IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA
WESTERN DIVISION
Civil Case No.: 5:11-cv-273-BO

HENRY PASHBY, ANNIE BAXLEY, MARGARET DREW, DEBORAH FORD, MELISSA GABIJAN, by her guardian and next friend JAMIE GABIJAN, MICHEAL HUTTER, LUCRETIA WILLIS, AYLEAH PHILLIPS, ALICE SHROPSHIRE, SANDY SPLAWN, ROBERT JONES, and REBECCA PETTIGREW on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

ALDONA WOS, in her official capacity as Secretary of the North Carolina Department of Health and Human Services,

Defendant.

SECOND AMENDED AND SUPPLEMENTAL COMPLAINT

CLASS ACTION

I. INTRODUCTION

1. This amended and supplemental complaint challenges the North Carolina Department of Health and Human Services' (DHHS) policies and practices restricting coverage of Medicaid-covered in-home Personal Care Services (PCS) for adults over age 20. PCS are provided to elderly and disabled individuals who require assistance with certain basic tasks of daily living, such as eating, bathing, dressing, and toileting. Two new Medicaid policies, which became effective June 1, 2011 and January 1, 2013, respectively, as implemented by DHHS, discriminate against applicants for and recipients of PCS provided in their homes in favor of recipients of PCS living in institutional settings known as Adult Care Homes (ACHs).

2. Thousands of class members were illegally denied or terminated from in-home PCS by DHHS in 2011 under PCS Policy 3E, which took effect June 1, 2011. Under DHHS's Policy 3E, individuals who resided in ACHs were required to meet much less restrictive Medicaid criteria to qualify for PCS than those living in their homes. Pursuant to this Court's December 8, 2011 Order certifying the Plaintiff class and granting a Preliminary Injunction, class members' PCS were reinstated in early 2012. However, pursuant to a Stay of this Court's Order issued by the United States Court of Appeals for the Fourth Circuit, DHHS terminated or denied in-home PCS for hundreds of class members in 2012 pursuant to Policy 3E. These class members are suffering ongoing harm from these denials and terminations under an illegal PCS policy and have not had their services reinstated by Defendant, despite the decision of the Court of Appeals to affirm this Court's Preliminary Injunction.

Effective January 1, 2013, DHHS implemented PCS Policy 3L, which purports to correct the violations of law in Policy 3E by making the eligibility rules for Medicaid PCS uniform across all settings. In practice, however, DHHS continues to treat the two populations differently, by applying the Medicaid rules very differently for the two populations, in a manner that is not justified by their need for the service, once again making it easier to qualify for PCS in an institutional ACH than at home. Moreover, under the state legislation passed in 2012 which required the implementation of Policy 3L, DHHS is substituting state funding for those in ACH's who lose Medicaid coverage of PCS but not for those who lost Medicaid coverage of PCS at home. DHHS thus continues its violations of the Medicaid Act and the Americans with Disabilities Act.

3. As a result of Defendant's policies and practices, individuals in ACHs with less severe disabilities and lesser needs are able to continue to receive PCS, while individuals living in their homes with greater needs do not have access to PCS unless they move to an ACH.

4. The named Plaintiffs and members of the Plaintiff class received notices informing them that they do not qualify for in-home PCS. While Defendant in early 2012 corrected deficiencies in its notices in response to this Court's preliminary injunction, the Plaintiff class continues to be threatened with future terminations or denials of PCS based on notices that lack necessary information and do not comply with the requirements of the Medicaid Act and the U.S. Constitution. Because DHHS notices are no longer being issued as a result of a "mass change" in program rules, the March 5, 2013 decision of the United States Court of Appeals for the Fourth Circuit did not rule on their legality.

5. DHHS's illegal policies and practices are causing or threaten irreparable harm to the Plaintiffs and the Plaintiff class. Terminating or denying coverage of PCS that has been found necessary by Plaintiffs' treating physicians places the health and safety of Plaintiffs and the plaintiff class at risk. In addition, in order to get the PCS they need, many have no option but to move into ACHs, which are more expensive institutional settings. In the alternative, the lack of in-home PCS has caused or is likely to cause class members' health to deteriorate to the point that they require hospitalization or placement in Medicaid-funded nursing facilities, which are also significantly more expensive than services provided in the home. Accordingly, DHHS's policies and practices have violated and continue to violate the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act, which require that publicly funded services, including Medicaid, be provided in the most integrated setting appropriate to an individual's needs.

6. DHHS's policies and practices used in denying and terminating PCS for class members have violated and continue to violate Medicaid requirements that services be made available in comparable amount, duration, and scope to similarly eligible individuals, and that states determine the extent of Medicaid services according to reasonable standards.

7. The Plaintiffs seek prospective declaratory and injunctive relief against DHHS Secretary Aldona Wos (Defendant), in her official capacity, to enjoin her from continuing to implement PCS rules in a manner that denies or terminates, coverage of PCS for those living at home who would qualify for Medicaid or state funding for PCS in an institutional ACH. Plaintiffs also seek a permanent injunction requiring Defendant to reinstate services that have been illegally denied or terminated in violation of this Court's preliminary injunction until Defendant has brought her practices and procedures into compliance with the Medicaid Act, the ADA, Section 504, and the Due Process Clause of the U.S. Constitution and then properly assessed the current needs of the reinstated class members under legal policies and practices.

II. JURISDICTION AND VENUE

8. Jurisdiction is conferred on this Court by 28 U.S.C. § 1331, which provides for original jurisdiction over all civil suits involving questions of federal law, and 28 U.S.C. §§ 1343(3) and (4), which grant this Court original jurisdiction in all actions authorized by 42 U.S.C. § 1983 to redress the deprivation under color of State law of any rights, privileges, or immunities guaranteed by the U.S. Constitution and Acts of Congress.

9. Plaintiff seeks declaratory, injunctive and other appropriate relief, pursuant to 28 U.S.C. §§ 2201 and 2202; Fed. R. Civ. P. 23, 57, and 65; 42 U.S.C. § 1983; and the Fourteenth Amendment to the U.S. Constitution.

10. Venue for this action lies in this District pursuant to 28 U.S.C. § 1391(b), because a substantial part of the events or omissions giving rise to Plaintiffs' claims occurred here and the Defendant may be found here.

III. PARTIES

11. Plaintiffs are elderly or disabled North Carolina citizens, all of whom are categorically needy Medicaid recipients and all of whom received notice from DHHS in May 2011 that Medicaid coverage for in-home PCS they received would be terminated effective June 1, 2011.

12. Defendant Aldona Wos is the Secretary of the North Carolina Department of Health and Human Services. She is charged with overall responsibility for the administration of DHHS, which administers the Medicaid program in North Carolina. She is sued in her official capacity.

13. DHHS has been designated as the "single state agency" with direct responsibility for administration of the state Medicaid plan. *See* 42 U.S.C. § 1396a(a)(5); N.C. Gen. Stat. § 108A-54.

14. DHHS is a recipient of federal funding in the form of Medicaid payments.

15. DHHS is a public entity within the meaning of the ADA.

IV. CLASS ACTION ALLEGATIONS

16. This amended and supplemental complaint is brought as a statewide class action pursuant to Fed. R. Civ. P. 23(a) and (b)(2) on behalf of all current or future North Carolina Medicaid recipients age 21 or older who had, or will have, coverage of Personal Care Services (PCS) denied, delayed, interrupted, terminated, or reduced by Defendant directly or through his agents or assigns as a result of the eligibility requirements for in-home PCS and unlawful

policies and practices in Defendant's implementation of Clinical Coverage Policies 3E and 3L (PCS Policies 3E and 3L).

17. The class is so numerous that joinder of all members is impracticable.

18. There are questions of law and fact as to the permissibility of the Defendant's policies and practices with respect to denying, reducing, and terminating PCS coverage for Medicaid beneficiaries that are common to all members of the class.

19. The claims of the class representative Plaintiffs are typical of the claims of the class.

20. Named Plaintiffs will fairly and adequately represent the interests of all members of the class. Specifically, they meet the eligibility requirements under the pre-June 2011 PCS policy, were informed they were ineligible for PCS under either Policy 3E or Policy 3L or both, or are at significant risk of receiving losing in-home PCS in the future, and are at risk of institutionalization without in-home PCS.

21. Prosecution of separate actions by individual class members would create a risk of inconsistent or varying adjudications with respect to individual class members which would establish incompatible standards of conduct for the party opposing the class or could as a practical matter be dispositive of the interests of the other members or substantially impair or impede their ability to protect their interests.

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

V. STATUTORY AND REGULATORY FRAMEWORK

A. Medicaid Requirements

23. The Medicaid Act, Title XIX of the Social Security Act, 42 U.S.C. § 1396-1396w-5, establishes a medical assistance program cooperatively funded by the federal and state governments. Medicaid is designed to "enabl[e] each State, as far as practicable . . . to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence and self-care. . ." 42 U.S.C. § 1396-1. States are required to administer Medicaid "in the best interests of recipients." *Id.* § 1396a(a)(19).

24. The Medicaid program typically does not directly provide health care services to eligible individuals, nor does it provide beneficiaries with money to purchase health care directly. Rather, Medicaid is a vendor payment program, wherein Medicaid-participating providers—including providers of PCS —are reimbursed by the program for the services they provide to recipients.

25. The Centers for Medicare & Medicaid Services (CMS) of the United States Department of Health and Human Services is the agency that administers Medicaid at the federal level, including publishing rules and guidelines. These rules and regulations are set forth in 42 C.F.R. §§ 430.0-483.480, and in the CMS *State Medicaid Manual*. These rules and regulations are binding on all states that participate in Medicaid.

26. A state's participation in Medicaid is voluntary. Once a state elects to participate, it must adhere to the federal legal requirements, as provided by the United States Constitution, the Medicaid Act, and the rules promulgated by CMS. North Carolina has elected to participate in the Medicaid program. N.C. Gen. Stat. § 108A-54.

27. The state must adopt a plan that meets the requirements of the Medicaid Act. 42 U.S.C. § 1396; 42 C.F.R. § 430.12. States can make changes to their Medicaid programs by submitting state plan amendments for CMS's approval. 42 U.S.C. § 1396; 42 C.F.R. § 430.12.

28. The Medicaid Act provides that the provisions of the state Medicaid plan become mandatory upon and must be in effect in all political subdivisions of the state. 42 U.S.C. § 1396a(a)(1); 42 C.F.R. § 431.50; *see* N.C. Gen. Stat. § 108-54.

29. States participating in Medicaid are entitled to receive Federal Financial Participation (FFP) for Medicaid services provided to eligible beneficiaries, which means that the federal government matches all state Medicaid expenditures at a specified rate. 42 U.S.C. § 1396b(a). North Carolina receives a federal matching rate of approximately 65%. 76 Fed. Reg. 5811 (Feb. 3, 2011).

30. In order for a service to be covered under the state Medicaid plan, it must fit within one of the service categories listed in the Medicaid Act. 42 U.S.C. § 1396d(a).

31. Coverage of certain services is mandatory under Medicaid. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a). 42 C.F.R. §§ 440.210, 440.220. For example, States that elect to participate in the Medicaid program must cover nursing facility services for individuals over 21 years of age. 42 U.S.C. § 1396d(a)(4)(A).

32. States may also cover certain optional services, including personal care services. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(24); 42 C.F.R. §§ 440.167, .225. Federal law defines PCS as "services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded or institution for mental diseases that are (1) authorized . . . by a physician in accordance with a plan of care or treatment. . . (2) provided by an individual who is qualified to provide such services who is not a member

of the individual's family; and (3) furnished in a home, and, at the State's option, in another location." 42 C.F.R. § 440.167.

33. CMS' *State Medicaid Manual* provides that personal care services "may include a range of human assistance provided to persons with disabilities and chronic conditions of all ages which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance (actually performing such a personal care task for a person) or cueing so the person performs the task by him/her self. Such assistance most often relates to performance of ADLs [activities of daily living] and IADLs [instrumental activities of daily living]. ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management." CMS, *State Medicaid Manual* § 4480.C, *available at* http://www.cms.gov/Manuals/PBM/list.asp?listpage=2.

34. North Carolina's state Medicaid plan includes coverage of PCS. 10A NCAC 22O. 0120.

35. Once a state chooses to provide an optional service, it must fully adhere to all applicable requirements of federal law and regulations.

36. Medicaid requires that states cover certain categories of individuals and allows coverage of others. "Categorically needy" Medicaid beneficiaries are those beneficiaries who fit into a particular category of children, pregnant women, or aged, blind or disabled individuals and have incomes below specified levels. 42 U.S.C. § 1396a(a)(10)(A), 42 C.F.R. § 435.100-435.236. "Medically needy" Medicaid beneficiaries are those who meet categorical

requirements for such assistance, have incomes exceeding categorically needy levels, but have medical expenses that are high enough to reduce their available monthly income to a specified low level. 42 U.S.C. § 1396a(a)(10)(C); 42 C.F.R. § 435.300-.350.

37. Under federal Medicaid requirements, states must ensure that services are available in an equal "amount, duration and scope" for all categorically needy Medicaid beneficiaries. 42 U.S.C. § 1396a(a)(10)(B)(i); 42 C.F.R. § 440.240(b)(1). States must also must ensure that services are available in an equal "amount, duration and scope" for all individuals in a covered medically needy group. 42 C.F.R. § 440.240(b)(2).

38. Therefore, with certain exceptions not relevant here, the federal Medicaid statute requires that Defendant cover benefits under its Medicaid program, including PCS, that are equal in amount, duration and scope to all categorically eligible beneficiaries.

39. A State Medicaid program must use "reasonable standards (which shall be comparable for all groups …) for determining eligibility for and the extent of medical assistance under the plan which … are consistent with the objectives" of the program. 42 U.S.C. § 1396a(a)(17).

40. The Medicaid Act requires that states provide for granting an opportunity for a hearing to individuals whose claims for medical assistance is denied or not acted upon with reasonable promptness. 42 U.S.C. § 1396a(a)(3).

B. Due Process

41. The Due Process Clause of the Fourteenth Amendment to the U.S. Constitution also prohibits states from denying, reducing, or terminating Medicaid services without due process of law. The Constitutional right includes the right to meaningful notice prior to the termination of Medicaid benefits, continued benefits pending a pre-termination hearing, and a

fair and impartial pre-termination hearing. *Goldberg v. Kelly*, 397 U.S. 254 (1970). Federal Medicaid regulations explicitly implement the due process requirements set forth in *Goldberg*. 42 C.F.R. § 431.205(d).

42. As set forth in *Goldberg* and incorporated in the Medicaid regulations, recipients are entitled to receive timely, adequate, and understandable written notices of their hearing rights when an action affects their claim for health services; the hearing must be fair and impartial and held at a meaningful time; and coverage of services must be continued at the prior-approved level until a final *de novo* hearing decision if: (a) a Medicaid recipient requests a fair hearing before the date that the services are to be stopped or reduced; (b) the recipient requests the hearing within 10 days of the mailing of the notice; or (c) the requisite notice is not sent. 42 C.F.R. Part 431.

C. <u>Anti-Discrimination Laws</u>

43. In enacting the Americans with Disabilities Act, Congress found that "[i]ndividuals with disabilities continually encounter various forms of discrimination, including…segregation…." 42 U.S.C. § 12101(a)(5).

44. Title II of the Americans with Disabilities Act provides that "no qualified individual with a disability shall, by reason of disability, be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity or be subjected to discrimination by such entity." 42 U.S.C. § 12132.

45. Regulations implementing Title II of the ADA make clear that the ADA requires that: "A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d).

46. Regulations implementing Title II of the ADA provide: "A public entity may not, directly or through contractual or other arrangements, utilize criteria or other methods of administration: (i) that have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability; [or] (ii) that have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the entity's program with respect to individuals with disabilities. . . ." 28 C.F.R. § 35.130(b)(3).

47. The U.S. Supreme Court in *Olmstead v. L.C. ex rel. Zimring,* 527 U.S. 581 (1999), held that the unnecessary institutionalization of individuals with disabilities is a form of discrimination under Title II of the ADA. In doing so, the Court interpreted the ADA's "integration mandate" to require that persons with disabilities be served in the community when: (1) community-based treatment is appropriate; (2) the individual does not oppose community placement; and (3) community placement can be reasonably accommodated. *Id.* at 607.

48. Section 504 of the Rehabilitation Act of 1973, on which the ADA is modeled, sets forth similar protections against discrimination by recipients of federal funds, such as the Defendant. 29 U.S.C. §§ 794-794a. These protections include the prohibition against unnecessary segregation of people with disabilities. Regulations implementing Section 504 require that a public entity administer its services, programs and activities in "the most integrated setting appropriate" to the needs of qualified individuals with disabilities. 28 C.F.R. § 41.51(d).

49. Section 504's regulations prohibit recipients of federal financial assistance from utiliz[ing] criteria or methods of administration ... (i) [t]hat have the effect of subjecting qualified handicapped persons to discrimination on the basis of handicap [or] (ii) that have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the recipient's

program with respect to handicapped persons. 28 C.F.R. § 41.51(b)(3)(I); 45 C.F.R. § 84.4(b)(4).

VI. STATEMENT OF FACTS

A. Named Plaintiffs.

Named Plaintiff Henry Pashby.

50. Henry Pashby is a 55 year-old resident of Rutherford County, North Carolina and is eligible to receive Medicaid services. Mr. Pashby has a number of medical conditions, including multiple sclerosis and carpal tunnel syndrome. Additionally, Mr. Pashby lost the use of his left leg as the result of two strokes. Mr. Pashby currently uses a motorized wheelchair because of the mobility issues related to his disabilities. Because of these medical conditions, Mr. Pashby required assistance in bathing and dressing in May 2011. He also required assistance with meal preparation and light housework as well as remembering to take his medications. He currently receives 80 hours per month of PCS through Medicaid.

51. In May 2011, Mr. Pashby received a letter from the Carolina Centers for Medical Excellence (CCME) informing him that PCS would end on June 1, 2011, and would be replaced by a program called In-Home Care for Adults (IHCA). The letter informed Mr. Pashby that he was not eligible for the new IHCA program, but it did not contain any information specific to his needs or assessment. The letter did not include CCME's determination of which of his ADLs require assistance and instead simply contained the generalized statement that his "assessed activities of daily living do not meet the minimum IHCA program requirements … ." Without information regarding the assessment of his particular needs, Mr. Pashby is not sufficiently informed to be able to challenge the decision.

52. Mr. Pashby continued receiving in-home PCS services after a successful mediation of his appeal of the May 2011 PCS denial. In October 2011, Mr. Pashby was reassessed and was approved for 80 hours of in-home PCS under Policy 3E. He maintained this level of services after an October 2012 assessment.

53. After a brief hospitalization, Mr. Pashby moved into an adult care home in November 2012. Until his hospitalization, Mr. Pashby depended on the assistance provided by his in-home PCS aide. He has no family who live in the area, and no other caretakers who would be able to provide him assistance with his activities of daily living.

54. Mr. Pashby would like to move back into his own apartment and would require in-home PCS to live in the community. Mr. Pashby does not like living in the restrictive setting of an adult care home where he rarely leaves the facility, has a regimented day, lacks privacy, and has limited control over important decisions such as when and where he goes to the doctor.

55. It would be significantly less expensive to cover the in-home PCS that Mr. Pashby needs than to cover services for him in an ACH, nursing facility, or other institutional setting.

Named Plaintiff Annie Baxley.

56. Annie Baxley is a 71 year-old resident of St. Pauls, North Carolina who is eligible to receive Medicaid services. Ms. Baxley has a number of medical problems, including lung cancer, anxiety, chronic obstructive pulmonary disease, dizziness, hyperlipidemia, and idiopathic peripheral neuropathy. Ms. Baxley was previously assessed at needing assistance with less than 3 ADLs. Ms. Baxley now requires assistance with bathing, dressing, eating, mobility and toileting, although she is assessed as only needing limited hands-on assistance with bathing, dressing and eating. She has difficulty getting in and out of the tub, is very unsteady on her feet

and sometimes needs the aide to hold her hand when she walks. She also requires assistance with cooking and household chores.

57. Prior to April 2011, Ms. Baxley was receiving 60 hours of PCS per month.

58. On May 13, 2011, Ms. Baxley received a letter from the CCME informing her that her 28 hours of PCS would end on June 1, 2011, and would be replaced by a program called In-Home Care for Adults (IHCA). The letter informed her that she was not eligible for the new IHCA program, but it did not contain any information specific to her needs or her assessment. The letter did not include CCME's determination of which of her ADLs require assistance and simply stated that her "assessed activities of daily living do not meet the minimum IHCA program requirements… ." Without information regarding the assessment of her particular needs, Ms. Baxley is not sufficiently informed to be able to challenge the decision.

59. Ms. Baxley appealed the denial of IHCA and settled for 51 hours of in-home PCS after a new assessment in May 2011. Ms. Baxley's PCS hours were cut in August 2012 from 51 to 41 hours. Ms. Baxley appealed that decision and settled for 44 hours. Ms. Baxley is subject to re-evaluation and therefore is at risk of another cut in hours or termination of her services.

60. Ms. Baxley lives alone and she does not have anyone else who is able to provide her with the same level of assistance as provided by her PCS aide. Although she is able to complete some tasks on her own, there is a substantial risk that Ms. Baxley might fall and injure herself should she attempt the activities of daily living with which she currently receives assistance.

61. If the in-home PCS provided to Ms. Baxley ends, it is likely that Ms. Baxley will be forced to enter a facility because she would be unable to adequately care for herself.

62. It would be significantly less expensive to cover the in-home PCS that Ms. Baxley needs than to cover services for her in an ACH, nursing facility, or other institutional setting.

Named Plaintiff Margaret Drew.

63. Margaret Drew is a 65 year-old resident of Charlotte, North Carolina who is eligible to receive Medicaid services. Ms. Drew has a number of medical problems, including pulmonary hypertension, arthritis, diabetes, vision impairment, carpal tunnel syndrome, heart disease, and orthopedic impairment. Because of these medical conditions, Ms. Drew requires assistance with bathing, dressing and meal preparation. She also requires assistance with household chores. She currently receives 80 hours per month of PCS through Medicaid.

64. In May 2011, Ms. Drew received a letter from the CCME informing her that PCS would end on June 1, 2011, and would be replaced by a program called In-Home Care for Adults (IHCA). The letter informed Ms. Drew that she was not eligible for the new IHCA program, but it did not contain any information specific to her needs or assessment. The letter did not include CCME's determination of which of her ADLs require assistance and instead simply contained the generalized statement that her "assessed activities of daily living do not meet the minimum IHCA program requirements … ." Without information regarding the assessment of her particular needs, Ms. Drew was not sufficiently informed to be able to challenge the decision.

65. Ms. Drew lives alone and she does not have anyone else who is able to provide her with the same level of assistance as provided by her PCS aide.

66. If the in-home PCS provided to Ms. Drew ends, it is likely that Ms. Drew will be forced to enter a facility because she would be unable to adequately care for herself.

67. Ms. Drew continued receiving in-home PCS services after a successful mediation of her appeal of the May 2011 IHCA denial. However, on July 5, 2012 Ms. Drew was notified that based on a reevaluation, her in-home PCS services would again be terminated.

68. Ms. Drew appealed that decision. At mediation, DHHS agreed to reassess her needs. After the reassessment, Ms. Drew was approved for 80 hours per month of in-home PCS.

69. Ms. Drew is due to be reassessed again for continuing eligibility for In-Home PCS in August 2013. If she again is terminated from in-home PCS, she will not be able to adequately care for herself at home, and would have to enter some type of facility because she has no friends or family who are able to provide her with the level of assistance that she needs.

70. It is significantly less expensive to cover the in-home PCS that Ms. Drew needs than to cover services for her in an ACH, nursing facility, or other institutional setting.

Named Plaintiff Deborah Ford.

71. Deborah Ford is a 62 year-old resident of Winston-Salem, North Carolina and is eligible to receive Medicaid services. Ms. Ford has a number of medical conditions, including depression, hypertension, incontinence and emphysema. Because of these medical conditions, Ms. Ford requires assistance in getting out of bed, bathing and dressing. She also requires assistance with light housework, meal preparation and the maintenance of her colostomy bag.

72. In May 2011, Ms. Ford received a letter from the CCME informing her that her 28 hours of Medicaid-funded PCS would end on June 1, 2011, and would be replaced by a program called In-Home Care for Adults (IHCA). The letter informed Ms. Ford that she was not eligible for the new IHCA program, but it did not contain any information specific to her needs or assessment. The letter did not include CCME's determination of which of her ADLs require assistance, rather it simply contained the generalized statement that her "assessed activities of

daily living do not meet the minimum IHCA program requirements … .” Without information regarding the assessment of her particular needs, Ms. Ford is not sufficiently informed to be able to challenge the decision.

73. Although Ms. Ford was receiving 28 hours per month of PCS at the time of the May 2011 letter, Ms. Ford had previously been authorized for 60 hours per month. Ms. Ford appealed the denial of IHCA and successfully settled her appeal. Ms. Ford was reassessed in June 2012 and was approved for 76 hours of in-home PCS.

74. Although Ms. Ford currently receives PCS hours, she is subject to reassessment and therefore is at risk of again having her in-home PCS reduced or terminated.

75. Ms. Ford does not have anyone else who is able to provide her with the same level of assistance as provided by her PCS aide. She has a daughter who is unable to provide assistance.

76. If the in-home PCS provided to Ms. Ford ends, it is likely that Ms. Ford will be forced to enter a facility because she would be unable to adequately care for herself.

77. It would be significantly less expensive to cover the in-home PCS that Ms. Ford needs than to cover services for her in an ACH, nursing facility, or other institutional setting.

Named Plaintiff Melissa Gabijan.

78. Melissa Gabijan is a 30 year-old resident of Raeford, North Carolina who is eligible to receive Medicaid services. Her mother, Jamie Gabijan, is her guardian. Ms. Gabijan has a number of medical problems, including traumatic brain injury, seizures, and early stage dementia. Because of these medical conditions, Ms. Gabijan requires assistance with bathing, dressing, eating and household tasks. She currently receives 66 hours per month of PCS through Medicaid.

79. In May 2011, Ms. Gabijan received a letter from the CCME informing her that PCS would end on June 1, 2011, and would be replaced by a program called In-Home Care for Adults (IHCA). The letter informed Ms. Gabijan that she was not eligible for the new IHCA program, but it did not contain any information specific to her needs or assessment. The letter did not include CCME's determination of which of her ADLs require assistance, rather, it simply contained the generalized statement that her "assessed activities of daily living do not meet the minimum IHCA program requirements ….." Without information regarding the assessment of her particular needs, Ms. Gabijan and her guardian are not sufficiently informed to be able to challenge the decision.

80. Ms. Gabijan was receiving 24 hours per month of PCS when she received the May 2011 letter that she did not qualify for IHCA. In May 2011, Ms. Gabijan was assessed as needing limited hands on assistance with bathing and eating. Ms. Gabijan appealed that decision and was authorized for 59 hours per month of in-home PCS after a reassessment.

81. In August 2012, Ms. Gabijan was approved for 66 hours of PCS under Policy 3E. Although Ms. Gabijan currently receives PCS, she is subject to reassessment and therefore is at risk of again having her in-home PCS reduced or terminated.

82. Ms. Gabijan does not have natural supports who are able to provide her with the same level of assistance as provided by her PCS aide. Her mother (with whom she lives) already provides a substantial amount of care for Ms. Gabijan. However, her mother works and cannot provide her with the amount of assistance that her aide provides.

83. If the in-home PCS provided to Ms. Gabijan ends, it is likely that Ms. Gabijan will be forced to enter a facility because she would be unable to adequately care for herself.

84. It would be significantly less expensive to cover the in-home PCS that Ms. Gabjian needs than to cover services for her in an ACH, nursing facility, or other institutional setting.

Named Plaintiff Micheal Hutter.

85. Micheal Hutter is a 37 year-old resident of Claremont, North Carolina and is eligible to receive Medicaid services. Mr. Hutter has a number of medical conditions, including cerebral palsy, Diabetes Mellitus Type II, Hyperlipidemia, Central Pain Syndrome, Anxiety, and Bipolar Disorder. Because of his cerebral palsy, he requires assistance in bathing, dressing, toileting, mobility, and meal preparation. He currently receives 50 hours per month of PCS through Medicaid.

86. In May 2011, Mr. Hutter received a letter from the CCME informing him that PCS would end on June 1, 2011, and would be replaced by a program called In-Home Care for Adults (IHCA). The letter informed Mr. Hutter that he was not eligible for the new IHCA program, but it did not contain any information specific to his needs or assessment. The letter did not include CCME's determination of which of his ADLs require assistance, rather it simply contained the generalized statement that his "assessed activities of daily living do not meet the minimum IHCA program requirements … ." Without information regarding the assessment of his particular needs, Mr. Hutter was not sufficiently informed to be able to challenge the decision.

87. Mr. Hutter does not have friends or family who are able to provide him with the same level of assistance as provided by his PCS aide. His parents are only able to help in a very limited way on the weekends. His father works full-time outside the home, and his mother is physically unable to help due to her own health conditions.

88. If the in-home PCS provided to Mr. Hutter ends, it is likely that Mr. Hutter will be forced to enter a facility because he would be unable to adequately care for himself.

89. Mr. Hutter continued receiving in-home PCS services after a successful mediation of his appeal of the May 2011 IHCA denial. However, Mr. Hutter was reevaluated in 2012 and as a result his PCS was reduced to 39 hours per month. He filed an administrative appeal of that decision and that appeal is still pending.

90. Mr. Hutter is due to be reassessed again for continuing eligibility for in-home PCS in July 2013. He therefore is at risk of again having his in-home PCS reduced or terminated. If he loses his current hours of PCS, he would have to be placed in a facility because he is unable to adequately care for himself, and his parents are unable to provide the level of assistance he needs.

91. It would be significantly less expensive to cover the in-home PCS that Mr. Hutter needs than to cover services for him in an ACH, nursing facility, or other institutional setting.

<u>Named Plaintiff Lucretia Willis.</u>

92. Lucretia Willis legally changed her name from Lucretia Moore since the time of filing the first complaint in this case on May 31, 2011.

93. Lucretia Willis is a 50 year-old resident of Leland, North Carolina and is eligible to receive Medicaid services. Ms. Willis has a number of medical conditions, including arthritis, bipolar disorder, tendonitis and degenerative disc disease. Because of these medical conditions, Ms. Willis required assistance in bathing and,dressing as of May 31, 2011. She also required assistance with light housework and needed to be reminded to take her medication.

94. In April 2011, Ms. Willis received a letter approving 29 hours a month of PCS.

95. In May 2011, Ms. Willis received a letter from the CCME informing her that PCS would end on June 1, 2011, and would be replaced by a program called In-Home Care for Adults (IHCA).The letter informed Ms. Willis that she was not eligible for the new IHCA program, but it did not contain any information specific to her needs or assessment. The letter did not include CCME's determination of which of her ADLs require assistance, rather it simply contained the generalized statement that her "assessed activities of daily living do not meet the minimum IHCA program requirements … ." Without information regarding the assessment of her particular needs, Ms. Moore is not sufficiently informed to be able to challenge the decision.

96. Ms. Willis appealed the May 2011 termination of her PCS hours and settled for 58 hours of PCS per month in November 2011. Ms. Willis continues to receive PCS services.

97. Ms. Willis does not have natural supports able to provide her with the same level of assistance as provided by her PCS aide. She has a young son who has autism and needs extensive assistance. No one else would be able to provide her with the amount of assistance that her aide currently provides.

98. If the in-home PCS provided to Ms. Willis ends, it is likely that Ms. Moore will be forced to enter a facility because she would be unable to adequately care for herself.

99. Ms. Willis is subject to re-evaluation and therefore is at risk that her in-home PCS will be reduced or terminated.

100. It would be significantly less expensive to cover the in-home PCS that Ms. Willis needs than to cover services for her in an ACH, nursing facility, or other institutional setting.

Former Named Plaintiff James Moore.

101. James Moore was a resident of Dunn, North Carolina and was eligible to receive Medicaid services. Mr. Moore had a number of medical conditions, including cancer, chronic

obstructive pulmonary disease, emphysema, chronic bronchitis and heart disease. Because of these medical conditions, Mr. Moore required assistance in bathing and eating. He also required assistance with light housework and his aide helped remind him to take his medications.

102. Mr. Moore passed away on November 27, 2012.

103. In May 2011, Mr. Moore received a letter from the CCME informing him that PCS would end on June 1, 2011, and would be replaced by a program called In-Home Care for Adults (IHCA). The letter informed Mr. Moore that he was not eligible for the new IHCA program, but it did not contain any information specific to his needs or assessment. The letter did not include CCME's determination of which of his ADLs require assistance, rather it simply contained the generalized statement that his "assessed activities of daily living do not meet the minimum IHCA program requirements … ." Without information regarding the assessment of her particular needs, Mr. Moore was not sufficiently informed to be able to challenge the decision.

104. Mr. Moore did not have sufficient natural supports able to provide him with the same level of assistance as provided by his PCS aide. Although h two daughters lived in the area and provided limited assistance, no one else was able to provide him with the amount of assistance that his aide provided.

105. In May 2011, Mr. Moore was receiving 28 hours per month of in-home PCS. He appealed this decision. Mr. Moore received multiple notices in May 2011. In November 2011, Mr. Moore was reassessed and authorized for 73 hours of in-home PCS. The in-home PCS provided to Mr. Moore were critical to helping him stay at home.

106. It was significantly less expensive to cover the in-home PCS that Mr. Moore needed than to cover services for him in an ACH, nursing facility, or other institutional setting.

Named Plaintiff Ayleah Phillips.

107. Ayleah Phillips is a 63 year-old resident of Asheboro, North Carolina and is eligible to receive Medicaid services. Ms. Phillips has a number of medical conditions, including multiple sclerosis, hypertension, hepatitis C, arthritis and heart problems. Because of these medical conditions, Ms. Phillips required assistance in bathing and dressing in May 2011. She also required assistance with light housework and in remembering to take her medications. As of May 2011, Ms. Phillips received 29 hours per month of PCS through Medicaid.

108. In May 2011, Ms. Phillips received a letter from the CCME informing her that PCS would end on June 1, 2011, and would be replaced by a program called In-Home Care for Adults (IHCA). The letter informed Ms. Phillips that she was not eligible for the new IHCA program, but it did not contain any information specific to her needs or assessment. The letter did not include CCME's determination of which of her ADLs require assistance, rather it simply contained the generalized statement that her "assessed activities of daily living do not meet the minimum IHCA program requirements … ." Without information regarding the assessment of her particular needs, Ms. Phillips is not sufficiently informed to be able to challenge the decision.

109. Ms. Phillips appealed the denial of IHCA and settled for 29 hours of in-home PCS in August 2011. Ms. Phillips was reassessed in March 2012 and approved for 59 hours of in-home PCS in May 2012. Ms. Phillips is subject to the risk of reduction or termination of her in-home PCS each time she is reassessed for PCS.

110. Ms. Phillips does not have family in friends in the area who are able to provide her with the same level of assistance as provided by her PCS aide. She has no family who live in the area. No one else would be able to provide her with the amount of assistance that her aide currently provides.

111. If the in-home PCS provided to Ms. Phillips ends, it is likely that Ms. Phillips will be forced to enter a facility because she would be unable to adequately care for herself.

112. It would be significantly less expensive to cover the in-home PCS that Ms. Phillips needs than to cover services for her in an ACH, nursing facility, or other institutional setting.

Named Plaintiff Alice Shropshire.

113. Alice Shropshire is a 70 year-old resident of Greensboro, North Carolina and is eligible to receive Medicaid services. Ms. Shropshire has a number of medical conditions, including diabetes, hypertension, depression, bronchitis and spondylosis of the cervical spine. Because of these medical conditions, Ms. Shropshire requires assistance in bathing and maintaining her balance. In May 2011, she also required assistance with light housework and meal preparation and was receiving 28 hours per month of PCS through Medicaid.

114. In May 2011, Ms. Shropshire received a letter from the CCME informing her that PCS would end on June 1, 2011, and would be replaced by a program called In-Home Care for Adults (IHCA). The letter informed Ms. Shropshire that she was not eligible for the new IHCA program, but it did not contain any information specific to her needs or assessment. The letter did not include CCME's determination of which of her ADLs require assistance, rather it simply contained the generalized statement that her "assessed activities of daily living do not meet the minimum IHCA program requirements … ." Without information regarding the assessment of her particular needs, Ms. Shropshire was not sufficiently informed to be able to challenge the decision.

115. Ms. Shropshire appealed the May 2011 denial of IHCA and settled in June 2011 for 45 hours of in-home PCS per month. In early 2012, Ms. Shropshire moved into a nursing home.

116. In-home PCS helped Ms. Shropshire stay at home until she went into the nursing home. Ms. Shropshire did not have natural supports able to provide her with the same level of assistance as provided by her PCS aide. No one else was able to provide her with the amount of assistance that her Personal Care aide provided.

117. It was significantly less expensive to cover the in-home PCS that Ms. Shropshire received while she was at home than to cover services for her in an ACH, nursing facility, or other institutional setting.

Named Plaintiff Sandy Splawn.

118. Sandy Splawn is a 51 year-old resident of Rutherfordton, North Carolina and is eligible to receive Medicaid services. Ms. Splawn has a number of medical conditions, including chronic obstructive pulmonary disease, emphysema, chronic asthma, degenerative disc disease, osteoporosis, diabetes, coronary artery disease, and obesity. Because of these medical conditions, Ms. Splawn required assistance with bathing and dressing in May 2011. She also required assistance with household chores.

119. In May 2011, Ms. Splawn received a letter from the CCME informing her that her 32 hours per month of Medicaid-funded PCS would end on June 1, 2011, and would be replaced by a program called In-Home Care for Adults (IHCA). The letter informed Ms. Splawn that she was not eligible for the new IHCA program, but it did not contain any information specific to her needs or assessment. The letter did not include CCME's determination of which of her ADLs require assistance, rather it simply contained the generalized statement that her "assessed

activities of daily living do not meet the minimum IHCA program requirements … .” Without information regarding the assessment of her particular needs, Ms. Splawn is not sufficiently informed to be able to challenge the decision.

120. Ms. Splawn appealed and settled her appeal for 52 hours of PCS per month in June 2011. She was reassessed for PCS in June 2012 and was approved for 71 hours per month of PCS. Ms. Splawn is subject to a change or termination in her PCS each time she is reassessed.

121. Ms. Splawn does not have family members who are able to provide her with the same level of assistance as provided by her PCS aide. If the in-home PCS provided to Ms. Splawn ends, it is likely that Ms. Splawn will be forced to enter a facility because she would be unable to adequately care for herself.

122. It would be significantly less expensive to cover the in-home PCS that Ms. Splawn needs than to cover services for her in an ACH, nursing facility, or other institutional setting.

Named Plaintiff Robert Jones.

123. Robert Jones is a 69-year-old resident of Elizabeth City, North Carolina who is eligible to receive Medicaid services. He lives with his cousin Alonzo Percer. Mr. Jones has a number of medical problems, including schizophrenia, mental retardation, diabetes and high blood pressure. Because of these conditions, Mr. Jones requires assistance with bathing, dressing, food preparation, taking his medications and managing his affairs. Mr. Jones was approved to receive PCS by CCME in 2007. Until November 2010 he was receiving 48 hours of PCS per month. At that time, his hours were reduced to 27 hours per month.

124. In May 2011, Mr. Jones received a letter from CCME notifying him that his PCS

would be terminated effective June 1, 2011. The letter stated that Mr. Jones was no longer eligible for PCS because he did not need help with three ADLs but it did not tell him which ADLs he needed assistance with and which ADLs could be considered in determining his eligibility. Neither Mr. Jones nor his attorney in fact was able to understand the notice.

125. Mr. Jones appealed the May 2011 notice of termination to the N.C. Office of Administrative Hearings. His PCS was reinstated pending the outcome of his appeal. Mr. Jones was represented in that administrative appeal by Faye Lewis, a paralegal with Legal Aid of North Carolina. At a telephone mediation on June 14, 2011, a representative of CCME informed Mr. Jones and Ms. Lewis that unless they could show that he needed help with three ADLs, Mr. Jones could not win his administrative appeal. Based on this representation, Mr. Jones agreed at the mediation to dismiss his administrative appeal. As a result, his PCS stopped on June 14, 2011.

126. Pursuant to this Court's preliminary injunction, Mr. Jones' PCS were reinstated in February 2012.

127. On April 3, 2013, Mr. Jones' continuing need for PCS was reassessed by CCME. On April 4, 2013, CCME notified Mr. Jones that his PCS would again be terminated. Mr. Jones filed an administrative appeal of this decision, which is still pending.

128. Mr. Jones does not have sufficient natural supports to replace the loss of PCS. Mr. Percer provides some assistance to him but has his own physical disability and can only provide limited help to him. According to his physicians, Mr. Jones is at significant risk of irreparable harm to his health and safety if his PCS is not continued. In addition, Mr. Jones is at significant risk of institutionalization if his PCS is not reinstated.

129. It would be significantly less expensive to cover the in-home PCS that Mr. Jones

needs than to cover services for him in an ACH, nursing facility, or other institutional setting.

Named Plaintiff Rebecca Pettigrew

130. Rebecca Pettigrew is a 57-year-old resident of Smithfield, North Carolina who is eligible to receive Medicaid services. Ms. Pettigrew has a number of medical problems, including arthritis, diabetes, chronic obstructive pulmonary disease, HIV/AIDS, asthma, fibromyalgia, diabetic neuropathy in both legs and one arm and problems associated with the sciatic nerve. Because of these conditions, Ms. Pettigrew requires assistance with bathing, dressing and eating.

131. In May 2011, Ms. Pettigrew received a letter from CCME notifying her that she was eligible to continue to receive her PCS through the new IHCA program.

132. In June 2011, Ms. Pettigrew received a letter from CCME notifying her that she was no longer eligible for services under the IHCA program. She has been receiving 25 hours of in-home aide services. The letter stated that Ms. Pettigrew was no longer eligible for IHCA because she did not need help with three ADLs but it did not tell her which ADLs she needed assistance with and which ADLs could be considered in determining her eligibility. The letter also did not tell Ms. Pettigrew what had changed in her level of need to cause her eligibility to change since the May 2011 letter approving her for IHCA.

133. Ms. Pettigrew received the June 2011 notification of termination from CCME the day after she was assessed by CCME. During the assessment, she was asked to do things she did not regularly do, such as try to enter the shower/bathtub by herself or move around her home using her rolling walker. Ms. Pettigrew also understood the nurse assessor to say that she should be getting more hours. Ms. Pettigrew injured her shoulder trying to enter the shower/bathtub independently and could not get out of bed by without assistance the following day.

134. Ms. Pettigrew appealed the June 2011 denial of in-home PCS and continued to receive 25 hours per month of PCS pending the outcome of her administrative appeal.

135. On February 29, 2012, Ms. Pettigrew's PCS was reinstated pursuant to implementation of the December 2011 order regarding the preliminary injunction. Because her hours were reinstated at 22 hours based on her last assessment, Ms. Pettigrew appealed. She was reassessed in April 2012 and authorized for 80 hours of PCS per month.

136. Ms. Pettigrew does not have sufficient natural supports to replace the loss of her in-home care services. Ms. Pettigrew's mother lives close by but needs assistance with her own care and cannot provide the necessary help for Ms. Pettigrew. Without assistance from an in-home aide, Ms. Pettigrew is at significant risk of falling and becoming injured.

137. It would be significantly less expensive to cover the in-home PCS that Ms. Pettigrew needs than to cover services for her in an ACH, nursing facility, or other institutional setting.

B. Adult Care Homes (ACHs)

138. ACHs are assisted living facilities in which staff members provide scheduled and unscheduled PCS to two or more residents. Some ACHs provide supervision to individuals with cognitive impairments whose decisions may jeopardize their safety or well being. N.C. Gen. Stat. § 131D-2.1(3); *see also* 10A NCAC 13F.

139. As of January 2011, there were more than 600 ACHs in North Carolina with a total of more than 36,000 beds.

140. Many ACHs are large facilities that have more than 80 beds.

141. The physical layout of many ACHs is similar to that of an institution.

142. Approximately 4,800 ACH beds are located in nursing homes and nearly 50% of the 400 licensed nursing homes in North Carolina also have licensed ACH beds. *See* 10 NCAC 13F .1303, .1304.

143. Many ACHs have special locked units. See 10 NCAC 13F.1304.

144. Many ACHs are in rural areas or other areas with little or no access to public transportation.

145. ACHs are designed to provide custodial care and supervision, which limits the resident's autonomy. Residents may be subject to 24-hour supervision. 10A NCAC 13F.0901.

146. Schedules are regimented for the convenience and efficiency of ACH staff rather than resident-centered.

147. Many activities in ACHs are done in a group, including meals, which are served in groups at set times.

148. Residents generally are unable to manage their own activities such as cooking, taking medication, cleaning, budgeting and handling their own money.

149. ACHs may impose restrictions on visits by family and friends. 10A NCAC 13F .0906(f)(2).

150. Residents in ACHs may be assigned a roommate not of their choice.

151. Residents are entitled to locked storage space only if the ACH administrator or supervisor has access. N.C. Gen. Stat. § 131D-21(12).

152. Chemical and physical restraints may be ordered against the resident's will. N.C. Gen. Stat. § 131D-21(5); 10A NCAC 13F .1501.

153. Medications are administered by staff unless a doctor orders otherwise. 10A NCAC 13F .1005

154. The facility often receives the resident's Social Security, Social Security Income, or Veteran's Administration benefits check directly and applies it to the facility's charges. *See*, 10A NCAC 13F .1103(b) and .1104

155. ACHs are licensed and regulated by the N.C. Division of Facility Services. N.C. Gen. Stat. 131D-2.4.

156. The resident has no right to smoke tobacco inside the ACH, even in his own room. N.C. Gen. Stat. 131D-4.4.

157. Residents of ACHs are required to be immunized annually. N.C. Gen. Stat. 131D-9.

158. Residents of ACHs are offered few activities in the community, and these activities frequently do not offer opportunities to interact with non-disabled peers.

159. Admission to an ACH requires only the "opinion of the resident, physician, family or social worker, and the administrator [that] the services and accommodations of the home will meet his particular needs." 10A NCAC 13F .0701(a).

160. North Carolina operates the State-County Special Assistance Program (Special Assistance) for individuals with monthly incomes below $1,182 living in ACHs. N.C. Gen. Stat. § 108A-40-47.1. To medically qualify for Special Assistance, a physician must determine that an individual needs care in an ACH. *See* 10A NCAC 71P.0906.

161. Approximately seventy percent of all ACH residents are eligible for Special Assistance.

C. <u>Coverage of Personal Care Services in North Carolina</u>

i. <u>In-Home PCS</u>

162. Prior to implementation of Defendant's challenged new eligibility requirements in Clinical Policy 3E on June 1, 2011, in order to qualify for PCS in the home, an individual had to require hands-on assistance with two or more of five listed ADLs: bathing, dressing, toileting, mobility, and eating. DMA 4/16/10 Clinical Coverage Policy 3C, pp. 7, 10.

163. It was also necessary to qualify for PCS prior to June 2011 for an individual to have a medical diagnosis that required a physician's care and be under the care of a physician. 10A NCAC 22O. 0120(a)(1).

164. Until April 1, 2010, a registered nurse for a certified home care provider could provide an assessment for an individual to receive PCS in their home.

165. In 2009, North Carolina entered into a contract with the Carolinas Center for Medical Excellence (CCME) to conduct independent assessments for in-home PCS. CCME began processing in-home PCS referrals and conducting independent assessments of PCS applicants and recipients on April 1, 2010.

166. Many individuals who have been referred by their physicians for in-home PCS have waited weeks and months for CCME to perform assessments, causing serious harm including hospitalization or placement in nursing facilities.

167. On June 30, 2010, the North Carolina General Assembly enacted a law renaming the in-home PCS benefit to In Home Care for Adults (IHCA) and In Home Care for Children (IHCC). N.C. Sess. Laws 2010-31, § 10.35, p. 87.

168. The 2010 provision stated that in-home PCS would be available to meet eating, dressing, bathing, toileting, and mobility needs of individuals 21 years and older who had unmet needs for three of five qualifying ADLs with limited hands-on assistance; or two ADLs, one of which required assistance at either the extensive or dependent level. N.C. Sess. Laws 2010-31, §

10.35, p. 87. This law made the eligibility requirements for in-home PCS for individuals 21 years or older much more strict.

169. On October 25, 2010, Defendant requested that CMS grant permission to amend its state Medicaid plan to make the changes described in N.C. Sess. Laws 2010-31, submitting a proposed state plan amendment (SPA) describing the requested changes. Dep't of Health & Human Servs., Transmittal and Notice of Approval of State Plan Material (SPA 10-31).

170. SPA 10-31 provided that PCS would be available to individuals living in private residences only if they required limited hands-on assistance with three or more ADLs or require assistance with two or more ADLs, one of which is at the extensive or full dependence level. Coverage was limited to 80 hours per month. SPA 10-31, p. 20.

171. CMS approved SPA 10-31 in April 2011. Letter from Jackie Glaze, Assoc. Regional Administrator, Div. of Medicaid & Children's Health Ops., CMS, to Craigan Gray, Director, DMA, N.C. DHHS (April 18, 2011) (Letter approving SPA) (Approval Letter).

172. Before CMS approved SPA 10-31, Defendant did not inform CMS of important differences between the amount, duration, and scope of coverage of PCS for individuals living in private residences and individuals living in ACHs.

173. Defendant incorrectly informed CMS in early 2011 that ACH residents require 24/7 supervision and PCS and that they are not able to live safely in their communities.

174. Defendant incorrectly informed CMS in early 2011 that ACH residents need medication management and those receiving PCS in their homes do not.

175. Defendant incorrectly informed CMS that in-home PCS residents would be assessed for their need for PCS in a timely manner.

When approving SPA 10-31, CMS indicated that "approval of this State Plan Amendment relates solely to the availability of FFP for Medicaid covered services. *This action does not in any way address the State's independent obligation under the Americans with Disabilities Act or the Supreme Court's Olmstead decision.*" (Emphasis added).

176. Defendant issued Clinical Coverage Policy 3E to govern the provision of in-home PCS effective June 1, 2011. Covered tasks included assistance with qualifying ADLs, IADLs directly related to the ADLs, assistance with assistive or adaptive devices or durable medical equipment, or assistance with certain Nurse Aide tasks. Policy 3E, p. 4. The five potentially qualifying ADLs were eating, dressing, bathing, toileting, and mobility. *Id.,* p. 1.

177. Clinical Coverage Policy 3E provided that individuals may only qualify for in-home PCS if they require hands-on assistance with three of the five qualifying ADLs at the limited assistance level or hands-on assistance with two ADLs, one of which was at either the extensive or full dependence level. Policy 3E, p. 10.

178. The assessment tool used to determine need for in-home PCS under Policy 3E was required to contain a rating of the individual's ability to perform a task. Ratings are described as follows:

(a) Can do with limited hands-on assistance: recipient is able to self-perform more than 50% of activity and requires hands-on assistance to complete remainder of activity;

(b) Can do with extensive hands on assistance: recipient is able to perform less than 50% of activity and requires hands-on assistance to complete remainder of activity.

(c) Cannot do at all (full dependence): recipient is unable to perform any of the activity and is totally dependent on another to perform all of the activity.

Id., p. 9.

179. In-home PCS recipients were required by Policy 3E to be under the direct care of a physician for the medical conditions causing the functional limitations necessitating PCS and the need for PCS was required to be directly linked to that medical condition. *Id.*, p. 3.

180. In order for in-home PCS to be authorized under Policy 3E, there must have been no available, willing, and able household member who could provide PCS on an ongoing basis. *Id.*, p. 4.

181. Defendant's Policy 3E provided that "cueing, prompting, guiding, or coaching may be provided as part of the hands-on assistance to recipients for the qualified ADLs, but do not constitute a covered service in and of themselves." *Id.,* p. 5.

182. The maximum amount of in home-PCS under Policy 3E that could be authorized for an adult was 80 hours per month. *Id.,* p. 4.

183. In May 2011, DMA issued notices terminating PCS effective June 1, 2011 under Policy 3E for over 2,000 individuals who were currently receiving in-home PCS.

184. On December 8, 2011 this Court certified the plaintiff class and preliminarily enjoined implementation of Policy 3E. Pursuant to this Order, in February 2012, DHHS approved PCS for those class members who had been denied or terminated for failure to meet the 3 ADL standard in Policy 3E but who were eligible under the 2 ADL standard in effect prior to June 1, 2011.

185. On December 9, 2011, DHHS appealed this Court's December 8, 2011 Order.

186. On March 6, 2012, the U.S. Court of Appeals for the Fourth Circuit issued an Order granting DHHS's Motion to Stay the December 8, 2011 Order.

187. After issuance of the Stay and continuing through December 31, 2012, DHHS denied or terminated in-home PCS pursuant to Policy 3E for hundreds of class members who were eligible for in-home PCS under the Court's Order.

188. Effective May 1, 2012, CMS terminated its approval of SPA 10-31. In the new SPA, CMS required that effective May 1, 2012, the eligibility rules for PCS be the same in all settings. Nonetheless, in violation of this CMS mandate, DHHS continued to apply Policy 3E through December 2012 and made no changes to its eligibility rules for coverage of PCS in ACHs.

189. On March 5, 2013, the Fourth Circuit Court of Appeals issued its judgment affirming the December 8, 2011 Order of this Court. On April 10, 2013, the Court of Appeals issued its mandate. To date, DHHS has taken no action to implement that judgment by approving in-home PCS for hundreds of class members who were denied or terminated from in-home PCS under Policy 3E.

ii. <u>PCS in Adult Care Homes Prior to January 1, 2013</u>

190. Prior to January 1, 2013, the eligibility requirements for PCS in ACHs were much lower than the eligibility requirements for receiving PCS at home. There were also a greater number of ADLs that could qualify an individual to receive PCS, a lower threshold for the degree of assistance required, no hour limitation on services, and a much easier, less cumbersome authorization process.

191. Regulations provided that individuals in ACHs could obtain assistance with the following seven ADL's: bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating. 10A NCAC 13F. 0801.

192. A care plan submitted to obtain approval for Medicaid-funded PCS in an ACH required only a physician's certification that the resident "has a medical diagnosis with associated physical/mental limitations warranting the provision of personal care services in the above care plan." 10A NCAC 13F .0802.

193. Unlike In-Home PCS, there was no requirement for prior approval by DHHS or its agent before an ACH resident can receive PCS.

194. Assessments for ACH PCS were performed by staff of the facility that were paid by Medicaid to provide PCS, not by CCME or any other agent of DHHS. 10A NCAC 13F. 0801.

195. DHHS did not promulgate or announce any Clinical Coverage Policy that set forth eligibility criteria for PCS in ACHs. Persons could receive PCS in ACHs who only required limited supervision and did not require hands-on assistance with their ADLs. Persons in ACHs could also receive PCS if they required only limited assistance with one ADL.

196. In contrast to the rules in Policy 3E governing in-home PCS, there were no restrictions on coverage of PCS in an ACH, no required link between a documented medical condition and the assistance needed, and no requirement that the recipient be under the direct care of a physician for that condition..

197. According to DHHS, individuals could qualify for ACH PCS if they needed assistance with one of the seven listed ADLs or required limited supervision.

198. SPA 10-31 provided that individuals living in ACHs were eligible for personal care services if they:

(a) Have a cognitive disorder, chronic or progressive medical condition, or physical disability that impedes their ability to self-perform common ADLs, and

(b) Are subject to health, safety, and security risks because there is no capable and willing caregiver to assure that health and welfare needs will be met in a private residence. SPA 10-31, p. 20.

In addition, SPA 10-31 specified that ACH residents must also require at least two of the following:

(a) Ongoing supervision;

(b) Medication administration or assistance;

(c) Limited, extensive, or full assistance with at least two of the following ADLs: toileting, eating, ambulation, bathing, personal hygiene, dressing, and transferring;

(d) Assistance with IADLs including light housework, meal preparation, shopping, errands, use of telephone, money management, and use of technology.

199. Defendant never implemented the new more strict eligibility requirements contained in SPA 10-31 to receive PCS in an ACH. Thus, the eligibility requirements for PCS in ACHs effectively remained the same through December 31, 2012: an individual could receive PCS if the individual required assistance with one or more ADL or the individual required limited supervision. The assessment continued to be performed by an ACH staff person, and no DHHS prior approval was required.

200. As a result of the differences between the policies and practices governing in-home PCS and ACH PCS beginning June 1, 2011, many individuals who lived in ACHs were

able to receive PCS if they remained in these facilities, while individuals with comparable or greater medical needs and need for assistance in performing basic ADLs who lived in their own homes could not receive PCS unless they moved into an ACH.

iii. January 2013 Changes

201. In 2012 the N.C. General Assembly enacted new legislation requiring DHHS to change the PCS program to make the eligibility requirements uniform across all settings effective Jan 1, 2013. N.C. Session Laws 2012-142§ 10.9F.(c).

202. On October 16, 2012, DHHS submitted SPA 12-13 to CMS seeking approval of the legislatively mandated changes to Medicaid PCS. CMS approved SPA 12-13 on November 30, 2012, specifying once again in its approval letter that *"This action does not in any way address the State's independent obligations under the Americans with Disabilities Act or the Supreme Court's Olmstead decision.*" (Emphasis added.)

203. Effective January 1, 2013, Defendant issued Clinical Policy 3L, which purported to implement SPA 12-13 and make eligibility requirements for PCS uniform across all settings.

204. However, Defendant's implementation of Policy 3L has not been uniform in the following ways:

A. Clinical Policy 3L requires denial of PCS when a family member or other informal caregiver is "willing, able, and available" on a regular basis to provide the care needed. However, the in-home PCS assessment form does not ask whether a family member or other informal caregiver is "willing" or "able" to provide the care that is needed, only whether the family member or other caregiver is "available." Class members are frequently denied or terminated from in-home PCS based on the determination by an assessor that

a family member or other caregiver is "available" to provide care with no inquiry by the assessor as to the willingness or ability of the family member other caregiver to provide the care that is needed. In contrast, the ACH assessment form and instructions make no inquiry at all as to this issue.

B. Policy 3L states that coverage for PCS is available only for "unmet needs with qualifying ADL's." In practice, however, DHHS treats assistance with meal preparation as a qualifying ADL for PCS in an ACH in all cases without inquiry into whether the resident is able to prepare his or her own meals. Moreover, DHHS counts meal preparation alone as a qualifying ADL in an ACH despite the fact that the need for meal preparation is not "unmet" in ACH cases. This is because state regulations require ACH's to provide meal preparation to all residents and because state and private funding for room and board services received by ACHs meets the need for meal preparation without Medicaid PCS. These practices discriminate against applicants for in-home PCS whose eligibility for PCS is assessed based on their actual unmet need for Medicaid-funded assistance with meal preparation.

C. The assessment form and procedure for ACH PCS require review of the individual's medical records and requires the reviewer to list the records that were reviewed. The in-home assessment form does not provide for any review of medical records.

D. The staff to be providing PCS are provided advance written notice of the date and time of the assessment for ACH PCS and are invited to be present and interviewed. None of this generally occurs for in-home PCS assessments.

E. Both the referral form and the assessment form for ACH PCS ask whether the resident is at risk of falls, malnutrition, skin breakdown, or medication noncompliance in the absence of care. The in-home PCS referral form and assessment form do not make these inquiries.

F. On information and belief, DHHS and its agent CCME have been very liberal in interpreting Policy 3L in favor of ACH residents' eligibility for PCS both during the assessment process and in settling appeals. These practices were not followed by DHHS or CCME when class members were terminated from in-home PCS in 2011 and 2012.

G. In April 2013, DHHS waived its rules to retroactively permit prior approval for PCS for approvals issued after January 1, 2013. The effect of this decision is to protect ACH providers from losing payment for services provided during a backlog in ACH PCS assessments. DHHS made no similar accommodations for in-home PCS during backlogs of assessments in 2011 and 2012.

H. In issuing notices in November and December 2012 to terminate PCS under Policy 3L for residents of ACHs , DHHS delayed the effective date of the terminations until January 30, 2013 in all cases and permitted all ACH residents to wait until at least January 30, 2013 to file administrative appeals of these decisions. By contrast, for terminations of in-home PCS, the effective date of the termination generally is ten days after the notice is sent and the deadline to appeal is always 30 days.

I. Prior to issuing notices to terminate PCS for ACH residents, DHHS and CCME repeatedly encouraged ACH providers to file appeals on behalf of

residents who were going to be terminated. DHHS and CCME did not engage in similar communications with in-home PCS providers prior to terminations in 2011 and 2012.

J. PCS termination and denial notices issued by DHHS and CCME are always sent by certified mail. Those who are not able to sign for certified mail when delivered must travel to a post office to obtain the notice, which sometimes causes the notice not to be received or to be received late. The practice of sending notices by certified mail thus favors those living in ACH's, where staff are always available to accept certified mail when delivered.

205. In 2012 The N.C. General Assembly appropriated $39,700,000 for the express purpose of paying for PCS for ACH residents terminated from Medicaid coverage for PCS. N.C. Session Laws 2012-142§ 10.23A.(f). No state funding has been made available to pay for in-home PCS for class members losing Medicaid coverage for in-home PCS under Policy 3E or Policy 3L.

206. As a result of these policies and practices, class members continue to be evaluated for PCS under a process that is not comparable to the process used by DHHS for residents of ACHs.

207. As a result of these policies and practices, plaintiffs and class members continue to be at serious risk of institutionalization because they may have to enter ACHs to obtain or retain PCS.

D. <u>Due Process Violations</u>

208. During May 2011, CCME used the results of the most recent assessment on file to determine whether many current PCS recipients would qualify for IHCA.

209. In May 2011, DHHS sent termination notices to recipients of in-home PCS, including Plaintiffs, informing them that they would no longer qualify for in-home PCS.

210. The May 2011 notices stated: "Medicaid did not approve the request to transfer to IHCA because your assessed activities of daily living do not meet the minimum IHCA program requirements of hands on assistance for unmet needs with three qualifying activities of daily living, or with two qualifying activities of daily living at least one of which requires extensive hands on assistance."

211. The May 2011 notices did not specify the relevant ADLs that were considered.

212. The May 2011 notices did not specify the level of assistance that CCME determined was needed by the individual recipient.

213. The May 2011 notices did not contain any attachment describing the assessment, despite the fact that DMA made representations to the contrary to CMS.

214. The May 2011 notices were not written in a manner that is understandable to PCS recipients, many of whom have cognitive impairments or limited literacy.

215. The May 2011 notices did not include the specific legal authority (Clinical Policy 3E) that supported the decision or a correct website address by which to locate that policy.

216. After Policy 3E was implemented on June 1, 2011, Defendant continued to use notices with most of the same defects as the May 2011 notices in denying, reducing, or terminating in-home PCS, except that these notices were not sent a result of a mass change in law or policy.

217. In early 2012, in response to this Court's preliminary injunction, Defendant changed its in home PCS notices to correct the above violations. However, Defendant continues

to defend the legality of these notices and is likely to return to the use of inadequate notices unless this Court permanently enjoins their use.

218. The notices used by DHHS to deny, terminate, or reduce PCS contain incorrect information about the appeal process, stating erroneously that the final agency decision on the appeal will be made by DHHS, when in fact the final agency decision is made by the N.C. Office of Administrative Hearings, an independent agency. As a result, class members are likely to have incorrect information that will discourage them from appealing the DHHS decision.

VII. CAUSES OF ACTION

First Cause of Action: Americans with Disabilities Act

219. Plaintiffs incorporate and re-allege paragraphs 1 through 218, as if set forth fully herein.

220. Defendant Wos is Secretary of the Department of Health and Human Services, which is a public entity under the ADA.

221. Each Plaintiff is a "qualified individual with a disability" within the meaning of the ADA in that they (1) have a physical impairment that substantially limits one or more major life activities; (2) are capable of safely living in their homes with necessary services; and (2) meet the essential requirements for the North Carolina Medicaid program with reasonable modifications to the rules, policies, and practices of the program. 42 U.S.C. § 12131(2).

222. Defendant's denial of coverage of personal care services that Plaintiffs require in order to avoid institutional placements and to remain in the integrated home settings appropriate to their needs constitutes unlawful discrimination in violation of Title II of the ADA, 42 U.S.C. § 12132.

223. Defendants have utilized criteria and methods of administration that subject Plaintiffs to discrimination on the basis of disability, including unnecessary institutionalization, by failing to ensure that Plaintiffs have access to Medicaid-covered personal care services that meet their needs in the community and/or requiring Plaintiffs to live in institutional settings in order to obtain the services they need.

224. Defendant's actions violate Title II of the ADA.

Second Cause of Action: Section 504 of the Rehabilitation Act

225. Plaintiffs incorporate and re-allege paragraphs 1 through 218, as if set forth fully herein.

226. Each Plaintiff is a "qualified person with a disability" within the meaning of Section 504, because they (1) have physical and/or mental impairments that substantially limit one or more major life activities; and (2) meet the essential eligibility requirements for North Carolina Medicaid.

227. Defendant conducts, operates, and/or administers the state Medicaid program, is a recipient of federal funds, and therefore is subject to the requirements of Section 504.

228. Defendant's denial of coverage for the personal care services that Plaintiffs require in order to avoid segregation in institutional placements and to remain in integrated home settings that are appropriate to their needs constitutes unlawful discrimination in violation of Section 504 of the Rehabilitation Act.

229. Defendant has utilized and continues to use policies, practices, and methods of administration that subject Plaintiffs to discrimination on the basis of disability, including unnecessary institution, by failing to ensure that Plaintiffs and class members have access to Medicaid-covered or state-funded personal care services that meet their needs in the community

and/or requiring Plaintiffs to live in institutional settings in order to obtain the services they need.

Third Cause of Action: Medicaid Comparability

230. Plaintiffs incorporate and re-allege paragraphs 1 through 218, as if set forth fully herein.

231. Defendant has instituted rules, policies, and procedures that reduce, suspend, deny, or terminate coverage of personal care services for many Medicaid beneficiaries based solely on the fact that they live in their own homes, while individuals living in Adult Care Homes who have the same or lesser need for personal care services will continue to receive them.

232. Defendant, by creating one set of eligibility procedures and practices for personal care services for individuals living in their homes and another more stringent set of procedures and practices for individuals living in Adult Care Homes, violates the federal Medicaid comparability requirement. 42 U.S.C. § 1396a(a)(10)(B).

Fourth Cause of Action: Medicaid Reasonable Standards

233. Plaintiffs incorporate and re-allege paragraphs 1 through 218, as if set forth fully herein.

234. Defendant covers personal care services for Medicaid recipients living in Adult Care Homes, while denying the same services to other Medicaid recipients with comparable needs, and uses eligibility practices and procedures that does not fairly and reasonably measure need for personal care services.

235. N.C. Medicaid Clinical Coverage Policies 3E and 3L, as implemented by Defendant, are inconsistent with and in conflict with the reasonable standards requirement of the

federal Medicaid Act, 42 U.S.C. § 1396a(a)(17), and interpretive federal guidelines, and are therefore preempted pursuant to the Supremacy Clause of the U.S. Constitution, art. IV.

Fifth Cause of Action: Medicaid Notice and Hearing Requirements

236. Plaintiffs incorporate and re-allege paragraphs 1 through 218, as if fully set forth herein.

237. Defendant has engaged in a practice of failing to provide an adequate explanation of the reasons for its decision in the written notice to the recipient.

238. Defendant's practices and procedures alleged herein violate the Medicaid Act, by failing to provide for granting an opportunity for a fair hearing before the state agency to any individual whose claim for medical assistance is denied or not acted upon with reasonable promptness.

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

Sixth Cause of Action: Constitutional Due Process

240. Plaintiffs incorporate and re-allege paragraphs 1 through 218, as if fully set forth herein.

241. Defendant's practices and procedures alleged herein violate the Due Process clause of the Fourteenth Amendment to the U.S. Constitution by, among other things, denying the Plaintiffs and Plaintiff class a fair and non-arbitrary decision-making process, meaningful notice, meaningful opportunity for a fair hearing; and advance notice and the opportunity for a fair hearing prior to suspension or termination of services previously authorized by the state.

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

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully request that this Court:

1. Amend the definition of the certified class pursuant to Fed. R. Civ. P. 23 as defined in paragraph 16 hereinabove;

2. Issue a declaratory judgment pursuant to 28 U.S.C. § 2201 and Fed. R. Civ. P. 57 that: (a) Defendant's laws, policies and practices governing coverage of personal care services violate the Americans with Disabilities Act and Section 504 of the Rehabilitation Act; (b) Defendant's laws, policies and practices governing coverage of personal care services violate Medicaid's comparability and reasonable standards requirements; and (c) Defendant's failure to provide proper notice and an opportunity for a hearing when denying, eliminating or reducing coverage of personal care services under Medicaid due to the practices and procedures alleged herein violates the named Plaintiffs' and the Plaintiff class's rights under the Due Process Clause of the Fourteenth Amendment and the Social Security Act, 42 U.S.C. § 1396a(a)(3); (b); and (c).

3. Grant a permanent injunction requiring the Defendant, her agents, successors, and employees to:

(a) prospectively reinstate and then continue to provide in-home personal care services to all class members who were receiving them prior to June 1, 2011 or who have been denied or terminated from in-home PCS since June 1, 2011, until Defendant corrects the illegal rules, policies, practices and procedures alleged herein;

(b) comply with the Due Process Clause of the U.S. Constitution, the Americans with Disabilities Act, and the Medicaid Act;

4. Retain jurisdiction over this action to insure Defendant's compliance with the mandates of the Court's Orders;

5. Award to the Plaintiffs costs and reasonable attorney fees pursuant to 42 U.S.C. § 1988; and

6. Order such other relief as this Court deems just and equitable.

Dated: April 26, 2013

ATTORNEYS FOR PLAINTIFF AND PLAINTIFF CLASS

/s/ John R. Rittelmeyer
John R. Rittelmeyer
N.C. State Bar No. 17204
Jennifer L. Bills
N.C. State Bar No. 37467
Elizabeth D. Edwards
N.C. State Bar No. 35262
DISABILITY RIGHTS NC
2626 Glenwood Avenue, Suite 550
Raleigh, NC 27608
Phone: (919) 856-2195
Fax: (919) 856-2244
john.rittelmeyer@disabilityrightsnc.org
jennifer.bills@disabilityrightsnc.org
elizabeth.edwards@disabilityrightsnc.org

/s/ Douglas S. Sea
Douglas Stuart Sea
State Bar No. 9455
LEGAL SERVICES OF SOUTHERN PIEDMONT, INC.
1431 Elizabeth Avenue
Charlotte, North Carolina 28204
Telephone: (704) 376-1600
dougs@lssp.org

/s/ Sarah Somers
Sarah Somers
State Bar No. 33165
Jane Perkins
State Bar No. 9993
NATIONAL HEALTH LAW PROGRAM
101 E. Weaver Street, Ste. G-7
Carrboro, NC 27510
Telephone: (919) 968-6308
somers@healthlaw.org
perkins@healthlaw.org

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of the attached document or pleading was electronically served upon counsel for Defendant through CM/ECF to:

Lisa Corbett
Iain Stauffer
Olga E. Vysotskaya de Brito
N.C. Department of Justice

This the 26th day of April, 2013.

/s/Douglas Stuart Sea
Douglas Stuart Sea