STATE OF INDIANA	)	IN THE MARION SUPERIOR COURT
	) SS:	
COUNTY OF MARION	)	CAUSE NO.

JAMES BOWMAN, as next friend for, JAMEEL BOWMAN and MELISSA GIBSON, as next friend for, COURTNEY ANDERSON, On behalf of themselves and others Similarly situated

Plaintiff,

vs.

INTERNATIONAL BUSINESS MACHINES CORP., ACS HUMAN SERVICES, LLC, PHOENIX DATA CORPORATION and ARBOR E&T, LLC

Defendants.

49D07 11 04 PL 013108

FILED

202 APR 01 2011

Elizabeth A. White
CLERK OF THE MARION CIRCUIT COURT

COMPLAINT FOR DAMAGES—CLASS ACTION

Introductory Statement

1. Plaintiffs are low-income beneficiaries of the Indiana Medicaid program who are dependent on Medicaid coverage for access to health care services. Plaintiffs have been harmed by illegal policies and practices of the Defendants by which they have been illegally cut off from Medicaid coverage, causing them to lose access to care and the value of continuous health coverage to which they are entitled by law. They seek recovery on behalf of themselves and thousands of other Medicaid beneficiaries who have had their benefits cut off by these illegal practices processes.

2. Plaintiffs bring their claims under 42 U.S.C. §1983 for Defendants' violations of their federal statutory rights and the due process clause of the 14th Amendment to the U.S. Constitution.

3. Plaintiffs also state claims in negligence and as third-party beneficiaries of the various contracts between and among the State of Indiana and the Defendant contractors.

Facts Related to IBM, ACS and Defendants

Violations of Federally-protected Rights of Plaintiffs and the Proposed Class

4. The Indiana Medicaid program is administered by the Family and Social Services Administration of the State of Indiana.

5. The Medicaid program exists for the benefit of people like Jameel Bowman and Courtney Anderson to assure that they have health coverage so that they can obtain necessary basic and specialized heath care services, despite their disabilities, low income and lack of other resources. The rules for eligibility and the rights of applicants and recipients are established under federal law and various state laws, rules and policies that implement the federal standards.

6. In December, 2006, Defendant IBM entered into a contract with the State of Indiana, Family and Social Services Administration (FSSA), as part of Indiana's plan to privatize and modernize the public benefits eligibility determination process. Under the terms of this agreement, IBM undertook most of FSSA's responsibilities to work with Medicaid applicants and recipients to properly determine Medicaid eligibility.

7. IBM assumed the role of overall management of the eligibility determination process, but most of the day-to-day responsibilities to work with beneficiaries to determine their eligibility, and even to process their appeals, were delegated to other contractors.

8. ACS Human Services, LLC (ACS) was the primary sub-contractor and Defendants Arbor E&T, LLC and Phoenix Data Corporation and other corporations carried out certain critical functions and continue to do so, even after IBM's role ended, as discussed below. The exact division of responsibilities and contractual arrangements between the various parties at various times are not known to Plaintiffs, but it is clear that the delegated functions included interviews of beneficiaries, explaining program requirements, determining the facts necessary to determine their eligibility, advising beneficiaries of their appeal rights, assisting them to appeal if they disagreed with the decision on their case and maintaining continuity of coverage when a Medicaid beneficiary transitioned from one category of Medicaid coverage to another or appealed a proposed termination of benefits.

9. As part of the privatization and modernization plan, FSSA had transitioned 1,500 state employees, into the employ of the IBM-coalition, primarily to ACS. Most of these former state employees had worked as caseworkers in FSSA's eligibility determination process.

10. In accordance with federal requirements, FSSA retained final authority to approve or disapprove eligibility. However, after March, 2007, FSSA's State Eligibility Consultants or "SEC's" were dependent on the fact-gathering, computer entries and recommendations of IBM Coalition staff to make correct determination whether to start, stop or change Medicaid coverage for a particular individual. Since 2007, state

workers have had little or no contact with individual Medicaid applicants and recipients. Virtually all communications between beneficiaries and the State are mediated through the Contractors.

11. Under the modernization arrangement, the Contractors hold themselves out to the public as the Indiana Family and Social Services Administration.

12. Offices run by the contractors carry the signage and official seal of FSSA.

13. Contractor staff represent themselves as being from FSSA when they answer the phone or call beneficiaries.

14. Contractor communications to Medicaid applicants and recipients carry the official Indiana FSSA seal or letterhead.

15. In interviews during re-determinations of eligibility and conferences with beneficiaries who question the determinations on their cases or appeal, Contractor staff identify themselves as representatives of FSSA.

16. In March, 2009, IBM was put on notice by the State of Indiana that its performance in managing the functions critical to eligibility determinations through its subcontractors was grossly deficient and after an effort to correct the multitude of problems through a Corrective Action Plan, the State terminated its $1.3 Billion contract with IBM. IBM's role was phased out through December 14, 2009, seven years before the expiration of the 10-year contract. FSSA and IBM have sued each other over the termination of that contract.

17. When IBM was terminated, FSSA established direct contracts with ACS, Arbor, Phoenix and other former sub-contractors of IBM to carry out the functions that were previously delegated to them through the IBM sub-contracts.

18. Although there were some modifications to methods of administration, the basic responsibilities of the former sub-contractors remained the same as they had been under FSSA's contract with IBM. The Contractors were to interview beneficiaries, gather documents, process them, enter facts into the computer systems, explain program requirements, explain appeal rights, assist clients who needed special help to assure that eligibility was correctly and properly determined and that appeal rights were honored.

19. Since 2007, each of the Defendants had assumed the State's obligation to follow the federal Medicaid law, state laws and the policies of FSSA and to assure that Medicaid beneficiaries' rights to due process were protected. This included the right to have benefits continue pending appeal for those who appealed proposed terminations of their benefits.

20. When beneficiary's ongoing eligibility was called into question and reduction or termination of benefits was proposed, Defendants' had the specific responsibility to a beneficiary who expressed disagreement to explain the beneficiary's appeal rights, assist the beneficiary to prepare an appeal request and to receive and properly process the appeal request to FSSA's Office of Hearings and Appeals.

21. When a beneficiary makes a timely appeal request from a decision to reduce or terminate Medicaid benefits, it is the Defendants' responsibility to assure that the appeal is recognized, promptly logged and accurately entered into the computer system.

22. Unless this process is completed accurately and timely, the State has no way to know if an appeal request is timely or even that it has been made at all.

23. Defendant ACS has the specific responsibility to review cases that are appealed, conduct pre-hearing conferences, take adjusting action whenever appropriate. ACS staff generally serve as the sole witness and representative of the State at fair hearings.

24. When a beneficiary makes a timely request for an appeal of a proposed termination or reduction of benefits, ACS and other Defendants are responsible to assure that all of the steps are taken to maintain Medicaid coverage for the individual or family unit without interruption until after FSSA's hearings and appeals office can hold a fair hearing, as required by due process, Goldberg v. Kelly 397 U.S. 254 (1970), and federal regulations, 42 C.F.R. §§431.230 and 431.231.

25. Thousands of beneficiaries, like the named plaintiffs, have had their benefits interrupted, cut or terminated despite their timely appeal requests because Defendants have not taken those steps.

26. Defendants also undertook to perform FSSA's duty to assess whether a recipient who no longer qualified under one category of Medicaid might qualify under a different category, before cutting off benefits, as required by 42 U.S.C. §1396a(a)(8), 42 C.F.R. §435.930(b). This procedure had been established in the Agreed Entry and Judgment in Clevidence v.Sullivan , Civ No. 94-836-C-M/S(S.D. Ind.) Judgment and Order Dec. 19, 1995.

27. Defendants have acted in such utter disregard of the rights of beneficiaries that none of these fundamental rights of a beneficiary have been safe. Defendants' workers were untrained in elements essential to protecting beneficiaries' rights.

28. Defendants' document-processing systems have routinely "lost" client documents, including appeal requests.

29. Defendants' workers are neither trained adequately, allocated sufficient time or even required to respond to beneficiaries who are in transition. As a result, workers routinely fail to return calls and act to deny or terminate benefits without adequate factual basis. They send demands for client-supplied information that are so poorly worded and non-specific that the client has little guidance on which to base a response. Workers are then actively encouraged or required to terminate benefits when the beneficiary responds to the best of their ability but not to the worker's unstated intent, without even calling the beneficiary for clarification. They lack the knowledge, time or ability to respond appropriately to rectify problems or even process cases properly.

30. Call centers established by Defendants were designed and operated in a way to block beneficiaries from having access to anyone with knowledge and authority to resolve problems, resulting in erroneous terminations and reductions of benefits.

31. Defendants' call center staff were neither trained nor permitted to investigate problems and errors reported by beneficiaries or to the call the beneficiary back with answers. Yet, beneficiaries lack access to anyone else.

32. Beneficiaries have not been and are not now able to obtain accurate information about the status of their cases and defendants as a matter of policy prohibit clients from having access to the computerized case records that Defendants use to record all facts about their cases, in violation of federal requirements and state rule and policy.

33. The volume of appeals to FSSA's Office of Hearings and Appeals has more than doubled from 2006 levels and appeals became so back-logged that Fair Hearings have been delayed for months beyond the 90-day time limits for hearing decisions established in federal law.

34. As a result of these actions, Plaintiffs and thousands of vulnerable Medicaid recipients similarly situated had and are having their benefits interrupted or terminated altogether, losing the value of access to health care and coverage afforded to them under the law. For these reasons and others to be developed through discovery and trial, Plaintiffs seek damages on behalf of themselves and all others similarly situated.

Facts of Individual Plaintiffs

Courtney Anderson

35. Melissa Gibson brings this action on behalf of her disable daughter, Courtney Anderson.

36. Courtney Anderson is now 20 years old and resides with her mother in Howard County, Indiana.

37. Ms. Anderson suffers from a serious seizure disorder that causes her to have both Grand Mal Seizures and Petit Mal Seizures.

38. Due to Courtney's disabling medical condition, she receives a limited social security income based on her disability.

39. Since shortly after her birth, Courtney Anderson has received Medicaid benefits through the Indiana and Family Services (FSSA), by which she has been able to have

medical treatments, prescription drugs, surgeries and medical devices to help control her seizures.

40. During the 18 years that Courtney's Medicaid eligibility had been administered by FSSA, she received the Medicaid benefit to which she was entitled without significant interruptions.

41. Until June, 2009, Courtney received her Medicaid through the Hoosier Healthwise program which covers children through the their 18th year.

42. Courtney had been declared disabled by the Social Security Administration and this fact and others showing the gravity of her medical problems from birth were contained throughout the case record that Defendants were provided by FSSA.

43. Knowing from experience with her other disabled daughter that the privatized workers were unlikely to identify and develop Courtney's case for Medicaid for the disabled, Melissa Gibson filed a Medicaid disability application on Courtney's behalf at the local FSSA office four months prior to Courtney's 19th birthday.

44. The contractors failed to process the Medicaid disability application properly causing Courtney's application to be denied on May 21, 2009.

45. Melissa Gibson immediately filed her daughter's appeal of the denial with the local FSSA office on May 26, 2009.

46. In the middle of June, the contractors re-determined Courtney's Medicaid eligibility through the Hoosier Healthwise program and without taking into account the pending appeal on Courtney's Medicaid Disability application, processed her case for closure, based on Courtney having "aged-out" of the Hoosier Healthwise program.

47. Melissa Gibson again filed her daughter's appeal of the termination with the local FSSA office on June 18, 2009, Exhibit A.

48. On July 1, 2009, Defendants submitted Courtney's case to the State workers for termination, despite the two pending appeals and the failure to develop the medical evidence of her disability.

49. The contractors thus also failed to take the steps required to maintain Courtney's benefits pending appeal.

50. Melissa Gibson learned of the termination when her attempt to re-fill Courtney's anti-seizure prescriptions was refused at the first of the month. Her health was in immediate jeopardy.

51. For two weeks, Melissa Gibson repeatedly phoned the call center inquiring into Courtney's Medicaid benefits but was unable to have Courtney's Medicaid benefits reinstated.

52. Melissa Gibson contacted one of the undersigned attorneys, Scott Severns of Indianapolis. After consulting with Mr. Severns, Melissa Gibson phoned FSSA's Call Center once again and was able to reach a worker who knew the rules and how to restore benefits.

53. Courtney's Medicaid benefits were finally reinstated on July 15, 2009, pending her appeal hearing.

54. On October 2, 2009, FSSA approved Courtney's Medicaid disability application.

Jameel Bowman

55. James Bowman brings this action on behalf of his minor son, Jameel Bowman.

56. Jameel Bowman is a 15 year old who resides at home with his parents, James and Loletta Bowman.

57. Jameel suffers from respiratory problems due to Asthma which requires medication to help with his breathing. Jameel also suffers from ADHD and requires medication to help him stay focused at school.

58. Jameel has received Medicaid benefits through FSSA, by which he has been able to received medical treatment and obtain his much needed prescription drugs.

59. Jameel relies Medicaid for all of his health coverage.

60. In April 2009, a contractor worker from FSSA's local Marion County office conducted the annual redetermination telephone interview with Loletta Bowman in order to determine the ongoing Medicaid eligibility for James, Jameel and Jameel's sister, Markeshia Walker.

61. After the telephone interview, the contractor worker mailed a request for information form to James Bowman which requested various documents. Exhibit B.

62. James Bowman submitted all documents requested to the Marion County DFR Office.

63. On April 22, 2009, the contractors sent a notice of action addressed to Jameel stating that his Medicaid benefits would be discontinued effective May 31, 2009 due to increase in income and failure to cooperate in verifying income, Exhibit C. The contractors also sent notices of actions to James and Markeshia terminating their benefits as well.

64. James spoke with the contractor worker on May 22, 2009, after several prior failed attempts and was informed for the first time that the worker was dissatisfied with the

documents that he had provided and told him that he needed to submit additional documents.

65. On May 27, 2009, James submitted the requested documents together with an appeal request to FSSA's local Marion County office, requesting an appeal of the notice that Medicaid would be terminated for members of his household.

66. On June 1, 2009, Jameel and his families' Medicaid benefits were terminated despite James hand-delivered appeal request.

67. The contractors failed to reinstate Jameel and his families' Medicaid benefits until December, 2009.

68. Jameel did not have any health coverage for over six months.

69. Jameel's parents have minimal income and could not afford to take Jameel to the doctor or pay for Jameel's medication.

70. Jameel could not obtain his much needed medication for his Asthma and his ADHD without his Medicaid coverage.

71. Without his prescribed medication, Jameel suffered respiratory problems and his focus in school declined as well as his grades.

CLASS ALLEGATIONS

72. Plaintiffs bring this action on behalf of the those who were similarly deprived of their Medicaid coverage the actions of the Defendants pursuant to Rules 23(a) and (b)(3).

73. The first proposed class consists of those beneficiaries who appealed or attempted to appeal terminations or reductions of their benefits within the timely notice period and

whose benefits were interrupted, reduced or terminated as a result of Defendants' actions or inactions.

74. The second proposed class consists of those beneficiaries whose Medicaid was terminated when Defendants' re-determined the facts of class members' eligibility in one category without making a determination of the beneficiaries' eligibility in another category, according to the requirements of 42 U.S.C. §1396a(a)(8), 42 C.F.R. §435.930(b), and the procedure established in Clevidence v. Sullivan, IP 94-836-C-M/S, Judgment and Order dated December 19, 1995.

75. The prerequisites of Rule 23(a) and (b)(3) are satisfied.

76. The size of the each class is so numerous and geographically dispersed throughout the state as to make joinder of all class members impracticable. Upon information and belief, each class consists of hundreds, if not thousands of individuals.

77. There are questions of law and fact common to the class, specifically, whether Defendants failed to train, supervise and require their employees to follow the procedures necessary to assure continued Medicaid benefits for qualified beneficiaries or otherwise to members of the plaintiff classes.

78. The named Plaintiffs claims are typical of the claims of class members.

79. The named Plaintiffs will fairly and adequately protect the interests of the class and subclasses. Plaintiffs have no interests adverse to or in conflict with those of other class members. Plaintiffs' attorneys are experienced in class action litigation under Indiana's Medicaid program.

80. Questions of law or fact common to the members of the class predominate over any questions affecting only individual members, and that a class action is superior to

other available methods for the fair and efficient adjudication of the controversy for class members.

Claims for Relief

81. At all times relevant to this action, Defendants have been acting under color of State law, on behalf of the Indiana Family and Social Services Administration.

82. Defendants violated the Plaintiffs' rights under the Due Process Clause of the Fourteenth Amendment to United States Constitution, 42 U.S.C. §1396a(a)(3) and its implementing regulations by refusing and failing to maintain or reinstate benefits to Medicaid recipients who attempted to appeal notices of terminations and reductions of Medicaid within the timely notice period.

83. Defendants violated the Plaintiffs' rights by terminating plaintiffs' benefits under one category of Medicaid assistance without first determining whether plaintiffs qualify for coverage under a different category as required by 42 U.S.C. §1396a(a)(8), 42 C.F.R. §435.930(b).

84. Defendants, negligently and with willful and with heedless disregard of the consequences, intentionally and carelessly:

    a. Failed to train and supervise their call centers and DFR office staff to properly inform Medicaid beneficiaries about Medicaid eligibility requirements, their appeal rights and their rights to continuing benefits pending an appeal or a determination of eligibility under an different category of Medicaid.

b. Established a document processing center that routinely "lost" documents, including appeal requests, submitted by applicants and recipients.

c. Instituted a "call center" with ill-trained and misinformed or uninformed service representatives who, in turn, provided false or misleading information to applicants whose cases were pending.

d. Failed to hire, train and supervise their sub-contractors and staff in such a way that the documents submitted by Plaintiffs and others like them to the various Service Centers and local offices were acknowledged, preserved and acted upon under the standards of the Medicaid law and FSSA's written policies;

e. Failed to take remedial action to protect recipients the failures of its management and technical systems were identified and when failures of its information management systems caused recipients' documents and appeal requests to be lost;

f. Failed to properly acknowledge, preserve, record and forward recipients' appeal requests to FSSA's division of hearings and appeals;

g. Withheld critical information from FSSA, and other applicants for Medicaid about extensive, system-wide failures that caused beneficiaries' Medicaid to be terminated as a result of inadequate factual development and misapplication of eligibility rules and policies.

2. Defendants also breached duties to Plaintiffs established by the laws of Indiana, including a duty of reasonable care and their duties to Plaintiffs.

3. Plaintiffs are intended beneficiaries of the Medicaid program and by necessary implication and the explicit terms of the Contracts with FSSA, and the Contracts between and among the Defendants, and by Defendants' own representations to the public, Plaintiffs and members of the putative classes are intended beneficiaries of the contractual agreements.
4. The type of harms suffered by the deprivation of Medicaid coverage to Plaintiffs are precisely the types of harms that Defendants undertook to prevent.

Prayer for Relief

WHEREFORE, Plaintiffs respectfully request that this Court:

1. Certify this action as a class action pursuant to Rule 23 of the Rules of Civil Procedure.
2. Direct the Defendants to provide appropriate notices to the class members.
3. Award compensatory damages to the Plaintiffs and all class members who were deprived of benefit of Medicaid coverage as a result of Defendants' violations.
4. Award attorneys' fees to Plaintiffs' counsel, and costs of this action.
5. Award such other relief to plaintiffs as is just and proper under the circumstances.

Respectfully submitted,

/s/ Scott R. Severns
/s/Anna M. Howard

Attorneys for Plaintiffs

Scott R. Severns, #252-49
Anna M. Howard, #28606-49
10293 N. Meridian Street, Suite #150
Indianapolis, Indiana 46290
Telephone: (317) 817-0300
sseverns@severns.com
amh@severn.com

Jury Demand

Plaintiffs hereby submit their request for jury trial on all issues triable by jury.

/s/ Scott R. Severns