IN THE DISTRICT COURT OF LANCASTER COUNTY, NEBRASKA

K.D., a minor child, by and through his mother, and S.L., a minor child, by and through his parents, individually and on behalf of all those similarly situated,

Petitioners,

v.

KERRY WINTERER, AS CHIEF EXECUTIVE OFFICER, AND VIVIANNE CHAUMONT, AS DIRECTOR OF THE DIVISION OF MEDICAID AND LONG-TERM CARE,

Respondents.

Case No. CI12-2009

PETITION AND PRAECIPE
(Class Action)

COME NOW, the Petitioners, by and through their attorneys and allege as follows:

PRELIMINARY STATEMENT

1. The Petitioners, K.D. and S.L., are Medicaid-eligible children whose treating physicians have screened and diagnosed them with serious behavioral and mental health conditions.

2. Their providers have prescribed clinically proven preventative and rehabilitative services to correct or ameliorate their conditions. The Medicaid Act requires that certain services, including behavioral health services, that are necessary to correct or ameliorate a physical or mental health condition, be covered for beneficiaries under the age of 21. 42 U.S.C. §§ 1396-1396w-5.

3. K.D. and S.L. bring this action because the Respondents refuse to provide Medicaid coverage of necessary services. The Respondents' rules, policies, and practices deny behavioral health services for children who, like K.D. and S.L. respectively, have been diagnosed with serious conditions, including developmental disabilities and Pica.

4. The Respondents' rules, policies, and practices also deny coverage of necessary behavioral health services, including Applied Behavioral Analysis. Respondents' policies deprive the Petitioners of their rights to medically necessary services and thus violate federal Medicaid law.

5. The Respondents' rules, policies, and practices also discriminate against Medicaid-eligible children by denying them coverage of medically necessary treatments on the basis of their disability. Respondents' policies thus violate the Americans with Disabilities Act and the Rehabilitation Act of 1973.

6. Petitioners seek declaratory and injunctive relief to enjoin Respondents from continuing to deny Petitioners medically necessary services in violation of federal law.

PARTIES

7. Petitioner, S.L., is a 3-year-old boy who lives with his mother, C.L., and father, B.L., as well as his three siblings, in Sarpy County, Nebraska.

8. Petitioner, K.D., is a 4-year-old boy who lives with his mother, C.S., as well as his two siblings, in Lancaster County, Nebraska.

9. Both K.D. and S.L are minor children and seek to proceed in this case using only their initials rather than their full names in order to afford them the opportunity to pursue this sensitive issue without public scrutiny.

10. Respondent, Kerry Winterer, is Chief Executive Officer of the Nebraska Department of Health and Human Services (the Department), Nebraska's single-state Medicaid Agency, and is responsible for overseeing all Department functions and their operation consistent with state and federal law. He is sued in his official capacity.

11. Respondent, Vivianne Chaumont, is the Director of the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care, and as such is responsible for the day-to-day administration of the Nebraska Medical Assistance Program, consistent with state and federal law. She is sued in her official capacity.

12. The Respondents have offices at 301 Centennial Mall South, Lincoln, Nebraska, and can be reached by mail at P.O. Box 95026, Lincoln, NE 68509-5026.

JURISDICTION AND VENUE

13. Jurisdiction over this action is proper pursuant to Neb. Rev. Stat. § 24-302, which vests Nebraska District Courts with general, original, and appellate jurisdiction in all matters, both civil and criminal.

14. Venue is proper in Lancaster County District Court pursuant to Neb. Rev. Stat. § 25-403.01.

CLASS ACTION ALLEGATIONS

15. Petitioners bring this action individually, and on behalf of all others similarly situated, pursuant to Neb. Rev. Stat. § 25-319.

16. Petitioners' class consists of all Medicaid-eligible children under the age of 19 that, since May 1, 2009, have been or will be denied Medicaid coverage as a result of: a) the Respondents' exclusion of "Behavior Modification Management" or Applied Behavior Analysis treatments from coverage, and b) the Respondents' application of 471 NAC 32-001, which excludes children with developmental disabilities from coverage of behavioral health services for a development disability.

17. Petitioners class is so numerous that it is impracticable to bring them all before the Court.

18. This case presents facts common to all members of the class. The common facts include that all members have had or will have behavioral health treatments recommended by their treating provider denied because Respondents deem the services not to be medical assistance, and because invalid regulations have been or will be applied to them.

19. The claims set forth in this Petition apply to all members of the class and do not vary with the individualized factual circumstances of the members of the class.

20. The common questions of law include: 1) Respondents broadly deny treatments recommended by a provider, and mandated by Medicaid, in conflict with the

Medicaid Act, and 2) Respondents enforce regulations regarding developmental disabilities that conflict with the Medicaid Act, the Americans with Disabilities Act, and the Rehabilitation Act.

21. The claims of the Petitioners are typical of the claims of the members of the class.

22. The Petitioners will fairly and adequately protect the interests of the class and present no issues adverse to the interests of the class.

23. Petitioner's counsel, Nebraska Appleseed Center for Law in the Public Interest, possesses the resources and skills necessary to represent this action on behalf of all members of this class.

24. Petitioner's counsel seeking to appear *pro hac vice*, the National Health Law Program, possesses the resources and skills necessary to represent this action on behalf of all members of this class.

STATUTORY AND REGULATORY FRAMEWORK

Medicaid

25. Medicaid is a jointly funded state and federal program that provides medical coverage to certain categories of low-income persons pursuant to Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 to 1396w-5.

26. State participation in the Medicaid program is optional. However, when a state chooses to participate, and thereby receives federal matching funds for its Medicaid program, the state must designate a single state Medicaid agency and comply with the requirements of the federal Medicaid Act and the rules and regulations governing state Medicaid programs promulgated by the U.S.

Department of Health and Human Services. 42 U.S.C. § 1396a(a)(5); *Kai v. Ross*, 336 F.3d 650, 651 (8th Cir. 2003).

27. Nebraska has chosen to participate in the Medicaid program and accepts federal matching funds for its program expenditures. The Medical Assistance Act establishes Nebraska's Medical Assistance Program. Neb. Rev. Stat. § 68-903.

28. In 2011, Nebraska received approximately 58.44 percent of federal matching funds for its Medicaid program expenditures.

29. The Nebraska Department of Health and Human Services has been designated as the single-state agency for administering the Nebraska Medicaid program.

30. Under the Medicaid program, Nebraska is required to cover certain groups of people and has the option of covering others.

31. States that participate in Medicaid must provide coverage to "categorically needy" individuals, and must provide several specific kinds of medical care or services. 42 U.S.C. § 1396a(a)(10)(A); 42 U.S.C. § 1396d(a).

32. The categorically needy include children under age six whose family incomes are at or below 133 percent of the federal poverty level (about $2,500 for a family of four) and children under age 19 whose family incomes are at or below 100 percent of the federal poverty level (about $1,900 for a family of four).

33. States may at their option, expand care and services to additional groups or populations over and above what is mandated. *Id.*

34. As a condition of participating in the federal Medicaid program, Nebraska must submit a Medicaid state plan to the U.S. Department of Health and Human Services that fulfills the requirements of the Medicaid Act. 42 U.S.C. § 1396a.

Medicaid, Reasonable Standards, and Discrimination

35. Under the Medicaid Act, "[a] State plan for medical assistance must…include reasonable standards…for determining eligibility for and the extent of medical assistance under the plan…which are consistent with the objectives of this [Title]." 42 U.S.C. § 1396a(a)(17)("Reasonable Standards Provision").

36. Federal regulations provide that "the [State] Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service…to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition." 42 C.F.R. § 440.230(c).

The Early and Periodic Screening Diagnosis and Treatment Program

37. Early and Period Screening Diagnosis and Treatment (EPSDT) is a mandatory service for Medicaid-eligible children and youth under age 21. 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).

38. EPSDT requires participating states to provide or arrange for the provision of screening services in all cases where they are requested. 42 U.S.C. § 1396a(a)(43)(B).

39. If a health condition is detected, EPSDT requires the state to arrange "[f]or (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services." 42 U.S.C. § 1396a(a)(43)(C).

40. The Medicaid Act requires states to cover all "necessary health care, diagnostic services, treatment, and other measures described in subsection (a) [1396d(a)] of this section to correct or ameliorate defects and physical and mental illnesses and

conditions discovered by the screening process, whether or not such services are covered under the State plan." 42 U.S.C. § 1396d(r)(5).

41. Title 42 U.S.C. § 1396d(a) lists all the categories of medical assistance that must be covered under EPSDT.

42. Under one category, states must provide "other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level." 42 U.S.C. § 1396d(a)(13).

43. Included among those services that can be covered under the category at § 1396d(a)(13) are behavioral health services, such as Applied Behavior Analysis (ABA) techniques.

44. States must also provide "medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law." 42 U.S.C. § 1396d(a)(6).

45. Included among those services that can be covered under the category described at 1396d(a)(6) are services provided by psychologists and other licensed mental health providers who offer remedial care to persons with autism or other disorders.

The Americans with Disabilities Act and the Rehabilitation Act

46. The Americans with Disabilities Act (ADA) is a remedial civil rights law that addresses discrimination against people with disabilities in many areas of public life. 42 U.S.C. § 12101 *et seq.*

47. Title II of the ADA states, "Subject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such 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 any such entity." 42 U.S.C. § 12132.

48. Additionally, the Rehabilitation Act of 1973 prohibits discrimination against people with disabilities on the basis of disability in programs and services that receive federal financial assistance. 29 U.S.C. § 794.

49. According to Section 504 of the Rehabilitation Act, "No otherwise qualified individual with a disability in the United States… shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance…" 29 U.S.C. § 794(a).

The Nebraska Medical Assistance Program

50. The Medical Assistance Act is intended to provide medical assistance to low-income Nebraskans, with an emphasis on prevention and early intervention. Neb. Rev. Stat. § 68-905.

51. Nebraska's EPSDT program is known as "HEALTH CHECK."

52. Title 471, Chapter 32 of the Nebraska Administrative Code implements EPSDT as it applies to behavioral and mental health services.

53. Chapter 32 makes certain services available for children under EPSDT, including Outpatient Mental Health or Substance Abuse Treatment. 471 NAC 32-001 *et seq.*

54. The Chapter 32 regulations entirely exclude coverage of treatments or services for developmental disorders, developmental disabilities, and mental retardation. 471 NAC 32-001; 471 NAC 32-001.02.

55. In addition, the Respondents have created and currently apply "draft" Chapter 32 regulations that have not been formally promulgated pursuant to the Nebraska Administrative Procedure Act.

56. The draft Chapter 32 regulations make certain types of services available for children under EPSDT, including Outpatient Services. DRAFT 471 NAC 32-001 *et seq.*

57. The draft Chapter 32 regulations entirely exclude Medicaid coverage of Applied Behavior Analysis (ABA). DRAFT 471 NAC 32-002.02.

58. Nebraska law recognizes ABA and its use under a Medicaid waiver service--the Home and Community-Based Waiver Services for Children with Autism Spectrum Disorder. 480 NAC 11-005.01.

59. However, the Home and Community-Based Waiver Services for Children with Autism Spectrum Disorder has never been implemented and no child receives services under it.

60. The draft Chapter 32 regulations further limit Medicaid coverage for treatments, by indicating "Developmental disabilities, mental retardation, or V code diagnosis are considered for psychotherapy services when these conditions are not the

primary diagnosis causing the symptoms and when the client's dysfunctions and problems can be relieved by providing psychotherapy services identified in this chapter." DRAFT 471 NAC 32-001.01A.

61. Thus, under the draft Chapter 32 regulations, a child cannot obtain Outpatient Health Services if the child's primary symptoms are due to a developmental disorder or a pervasive developmental disorder. DRAFT 471 NAC 32-002.02.

62. The draft Chapter 32 regulations also entirely exclude Medicaid coverage of certain types of treatment, including "Behavior Modification Management and Planning." DRAFT 471 NAC 32-002.02.

63. The Department contracts with Magellan Health Services (Magellan) to provide utilization management of mental health and substance abuse treatment for Medicaid-eligible children.

64. Magellan applies the policies and regulations of the Department.

65. Magellan has also developed and applies Clinical Guidelines to determine medical or clinical necessity for EPSDT services.

FACTUAL ALLEGATIONS

Applied Behavior Analysis

66. Applied Behavior Analysis (ABA) is a science that involves the use of clinically proven techniques to change behaviors.

67. ABA techniques that an ABA provider may utilize include systematic control of a child's environment, goal-based motivation, statistical trials for tracking a child's progress, and reinforcement of successful behaviors.

68. Early, intensive behavioral interventions using ABA methods typically involve the use of one-on-one techniques.

69. Early, intensive behavioral interventions using ABA methods can get some children as close to typical developmental functioning as possible.

70. ABA methods are highly effective in correcting or ameliorating symptoms related to certain developmental disabilities, Pica, and other disorders.

71. Children can benefit from receiving ABA methods. Benefits may include increased IQ levels, reduction in developmental disabilities, increased communication skills, and decreased behavioral outbursts.

72. The use of ABA techniques can result in the maximum reduction of physical and mental disabilities and restoration to the best possible functional level.

73. The use of ABA techniques can also be preventative in nature.

74. ABA techniques are recognized under a Medicaid waiver service--the Home and Community-Based Waiver Services for Children with Autism when furnished by licensed practitioners within the scope of their practice. 480 NAC 11-005.01. However, this waiver services has never been implemented and no child receives services under it.

Failure to Provide Treatments Mandated by EPSDT

75. Under EPSDT, Nebraska must cover every type of service that is allowable under 1396d(a) if it is necessary to correct or ameliorate the child's physical or mental health condition. 42 U.S.C. §§ 1396a(a)(10)(A); 1396a(a)(43); 1396d(a)(4)(B); 1396d(r)(5).

76. Services under 42 U.S.C. § 1396d(a) include "other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services...recommended by a physician or other licensed practitioner...for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level." 42 U.S.C. § 1396d(a)(13).

77. ABA techniques and interventions are medical assistance under 42 U.S.C. § 1396d(a)(13) and must, therefore, be provided when necessary to correct or ameliorate a child's mental conditions.

78. Moreover, states must also provide "medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law." 42 U.S.C. § 1396d(a)(6).

79. ABA techniques are recognized under the Medicaid waiver, Home and Community-Based Waiver Services for Children with Autism. 480 NAC 11-005.01.

80. The Respondents, however, have a rule, practice and policy of denying "Behavior Modification Management" in general, and ABA specifically, to Medicaid-eligible children, regardless of whether the treating provider has determined that the treatment is necessary to correct or ameliorate the child's condition.

81. The Respondents have promulgated and utilize medical necessity regulations that exclude services for children with diagnoses of developmental disabilities and disorders, regardless of whether the service is necessary to correct or ameliorate the child's condition. 471 NAC 32-001; 471 NAC 32-001.02.

82. Similarly, the draft Chapter 32 regulations exclude services where children's primary symptoms are due to a developmental disorder. DRAFT 471 NAC 32-001 *et seq.*

83. As a result of Respondents failure to follow EPSDT's requirements, Medicaid-eligible children do not receive necessary treatments that could correct or ameliorate their conditions.

Unreasonable Policy Regarding Services for Children with Developmental Disabilities or Disorders

84. According to 471 NAC 32, Medicaid will not cover services for diagnoses relating to developmental disabilities. 471 NAC 32-001; 471 NAC 32-001.02.

85. Title 471 NAC 32-001 and 471 NAC 32-001.02 therefore deny coverage of treatment for developmental disorders in children, without consideration of whether the services would correct or ameliorate a child's condition.

86. Similarly, the draft Chapter 32 regulations exclude coverage of treatment for children where a child's primary symptoms are due to a developmental disorder. DRAFT 471 NAC 32-001 *et seq.*

87. Title 471 NAC 32-001, 471 NAC 32-001.02, and DRAFT 471 NAC 32-001 establish an irrebuttable presumption that treatment or services for diagnoses of development disabilities are never medically necessary.

88. Consequently, services to treat developmental disabilities and disorders are deemed to not be medically necessary, and treatment requests will result in a denial, without consideration of whether the treatment would correct or ameliorate the condition.

89. Yet, services allowed under 42 U.S.C. § 1396d(a), such as ABA interventions, can correct or ameliorate children's conditions, including developmental disabilities and disorders, and are usually the most effective form of treatment.

Discrimination on the Basis of Diagnosis or Condition

90. According to 471 NAC 32, Medicaid will not cover services for diagnoses relating to developmental disabilities. 471 NAC 32-001; 471 NAC 32-001.02.

91. Title 471 NAC 32-001 and 471 NAC 32-001.02 therefore discriminate solely on the basis of diagnosis, type of illness, or condition.

92. Similarly, the draft Chapter 32 regulations exclude coverage of treatment for children where a child's primary symptoms are due to a developmental disorder. DRAFT 471 NAC 32-001 *et seq.*

93. Yet, the need for treatment of developmental disabilities in children is at least as great as the need for treatment of other mental or behavioral disorders children may have.

Discrimination Against Medicaid-Eligible Children with Disabilities

94. According to 471 NAC 32, Medicaid will not cover services for Medicaid-eligible children for diagnoses relating to developmental disabilities. 471 NAC 32-001; 471 NAC 32-001.02.

95. Title 471 NAC 32-001 and 471 NAC 32-001.02 therefore deny coverage of services to Medicaid-eligible children based on their disability, even when such services are deemed to be medically necessary by a treating provider.

96. Similarly, the draft Chapter 32 regulations exclude coverage of treatment for children where a child's primary symptoms are due to a developmental disorder. DRAFT 471 NAC 32-001 *et seq.*

97. Consequently, Medicaid-eligible children under the age of nineteen with developmental disabilities cannot receive coverage for medically necessary treatments by reason of their disability.

Named Petitioner S.L.

98. The Petitioner, S.L., is a three year-old boy, with serious behavioral and mental health issues.

99. In 2008, S.L. was born with cocaine in his system.

100. S.L. was placed in foster care with C.L. and B.L.'s family when S.L. was about one week old. When the family brought S.L. home from the hospital, he weighed approximately four pounds.

101. In the fall of 2008, a petition to terminate S.L.'s biological mother's parental rights was filed and her parental rights were subsequently terminated. S.L.'s biological father's parental rights were terminated the following year.

102. C.L. and B.L. later adopted S.L.

103. C.L. and B.L. also adopted S.L.'s biological sister.

104. As an adopted child with numerous health needs, S.L. is eligible for and receives Medicaid coverage.

105. C.L. and B.L. are the primary support for S.L., as well as their other three children. C.L. is unable to work full-time due to having multiple sclerosis.

106. When S.L. was around two years of age, he began to exhibit fits of rage, including extreme tantrums, slamming his head into walls, tables, and floors, and slapping and biting himself and biting other children.

107. S.L. also experienced developmental delays at age two, including expressive speech delays and articulation difficulties.

108. S.L. also began to elope, or run away from his parents and caretakers. On some occasions, S.L. ran at moving cars.

109. Later, S.L. stopped sleeping at night and would run from one end of a room to the other slamming his body into the walls and screaming.

110. S.L. also started eating curtains, bedding, and walls. On one occasion, S.L. pulled off electric outlet covers and stuck his tongue in the outlets.

111. On another occasion, S.L. complained of stomach pain, was taken to the hospital, and an x-ray revealed S.L. had eaten a loofah sponge.

112. These behaviors continue to the present day, and new behaviors have also emerged.

113. Due to the symptoms S.L. was exhibiting, in May of 2010, S.L.'s primary care physician, Dr. Tina Scott-Mordhorst, referred S.L. to the Monroe Meyer Institute at the University of Nebraska Medical Center (UNMC) in Omaha, Nebraska.

114. The Monroe Meyer Institute (MMI) specializes in providing services and support for persons with genetic disorders and developmental disabilities.

115. At MMI, S.L. was seen by Dr. Judith Matthews, Ph.D. C.L. reported to Dr. Matthews that S.L. bangs his head against objects, has frequent temper tantrums, and lacks physical coordination.

116. On July 21, 2010, S.L. was evaluated at the Fetal Alcohol Syndrome Diagnostic Clinic at MMI by a Certified Genetic Counselor, Elizabeth Conover, M.S., A.P.R.N., for prenatal exposure to alcohol and drugs.

117. At this evaluation, genetic testing for S.L. was recommended, as well as a comprehensive educational evaluation, which included speech, language, hearing, and cognitive components. Ongoing counseling with MMI was also recommended due to significant behavior issues.

118. After this meeting, a referral was made for a developmental evaluation of S.L. through Omaha Public Schools (OPS).

119. On September 14, 2010, OPS concluded that S.L. did not qualify for early services because, at that time, OPS determined S.L. did not have a valid disability.

120. On September 17, 2010, a genetic analysis was conducted on S.L. by Dr. Richard Lutz, M.D., an Associate Professor of Pediatrics at the UNMC and Clinical Geneticist and Pediatric Endocrinologist at MMI.

121. Dr. Lutz' analysis showed duplication in the chromosome regions. According to the report, chromosomal duplication commonly results in difficulties with mood, impulse control, cardiovascular problems, and an increased risk of mental health problems.

122. On April 25, 2011, Dr. Lutz reported that S.L. was at risk for developmental and behavioral problems and recommended behavioral psychology as a treatment intervention.

123. On May 4, 2011, S.L. was referred by S.L.'s pediatrician, Dr. Scott-Mordhorst to Dr. Jennifer Kazmerski, Ph.D., a licensed psychologist with MMI, for a diagnostic screening.

124. Dr. Kazmerski indicated in her diagnostic assessment of S.L. that he presents with significant disruptive, dangerous, self-injurious and noncompliant behaviors in the home and daycare settings.

125. Dr. Kazmerski diagnosed S.L. with Disruptive Behavior Disorder Not Otherwise Specified, which is characterized by a pattern of serious and troublesome behavior.

126. Dr. Kazmerski recommended behavioral intervention strategies to increase appropriate behaviors and to decrease or eliminate problem behaviors and reduce noncompliance.

127. Dr. Kazmerski sought authorization from Magellan to treat S.L.

128. On May 18, 2011, Magellan denied treatment authorization for outpatient treatment. The reason for the denial was that "this therapy appears to be for behavioral management and focused on parent-child interaction. This type of therapy is not covered in your benefit plan."

129. On May 31, 2011, Magellan's treatment denial was affirmed within Magellan's organization.

130. On June 6, 2011, OPS indicated they wanted to conduct a multi-disciplinary evaluation of S.L. in order to see if S.L. would be eligible for early services. This included evaluation of S.L.'s speech, development, and cognition.

131. On June 8, 2011, Dr. Jennifer Brock, a Speech Pathologist at UNMC, saw S.L. for a speech and language screening. S.L. was almost three years old at this time.

132. According to Dr. Brock, S.L. displayed problems with instructions and used two to six word utterances to communicate. On June 29, 2011, Dr. Brock gave C.L. details about her evaluation of S.L., including a diagnosis of receptive language impairment and language delay.

133. Dr. Brock referred S.L. to the Center for Autism Spectrum Disorders Severe Behavior Program at MMI.

134. On June 22, 2011, C.L. requested that S.L. be evaluated for special education services through OPS because of S.L.'s difficulty with speech and behavior.

135. On July 11, 2011, an Individualized Education Program (IEP) was created for S.L. The IEP indicated that S.L. may need occupational therapy to adapt to a classroom environment, and may need additional verbal and visual cues to transition from one activity to another in a classroom.

136. S.L.'s IEP did not include a behavioral intervention plan.

137. Leading up to the summer of 2011, S.L. attended five different day care centers. However, S.L. was removed from each of these day care centers because he had to be restrained for long periods due to his severe behaviors, and was a danger to himself and others, including biting teachers and students, throwing objects at teachers, and self-injury. S.L. also destroyed property, including walking on bookshelves and knocking objects off of walls.

138. During the summer of 2011, S.L.'s behavior continued to deteriorate, including engaging in behaviors such as licking open electric sockets and eating inedible objects.

139. S.L. attended an early start program at OPS from approximately August 18 to August 31, 2011. C.L. removed S.L. from the early start program because S.L.'s IEP did not include a behavioral intervention component and because C.L was concerned some of S.L.'s behaviors were not being sufficiently monitored, including eating non-food objects.

140. C.L. attempted to have a behavioral intervention component added to the early start program but no change was made to S.L's IEP.

141. According to C.L., OPS agreed that Behaven Kids (Behaven) would be a more appropriate setting for S.L. and that he should attend Behaven for a least a year before attending school.

142. S.L. started day care at Behaven in September of 2011.

143. Behaven is a specialized day care that provides a range of behavioral health services. At this time, Behaven managed S.L.'s behaviors in the day care setting, but did not provide individual treatment.

Denial of Treatment for S.L. with Dr. Kelley

144. On September 14, 2011, Dr. Michael Kelley, Ph.D., Director of MMI's Severe Behavior Disorders Program, performed a diagnostic evaluation of S.L. after Dr. Brock referred S.L. to Dr. Kelley.

145. Dr. Kelley reported in his evaluation that S.L.'s major behavioral concerns include Pica (a disorder characterized by the persistent eating of non-nutritious

substances), self-injurious behavior, physical aggression towards others, property destruction, noncompliance, and elopement.

146. C.L. reported to Dr. Kelley that S.L. engages in Pica multiple times per day and has consumed dangerous items, such as dry wall, pillow stuffing, strings, shower loofahs, wood chips, and garbage. C.L. reported that due to the severity of Pica, S.L.'s parents removed everything from his bedroom except S.L.'s bed, which is a specialized bed with a tent that is secured to the floor.

147. C.L. also reported to Dr. Kelley that S.L. self-injures multiple times per day, including hitting himself in the head and banging his head on hard surfaces such as walls, windows, and concrete.

148. Dr. Kelley reported in his evaluation that C.L. and her family reportedly have tried many strategies to manage S.L.'s destructive and aggressive behaviors, including verbal reprimands, restraint, and time-out, but none of the strategies were effective.

149. Dr. Kelley diagnosed S.L. with Pica.

150. Dr. Kelley also diagnosed S.L. with Stereotypic Movement Disorder, which is a condition characterized by persistent repetitive movements, such as head banging or biting, that interfere with normal activity and may cause bodily harm.

151. Dr. Kelley reported in his evaluation that S.L. is an appropriate candidate for the MMI Severe Behavior Disorders Program for the assessment and treatment of his behavior problems.

152. Dr. Kelley also recommended outpatient services at MMI, where S.L. would receive treatment for three hours per day, five days per week, for 8-12 weeks in order to decrease aggression and concerning behaviors.

153. The focus of this treatment would be to decrease S.L.'s aggression, self-injury, Pica, and elopement.

154. Dr. Kelley strongly recommended that S.L. begin getting treatment immediately.

155. In early 2012, Dr. Kelley requested authorization from Magellan for outpatient services for S.L.

156. On January 20, 2012, Magellan denied the outpatient service authorization, stating, "[i]t appears your symptoms are related to a diagnosis that is not covered in your plan [sic] It appears the focus of treatment is behavioral management which is not a covered mental health benefit."

157. Instead, in a written denial, Magellan recommended five customer assistance program (CAP) sessions as an alternative to treatment at MMI.

158. CAP sessions are short-term interventions that may not exceed five services per client per year and are aimed at assisting the individual and/or family with stressors interfering with daily living and general well-being. These sessions are intended to provide assistance to individuals and families for whom long-term intervention does not appear to be needed.

159. On January 24, 2012, C.L. informed Omaha Public Schools that S.L. would not be attending pre-school because S.L.'s IEP did not have a behavioral component and because Omaha Public Schools agreed Behaven is a more appropriate setting for S.L.

160. A few months earlier Behaven evaluated S.L.'s need for treatment.

161. In a pre-treatment assessment of S.L., dated December 27, 2011, Kelly Beecham, Provisionally Licensed Mental Health Practitioner (PLMHP), indicated that S.L. struggles with compliance, anger control, Pica, and self-injurious behaviors. In the assessment, she describes S.L. throwing tantrums, slapping and biting himself, hitting walls, and being physically aggressive.

162. Beecham recommended that S.L. participate in intensive outpatient therapy, including group therapy, psycho-education, individual therapy, and family therapy.

163. On December 28, 2011, Dr. Blake Lancaster, Ph.D., a Licensed Psychologist and Supervising Practitioner at Behaven, performed a mental status examination with S.L.

164. In the mental status exam, Dr. Lancaster discussed S.L.'s problem behaviors and made recommendations for treatment.

165. Dr. Lancaster indicated his diagnostic impressions included diagnoses for S.L. consisting of Disruptive Behavior Disorder Not Otherwise Specified, Pica, and Stereotypic Movement Disorder.

166. Dr. Lancaster indicated that S.L. appeared to be at risk for developing further behavior problems in the home, school, and community.

167. Dr. Lancaster recommended intensive outpatient therapy at Behaven, including individual psychotherapy, family psychotherapy, group psychotherapy, and group psycho-educational therapy.

168. Dr. Lancaster certified that treatment was medically necessary at this level of care.

169. In February of 2012, Behaven sought authorization for intensive outpatient services for S.L.

170. However, on February 29, 2012, Magellan denied intensive outpatient services requested by Behaven Kids.

171. Magellan denied treatment and indicated the basis for denial was, "Under Medicaid Mental Health guidelines the type of therapy considered is not covered."

172. Instead, Magellan recommended five customer assistance program (CAP) sessions.

173. On March 23, 2012, Dr. Kelley re-evaluated S.L. at MMI in order to discuss present behavioral concerns. The chief complaints continued to be tantrums, property destruction, Pica, self-injurious behaviors, and elopement.

174. Dr. Kelley indicated that C.L. reported it is difficult to keep S.L. focused and that he often elopes.

175. C.L. also reported continued aggression, self-injury, and destruction.

176. Dr. Kelley indicated in his evaluation that S.L. frequently engages in dangerous behaviors that pose considerable risk for his safety.

177. C.L. reported that S.L. continues to engage in Pica multiple times per day, eating objects such as paper, plastic, toys, cardboard, sticks, wrappers, and garbage.

178. C.L. reported that S.L. continues to engage in self-injurious behavior multiple times per day, including head banging on hard surfaces, biting himself, slapping his legs, and picking his skin and eating the scabs.

179. C.L. also reported that S.L. continues to engage in aggression towards his siblings and adults. He also continues to have disruptive behavior and elopement.

180. In addition, C.L. reported S.L. has started to exhibit new unusual behaviors.

181. The unusual behaviors included dropping to the ground while kicking and screaming "It's too loud," even in the absence of loud sounds, going into trance-like states, grabbing imaginary items out of the air and pretending to eat them, and talking to imaginary figures.

182. C.L. also reported that the family has unsuccessfully tried many strategies to manage S.L.'s problematic behavior.

183. Dr. Kelley concluded that, "In general, S.L.'s behavior remains a significant concern. He has not shown any improvement since the last evaluation."

184. Dr. Kelley continued to recommend outpatient services, where S.L. would receive treatment for three hours per day, five days per week, for 8-12 weeks in order to decrease aggression and concerning behaviors.

185. S.L.'s behaviors continue to deteriorate. Recently S.L. has started to urinate in his bed then roll in the urine, as well as defecate in his pants.

186. To date, S.L. is not receiving any treatments that have been recommended and requested by Dr. Kelley or any other provider.

Named Petitioner K.D.

187. The Petitioner, K.D., is a four year-old boy, with serious behavioral and mental health issues.

188. K.D. receives medical assistance coverage through Medicaid.

189. In 2007, K.D. was born six weeks premature. K.D. was born weighing five pounds, three ounces; his twin brother, E.D. was born at five pounds, five ounces. Both K.D. and E.D. were placed on oxygen for the first two days of life and spent three weeks in the Neonatal Intensive Care Unit.

190. K.D. appeared to develop normally up until about the age of six months.

191. After six months of age, K.D. started to display developmental delays. He was unable to hold his head up at nine months of age and was unable to crawl until his first birthday.

192. A CT scan was performed when K.D. was approximately nine months of age. The scan showed bilateral hematomas and K.D. was diagnosed with Shaken Baby Syndrome.

193. K.D. continued to exhibit delayed development. For instance, K.D. was not toilet trained and did not begin speaking in full sentences until he was nearly four years of age.

194. K.D. later began to display a number of behavioral problems, including screaming, twirling, tantrums, pinching, biting and pulling others' hair, and banging his head on objects.

195. K.D. also covers his ears and complains of noise when there are no loud sounds.

196. K.D. also self-isolates and plays alone most of the time. He usually must be prompted to speak with other children.

197. In August of 2010 K.D. began an Individualized Education Program (IEP) and started in a Head Start program.

198. In September of 2010 K.D. was seen by Dr. Heather Dews, M.D., for a Well Child Check. Dr. Dews reported that K.D. displayed behaviors consistent with Pervasive Developmental Disorder (PDD), including isolating himself from peers, limited verbal communication, and not playing with toys appropriately.

199. PDD includes a group of conditions that is characterized by developmental delays in many areas, including communication and socialization.

200. In March 2011, Dr. Dews again visited with K.D. and reported K.D.'s developmental delays were consistent with PDD.

201. During April of 2011 K.D. continued to attend a Head Start program.

Denial of Treatment for K.D. with Dr. Wilson

202. In September of 2011 K.D. attended a "Well Child Check" with Dr. Dews, and she reported that K.D. had sensory issues and possibly Autism.

203. Dr. Dews referred K.D. to Dr. Caryll Palmer Wilson in November of 2011.

204. In November, 2011, K.D. was evaluated by Dr. Caryll Palmer Wilson, Ph.D., a private practice psychologist in Lincoln, Nebraska, in order to rule out behavioral or developmental disorders.

205. Dr. Wilson indicated her diagnostic impressions were: Disruptive Behavior Disorder, other developmental delays, Autistic Disorder, Attention Deficit Hyperactivity Disorder (ADHD), Shaken Infant Syndrome (bilateral subdural hematomas), Reactive Airway Disease, communication and motor problems, noncompliance and anxiety.

206. Later, in December 2011, K.D. was evaluated by Dr. Howard Needelman, M.D., as part of a developmental pediatrics consultation at the Munroe-Myer Institute.

207. Dr. Needelman recommended continued services through the early Head Start program and recommended continued behavioral intervention with Dr. Wilson.

208. Subsequent to Dr. Needelman's evaluation, Dr. Wilson continued to work with and evaluate K.D.

209. In approximately February 2012, Dr. Wilson diagnosed K.D. with Asperger's Syndrome.

210. Asperger's Syndrome is an Autism Spectrum Disorder that is characterized by difficulties in socialization, communication, and often involves repetitive patterns of behavior.

211. In March 2012, Dr. Wilson requested authorization from Magellan for outpatient services for K.D.

212. As part of outpatient services, Dr. Wilson intended to apply Applied Behavioral Analysis interventions, in order to increase compliance, use of verbal communications, ability to tolerate frustration, reduce temper tantrums and incidence of aggression.

213. On March 16, 2012, Magellan denied the outpatient service authorization, stating, "It appears your symptoms are unlikely to improve with mental health treatment."

214. According to Dr. Wilson, Medicaid would not provide coverage of treatment for K.D. because he falls on the Autism Spectrum.

215. To date, K.D. is not receiving treatment as recommended and requested by Dr. Wilson.

FIRST CLAIM FOR RELIEF--EPSDT

216. The Petitioners incorporate herein, as if fully set forth, the allegations contained in paragraphs 1 to 216.

217. Respondents' rules, policies and practices, as described herein, excluding coverage of "behavior modification management" and ABA therapy, and excluding developmentally disabled children from obtaining coverage of necessary behavioral health services, violate the Medicaid Act EPSDT provisions, 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), and 1396d(r)(5), which are enforceable by Petitioners pursuant to 42 U.S.C. § 1983.

SECOND CLAIM FOR RELIEF--EPSDT

218. The Petitioners incorporate herein, as if fully set forth, the allegations contained in paragraphs 1 to 217.

219. The Respondents' draft regulation, 471 NAC 32-002.02, which excludes Medicaid-eligible children from coverage of "behavior modification management" services, draft regulation 471 NAC 32-002.02, which excludes Medicaid-eligible children from coverage of ABA therapy, and regulations 471 NAC 32-001, 471 NAC 32-001.02, and draft 471 NAC 32-001.01A, which exclude Medicaid-eligible children with developmental disability diagnoses from Medicaid coverage of behavioral health services, are in conflict with the Medicaid Act EPSDT provisions, 42 U.S.C. § 1396a(a)(10)(A); 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § 1396d(a)(4)(B); 42 U.S.C. § 1396d(r)(5), and are thus preempted by federal law and invalid pursuant to the Supremacy Clause of the United States Constitution, U.S. CONST. art. VI, cl.2.

THIRD CLAIM FOR RELIEF--REASONABLE STANDARDS

220. The Petitioners incorporate herein, as if fully set forth, the allegations contained in paragraphs 1 to 219.

221. The Respondents' draft regulation, 471 NAC 32-002.02, which excludes Medicaid-eligible children under age 19 from coverage of "behavior modification management" services, draft regulation 471 NAC 32-002.02, which excludes Medicaid-eligible children from coverage of ABA therapy, and regulations 471 NAC 32-001, 471 NAC 32-001.02, and draft 471 NAC 32-001.01A, which exclude Medicaid-eligible children with developmental disability diagnoses from Medicaid coverage of behavioral health services, are in conflict with the reasonable standards requirements of federal Medicaid Act, 42 U.S.C. § 1396a(a)(17) and are thus preempted by the Supremacy Clause of the United States Constitution, art. VI, cl. 2.

FOURTH CLAIM FOR RELIEF-- § 440.230(c)

222. The Petitioners incorporate herein, as if fully set forth, the allegations contained in paragraphs 1 to 221.

223. The Respondents' regulations 471 NAC 32-001, 471 NAC 32-001.02, and draft 471 NAC 32-001.01A, which exclude Medicaid-eligible children with developmental disability diagnoses from Medicaid coverage of behavioral health services, are in conflict with 42 C.F.R. § 440.230(c) and are thus preempted by the Supremacy Clause of the United States Constitution, art. VI, cl. 2.

FIFTH CLAIM FOR RELIEF--ADA TITLE II and SECTION 504

224. The Petitioners incorporate herein, as if fully set forth, the allegations contained in paragraphs 1 to 223.

225. The Respondents' regulations 471 NAC 32-001, 471 NAC 32-001.02, and draft 471 NAC 32-001.01A, which exclude Medicaid-eligible children with developmental disability diagnoses from Medicaid coverage of behavioral health services, violate Title II of the ADA, 42 U. S. C. § 12132, and Section 504 of the Rehabilitation Act, 29 U.S.C. § 794, which are enforceable under 42 U. S. C. § 12133 and 29 U. S. C. § 794a(a)(2).

PRAYER FOR RELIEF

WHEREFORE, the Petitioner respectfully requests that the Court:

A. Declare the Respondents' rule, policy, and practice of denying Medicaid coverage for ABA methods invalid as being inconsistent with the Medicaid Act's EPSDT and the reasonable standard provisions.

B. Declare ABA methods are a covered service under Medicaid when they are necessary to correct or ameliorate a condition.

C. Enjoin the Respondents' rule, policy, and practice of denying Medicaid coverage for ABA methods.

D. Declare the Respondents' rule, policy, and practice of denying Medicaid coverage for "behavioral modification management" treatments invalid as being inconsistent with the Medicaid Act's EPSDT and reasonable standard provisions.

E. Enjoin the Respondents' rule, policy, and practice of denying Medicaid coverage of "behavioral modification management" treatments that are necessary to correct or ameliorate a condition.

F. Declare 471 NAC 32-001, 471 NAC 32-001.02, and DRAFT 471 NAC 32-001 to conflict with and be preempted by the Medicaid Act's EPSDT and reasonable standards provisions.

G. Enjoin the Respondents' enforcement of the invalid sections of Title 471 NAC 32-001, 471 NAC 32-001.02 and DRAFT 471 NAC 32-001.

H. Declare Title 471 NAC 32-001, 471 NAC 32-001.02, and DRAFT 471 NAC 32-001 to conflict with and be preempted by 42 C.F.R. § 440.230(c).

I. Enjoin the Respondents' enforcement of the invalid sections of Title 471 NAC 32-001, 471 NAC 32-001.02, and DRAFT 471 NAC 32-001.

J. Declare Title 471 NAC 32-001, 471 NAC 32-001.02, and DRAFT 471 NAC 32-001 to be invalid as inconsistent with Title II of the ADA and Section 504 of the Rehabilitation Act.

K. Enjoin the Respondents' enforcement of the invalid sections of Title 471 NAC 32-001, 471 NAC 32-001.02, and DRAFT 471 NAC 32-001.

L. Award Petitioners reasonable attorney fees and court costs.

M. Grant such other and further relief as may be deemed just and proper.

DATED:

May 18, 2012

K.D. and S.L.

BY THEIR ATTORNEYS:

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PRAECIPE

TO THE CLERK OF THE DISTRICT COURT OF LANCASTER COUNTY:

Please prepare a Summons for personal service in the above captioned matter to be served by the Lancaster County Sheriff, upon each of the Respondents, Kerry Winterer as Chief Executive Officer of the Nebraska Department of Health and Human Services, and Vivianne Chaumont, Director of Division of Medicaid and Long-Term Care, who can be served at the office of the Attorney General, Room 2115 State Capitol, Lincoln, NE 68509, during usual business hours.

In addition to the service of Summons, include a copy of the following:

1. The Petition;
2. Motion of S.L. For Leave to Proceed Under the Initials S.L. and for a Protective Order;
3. Motion of S.L. to Seal the Affidavit Disclosing His True Identity;
4. Motion of S.L. to Proceed In Forma Pauperis;
5. Motion of K.D. For Leave to Proceed Under the Initials K.D. and for a Protective Order;
6. Motion of K.D. to Seal the Affidavit Disclosing His True Identity;
7. Motion of K.D. to Proceed In Forma Pauperis;
8. Motion of Petitioners for Class Certification;
9. Motion to Allow Jane Perkins to Appear Pro Hac Vice; and
10. Motion to Allow Sarah Somers to Appear Pro Hac Vice.

By: _____

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This action was filed In Forma Pauperis.