UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NORTH CAROLINA
Raleigh Division
Civ. No. 7:08-CV-57-H

DEVON TYLER MCCARTNEY, a minor child, by his mother Penny McCartney; ERIC CROMARTIE, a minor child, by his mother Selena McMillan; KATIE TIPTON, a minor child, by her father, Greg Tipton, individually and on behalf of all others similarly situated,	)
Plaintiffs,	)
v.	)
Dempsey Benton, Secretary, North Carolina Department of Health and Human Services,	)
Defendant.	)

MEMORANDUM IN SUPPORT OF CLASS CERTIFICATION

The named Plaintiffs allege that the Defendant state official has failed to provide basic due process protections for Medicaid recipients when their requests for behavioral and developmental services are denied, reduced or terminated by the North Carolina Department of Health and Human Services (DHHS) or its agent ValueOptions.

In 2006, DHHS contracted with ValueOptions, Inc. (VO) to be its statewide agent responsible for authorizing coverage of behavioral health services under the Medicaid program. Under this system, DHHS has instructed health care providers to obtain authorization from VO for the services they are prescribing as necessary for their Medicaid-eligible patients. The affected recipients have behavioral health needs, including developmental disabilities. Affected services include the range of services that North Carolina Medicaid recipients with behavioral health problems need, such as community

support services, intensive in-home services, residential treatment, case management services, psychologist's services, and inpatient psychiatric care. Amended Complaint, ¶2 (filed May 19, 2008).

Since July 2006, VO and DHHS have denied, reduced, and terminated coverage of services to thousands of North Carolina Medicaid recipients under illegal practices and procedures. These practices and procedures were either dictated or ratified by DHHS. Amended Complaint, ¶¶ 117-158. Among other things, the Plaintiffs allege that the Defendant fails to provide timely and adequate written notices of decisions to reduce services; written notices do not contain the legally-required information that will allow Plaintiffs to understand the decision or what to do about it; notices are provided after the service has already been cut so that Plaintiffs cannot continue to receive Medicaid services pending appeal as the federal law requires; and in some circumstances, services are denied, reduced, or terminated with no written notice at all. *Id.* The Plaintiffs also contend that when an appeal is filed, the Defendant often fails to provide continued services pending appeal as required by due process, delays for months before making a decision on the appeal, and fails to permit a *de novo* hearing as required by law, which can render the appeal meaningless. *Id.* Plaintiffs intend to prove that:

> Defendant's policies and practices used in reducing and terminating services violate the procedural due process rights of the plaintiffs and plaintiff class that are guaranteed to them by the U.S. Constitution and also violate their rights under the Medicaid Act. By depriving them coverage of essential health services to which they are entitled without due process or statutory authority, defendant leaves many of the most vulnerable children and adults in North Carolina without adequate health care services, even though such services are critical to their health, safety, and development.

Id. at ¶ 4.

Thus, this case is a straight-forward due process case that concerns the legality of the procedures used by DHHS when making Medicaid coverage decisions and in the appeals of such decisions. Plaintiffs are not asking the Court to make decisions about the individual plaintiffs' medical conditions or service needs but to assure that the process that the DHHS uses to make those decisions is fair and legal. This case should be certified as a class action pursuant to Rule 23(a) and (b)(2), Fed. R. Civ. P., and the class should be defined as all current or future North Carolina Medicaid recipients who have, or will have, their claims for behavioral health or developmental disability services denied, delayed, interrupted, terminated, or reduced by the Department of Health and Human Services directly or through its agents or assigns.

ARGUMENT

The party seeking class certification bears the burden of proof. *In re A.H. Robins Company, Inc.*, 880 F.2d 709, 728 (4th Cir. 1989). As the moving party, the Plaintiff must satisfy the four provisions of Rule 23(a) and one of the subdivisions of Rule 23(b). *See*, *e.g.*, *Lukenas v. Bryce's Mountain Resort, Inc.,* 538 F.2d 594, 595 n.2 (4th Cir. 1976). The plaintiffs in this case seek certification under Rule 23(b)(2).

Rule 23 is to be interpreted flexibly and given a liberal construction. *See, e.g., In re A.H. Robins Company, Inc.*, 880 F.2d at 740 (Rule 23 should be given "a liberal rather than a restrictive construction").

A. Rule 23(a)(1) Numerosity

Rule 23(a)(1) requires the class to be so numerous that joinder of all parties is impracticable. "No specified number is needed to maintain a class action." *Brady v. Thurston Motor Lines*, 726 F.2d 136, 145 (4th Cir. 1984). For example, classes of eighteen

and seventy-four persons have been found to satisfy the numerosity requirement. S*ee Id.* (class of seventy-four persons is "well within the range appropriate for class certification"); *Cypress v. Newport News General & Nonsectarian Hospital Ass'n,* 375 F.2d 648, 653 (4th Cir. 1967) (class of eighteen members); *see also Rodger v. Electronic Data Systems*, 160 F.R.D. 532, 535-36 (E.D. N.C. 1995) (certifying class of at least fifty-seven individuals and citing, *In Re Kirschner Medical Corp. Securities Litigation*, 139 F.R.D. 74, 78 (D. Md. 1991), as holding that a class of as few as twenty-five to thirty members raises a presumption that joinder would be impracticable); *Edmonds v. Levine,* 233 F.R.D. 638, 640-41 (S.D. Fla. 2006) (finding numerosity where "Plaintiffs estimated thousands of individuals in the state" affected by Medicaid agency denial of coverage for a prescription drugs).

While it is not possible to establish the exact size of the proposed class, it is clear that the number is quite large. As of June 2007, there were 1,330,486 individuals enrolled in the North Carolina Medicaid program, over 15% of the state population. North Carolina Division of Medical Assistance, *2008 County Snapshot Reports* (excerpt at Ex. A, hereto). VO states that it provides authorization/utilization review for over 1.3 million North Carolina Medicaid recipients. *See* ValueOptions Provider Services Online: North Carolina Medicaid, at http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm (excerpt at Ex. B, hereto).

In state fiscal year 2006-2007, 165,434 individuals obtained mental health services through the N.C. Medicaid program. North Carolina Division of Medical Assistance, *2007 County Snapshot Reports* (excerpt at Ex. C, hereto). Another 22,304 North Carolina residents receive developmental disability services (targeted case management or services through a program called Community Alternatives Program- Mental

Retardation/Developmental Disability (CAP-MR/DD services) through Medicaid. *See* Value Options, *N.C. Medicaid Managed Care Activity Report* (excerpt at Ex. D, hereto). According to VO, the volume of claims reviewed is significant. The company reports receiving 7000 to 9000 faxed requests for coverage per week, with most faxes including multiple recipient requests. ValueOptions Training Slides for Providers (2008) (excerpt at Ex. E, hereto).

Even by the Defendant's count (which does not include verbal, informal denials), the number of persons denied services by Value Options satisfies Rule 23(a)(1). Value Options' own data show that in first quarter of 2008, VO denied, reduced, or terminated mental health or developmental disability services to 9,983 Medicaid recipients. *See* Value Options, *N.C. Medicaid Managed Care Activity Reports* (excerpts at Ex. F, hereto). In the fourth quarter of 2007, Value Options reported that 13,985 denials, terminations, or reductions occurred; while the third quarter of 2007 saw 3,545 denials, terminations or reductions in services. *Id.* Denials, reductions, and terminations for one service alone, Community Support, increased nine-fold in just one three month period—from 4,199 for the first three quarters of 2007 (an average of 1400 per quarter) to 12,778 in the fourth quarter of 2007. *Id.* Denials, reductions and terminations of community-based services under CAP-MR/DD also increased from 285 in the first two quarters of 2007 to 528 in the last six months of 2007. *Id.*

A recent report issued by the North Carolina General Assembly confirms that many individuals are being adversely affected by the Department's policies and practices:

> The outside vendor's [VO's] performance of utilization review has been ineffective and inconsistent in its application, due in part to the absence of uniform review standards.… Recent actions taken by the DHHS to reduce or eliminate services has caused a substantial increase in the volume of appeals, which in turn has caused a very large backlog of appeals pending…[and] case resolution far in excess of the time allowed under federal law….

Report of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (Apr. 2008) (excerpt at Ex.G, hereto).

In addition, impracticality of joinder is not determined by a numerical test alone. *Ballard v. Blue Shield of Southern West Virginia*, 543 F.2d 1075, 1080 (4th Cir. 1976). Relevant considerations include the geographic dispersion of class members, the limited financial resources of class members, and the negative impact on judicial economy if individual suits were required. *See, e.g., Rodger*, 160 F.R.D. at 536 (citation omitted).[1]

The impracticability of joinder in this case is supported by these factors. The Medicaid recipients are geographically dispersed throughout North Carolina. Moreover, the class consists of individuals who qualify for Medicaid and thus have insufficient financial resources to meet their subsistence needs. Therefore, members of the class are almost by definition low-income persons lacking the financial means to pursue individual legal actions. *See Carr v. Wilson-Coker,* 203 F.R.D. 66, 73 (D. Conn. 2001) (finding joinder impractical when "many of the class members … by reason of ignorance, poverty, illness, or lack of counsel, may not … [be] in a position to seek [a hearing] on their behalf" or obtain information concerning their rights) (citing *United States ex rel. Morgan v. Sielaff,* 546 F.2d 218, 222 (7th Cir. 1976)). Certification of this case as a class action will ensure that the

[1] The named plaintiffs also seek to represent future Medicaid recipients, another factor that supports numerosity. *See* 1 Newberg on Class Actions § 3:17 at 265 (4th ed. 2002). *See also, e.g., Weaver v. Reagen,* 701 F. Supp. 717, 721 (W.D. Mo. 1988) (finding numerosity satisfied in a Medicaid case because class included future members); *Bruce v. Christian*, 113 F.R.D. 554, 557 (S.D.N.Y. 1986) (finding impracticality where class included individuals who would be affected in the future, and fluid nature of the class meant identity of individuals would change even as harm and basic parameters of the group affected would remain constant).

Defendant is not subjected to various rulings by differing courts in individual cases, thus enhancing judicial economy.

Finally, where, as here, the only relief sought for the class is injunctive and declaratory in nature, "even speculative and conclusory representations as to the size of the class suffice as to the requirement of many." *Doe v. Charleston Area Med. Ctr., Inc.,* 529 F.2d 638, 645 (4th Cir. 1975). Joinder of all members is impracticable due to the size of the class, their dispersion across the State, and the fluidity of the class composition. The requirements of Rule 23(a)(1) are met.

B. Rule 23(a)(2) Commonality

Rule 23(a)(2), the "commonality" factor, requires that there be "questions of law or fact common to the class." Fed. R. Civ. P. 23(a)(2). The commonality factor has been "liberally construed" and courts have given it a "permissive application so that common questions have been found to exist in a wide range of contexts." *Rodger,* 160 F.R.D. at 537 (citation omitted)*, see also* 1 *Newberg on Class Actions*, section 3.10 (3d ed. 1992) (describing this requirement as "easily met," in cases "when the party opposing the class has engaged in some course of conduct that affects a group of persons and gives rise to a cause of action…."). Only a single common question of law or fact must exist. *See Id.* (citation omitted). Moreover, "[f]actual differences among the class members' cases do not violate the rule, so long as a common legal theory is shared." *Woodward v. Online Information Services,* 191 F.R.D. 502, 505 (E.D. N.C. 2000) (citing *Brown v. Eckerd Drugs, Inc.,* 663 F.2d 1268, 1275 (4th Cir. 1981). The United States Supreme Court has stated:

> Class relief is "particularly appropriate" when the "issues involved are common to the class as a whole" and when they "turn on questions of law applicable in the same manner to each member of the class." [cite omitted] For in such cases, "the class action device saves the resources of both the courts and the parties by permitting an

> issue potentially affecting every [class member] to be litigated in an economical fashion under Rule 23.

General Telephone Co. of Southwest v. Falcon, 457 U.S. 147, 155 (1982) (quoting *Califano v. Yamasaki*, 442 U.S. 682, 700-01 (1979)). Here, the Plaintiffs present several questions of fact and law common to the class members.

All of the putative class members are or will be eligible for Medicaid. They all have or will have mental health problems and/or developmental disabilities. All have or will submit requests to DHHS for Medicaid coverage of behavioral or developmental disability services. The plaintiffs allege that, due to systemic, illegal policies and practices of the Defendant, the named plaintiffs and many others have experienced improper denials, delays, reductions, or terminations of services that have been prescribed by their health care providers. *See, generally*, Amended Complaint. The systemic, repeated pattern of the alleged violations suffered by the named plaintiffs and others is clearly alleged in the amended complaint (at ¶¶ 117-158) and is supported by the attached sworn declarations of behavioral health care providers from different parts of the state who treat hundreds of N.C. Medicaid recipients. *See* Declarations of Mark W. Brown, Gardner Hawkins, Denise Mercado, and Rick Zehr (Exs. H-K, hereto).

The widespread application of the policies and practices challenged by this lawsuit is also supported by Defendant's own documents and statements. For example, the allegation in paragraph 147 of the Amended Complaint that Defendant is not deciding Medicaid appeals in a timely manner as required by federal law is fully supported by the quoted language from the Legislative Oversight Committee at pages 5-6 above. (Ex. G). Defendant's uniform position that *de novo* hearings are not permitted in Medicaid appeals, as alleged in paragraphs 148 and 149 of the Amended Complaint has been defended by the Defendant in

briefs and motions filed in individual cases. *See*, *e.g.,* Woody v. DHHS, Resp. to Mot. In Limine (June 21, 2006)(Ex. L, hereto). The allegations in paragraphs 154-156 that services are terminated without due process when a recipient changes from one Medicaid provider to another are admitted by the Defendant in policy instructions. DHHS Implem. Update 39, p.5 (Feb. 6, 2008) (excerpts at Ex. M hereto). The allegations in paragraphs 126, 132, 133, 136, 138, 139, and 141 of the Amended Complaint, challenging the content of Defendant's notices as in violation of due process (illegal use of checklist of alternative services; failing to mail notice to legal guardians and parents of minors; failing to cite relevant legal authority; using confusing, overly complex language; failing to specify whether there is a right to continued services pending appeal; failing to identify the proper Respondent for filing a formal appeal), are in large part based upon Defendant's uniform forms and instructions. *See, e.g.*, Jan.31, 2008 Email from Tracy Hayes to Doug Sea and attachment (Ex. N, hereto). The allegation in paragraph 144 of the Amended Complaint, that Defendant denies continued services pending appeal if the reauthorization request is even one day late, despite repeatedly telling providers that they have a thirty day grace period, is proven by Defendant's own contradictory policy instructions. *Compare*, *e.g.,* DHHS EPSDT Policy Instruction Update, p.8, ¶m. (Aug. 17, 2007) *with* DHHS Implem. Update 39, p.5 (Feb. 6, 2008) (excerpts at Exs. O and M hereto). It is clear, even from this preliminary and small sample of the evidence plaintiffs will offer at trial, that the practices alleged in the Amended Complaint are systemic.

This common fact pattern gives rise to the following common questions of law:

1. Whether the Defendant's policies and practices violate the Due Process clause of the Fourteenth Amendment to the U.S. Constitution; and

2. Whether the Defendant's policies and practices violate the Medicaid Act, 42 U.S.C. § 1396a(a)(3).

Plaintiffs' prayer for relief, which seeks uniform declaratory and injunctive relief for the named plaintiffs and all class members, evidences the significance of these common questions of law to the resolution of this lawsuit.

The class satisfies the commonality requirement of Rule 23(a)(2). In *Hernandez v. Medows*, 209 F.R.D. 665 (S.D. Fla. 2002), a case similar to this one, the plaintiffs challenged the due process practices being used by the Florida Medicaid agency and its agents. The court certified the case as a class action, finding that common questions of fact included whether the "Defendant has failed to ensure that Plaintiffs receive adequate notice and the opportunity for a fair hearing when their prescription drug coverage is denied, delayed, terminated, or reduced" and whether the "Defendant has failed to ensure Plaintiffs the opportunity to pursue pretermination hearings when their prescription drug coverage is reduced or terminated." *Id.* at 669. The *Hernandez* court also found that common questions of law existed and included whether the "the Defendant has violated the federal Medicaid Act and procedural due process under the Fourteenth Amendment to the United States Constitution by failing to ensure that Plaintiffs receive adequate notice and hearing rights when their prescription drug coverage is denied, delayed, terminated, or reduced" and whether the Defendant "has violated the federal Medicaid Act and procedural due process under the Fourteenth Amendment to the United States Constitution by failing to ensure Plaintiffs the opportunity to pursue pretermination hearings when their prescription drug coverage is reduced or terminated." *Id.; see also, e.g., Carr,* 203 F.R.D. at 73 (finding commonality, noting that "while there is variation in the specifics of their individual circumstances, the plaintiffs do not allege that they have suffered isolated difficulties, but rather, that they face systemic barriers to finding effective and local dental services" through

the state Medicaid program); *Risinger v. Concannon,* 201 F.R.D. 16, 19 (D. Me. 2001) (finding commonality where plaintiffs alleged Defendant's provision of services violated Medicaid EPSDT, reasonable promptness, and adequacy of rates requirements); *Dajour B. v. City of New York and Novello,* No. 00 Civ. 2044 (JGK), 2001 U.S. Dist. LEXIS 15661, *18-19 (S.D. N.Y. 2001) (Ex. J, hereto) (finding commonality where "entire controversy turns on common question of law," whether the defendants are required under the Medicaid Act to provide for screening and treatment services as the plaintiffs allege).

C. Rule 23(a)(3) Typicality

Rule 23(a)(3), the "typicality" factor, says the claims or defenses of the representative parties must be typical of the claims or defenses of the class. Fed. R. Civ. P. 23(a)(3). "Typicality does not mean identicalness." *Woodward,* 191 F.R.D. at 505. Rather, this test requires a relationship between the plaintiff's claims and those of the class.

> A plaintiff's claim is typical if it arises from the same event or practice or course of conduct that gives rise to the claims of other class members, and if his or her claims are based on the same legal theory. When it is alleged that the same unlawful conduct was directed at or affected both the named plaintiff and the class sought to be represented, the typicality requirement is usually met irrespective of varying fact patterns, which underlie individual claims.

1 *Newberg on Class Actions,* section 3.13. (3d ed. 1992) (footnotes omitted); . "In government benefit class actions, the typicality requirement is generally satisfied when the representative plaintiff is subject to the same statute, regulation, or policy as class members." *Carr*, 203 F.R.D. at 75 (quoting *Newberg*); *Rodger*, 160 F.R.D. at 538 (stating that courts "will generally look to the defendant's alleged conduct and the legal theory advanced by the plaintiff to determine whether certification is appropriate.… A court may determine that the typicality requirement is satisfied even when the plaintiffs' claims and the claims of the class members are not identical.") (citation omitted). *See also Hernandez*, 209 F.R.D. at 672

(refusing to find that "multiple reasons for prescription drug denials and disparate factual situations between named Plaintiffs and the class" defeat typicality in plaintiffs' challenge of Florida Medicaid agency's procedures for denying, reducing and terminating coverage).

The typicality requirement is satisfied in this case. The named Plaintiffs' claims arise from the same legal theory as the claims of the class, that the Defendant improperly terminated, reduced or denied Medicaid coverage pursuant to policies and practices in violation of constitutional and federal law. *See* Amended Complaint ¶¶ 159-164 (describing legal claims). The named plaintiffs' factual allegations are also typical and arise from the same systemic practices challenged on behalf of the class. *Compare, e.g*., Amended Complaint, ¶¶ 52-60, 77-88, 110-116 *to* ¶¶ 117-158.

It is clear from reading the Amended Complaint that the experiences and claims of the named plaintiffs and proposed class are closely related to one another. They stem from the same policies and practices of the Defendants and rest on the same legal theories. The alignment of interests is further shown by the fact that the requested declaratory and injunctive relief, if granted, will equally benefit the named plaintiffs and all class members. Variations in the specifics of the Plaintiffs' fact patterns will not defeat typicality. *See, e.g., Edmonds,* 233 F.R.D. 638, 641-42 (S.D. Fla. 2006) (finding that differences in medical condition are irrelevant for typicality where plaintiffs are alleging that the Medicaid agency's practices in denying drug coverage violate federal Medicaid statute); *Boulet v. Cellucci*, 107 F. Supp. 2d 61, 81 (D. Mass. 2000) (finding that plaintiffs claiming they had not received

Medicaid services with "reasonable promptness" had satisfied the typicality requirement despite their "unique medical and support requirements").[2] Rule 23(a)(3) has been met.

D. Rule 23(a)(4) Adequacy of Representation

The final prong of Rule 23(a), the "adequate representation" factor, requires the Court to find that the "representative parties will fairly and adequately protect the interests of the class." Fed. R. Civ. P. 23(a)(4). The Fourth Circuit looks for two separate requirements: named plaintiffs whose interests are not antagonistic to the class and adequate counsel. *See Woodward,* 191 F.R. D. at 506 (citations omitted).

First, the named Plaintiffs do not have interests antagonistic to the class as a whole. The individual plaintiffs have sworn to protect the rights of the absent class members and perform their duties as class representatives to the best of their ability. *See* Declarations of Penny McCartney, Selena McMillan, and Greg Tipton (Exs. P, Q, and R, hereto). Moreover, no conflict exists between the Plaintiffs and the unnamed class members because all of the claims involve a challenge to the same policies course of conduct by the Defendant. Each of the putative class representatives wants all class members to receive the due process to which each of North Carolina's Medicaid-eligible individuals are entitled.

Second, Legal Services of the Southern Piedmont and the National Health Law Program will adequately represent the interests of the class members. Counsel is "qualified, experienced, and able to vigorously conduct the proposed litigation." *See* 1 *Newberg on Class Actions*, Section 3.22 (3d ed. 1992) ("assurance of vigorous prosecution" by counsel is

[2] *See Woodward,* 191 F.R.D. at 506 n.5 (noting with favor the "large number of cases in which class certification was allowed for [federal] claims that are nearly identical to the instant case") (string citation omitted).

a basic guideline for the Rule 23(b)(2) prerequisite). Each of plaintiffs' attorneys is experienced in prosecuting class action litigation on behalf of Medicaid recipients. *See* Declarations of Douglas Sea, Jane Perkins, and Sarah Somers (Exs. S, T, and U, hereto). The requirements of Rule 23(a)(4) are met.

5. Rule 23(b)(2)

The Plaintiffs must also satisfy one subdivision of Rule 23(b). This lawsuit meets the Rule 23(b)(2) requirement that "the party opposing the class has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole…." Fed. R. Civ. P. 23(b)(2). "Rule 23(b)(2) class actions were designed specifically for civil rights cases seeking broad declaratory or injunctive relief for a numerous and often unascertainable or amorphous class of persons…." *Newberg on Class Actions*, section 4.11 (3d ed. 1992) (footnotes omitted).

As discussed previously, Defendant's illegal policies and practices concerning the authorization of Medicaid mental health and developmental disability services are affecting thousands of Medicaid recipients similarly throughout the state and, thus, have equal application to all class members as current or future recipients of Medicaid. Moreover, the Plaintiffs allege that the Defendant has "repeatedly failed," after being informed of problems to "timely and effectively take action" to brings its policies and practices into compliance with the federal requirements on grounds generally applicable to the class. Plaintiffs ask the Court to enter final injunctive and declaratory relief with respect to the class as a whole. Because the Defendant's actions and inactions have affected all the class members in the same or very similar ways, this action should be certified pursuant to Rule 23(b)(2). *See,*

e.g., Gratz v. Bollinger, 539 U.S. 244, 267-68 (2003) (affirming (b)(2) class certification and noting that certification saved resources of both the court and the parties); *Carr,* 203 F.R.D. at 75 (certifying (b)(2) class because child Medicaid plaintiffs sued the commissioner of the single state agency charged with administering dental services and continuance of the commissioner's policies might require injunctive relief).

CONCLUSION

For the reasons stated above, the Plaintiffs respectfully ask this Court to certify this case as a class action pursuant to Fed. R. Civ. P. 23(a) and 23(b)(2).

Dated: June 6, 2008

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