



this action on their own behalf and on behalf of similarly situated Connecticut residents whose applications have not been timely processed and/or who have not been timely provided Medicaid benefits in violation of federal law.

2. The defendant Commissioner's long-standing failure or refusal to timely process Medicaid applications and provide Medicaid benefits to eligible Connecticut residents violates rights secured to plaintiffs by 42 U.S.C. § 1396a(a)(8) and the implementing federal regulations promulgated pursuant to federal Medicaid law, 42 C.F.R. §§ 435.911 and 435.930.

3. Plaintiff Paul Shafer is one of nearly 5,000 Connecticut residents whose applications for Medicaid have been pending well beyond the 45-day time period generally required for the processing of Medicaid applications. At the end of November, 2011, nearly 55% of all of the Medicaid applications were pending beyond the federally-mandated time limits. As a result of the defendant's failure or refusal to process Medicaid applications in a timely manner, he has been unable to access Medicaid coverage for his anti-seizure medication or other medically necessary treatment for his seizure disorder.

4. Plaintiff Joshua Harder is one of the thousands of individuals whose applications for Medicaid have been approved, subject to a designated "spend-down" requirement. Every month, several hundred such "medically needy" individuals are newly found to be eligible for Medicaid subject to this requirement. Although Plaintiff Harder provided documentation in October 2011, in the form of medical bills, of compliance with his "spend-down" requirement for the six month period between July 1 to December 2011, he was not provided Medicaid benefits. As a result of the defendant's failure or refusal to provide Medicaid benefits in a timely manner to persons who have demonstrated compliance with their respective "spend-down" requirements, Plaintiff Joshua Harder has been unable to access Medicaid coverage for his needed medical treatment. Neither of

the named plaintiffs has received timely or adequate notice of a reason for the delay in the processing or the receipt of their Medicaid benefits.

5. Plaintiffs seek declaratory, as well as preliminary and permanent injunctive, relief enjoining the Defendant, in his official capacity as the Commissioner of the Department of Social Services (DSS), from failing or refusing to process applications for eligibility for Medicaid and failing to provide Medicaid benefits to eligible persons within the time frames required by federal law, as well as from failing or refusing to provide timely and adequate written notice of delays in the processing of applications and the provision of benefits , that includes notice of fair hearing rights.

## **II. JURISDICTION**

6. This action is authorized by 42 U.S.C. § 1983 to redress the deprivation of federal statutory and Constitutional rights. Accordingly, jurisdiction over this action is conferred by 28 U.S.C. § 1331, which provides jurisdiction in United States district courts of civil actions arising under the U.S. Constitution and federal laws. Injunctive relief is authorized by Rule 65 of the Federal Rules of Civil Procedure. Declaratory relief is authorized by 28 U.S.C. §§ 2201(a) and 2202 and Rule 57 of the Federal Rules of Civil Procedure.

## **III. PARTIES**

### **A. Plaintiffs**

7. Plaintiff Paul Shafer is an adult resident of Trumbull, Connecticut. He filed an application for state medical assistance through DSS's enrollment contractor, Affiliated Computer Services (ACS), in July, 2011. Although his application was referred to the DSS regional office for his area by ACS on or about August 8, 2011, and is complete, DSS has not completed processing of his application, and has not provided him with Medicaid benefits. He brings this

action on his own behalf and on behalf of the proposed subclass of individuals who have applied, or will in the future apply, for Medicaid.

8. Plaintiff Joshua Harder is an adult resident of New Haven, Connecticut. He received a written notice from DSS dated June 27, 2011 advising him that he would be eligible for Medicaid for the period from July 1, 2011 to December 30, 2011, as soon as he presented medical bills to his DSS worker showing he had incurred medical expenses of \$214 or more. In October of 2011, his case manager submitted bills totaling \$218 to his DSS worker, along with a note from Mr. Harder explaining the medical services provided for each bill. He was not provided with any Medicaid benefits during the six month period and has recently received another notice saying he has to incur a similar “spend-down “ amount for the next six month period, from January 1 to June 30, 2012. He brings this action on behalf of himself and a subclass of individuals who have been found eligible for Medicaid subject to satisfaction of a spend-down requirement.

**B. Defendant**

9. Defendant RODERICK BREMBY is Commissioner of the Connecticut Department of Social Services. In his official capacity as DSS Commissioner, Defendant Bremby administers the Medicaid program and the benefits that plaintiffs and the proposed class they represent are entitled to receive, and is responsible for complying with federal law and regulations and state regulations governing administration of the Medicaid program. Conn. Gen. Stat. § 17b-2. Mr. Bremby is sued in his official capacity.

**IV. CLASS ACTION ALLEGATIONS**

10. Plaintiffs are impoverished persons seeking Medicaid benefits who sue on behalf of themselves and similarly situated persons pursuant to Fed. R. Civ. P. 23(a) and (b)(2). The class is defined as follows:

All Connecticut residents who have applied, or will in the future apply, for Medicaid benefits administered by the Connecticut Department of Social Services and who have not been provided such benefits.

The proposed two subclasses are:

- (1) Individuals who have applied or will apply for Medicaid (the “Applicant” subclass).
- (2) Individuals who have been or will be found eligible for Medicaid subject to a spend-down requirement (the “Spend-down” subclass).

11. The prerequisites to a class action specified in Fed. R. Civ. P. 23(a) are met in this action by the proposed plaintiff class:

(a) The proposed class is so numerous that joinder of all of the respective members would be impracticable. The precise number of persons adversely affected by the defendant’s failure or refusal to comply with federal law by processing Medicaid applications and providing Medicaid benefits on a timely basis are in the possession and control of DSS, which also has possession and control of records for the plaintiffs and members of the proposed class. However, based on defendant’s internal reports for the month of November, 2011, there were 12,580 pending applications for Medicaid on November 30, 2011 of which 6,896 applications -- 55% of the total pending – have been pending for more than the applicable deadline set by federal law. And, based on the same reports, several hundred individuals newly qualify for Medicaid each month based on DSS’s determination of their eligibility subject to spending down their excess income on medical bills incurred which meet or exceed their respective spend-down amounts.

(b) There are questions of law and fact common to the class, including whether the defendant Commissioner has a policy and/or practice of: failing to timely process applications and provide benefits under the Medicaid program, including failing to timely process medical bills submitted by individuals subject to a “spend-down” requirement, and failing to provide timely and adequate written notices of delays in the processing of applications and the provision of benefits, including notice of hearing rights, all in violation of the federal Medicaid Act and the Due Process Clause of the Fourteenth Amendment.

(c) The two named plaintiffs' claims are typical of the claims of the proposed class, and typical of the claims of the subclass they seek to represent. Named plaintiff Paul Shafer has applied for Medicaid but the defendant has not processed applications within the time frames required by law. Named plaintiff Joshua Harder was found eligible for Medicaid subject to a spend-down requirement and submitted medical bills to satisfy his spend-down, but Defendant has failed to timely act on these medical bills. For all of the members of the class, Defendant has failed to provide timely and adequate written notice of delays in the processing of applications and the provision of Medicaid benefits.

(d) The named plaintiffs will fairly and adequately protect the interests of the proposed class. In supporting their individual claims, the named plaintiffs will simultaneously advance the claims of absent class members.

(e) Plaintiffs' counsel are experienced in complex class litigation involving public benefit programs, including Medicaid, and civil rights laws, have the resources, expertise and experience to prosecute this action, and will adequately represent the class.

(f) Declaratory and injunctive relief is appropriate with respect to the class as a whole because defendant has acted on grounds generally applicable to the class.

## **V. STATUTORY AND REGULATORY SCHEME**

12. Since its enactment in 1965 under Title XIX of the Social Security Act, 42 U.S.C. § 1396, *et seq.*, Medicaid has provided a crucial health care safety net to millions of Americans and hundreds of thousands of Connecticut residents.

13. Medicaid is a jointly-funded state and federal program. The program primarily serves low income children and parents, and elderly, disabled and other very low income adults. Medicaid provides a broad array of health and long-term care services including but not limited to physicians' services, hospital services (inpatient and outpatient), laboratory and x-ray services, prescription drugs, family planning services, vision services, and durable medical equipment.

14. State participation in the Medicaid program is optional. However, a state choosing

to participate, and thereby receiving federal matching funds for its Medicaid program, must comply with the requirements of the federal Medicaid Act, and the regulations governing state Medicaid programs.

15. Connecticut has chosen to participate in the Medicaid program and accepts 50% federal matching funds for its program expenditures. Once Connecticut elected to participate in the Medicaid program, it became obligated to administer its program pursuant to a state plan approved by the Center for Medicare and Medicaid Services (“CMS”) that complies with the requirements set forth in the Medicaid Act and its implementing regulations. The provisions of the Connecticut state Medicaid plan are mandatory with respect to all political subdivisions in the state. 42 U.S.C. § 1396a(a)(1).

16. The state Department of Social Services is the "single state agency" charged with the administration of the Medicaid program in Connecticut. 42 U.S.C. § 1396a(a)(5). The defendant Commissioner is the head of the Department of Social Services.

17. The Connecticut Medicaid program includes different coverage groups, the primary ones being HUSKY A (children, families with minor children and pregnant women), HUSKY C (Medicaid for the Aged, Blind and Disabled) (adults who are aged, blind, or disabled), and HUSKY D (Medicaid for Low Income Adults) (all other adults). There are approximately 556,000 individuals enrolled in these programs in total. The overwhelming majority of current Medicaid recipients, about 397,000, are in the HUSKY A coverage group. Children are 48% of the current Medicaid population. There are about 159,000 persons in the other coverage groups.

18. The income limit for HUSKY A is 185% of the Federal Poverty Level. Therefore, for a family of 4, the income limit is \$41,348 per year. The income limit for HUSKY C and D is based on the Medically Needy Income Limit, which is \$506.22 or \$610.61, depending on the region of the state in which the recipient lives. This is equivalent to only 56% or 67% of the Federal Poverty Level, respectively, exclusive of any applicable income disregards.

19. Under federal Medicaid law, states are required to “provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so,

and that such assistance shall be furnished with reasonable promptness to all eligible individuals.” 42 U.S.C. § 1396a(a)(8); *see* 42 C.F.R. §§ 435.911 and 435.930. Medicaid applications must be processed, and eligibility determined, within 45 days, 42 C.F.R. § 435.911(a)(2), with the exception of applications based on disability which must be processed in 90 days, 42 C.F.R. § 435.911(a)(1). The federal Medicaid regulations provide very narrow exceptions to these strict, mandatory, time frames. *See* 42 C.F.R. § 435.911(c).

20. Also under federal Medicaid law, Medicaid applicants are entitled to a hearing whenever their application for assistance is denied or not acted upon with reasonable promptness, 42 U.S.C. § 1396a(a)(3), and the state Medicaid agency “must send each applicant a written notice of the agency’s decision on his application, and, if eligibility is denied, the reasons for the action, the specific regulation supporting the action, and an explanation of his right to a hearing,” 42 C.F.R. § 435.912.

21. The vast majority of applications are for HUSKY A or D (Medicaid for children, families with children and pregnant women, and Low Income Adults) which are required to be processed within 45 days. Relatively little information and documentation is required. Needs-based eligibility for HUSKY A and HUSKY D is based only on income. There is no asset limit. With rare exceptions, only income must be verified and such verification can often be easily obtained from third-party sources such the Social Security Administration or the Department of Labor, or by a copy of a recent pay stub or pay check.

22. Only HUSKY C (Medicaid for the Aged, Blind and Disabled), a relatively small percentage of the total applications, also requires proof of assets as well as proof of age, blindness, or disability. However, information on age and blindness, and sometimes disability as well, is readily obtained from the Social Security Administration as well as from other sources. Moreover, only applications for HUSKY C that are based on disability are subject to the 90 day time limit for processing.

23. Applicants are able to initiate applications for Medicaid either through DSS or through its enrollment contractor, ACS. However, ACS can only process applications for the

HUSKY B, Charter Oak Health Insurance or Preexisting Condition Insurance programs, all of which are non-Medicaid programs. If an applicant appears to be eligible for one of the Medicaid programs, their application must be forwarded to DSS for processing.

24. Whether initiated through ACS or through DSS directly, Medicaid applicants are required to be promptly notified of any documents or other information that is required to be provided to determine eligibility and afforded a reasonable period of time to respond, which is generally ten days under the defendant's current policies and practices. Such notification needs to be sent sufficiently in advance of the federal deadline for acting on an application – generally 45 days – to ensure that information provided within the ten day period can be acted on by that deadline.

25. Defendant has set up a system to circumvent the federal timeliness requirements by making it appear that the applicant has failed to provide required documentation. Written notices are programmed to be sent out to Medicaid applicants whose applications have not been acted on by the applicable deadline for making the eligibility determination, stating that DSS needs additional information and/or documentation from applicants even when the applicant has provided all the requested information and no additional information or documentation is required to determine eligibility. These generic letters do not identify the information claimed to be both necessary and not yet provided. Although a DSS eligibility worker has the ability to stop these notices from going out to a particular individual or to individually modify the notices to identify the specific missing information or documentation, they nevertheless routinely go out unmodified because there is in fact no missing information or the worker has such a high caseload that he or she is unable even to check if the notice is accurate. These generic letters serve the purpose of presenting a façade of compliance with federal law, by suggesting that the delay beyond the federal law requirement is the applicant's fault, when in reality the notices are routinely issued in the absence of any missing information from the applicant.

26. Individuals who apply for Medicaid and meet all requirements for Medicaid except that they have incomes in excess of the applicable income guideline are entitled to receive

Medicaid subject to a “spend-down” requirement. See 42 C.F.R. 435.831(d). 27. These “medically needy” individuals receive a notice from DSS every six months advising them that they are eligible for Medicaid once they satisfy the designated spend-down amount for that period, an amount which is equal to the amount by which their income exceeds the medically needy income limit in their part of the state plus any applicable disregard, multiplied by six.

28. The notices advise these “medically needy” individuals that their Medicaid benefits will be activated upon the submission of any medical bills for the current six month period, or any unpaid medical bills from a previous period, meeting or exceeding their particular spend-down amount, and that, upon such submission, they will be eligible for full Medicaid benefits until the end of that six month period, at which point a new spend-down period will begin with potentially a different spend-down amount.

29. In response to these notices, “medically needy” recipients routinely present medical bills to demonstrate satisfaction of their spend-down amounts.

30. The same DSS eligibility workers who process Medicaid applications commonly process medical bills submitted in an attempt to satisfy spend-down amounts.

31. Because of their high caseloads, these workers are not able to timely process these medical bills to determine that spend-down amounts have been satisfied, resulting in eligible recipients waiting weeks or months for the calculation to be completed and Medicaid benefits to be provided.

32. Sometimes, the processing of medical bills submitted to establish satisfaction of Medicaid spend-downs is so untimely that the end of the six month spend-down period arrives before the DSS worker has been able to review the medical bills submitted.

33. The delays in the provision of Medicaid benefits to “medically needy” individuals eligible for Medicaid on a spend-down basis are exacerbated by the failure of the defendant to promulgate any regulation or internal rule establishing a standard for timeliness in processing medical bills for such individuals or to provide written notices to individuals who have submitted medical bills but whose bills have been found to be insufficient to satisfy their respective

spend-down amounts.

34. The systemic delays in the processing of Medicaid applications, and of medical bills submitted for purposes of establishing satisfaction of Medicaid spend-downs, are not attributable to the failure of applicants to provide eligibility information or to take any other required action. Rather, the delays are attributable to the inability of workers, who are clearly short-staffed with large caseloads, to process information provided by applicants in a timely manner and, secondarily, in the case of spend-down, to the failure of the defendant to establish a standard for prompt processing of medical bills submitted to satisfy spend-down amounts.

35. All provisions of federal Medicaid law and implementing regulations apply to the above listed programs unless explicitly waived through the process provided by § 1115 of the Social Security Act. Connecticut has not waived the timeliness provisions of the Medicaid Act.

#### **VI. APPLICABLE CONSTITUTIONAL PROVISION**

36. Under the Due Process Clause of the Fourteenth Amendment to the United States Constitution, no state may deprive its citizens of a property interest without due process of law. This includes the property interest in a claim for public benefits.

#### **VII. FACTUAL ALLEGATIONS COMMON TO THE PLAINTIFF CLASSES**

37. The defendant Commissioner has a long-standing pattern and practice of failing or refusing to process applications, make eligibility determinations, and provide Medicaid benefits to eligible individuals and families within the deadlines required by federal law.

38. In the last 18 months, the defendant Commissioner has received an average of 10,000 new applications for Medicaid each month, compared to an average of 8,300 in 2004. According to DSS' own data, the defendant Commissioner has failed and continues to systematically fail to process these Medicaid applications within the time frames mandated by federal law. During this same 18-month time period, although the more recent numbers are higher, an average of 4,600 applications, representing an average of 45% of all applications pending at the

end of the month, were delayed in violation of federal law. For the last month for which data is available, November of 2011, the number of Medicaid applications delayed jumped to 55%.

39. The defendant Commissioner’s own reports demonstrate the following delays in application processing by percentage of all pending applications:

Overdue Medicaid Applications (data from monthly DSS “Application Length Pending Report,” DMF 8030A-DMF 80271, pp. 239-240 and DSS “Pending Overdue Application Report” )

Month	Number of Medicaid cases pending at the end of the month	Number of pending cases that are overdue, i.e. pending beyond applicable time frame	% of total pending cases that are overdue, i.e. pending beyond applicable time frame
June, 2010	11,053	4,582	41%
July, 2010	9,808	4,070	41 %
August, 2010	9,810	3,700	38%
September, 2010	10,182	3,991	39 %
October, 2010	10,152	3,497	34 %
November, 2010	9,995	4,151	41.5%
December, 2010	10,038	4,675	46.5%
January, 2011	10,100	4,823	48 %
February, 2011	10,634	4,839	45.5%
March, 2011	10,968	4,682	43%
April, 2011	11,126	4,845	43.5%
May, 2011	10,616	4,599	43%
June, 2011	10,628	4,956	47%
July, 2011	10,924	5,018	46%
August, 2011	10,891	5,530	51%
September, 2011	11,071	5,650	51%
October, 2011	12,179	5,871	48%
November, 2011	12,580	6,896	55%

40. The primary cause of the high number of untimely decided Medicaid applications is excessive DSS eligibility worker caseloads. There has been an approximate increase in the total number of Medicaid enrollees of 52% in the last ten years. During this same time period, the total number of DSS employees has not gone up, but rather has dropped by about 20%. And,

since July of 2002, the number of DSS employees involved in eligibility determinations for all programs has dropped even further, by 30%, from 845 to 586 (before further reductions in October 2011 due to early retirements). In just a two-year period, from 2008 to 2010, the caseload of households for all programs has gone up 33%, while the overall staffing has gone down about 8%.

41. The same cause is at the root of the delay in processing medical bills for spend-down purposes. Workers are unable to review bills submitted by medically needy recipients subject to the spend-down requirement to determine if the requirement has been met, enabling the recipient to receive Medicaid benefits for the rest of a six-month spend-down period.

42. DSS has acknowledged that its current caseloads for its eligibility workers for all programs average a very high 1,750. In addition, the legislature's December 2004 report on Medicaid processing delays, produced by the Program Review and Investigations Committee ("PRI Report"), which looked at delays at a time when they were not nearly as severe as they are today, stated: "Since July 2002, eligibility worker staffing levels have been reduced about 25 percent statewide, while caseloads have increased. This has resulted in a per-staff workload increase of 40 percent." See PRI Report at 50. The same report also noted the obvious: "there is a significant relationship between staffing reductions and overdue applications by office." *Id.* at 51.

### **VIII. FACTS OF INDIVIDUAL NAMED PLAINTIFFS**

43. Plaintiff Paul Shafar is a single adult who is unemployed and who suffers from a seizure disorder which can result in severe seizures without warning. During a seizure, he can suffer physical injuries due to involuntary movements and falls. He suffered a major seizure on December 18, 2011.

44. The only thing which has been found to control Plaintiff Shafer's seizures is medication. He currently takes the prescribed anti-seizure medication Neurontin. This medication costs \$ 165 per month. It also is important for him to be under the care of a neurologist, to make sure the right medication(s) continue to be prescribed.

45. Until May of 2011, Plaintiff Shafer was a full time student at the University of Connecticut. Since leaving the University of Connecticut, he has been unemployed and has had no other source of income. He has not been able to find work in part because of his seizure disorder. He relies on his parents for food and shelter.

46. Mr. Shafer's health insurance as a student terminated on August 15, 2011, because he is no longer a college student. Because he is not working and has no income, he does not have any health insurance through an employer and cannot afford to buy it on his own.

47. In July of this year, knowing that his student insurance was going to come to an end, he applied for state health insurance. He received a letter dated July 20, 2011, and postmarked July 21, 2011, from the "HUSKY B/Charter Oak/CT PCIP Programs." The letter said, among other things, that "we are unable to process [your Application for health coverage] because required information and/or income verification is missing" and "[w]e were unable to reach you by phone."

48. In early August, Plaintiff Shafer received a call from someone concerning his application for state health insurance. On the telephone, Plaintiff Shafer was asked about his income and he explained that he was not employed and did not have any income.

49. Plaintiff Shafer received a letter dated August 8, 2011, and postmarked August 9, 2011, from ACS (also known as the "HUSKY B/Charter Oak/CT PCIP Programs"). This letter said that, "[b]ased on your application information," Plaintiff Shafer had "been evaluated for

eligibility for health coverage” and was being “Referred Potentially eligible for Medicaid for Low Income Adults.” Under the heading “REFERRED,” the letter also said “The household members listed below as Referred have been forwarded to the State of Connecticut, Department of Social Services (DSS), for review.” Plaintiff Shafer was the only one listed. The letter ended by telling Plaintiff Shafer: “Your local DSS office will contact you about your application status.”

50. Plaintiff Shafer did not receive any telephone call or letter from DSS until the Bridgeport office of DSS sent him a letter dated September 23, 2011 (but postmarked September 26, 2011) – 46 days after his application was referred to the DSS Bridgeport office -- entitled “Application Delay Medicaid for Low Income Adults – AU 051546080.” The letter from DSS said that he had applied for medical assistance on August 8, 2011, that “[w]e are required to complete work on your case within 45 days,” but that “We have been unable to do this because: YOU HAVE NOT YET SENT US THE INFORMATION WE NEED TO DECIDE IF YOU ARE ELIGIBLE AND WE MUST ALLOW YOU TEN DAYS TO GET IT.” The letter also said: “PROOF STILL NEEDED.”

51. The September 23, 2011 letter did not identify any specific kind of information that DSS needed or which Plaintiff Shafer had supposedly not provided. But it said that “If you do not send us the information by the due date or call your worker for an extension, your application will be denied.”

52. Not understanding what he could possibly be lacking, Plaintiff Shafer went to the Bridgeport DSS office shortly after getting this September 23rd letter to ask what it meant. He wanted to talk to his worker about the letter, but could not get in to see her. However, another person whom Plaintiff believes to work for DSS told him that letters like the September 23rd letter were routinely being sent out saying that information was needed and had not been

provided, even though it was not accurate, because DSS was unable to process applications due to a backlog.

53. It has been six months since Plaintiff Shafer originally applied for state medical assistance and five months since the state sent him a letter acknowledging his application as having been submitted on August 8, 2011 (even though he really applied in July) when ACS referred his application to DSS for probable eligibility for Medicaid for Low Income Adults.

54. As of the date of filing, Plaintiff Shafer has not received Medicaid through the Low Income Adult program or otherwise, nor has he received any notice of denial of these benefits.

55. Because he has no health insurance, Plaintiff Shafer's father has paid for his anti-seizure medications. But since the prescribed medications are so expensive, plaintiff has cut back on them, taking ½ the recommended dosage.

56. Plaintiff Shafer has done nothing to cause DSS to delay processing his application or delay providing him with benefits. He has provided the state with everything it has specifically asked for from him.

57. Plaintiff Joshua Harder is an adult resident of New Haven, Connecticut. He suffers from a degenerative brain disorder which has not been definitively diagnosed but has resulted in stiffness in the entire left side of his body and split vision. He also has a speech impediment.

58. Plaintiff Harder requires several medications and ongoing treatment due to his condition. Because of his brain disorder, he needs to see doctors with some frequency. Without Medicaid, he cannot afford the copays that Medicare imposes for these services.

59. Due to his disability, Plaintiff Harder receives Social Security Disability payments of \$846 per month, as of January 1, 2012. For the year 2011, his income from Social Security Disability was \$820 per month. This is his only source of income.

60. Plaintiff Harder also receives Medicare, but it does not cover all of his medical expenses, and requires substantial copays and deductibles, which the Connecticut Medicaid program mostly covers.

61. Plaintiff Harder has been eligible for Medicaid for about twelve years. But for the last three years or so, due to having income slightly higher than the limit for Medicaid, he has had a “spend-down” every six months to actually receive Medicaid benefits. Throughout this period, his spend-down has been about \$200 every six months.

62. For the last spend-down period, from July 1, 2011 to December 31, 2011, Plaintiff Harder had a spend-down amount of \$214.68. In October 2011, his case manager with Phoenix Case Management submitted \$218.39 in medical bills on his behalf to his DSS worker, along with a note from him explaining what the bills were for. Notwithstanding the submission of medical bills that exceeded his spend-down amount, DSS did not activate his Medicaid any time during the July 1 to December 31, 2011 period, nor was he contacted about any deficiency in the medical bills he had submitted.

63. As a result, plaintiff Harder received no Medicaid benefits during any portion of his last spend-down period, July 1 to December 31, 2011, including the two and one-half month period after these bills were submitted to his DSS worker.

64. Plaintiff Harder has since received a notice from DSS dated December 9, 2011 advising him that a new spend-down amount of \$244.68 has been established for the current period of January 1 to June 30, 2012.

65. Plaintiffs are being irreparably harmed by the defendant Commissioner's failure or refusal to timely process applications for Medicaid and/or timely provide benefits to eligible persons, including his failure or refusal to timely review medical bills submitted for purposes of satisfying spend-down requirements of medically needy individuals subject to a spend-down, as well as by the defendant Commissioner's failure or refusal to provide timely and adequate written notice of delays in the processing of applications and the provision of benefits , that includes notice of fair hearing rights.**IX. CAUSES OF ACTION**

**A. First Cause of Action: Violation of Medicaid Law**

66. Paragraphs 1 through 65 are incorporated by reference as if fully stated herein.

67. Defendant's longstanding policy and practice of failing or refusing to timely process applications for Medicaid and timely provide Medicaid benefits violates plaintiffs' and plaintiff class members' rights under 42 U.S.C. § 1396a(a)(8) and 42 C.F.R. §§ 435.911 and 435.930. This violation of federal law is actionable pursuant to 42 U.S.C. § 1983.

68. Defendant's longstanding policy and practice of failing or refusing to timely process medical bills for individuals found eligible for Medicaid subject to a spend-down requirement, to determine whether their respective spend-down requirements have been met, violates plaintiffs' and plaintiff class members' rights under 42 U.S.C. § 1396a(a)(8) and 42 C.F.R. § 435.930. This violation of federal law is actionable pursuant to 42 U.S.C. § 1983.

69. Defendant's longstanding policy and practice of failing or refusing to provide adequate written notice when defendant has exceeded the time permitted by law for a determination of eligibility for Medicaid, including notice of hearing rights, violates plaintiffs' and plaintiff class members' rights under 42 U.S.C. § 1396a(a)(3) and 42 C.F.R. §§ 431.206(b) and (c) and 435.912. This violation of federal law is actionable pursuant to 42 U.S.C. § 1983.

70. Defendant's longstanding policy and practice of failing or refusing to provide adequate written notice concerning the inadequacy of medical bills submitted to satisfy a spend-down requirement , including notice of fair hearing rights, violates plaintiffs' and plaintiff

class members' rights under 42 U.S.C. § 1396a(a)(3) and 42 C.F.R. §§ 431.206(b) and (c) and 435.912. This violation of federal law is actionable pursuant to 42 U.S.C. § 1983.

**B. Second Cause of Action: Violation of Due Process**

71. Paragraphs 1 through 70 are incorporated by reference as if fully stated herein.

72. Defendant's longstanding policy and practice of failing or refusing to provide adequate written notice when defendant has exceeded the time permitted by law for a determination of eligibility for Medicaid, including notice of fair hearing rights, violates plaintiffs' and plaintiff class members' rights under the Due Process Clause of the Fourteenth Amendment of the United States Constitution. This violation of federal law is actionable pursuant to 42 U.S.C. § 1983.

73. Defendant's longstanding policy and practice of failing or refusing to provide adequate written notice concerning the inadequacy of medical bills submitted to satisfy a spend-down requirement, including notice of fair hearing rights, when individuals submit medical bills to satisfy their respective spend-down amounts, violates plaintiffs' and plaintiff class members' rights under the Due Process Clause of the Fourteenth Amendment of the United States Constitution. This violation of federal law is actionable pursuant to 42 U.S.C. § 1983.

**X. REQUEST FOR RELIEF**

WHEREFORE, plaintiffs respectfully request that this Court:

- A. Assume jurisdiction of this matter;
- B. Certify this action as a class action pursuant to Fed. R. Civ. P. 23(a) and (b)(2) with respect to the proposed class and two subclasses;
- C. Enter a declaratory judgment, in accordance with 28 U.S.C. § 2201 and Fed. R. Civ. P. 57, declaring that the defendant Commissioner has violated and continues to violate plaintiffs' and plaintiff class members' rights under federal law, including the Due Process Clause of the United States Constitution, in:

- a. failing to process all applications for Medicaid within the timeframes required by federal law;
- b. failing to adopt any standard for processing of medical bills submitted in an attempt to establish satisfaction of Medicaid spend-downs and failing to process such medical bills in a timely fashion;
- c. failing to provide Medicaid benefits to eligible individuals and families within the timeframes required by federal law;
- d. failing to provide adequate written notification of delays in eligibility determinations, as required by federal statutory and constitutional law; and
- e. failing to provide adequate written notification of lack of satisfaction of spend-down amounts when medical bills have been submitted, as required by federal statutory and constitutional law.

D. Preliminarily and permanently enjoin the defendant Commissioner to:

- a. process all Medicaid applications, and provide Medicaid benefits, within the timeframes required by the federal Medicaid Act and its implementing regulations;
- b. establish and comply with a two business day turnaround time for acting on all Medicaid bills submitted for spend-down purposes;
- c. provide timely and adequate written notice of delays in the processing of Medicaid applications, including notice of fair hearing rights, as required by the federal Medicaid Act and the Due Process Clause of the Fourteenth Amendment;
- d. provide timely and adequate written notice of lack of satisfaction of spend-down amounts when medical bills have been submitted, including notice of fair hearing rights, as required by the federal Medicaid Act and the Due Process Clause of the Fourteenth Amendment;

E. Award reasonable attorneys' fees as provided by 42 U.S.C. § 1988.

F. Award costs and disbursements.

G. Order such other, further or additional relief as the Court deems equitable, just and proper.

Respectfully submitted,

PLAINTIFFS

By Their Attorneys:

/s/ Sheldon Toubman

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