver Program in current and past state budget cycles, even though:

- (1) each extra dollar appropriated would bring in about $3.00 of federal matching funds to boost West Virginia's economy, and
- (2) the state's November 1, 2005 *Olmstead* Plan required it to seek increased funding for many aspects of the program, including increasing the number of filled "slots" (Goal/Mission 5.2); further improving reimbursement rates as needed to assure community options (Goal/Mission 6.3); and increasing services for the unserved and the underserved. (Goal/Mission 10.3)

246. The political decision to cut needed services to the most vulnerable West Virginians rather than seek increased funding has prompted a backlash, including a letter from members of the West Virginia Legislature outraged at DHHR's failure to request the funding necessary to sustain the program in its current form. *See* Exhibit 5, attached and incorporated here by reference.

E. Administration of the I/DD Waiver Program in West Virginia

247. DHHR, through its Bureau for Medical Services (BMS), is responsible for the administration of the I/DD Waiver program in West Virginia.

248. However, for several years DHHR has contracted with Innovative Resources Group LLC, d/b/a APS Healthcare, Inc. (APS), a New York-based company, for the day-to-day operation of the I/DD Waiver Program under DHHR supervision and responsibility.

249. Matters delegated to and performed for DHHR by APS include "processing initial applications, investigating complaints, assessing waiver members' needs, functionality and

supports and determining an individualized budget."

250. APS is also responsible for providing "authorization for services that are based on the member's assessed needs."

251. As the single state agency for the Medicaid program, DHHR has the duty to monitor and supervise the operations and activities of APS in its administration and operation of the waiver program, and is responsible for APS' operations and activities.

252. Waiver services are actually provided to individual recipients through contracts with local service provider agencies. I/DD Op. Man. at 513.2.1.

253. Each year, I/DD Waiver program recipients undergo a functional assessment by APS. That assessment supposedly reviews standardized measures of adaptive behavior in six major life areas to ensure continued medical eligibility for the I/DD Waiver Program. I/DD Op. Man. at Chapter 513.4.1.

254. If the recipient has continued medical and income/resource eligibility for Medicaid waiver services, an interdisciplinary team of care professionals put together by the local service provider agency is to develop an Individualized Program Plan (IPP) for that recipient. *Id*. at 513.8.

255. The IPP sets forth specific details of the individual member's actual care needs and makes a proposed care plan for the upcoming year; in other words "what needs to be done, by whom, when and how." *Id*.

256. "The content of the IPP must be guided by the member's needs, wishes, desires and goals *but based on the member's assessed needs*." I/DD Op. Man. at 513.1 (emphasis added).

257. In creating an IPP, the interdisciplinary team considers the array of services available through the I/DD Waiver Program, and creates a plan detailing the amount of each type of service needed to meet that recipient's individually-assessed safety, health, and care needs. I/DD Op. Man. at 513.8.

F. Determination of Individual Annual Budgets

258. The amount of waiver benefits received by an individual recipient is equal to the amount that is authorized during that budget year to provide needed services.

259. The I/DD Waiver Operations Manual does not set forth or establish eligibility criteria or standards computing the amount of waiver benefits for which an individual recipient is eligible. It provides only that APS assigns an initial amount of waiver benefits for each recipient. *C.f.*, I/DD Op. Man. Chapter 513.1 through 513.14.

260. APS uses a proprietary computer algorithm to set waiver benefit levels for West Virginia waiver program recipients.

261. APS keeps that algorithm secret. Little is known as to what facts or legal elements the algorithm factors; the comparative weights given any element considered; the manner in which the algorithm scores or determines need; how or whether the algorithm takes into account (i) the type and amount of services an individual would receive if institutionalized, or their cost; (ii) changes or the absence of changes in the recipient's circumstances; (iii) the existence, or lack of, or reduction in the availability of formal or informal support resources; (iv) an increased risk of institutionalization; etc.

262. It is known that the algorithm ignores the amount of benefits and services authorized and provided in the immediately preceding budget year as being necessary for that

particular recipient to remain safe and healthy in their current living arrangement.

263. Patricia Nesbit, the Director of DDHR's Home and Community Based Services (HCBS) Unit and a previous Program Manager of the I/DD Waiver Program that now operates as part of her HCBS unit, recently testified under oath: "We did not say that last year's budget was figured into the calculation . . . it was not part of the, our mat – our statistical model that we used to calculate" the algorithm budget.

264. Second, it is known that the end result of the APS algorithm calculation is not the straightforward application of statutory eligibility, payment standards, and resource criteria to an individual recipient's financial circumstances as used to calculate TANF, SNAP, SSI, or similar benefits. Ms. Nesbit testified that the algorithm result instead is *APS's prediction of the cost of the services that person requires*: "When APS assessed him they determined his needs could be met with $91,946.37."

265. APS began using its secret algorithm to predict service costs and set waiver benefit levels in or around the fall of 2011. Service providers working with I/DD waiver program recipients soon began to notice changes from the benefit levels previously set by DHHR.

266. For example, on information and belief, providers began seeing a substantial number of recipients assigned annual budgets far in excess of amounts needed or historically expended to meet their care needs.

267. Many were under eighteen years of age, so that their care needs were met or subsidized through separate educational programs not funded through Medicaid.

268. But others were adults living at home, suddenly assigned annual budgets in amounts never previously expended or required to fully meet actual needs.

269. Arbitrary benefit levels established without meaningful reference to or reconciliation with the actual benefit amounts previously spent to meet a recipient's unchanged needs obscure the determination of actual program costs, and may result in longer waiting list delays.

270. Arbitrariness also effected many recipients to whom the algorithm assigned budgets substantially smaller than the total benefits received and authorized in prior years as needed to meet the recipient's care needs, in the absence of any DHHR showing that those needs had significantly decreased.

271. However, between 2011 and late 2014, when the APS algorithm assigned an initial waiver benefit allotment insufficient to meet individualized needs, that recipient's service coordinator could seek a reasonable accommodation between application of that general policy and an individual's particular needs. By submitting documentation of unmet need and the total of expenditures authorized to meet those needs in the immediately prior year, and requesting that APS authorize additional waiver benefits and services over and above the algorithm-assigned budget, individual recipients had the ability to seek accommodation so as to meet the recipient's actual needs.

272. Prior to the fall of 2014, APS routinely authorized additional benefits to reinstate the approximate level of the prior year's benefit level when submissions showed unchanged circumstances and a recipient's continuing need for the same level of services.

273. At one time or another, all the named plaintiffs received authorization for and waiver benefits in amounts significantly in excess of their algorithm-calculated initial waiver benefit allotment through this accommodation process.

274. In each case, the adjustments happened because APS agreed the algorithm-assigned benefit level did not adequately cover the plaintiffs' actual need for services.

275. But for unexplained reasons, APS's explicit authorization of continued benefits at levels of prior years, as required to serve that individual's actual needs, had no discernible impact on the initial budget its algorithm spit out for that recipient the following year.

276. For some plaintiffs therefore, the accommodation process was a yearly event.

277. DHHR's Memorandum of Law in Support of Motion to Dismiss Plaintiffs' Complaint (DHHR Memo.), Dkt. #11, filed 09/14/15, represents at page 13 that it was only in 2014 that DHHR "discovered" APS had "a practice of approving services in excess of the budget."

278. However, the 2011 State Plan allocates *exactly* that authority and role to APS:

> Through the annual assessment of each program participant, the ASO[1] compiles comprehensive data pertaining to participants' abilities, strengths, and support needs. Statistical analysis of this data results in customized algorithms for adults and children. Through the application of these algorithms against each participant's unique assessment data, an individualized budget is determined. The participant and his/her chosen Service Coordinator is notified of the budget amount and assessment results a minimum of 45 days prior to the participant's annual team meeting. . . Through the ASO's web-based application, each participant's Service Coordinator purchases services as determined necessary by the participant's team. Upon submission of requested services, the ASO reviews the request to ensure services/supports are within policy and program parameters and that the participant's identified health & safety issues are addressed. *Requests for services that exceed the participant's budget allocation are negotiated and the budget adjusted as necessary so that the most clinically appropriate services/amounts of services are authorized*.

Quoted from 2011 Amended Waiver Plan, Appendix A, #3, p. 19 (emphasis added).

[1] "Administrative Service Organization" which in West Virginia is the contracting administrator, APS.

G. DHHR's New Policy

279. In the fall of 2014, DHHR instructed APS not to authorize any waiver benefits or services over and above the algorithm-set benefit level, even though the 2011 waiver state plan requires APS to perform exactly that role.

280. That order eliminated the process by which individual recipients could seek and obtain a reasonable accommodation between the algorithm-calculated budget and the most clinically appropriate services and amounts of services required by the particular circumstances of their disabilities and living circumstances.

281. Since then, APS has obediently rejected all requests to make a reasonable accommodation to the algorithm-assigned benefit level, for the stated reason that "individual program budgets cannot be exceeded."

282. Pursuant to DHHR's challenged policy, on or about June 10, 2015, BMS issued a memorandum to I/DD waiver service providers who manage individual recipient IPPs and provide care to meet that individual's actual needs. The memorandum stated that DHHR would not approve *any* requests for new or additional services needed by I/DD waiver program recipients "UNTIL the cost of all services requested are at or below the individualized Waiver budget." *See* June 10, 2015 Memo from DHHR's Tanuia Hardy, attached as Exhibit 6, incorporated here by reference.

H. The Effect of DHHR's New Policy - The Plaintiffs

283. Each of the named plaintiffs began their 2015 waiver budget year around or shortly after the beginning of calendar year 2015.

284. In budget year 2014, each of the named plaintiffs were authorized by APS to

receive waiver benefits and services in amounts substantially in excess of the 2014 algorithm-assigned benefit level, after APS agreed that level was not sufficient to meet their individual clinical-appropriate service needs.

285. APS's 2015 determinations of the amount of waiver benefits to be provided the named plaintiffs documented no significant change in the named plaintiffs' abilities, functioning level, or health or care service needs since the 2014 budget year.

286. In truth, no meaningful improvement occurred in any of the circumstances of the named plaintiffs relevant to their physical or medical needs or the type and amount of services needed to meet those needs in the period between APS's authorization of a total benefit level for 2014 and the beginning of the 2015 budget period.

287. Nonetheless, each of the named plaintiffs received an algorithm-assigned benefit level substantially less than the benefit and services level authorized by APS and received in 2014 and prior years.

288. No explanation was provided as to how that budget was calculated or why APS reduced the amount of waiver benefits and services the named plaintiffs had been previously receiving. *See* notices attached as Exhibit 1.

289. As in years past, the named plaintiffs' service coordinators independently submitted requests to reinstate waiver benefits and services as authorized and received in prior years, providing documentation showing why that continuing those levels of benefits and services was necessary to meet the individual clinical service needs of the named plaintiffs.

290. However, in 2015, APS (pursuant to DHHR's new policy) wrongly refused to reinstate the same level of waiver benefits and services previously authorized and received by the

named plaintiffs, though DHHR had no proof that the named plaintiffs' clinical needs or overall circumstances had changed such that the same level of benefits were no longer needed.

291. In fact, APS's assessment of Jeremy C. and Michael T. established circumstances had significantly worsened, mitigating toward a need for additional benefits, not reduced benefits.

292. Moreover, in implementing the new policy, DHHR and APS failed to provide adequate prior notice and meaningful opportunity for a timely due process hearing and a decision based on the controlling law, as required by the Constitution and the fair hearing regulations of the Medicaid Act.

293. For instance, the standard form notices to plaintiffs and the members of the plaintiff class, exemplars of which attached here as Exhibit 1, constitute the written notice class members received that DHHR and APS were reducing their waiver benefits and services below the levels and amounts then being received by that person.

294. These form notices do not explain that DHHR is actually cutting the recipient's benefits; do not specify the amount of the proposed cut; do not state the facts allegedly justifying the cuts, or the legal policies or reasons supporting the reduction; do not explain how a person might object to the proposed reduction, or why objection might be necessary to protect the recipient's right to continue to receive needed services; do not explain the recipient's right to have benefits continue at the previously-authorized level pending any appeal, etc. *Cf, e.g.*, 42 C.F.R. §431.210; §438.404.

295. Additionally, anecdotal reports are consistent that many family members representing waiver recipients have been dissuaded from appealing, or persuaded to drop

previously filed appeals, by DHHR and/or APS representations that appeal could result in loss or delay of all benefits and services.

296. Many adult waiver recipients – especially older persons without family support – have legal guardians or Health Care Surrogates employed in DHHR's Office of Adult Protective Services, as overseen by APS.

297. These appointees owe fiduciary responsibilities to the waiver recipients they represent and are required to act and make decisions to assert and protect the best interests of their wards.

298. However, on information and belief, the employees of DHHR's Office of Adult Protective Services acting as legal guardian or Health Care Surrogates for waiver recipients have been instructed by DHHR not to object to the benefit reductions suffered because of the challenged policy by those to whom they owe fiduciary duties.

299. Consequently, DHHR has guaranteed that waiver recipients similarly situated to plaintiff Michael T. have no meaningful ability to contest these benefit reductions.

300. Moreover, even for those who seek administrative review, the DHHR fair hearing process for contesting these reductions is an illegal, arbitrary, and unconstitutional sham.

301. APS, BMS, and every state actor in the appeal process, including the Board of Review, has undertaken to work in concert with DHHR to support and implement this new policy by rejecting arbitrarily any challenge to benefit reductions or terminations, based on application of the very policy being challenged, and not the laws and rules that actually govern eligibility.

302. For instance, APS for months rejected service coordinator requests to restore

waiver benefits and services to previously received levels to continue clinically-required services for the sole reason that "assigned budgets cannot be exceeded."

303. These rejections were contrary to the State Plan, and contrary to law, in that they result in a reduction or termination of benefits and services (i) without proof of a change in the recipient's circumstances or evidence of reduced need; and without consideration of (ii) whether the recipient would receive those services if institutionalized, or the comparative cost thereof, and (iii) the risk of institutionalization if the services are lost.

304. Second level appeals to BMS disputing the benefit reductions and terminations in individually-needed services imposed by the challenged policy are likewise summarily rejected, on the sole justification that DHHR policy does not allow assigned budgets to be exceeded. *See* exemplars of BMS second level decisions gathered in Exhibit 2. These rejections are contrary to the 2011 waiver state plan, and are contrary to law, in that they result in a reduction or termination of benefits and services (i) without proof of a change in the recipient's circumstances or evidence of reduced need; and without consideration of (ii) whether the recipient would receive those services if institutionalized, or the comparative cost thereof, and (iii) the risk of institutionalization if the services are lost.

305. Waiver recipients who seek a Medicaid fair hearing within 13 days are entitled to continue to receive benefits at the previous year's level until the appeal is finished.

306. At the time the original complaint was filed, waiver recipients timely requesting Medicaid fair hearing on waiver benefit and service reduction appeals were being denied those continuing benefits, so that the contested benefit cuts are imposed even when timely appeals have been filed. After the filing of this action, DHHR resumed providing continuing benefits

for those who timely appeal.

307. The West Virginia Board of Review has denied opportunity for any fair hearing at all to at least one waiver recipient contesting his benefit reduction. That recipient's appeal was summarily dismissed, with the Board of Review stating it lacked power to hear it because restoring benefits would exceed the algorithm-assigned budget, and state policy was that the budget could not be exceeded. *See* April 21, 2015 Order of Dismissal, Action No. 15-BOR-1518, a true but redacted copy of which is attached as Exhibit 7, incorporated by reference.

308. Other recipients have been granted fair hearings, and given opportunity to present evidence showing receipt of authorized waiver benefits and services in greater amounts in the prior year, the lack of any change in circumstances, and a continuing need for that level of waiver benefits and services.

309. Even when DHHR presents no proof of any meaningful change in these recipients' circumstances, or any reduction in the need for benefits at the level previously received, the Board of Review nonetheless routinely and arbitrarily rejects these appeals, without consideration of governing rules, regulations and laws, because DHHR has instructed it that "individual budgets cannot be exceeded." *See* Exhibits 3 and 4, incorporated here by reference.

310. In recent months, DHHR has begun moving to dismiss state hearing appeals, to deny appellant requests for evidence as to the algorithm and how it works, and/or to limit the issues an appellant may present on the basis that I/DD waiver is an "optional" program in which the amount and type of benefits and services for which a recipient is eligible is discretionary with DHHR, and therefore a matter of unreviewable "policy."

311. Ms. Mary McQuain, Esq. of the Attorney General's Office, while representing

DHHR in a recent fair hearing, explained DHHR's policy this way:

> "Another thing about waiver, and this is really important, that a lot of people forget, is that it's a voluntary program. It's an optional program. And the individuals who participate in it have the freedom to choose institutional services or the IDD waiver program. And when they chose the IDD waiver program, it's subject to all the limitations in the program. And as I mentioned, one of those limitations is the amount of the budget. . . So, even though everybody in the program needs twenty-four hour of uh supervision, the chances are that due to budget limitations that uhm few, if anyone, will actually get twenty-four hours of supervision. And, and that's true about all the services". . .
>
> "So, it's very, very clear that the budget, the overall Medicaid budget as well as the individualized budget, is uhm a policy limitation . . . then what you might have is discretion by the Bureau . . . that's outside the limited jurisdiction of the Board of Review because only the single state agency has authority to exercise discretion in the administration of the program on program matters". . . .
>
> "The purpose of the [waiver] program is to supplement informal support, not to supplant them. If you want all the services that you think you're entitled to, then maybe you should opt for an institution". . .
>
> "[I]n the IDD waiver program, uhm the the [inaudible 1:15:15] doesn't really decide what to spend the budget on, it's really up to the individual. . . So if they can't work within their budget, that's kind of their fault."

312. As a result of all the foregoing, the named plaintiffs and the members of the plaintiff class have unjustifiably and wrongly suffered, or are in imminent threat of unjustifiably and wrongly suffering, substantial reductions in previously-authorized waiver benefits, and termination of needed services:

- (i) without an individualized determination of need or proof of a change in circumstances as required by under the laws and rules actually governing benefit eligibility;

- (ii) without first being afforded the rights guaranteed them by due process and regulations governing notice and hearing rights in Medicaid programs; and

- (iii) in violation of their rights under the Medicaid Act, the ADA, and Section 504 of the Rehabilitation Act.

313. Each of the named plaintiffs is suffering irreparable harm and now faces a heightened risk of institutionalization as the result of DHHR's illegal, discriminatory, and unconstitutional actions and policy that have reduced their waiver benefit levels below the amounts for which they are lawfully eligible.

314. As a result, DHHR has failed and refused, without justification, to operate and administer the I/DD waiver program so as to allow "the most integrated setting appropriate" to the meet the needs of qualified individuals with disabilities.

CLAIMS FOR RELIEF

COUNT I
(42 .S.C. §1983 and Due Process)

315. DHHR may not reduce or terminate the amount of waiver benefits provided plaintiffs and the absent members of the plaintiff class without first providing adequate prior notice and opportunity for a meaningful hearing at which a decision will be rendered in conformity with the laws and regulations actually governing eligibility.

316. DHHR may not reduce or terminate the amount of waiver benefits provided plaintiffs and the absent members of the plaintiff class unless and until DHHR first establishes that a change has occurred in the recipient's medical or financial circumstances which justifies the reduction or termination. *See, e.g., Hardy v. B.H.*, 228 W. Va. 334, 719 S.E.2d 804 (2011).

317. Moreover, due process requires that DHHR use reasonable, ascertainable, non-arbitrary standards and procedures for calculating waiver benefit eligibility for plaintiffs and the absent members of the class:

> "[L]aw is the opposite of arbitrariness . . . It is not *ipse dixit*—not merely that someone in power has said so . . . if government imposes a rule without following the procedures whereby a rule obtains its official character, the final product cannot be called law; likewise, when government imposes something . . . which is nevertheless arbitrary, self-serving, *ipse dixit*, that, too, cannot be called law."

318. Determining whether a recipient will continue to receive benefits and services long agreed as necessary to their health, safety, well-being, and continued freedom to live in a family or community setting, or must give up that liberty for institutionalization, is a state action that may not constitutionally depend on unreviewable administrative discretion or broad policy decisions made in the exercise of undelegated, and/or unconstitutionally delegated, executive power.

319. The APS benefit calculation algorithm utilizes secret, unpublished, non-legislatively adopted, arbitrary standards, factors, or other bases that fail to give required weight to an individual's actual need for waiver services, the level of benefits previously approved, the lack of any change in the recipient's circumstances, or the laws and regulations governing eligibility.

320. Consistent with due process, DHHR may not establish, reduce, or terminate the amount of waiver benefits provided plaintiffs and the absent members of the plaintiff class based on secret, non-legislatively enacted, or arbitrary criteria.

321. Through the actions complained of above, and by official custom and policy, DHHR has employed a secret algorithm and unpublished policy to arbitrarily, unreasonably, and unfairly deprive plaintiffs and the members of the plaintiff class of the Medicaid waiver services they need, and which they have been receiving, in the absence of proof of any relevant change in the recipient's circumstances, and without adequate prior notice or timely, meaningful hearing

and a reasoned decision based on the governing law.

322. As a result, defendant Secretary Bowling, under color of state law, custom, or usage, has subjected or caused plaintiffs and the absent members of the plaintiff class to be subjected to deprivation of rights, privileges, or immunities secured to them by the due process clause of the United States Constitution, to their continuing and irreparable injury without adequate remedy at law.

COUNT II
(42 U.S.C. § 1983 and Medicaid Act Notice and Fair Hearing Requirements)

323. Under the federal Medicaid Act, West Virginia must afford proper, prior notice and opportunity for 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).

324. As set forth above, as a matter of policy and custom, DHHR has implemented and enforced the challenged policy in violation of the Medicaid Act by failing to provide proper notice, or to grant the opportunity for fair hearing as required by law, to plaintiffs and the members of the plaintiff class whose claims for medical assistance have been denied, reduced, terminated, or not acted upon with reasonable promptness.

325. As a result, defendant Secretary Bowling, under color of state law, custom, or usage, has subjected, or caused plaintiffs and the absent members of the plaintiff class to be subjected, to deprivation of rights, privileges, or immunities secured to them by law, to their continuing and irreparable injury without adequate remedy at law.

COUNT III
(Americans with Disabilities Act)

326. Title II of the ADA, 42 U.S.C. §12132, provides:

> "no qualified individual with a disability shall, by reason of disability, be excluded from any participation in or be denied the benefits of the servicers, programs, or activities of a public entity, or be subject to discrimination by such entity."

327. Regulations implementing the ADA, including 28 C.F.R. §35.130(d), require that public entities like DHHR administer services, programs, and activities to allow "the most integrated setting appropriate" to the needs of qualified individuals with disabilities.

328. Under §35.130(b), the following constitute unlawful acts of discrimination:

> (b)(1) A public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of disability—
>
> (ii) Afford a qualified individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;
>
> (iii) Provide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others; . . . .
>
> (3) A public entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration:
>
> (i) That have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability;
>
> (ii) That have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities. . . .
>
> (5) A public entity, in the selection of procurement contractors, may not use criteria that subject qualified individuals with disabilities to discrimination on the basis of disability. . . . .
>
> (7) A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of

> disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.
>
> (8) A public entity shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any service, program, or activity, unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered.

329. In *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999), the United States Supreme Court held that a public entity violates the "integrated setting" mandate of Title II when it administers programs in a way that unjustifiably results in a heightened risk that individuals with disabilities will be forced into segregated institutionalization.

330. The named plaintiffs and the absent members of the plaintiff class are qualified persons with disabilities protected against discrimination because of their disabilities by the Americans with Disability Act.

331. DHHR is a public entity whose operation and administration of West Virginia's I/DD Waiver program is subject to and governed by the "integration mandate" and other requirements and prohibitions of Title II of the ADA.

280. DHHR violates that mandate in several ways, including by:

- denying plaintiffs and the members of the plaintiff class services the state would provide if they were institutionalized;
- making it more difficult for community integrated recipients such as plaintiffs and the plaintiff class to obtain and maintain clinically needed services than it is for the institutionalized to obtain and maintain needed services;
- failing and refusing to comply with the increased funding requirements of the state's 2005 *Olmstead* plan;

- utilizing an arbitrary, secret budget algorithm and unconstitutional, unconstitutionally-delegated administrative "discretion" to limit and reduce pre-existing benefit and service levels;
- and eliminating the ability or opportunity of plaintiffs and the absent members to seek and obtain a reasonable accommodation between DHHR policy and a recipient's actual clinical needs.

332. Through the policy and actions complained of above, DHHR has discriminated and continues to discriminate against plaintiffs and the absent members of the plaintiff class in violation of 42 U.S.C. §12132, the "most integrated setting appropriate" mandate, and other substantive requirements and prohibitions of the ADA and its implementing regulations at 28 C.F.R. §35.10, so as to unjustifiably heighten their risk of institutionalization, to their continuing and irreparable injury.

COUNT IV
(Section 504 of the Rehabilitation Act of 1973)

333. The I/DD Waiver program that DHHR operates in West Virginia is a "program or activity" subject to the requirements and prohibitions of Section 504 of the Rehabilitation Act of 1973. *See* 29 U.S.C. §794(b).

334. 29 U.S.C. §794(a) provides in pertinent part:

> No otherwise qualified individual with a disability in the United States, as defined in section 705(20) of this title, shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance . . .

335. Plaintiffs and the members of the plaintiff class are qualified individuals with disabilities entitled to the protections of Section 504, including but not limited to its "most integrated setting appropriate" requirement.

336. Through the policy and actions complained of, including those detailed in Count V, above, DHHR has discriminated and continues to discriminate against plaintiffs and the absent members of the plaintiff class in violation of 29 U.S.C. § 794, the "most integrated setting appropriate" mandate, and other substantive requirements and prohibitions of Section 504 and its implementing regulations, so as to unjustifiably heighten their risk of institutionalization, to their continuing and irreparable injury.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully request that this Court:

(a) Appoint a guardian ad litem to represent and protect the interest of plaintiff Michael T. during the pendency of this action;

(b) Certify the class pursuant to Federal Rule of Civil Procedure 23(b)(2);

(c) Declare Defendant in violation of the Constitution and federal laws as explained above;

(d) Issue without bond a preliminary and permanent injunction:

(i) restoring plaintiffs and the members of the plaintiff class, and the operation and requirements of DHHR's I/DD waiver program, to the *status quo ante*, the last uncontested status between these parties (*i.e.*, prior to DHHR's elimination of the reasonable accommodation process and implementation of the new policy denying needed services exceeding the algorithm-calculated budget);

(ii) enjoining Defendant from reducing I/DD waiver program benefits or services from previously authorized amounts without (1) adequate prior notice and meaningful hearing according to due process and Medicaid fair hearing requirements; or (2) in the absence of proof

of a change in the individual recipient's circumstances reducing her or his actual clinical needs;

(ii) from failing or refusing to provide waiver benefits at a level equal to that provided the institutionalized, as consistent with the recipient's actual needs and computed by means of reasonable, public, lawfully established, and non-arbitrary standards and methods, not through secrecy, unbridled administrative discretion, or solely on budget considerations;

(iii) to end and prevent current and future discrimination in the administration of DHHR's waiver program by enjoining DHHR from implementing any future reductions, terminations, or other adverse changes in the waiver program or benefit or service levels save in conformity with the federal statutory and regulatory requirements of the ADA and the Rehabilitation Act;

(e) Award plaintiffs their costs and reasonable attorney's fees in accordance with 42 U.S.C. §1988; and

(f) Grant such other and further relief to which plaintiffs or the class members may be entitled in law or equity.

MICHAEL T., a person with diminished capacity; ERIC D., by his guardian, CONNIE D.; SARA F., by her guardians REBECCA F. and DAVID F.; JEREMY C., by his guardian, JO C.; and TARA R., by her guardian HARV CHRISTIAN R., on their own behalf and on behalf of and all other similarly situated,
By Counsel,

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CERTIFICATE OF SERVICE

I, Gary M. Smith, counsel for plaintiffs, do hereby certify that on September 28, 2015, I electronically filed this ***First Amended Complaint*** with the Clerk of the Court using the CM/ECF system which will send notification of such filing to the following CM/ECF participants who constitute counsel for defendant Bowling:

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