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STATE OF NORTH CAROLINA

COUNTY OF WAKE

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WAKE COUNTY, C.S.C.

IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION

ABRONS FAMILY PRACTICE AND URGENT CARE, P.A., NASH OB-GYN ASSOCIATES, P.A., HIGHLAND OBSTETRICAL-GYNECOLOGICAL CLINIC, P.A., CHILDREN'S HEALTH OF CAROLINA, P.A., CAPITAL NEPHROLOGY ASSOCIATES, P.A., HICKORY ALLERGY & ASTHMA CLINIC, P.A., and HALIFAX MEDICAL SPECIALISTS, P.A., Individually and on behalf of All Others Similarly Situated, Plaintiffs, v. NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, COMPUTER SCIENCES CORPORATION, MAXIMUS CONSULTING SERVICES, INC., AND SLI GLOBAL SOLUTIONS, INC., Defendants.	**CLASS ACTION COMPLAINT**

NOW COME Plaintiffs, on behalf of themselves and all others similarly situated, and

allege as follows:

I.   INTRODUCTION

1.   On July 1, 2013, the State of North Carolina implemented a software system

known as "NCTracks," which was intended to manage enrollments for providers of Medicaid-

covered services and reimbursement payments to those providers who serve North Carolina

Medicaid recipients. NCTracks was supposed to be a model of health care information

technology that would seamlessly and efficiently process and pay billions of dollars of claims

each year. Instead, NCTracks has been a disaster, inflicting millions of dollars in damages upon North Carolina's Medicaid providers. As was known to Defendants well in advance of the July 1, 2013 "go-live" date, NCTracks was negligently developed and designed, the system was untested, and it was plainly not ready for implementation. Indeed, when Medicaid providers began to use NCTracks, they were immediately confronted with a host of errors. The system would lock up and advise that "maintenance" was ongoing for significant periods of time; the system lost provider information (without which providers could not be paid reimbursements); it rejected reimbursement claims for services that were plainly authorized for payment; it paid the wrong amounts for others; and, compounding these problems, neither the State nor Defendant CSC could or would offer the providers the help they desperately needed to get paid. In all, NCTracks had over 3,200 software errors in the first few months of operation, and payments to Medicaid providers were delayed, unpaid, or "shorted" by over half a *billion* dollars in the first 90 days.

2.   As a result of the Defendants' wrongful acts, North Carolina health care providers have suffered catastrophic losses. In some instances, providers have decided not to accept Medicaid patients or have even closed their practices, and some of North Carolina's most needy citizens have suffered a reduction in the health care resources available to them. Moreover, CSC, SLI and Maximus have caused the State of North Carolina to be out of compliance with Medicaid reimbursement rules and other applicable law.

3.   This suit is brought by Plaintiffs on behalf of themselves and on behalf of the below-defined Class and Subclasses against the Defendants in order to obtain damages, declaratory relief, and injunctive relief arising out of Defendants' wrongful conduct.

4.   As detailed below, North Carolina physicians, other providers, and the practices that provide Medicaid-reimbursable services were all known end-users of NCTracks, and have been damaged by the wrongful acts of the Defendants. Had Defendants not acted wrongfully, the Plaintiffs and the Class Members, among other things, would have been able to submit reimbursement claims and had them timely paid in accordance with the law, thereby avoiding catastrophic losses.

II.   PARTIES

A.   Plaintiffs

5.   Plaintiff Abrons Family Practice and Urgent Care, P.A. ("Abrons") is a medical practice with its principal place of business in New Hanover County, North Carolina. Abrons provides general practice medical services to Medicaid-eligible patients. Abrons has a Medicaid contract with the State of North Carolina and was of the category of persons known to Defendants prior to July 1, 2013 to be an intended end user of NCTracks.

6.   Plaintiff Nash OB-GYN Associates, P.A. ("Nash") is a medical practice with its principal place of business in Nash County, North Carolina. Among other services, Nash provides obstetrical and gynecological medical services to Medicaid-eligible patients. Nash has a Medicaid contract with the State of North Carolina and was of the category of persons known to Defendants prior to July 1, 2013 to be an intended end user of NCTracks.

7.   Plaintiff Highland Obstetrical-Gynecological Clinic, P.A. ("Highland") is a medical practice with its principal place of business in Cumberland County, North Carolina. Among other services, Highland provides obstetrical and gynecological medical services to Medicaid-eligible patients. Highland has a Medicaid contract with the State of North Carolina

and was of the category of persons known to Defendants prior to July 1, 2013 to be an intended end user of NCTracks.

8. Plaintiff Children's Health of Carolina, P.A. ("Children's Health") is a medical practice with its principal place of business in Robeson County, North Carolina. Children's Health provides pediatric services to Medicaid-eligible patients. Children's Health has a Medicaid contract with the State of North Carolina and was of the category of persons known to Defendants prior to July 1, 2013 to be an intended end user of NCTracks.

9. Plaintiff Capital Nephrology Associates, P.A. ("Capital Nephrology") is a medical practice with its principal place of business in Wake County, North Carolina. Capital Nephrology provides nephrology services to Medicaid-eligible patients. Capital Nephrology has a Medicaid contract with the State of North Carolina and was of the category of persons known to Defendants prior to July 1, 2013 to be an intended end user of NCTracks.

10. Plaintiff Hickory Allergy and Asthma Clinic, P.A. ("Hickory") is a medical practice with its principal place of business in Catawba County, North Carolina. Hickory provides specialty medical services to Medicaid-eligible patients. Hickory has a Medicaid contract with the State of North Carolina and was of the category of persons known to Defendants prior to July 1, 2013 to be an intended end user of NCTracks.

11. Plaintiff Halifax Medical Specialists, P.A. ("Halifax") is a medical practice with its principal place of business in Halifax County, North Carolina. Halifax is a multi-specialty practice providing medical services to Medicaid-eligible patients. Halifax has a Medicaid contract with the State of North Carolina and was of the category of persons known to Defendants prior to July 1, 2013 to be an intended end user of NCTracks.

B.   Defendants

12.   Defendant North Carolina Department of Health and Human Services itself and through its vendors, contractors and agents ("DHHS") is an administrative agency of the State of North Carolina created pursuant to N.C.Gen. Stat. § 143B-136.1 et seq., which conducts its business in Wake County, North Carolina, and throughout the State. DHHS is the single state agency designated in North Carolina to administer or to supervise the administration of the North Carolina state Medicaid plan.

13.   Defendant Computer Sciences Corporation ("CSC") is a corporation organized and existing under the laws of the State of Nevada with its principal office in Falls Church, Virginia. CSC designed and developed NCTracks and currently operates NCTracks.

14.   Defendant Maximus Consulting Services, Inc. ("Maximus") is a corporation organized and existing under the laws of the Commonwealth of Virginia with its principal office in Reston, Virginia. Maximus was the vendor on the NCTracks project responsible for Independent Verification and Validation of the software.

15.   Defendant SLI Global Solutions, Inc. ("SLI") is a corporation organized and existing under the laws of the State of Colorado with its principal office in Denver, Colorado. SLI was the vendor responsible for testing NCTracks prior to "go-live."

III.   FACTS

A.   The North Carolina Medicaid System

16.   The North Carolina Medicaid system processes approximately $13 billion per year in Medicaid reimbursement claims for more than 70,000 Medicaid providers who serve over 1.5 million North Carolinians. DHHS, through its vendors, contractors, and agents, processes approximately 88 million Medicaid claims per year.

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17. Medicaid is a government-sponsored health insurance program for low-income parents, children, seniors, and people with disabilities. Under Medicaid, a medical provider first provides services to a qualified Medicaid recipient, then submits a claim for reimbursement, and is then reimbursed by DHHS, through its vendors, contractors and agents.

18. The law prohibits a Medicaid provider from attempting to collect payment from a patient Medicaid recipient once the provider has accepted Medicaid as the insurance for the patient and has rendered service to that patient. Accordingly, if DHHS does not pay Medicaid reimbursements that are owed to providers, as required by law, the providers simply do not get paid for their services.

19. Reliable claims processing and reimbursement are therefore crucial for the successful operation of the North Carolina Medicaid system. If a claims processing system fails to pay providers the amounts they are owed, the providers suffer the loss. Ultimately, medical professionals faced with a system that fails to pay what is owed would decide to no longer accept Medicaid. This, in turn, would limit the health care options available to North Carolina's most vulnerable citizens.

20. Prior to July 1, 2013, a North Carolina Medicaid provider would provide a service to a Medicaid recipient, with the recipient paying the statutorily allowed co-pay, if applicable. The provider would send a Medicaid claim to DHHS for reimbursement, and DHHS would then process the reimbursement claim and approve payment. DHHS provides an annual checkwrite schedule that documents weekly checkwrite dates, with minor derivations for holidays. Approved payments would be issued with each checkwrite, and Medicaid providers would receive payment from DHHS for all approved reimbursement claims that had been submitted leading up to each checkwrite. Prior to July 1, 2013, Medicaid providers routinely submitted

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bills and received weekly electronic payments for services rendered, and payments were made in accordance with Medicaid reimbursement rules.

21. Upon information and belief, Defendants CSC, Maximus, and SLI knew these facts about the North Carolina Medicaid system when they entered into their contracts with the State and agreed to produce a new claims processing system and when they designed, developed, tested, and implemented NCTracks.

B.   The State's Procurement of NCTracks

22. In 2003, the federal Centers for Medicare and Medicaid Services mandated that the State procure a new Medicaid Management Information System ("MMIS") with new technology because the "legacy" MMIS system was antiquated.

23. In September, 2003, the State issued a Request for Proposal ("RFP") for a new MMIS system, and awarded a contract for this new system in April, 2004. However, this project was a failure, and the State terminated the contract in July, 2006. The State spent over $30 million on this failed project.

24. The State then issued another RFP for the new MMIS in July, 2007. However, this RFP was withdrawn, revised, and re-issued in December, 2007.

25. The RFP issued in December, 2007 contemplated that the State would purchase a single, comprehensive computer system that would handle all Medicaid provider enrollments and claims processing.

26. In December, 2008, the State awarded the contract for the new MMIS to CSC. The new MMIS would be known as NCTracks.

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27.   The original contract price to be paid to CSC for NCTracks was $287 million, and the system was to be implemented by August 22, 2011. Ultimately, however, NCTracks was $207 million over budget and nearly two years late.

28.   The State also entered into contracts with Defendants Maximus and SLI. SLI contracted with the State to conduct testing of the software, and Maximus contracted with the State to conduct Independent Verification and Validation of the software.

29.   When they contracted with the State, and when they performed their duties under the contracts, CSC, SLI, and Maximus were aware that North Carolina Medicaid providers were intended end users of NCTracks.

C.   The Vendor-Defendants' Basic Obligations

(1)   CSC's Obligations

30.   CSC's contract with the State obligated CSC to design and develop a software solution that provides a common, unified, and flexible system meeting DHHS' business requirements regarding Medicaid.

31.   CSC had a duty to design and develop a software system that would allow health care providers to apply for and become enrolled Medicaid providers and would accept claims for Medicaid reimbursements, process those claims, and pay those claims in accordance with the law. Accordingly, CSC was obligated to produce a software system that complied with North Carolina Medicaid reimbursement rules.

32.   CSC's contract also requires it to operate NCTracks after implementation.

33.   One crucial aspect of CSC's duty to operate NCTracks is CSC's obligation to run a Call Center that answers Medicaid providers' questions about NCTracks and reimbursement procedures under the new system.

34.   CSC also undertook to conduct training of Medicaid providers so that those providers were adequately prepared to use NCTracks.

(2)   SLI's Obligations

35.   SLI contracted with the State to conduct thorough testing of the software. A software system as large as NCTracks must be tested prior to its use to ensure that it works as designed and that it meets end users' needs. In the case of NCTracks, SLI was obligated to conduct, among other things, User Acceptance Testing ("UAT") and Production Simulation Testing ("PST").

36.   UAT is a crucial process in software development. It involves putting software through "test cases" to determine whether the software is ready for the intended end users. These test cases run scenarios that are likely to be encountered when the end users begin operating the software. Test cases are prioritized, with "critical" test cases being the most important. A critical test case simulates a crucial operation of the software.

37.   PST is intended to test whether a software system is ready to support production, or "back office" operations of the software. As distinct from UAT, PST tests the functions of the software that the user does not see when operating the software.

38.   SLI had a duty to conduct proper UAT, PST, and related tasks, which were crucial to the successful deployment of NCTracks. Without such proper testing, there was a high likelihood that the software would not function as intended upon go-live.

(3)   Maximus' Obligations

39.   Maximus contracted with the State to conduct Independent Verification and Validation ("IV&V"). IV&V is a procedure through which a party, independent of any other

party on a software project, conducts independent reviews of some or all aspects of the software development process and identifies potential problems and improvements.

40.   IV&V is a particularly important aspect of large software development projects. By conducting proper IV&V, the reviewing party can spot and help prevent problems in design, development, testing, and other processes, throughout the project. IV&V thereby ensures that appropriate steps are followed and that the software is ultimately of the quality required by the end users.

D.   The Wrongful Acts of CSC, SLI, and Maximus Prior to July 1, 2013 "Go-Live"

(1)   CSC's Design, Development, and Implementation of the Software

41.   CSC was negligent in its design, development, and implementation of NCTracks, and upon go-live, the system caused foreseeable harm to the end users of NCTracks, including the Plaintiffs and the Class Members.

(a)   CSC's Flawed Design and Development Decisions

42.   From the start, CSC made fundamental design and development decisions that doomed the success of NCTracks.

43.   CSC's bad decision-making began when it decided to base NCTracks on an antiquated and deficient system it had previously developed for another state. Upon information and belief, CSC made this decision in order to maximize its profit on the NCTracks contract, notwithstanding the unreasonable risks to the end users of NCTracks that such a decision would introduce.

44.   In 2000, CSC was awarded a contract to develop a replacement MMIS for the State of New York (the "New York MMIS"). The initial contract for the New York MMIS required implementation by July 1, 2002, at an overall cost of $357 million. Following a series

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of delays, CSC implemented the New York MMIS in 2005, 33 months later than scheduled, and $166.4 million over budget.

45.   CSC failed to provide several important contract deliverables for the New York MMIS, the system was not based on the best available technology, and the system was plagued with problems. Importantly, the system could not accommodate changes on a timely basis, despite an ongoing need for modification due to changes in state and federal laws, state budgets, and policy changes. The problems with the New York MMIS were so severe that in 2007 the State of New York considered hiring a new vendor to replace CSC and try and improve the system that CSC had developed. Ultimately, in 2010, the New York State Comptroller recommended abandoning the CSC-developed New York MMIS and issuing an RFP for the development of a new replacement MMIS that would "put an end to problems that plagued [the CSC-developed New York MMIS]." Shortly thereafter, and despite having paid half a billion dollars for the New York MMIS a mere five years earlier, the New York Department of Health issued an RFP seeking a replacement of the New York MMIS by 2014.

46.   Upon information and belief, at least one factor in the failure of the New York MMIS was the use of Common Business-Oriented Language (COBOL), a computer programming language developed in the late 1950s. While some legacy business, finance, and administrative systems still in use by government agencies and companies were programmed many years ago in COBOL, COBOL is scarcely taught in modern United States college and university computer science programs. As a result, the numbers of programmers in the United States who are versed and proficient in COBOL, and who are capable of developing and supporting systems developed in COBOL, have dwindled significantly over time. Because

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systems developed in COBOL are therefore difficult and problematic to maintain, new systems are seldom developed from scratch using COBOL.

47.   CSC, of course, knew full well about the problems with the New York MMIS. It nonetheless decided to base NCTracks on the problematic New York MMIS.

48.   Upon information and belief, CSC decided to base NCTracks on the troubled New York MMIS for its own financial benefit, but this decision ultimately caused serious problems in the development of the North Carolina system. CSC represented to the State of North Carolina that many of the NCTracks functionality requirements already existed and were available in the New York MMIS, and that CSC would be able to re-use an estimated 90 percent of the code from the New York MMIS, ostensibly offering a shortcut to NCTracks' implementation. But this figure proved to be vastly overestimated. While CSC subsequently adjusted its estimate downward to 73 percent, it ultimately used a mere 32 percent of the New York MMIS code in NCTracks. CSC's miscalculations directly contributed to delays in the roll-out of NCTracks, in part because CSC was forced to develop significantly more code from scratch than it had initially represented. The miscalculations further increased the likelihood of defects in the software given the volume of new code that needed to be written. And, upon information and belief, CSC cut corners and failed to develop a robust software system because it had poorly planned the development of the software and could not meet project deadlines with quality work.

49.   The proof of CSC's wrongdoing was the disastrous state of the software upon go-live. Medicaid providers experienced hundreds of problems with NCTracks, and the system could not reliably perform its core function of processing reimbursement claims.

50.   As of November 5, 2013, only four months after go-live, NCTracks had exhibited more than 3,200 defects, and these defects are not being resolved in a timely manner. Approximately 200 of these defects were classified as "critical," and represented system-wide failures. Further, the numbers of new "high" and "medium" defects discovered each month since go-live had not decreased in the first four months of NCTracks' operation. In fact, as of November 5, 2013, NCTracks had 637 unresolved defects.

51.   The defects in NCTracks have been so numerous and severe that, as of December, 2013, CSC had not implemented 12 legislative or regulatory mandated changes by their required implementation dates. CSC had thus designed and developed NCTracks in a manner that put the State of North Carolina out of compliance with applicable law.

52.   Moreover, the defects in NCTracks affect the system's core functionality. Over 30% of all reported defects affect the "Provider Portal," i.e., the entry point for Medicaid providers, like the Plaintiffs and Class Members. Necessary actions, such as checking Medicaid recipient eligibility, creating and checking the status of Medicaid claims, searching and verifying procedure codes, and updating provider data, have been prevented or hindered. In addition, 17% of all reported defects affect the batch processing function of the system, including the automated processing of Medicaid claims and checkwrites. Timely remediation of such defects is critical for the Plaintiffs and the Class Members who, if they are denied access to the system or otherwise denied timely reimbursements, cannot survive financially.

53.   CSC professes to be working diligently to correct the hundreds of defects materializing each month in NCTracks. In the meantime, over 70,000 Medicaid providers, including the Plaintiffs and Class Members, have suffered and continue to suffer harm as a result of the defects and as a result of CSC's inability to timely correct them.

54.   As the vendor responsible for designing, developing, and implementing a system to process and pay Medicaid claims to more than 70,000 provider users who would foreseeably use the system, CSC owed a duty to these users, including the Plaintiffs and Class Members, to exercise reasonable care in the design, development, and implementation of the system. CSC has failed to exercise reasonable care to these users, who have been foreseeably harmed as a result.

(b)   Additional Deficiencies in the Software

55.   In addition to its design being fundamentally deficient, NCTracks demonstrated numerous operational deficiencies upon go-live. This reflects further negligence on the part of CSC, which by releasing such a system to users who would foreseeably be harmed, failed to exercise a reasonable degree of care.

56.   Almost immediately after go-live, for instance, NCTracks was inaccessible to many users, who either could not log onto the NCTracks system at all, or otherwise could not remain logged on long enough to file their claims. Upon go-live, users received the message: "NOTICE: NCTRACKS System Maintenance is Occurring. We are performing scheduled maintenance, please check back soon." The NCTracks website further stated: "Provider portal is experiencing some performance issues." As detailed below, many users had difficulty reaching support staff at CSC's Call Center, and the ones who did were advised to attempt log in at a different time.

57.   NCTracks was also not prepared to handle the volume of users attempting to simultaneously access the provider portal, despite the fact that CSC knew how many providers would use NCTracks simultaneously. Upon information and belief, CSC did not adequately test

the capacity of NCTracks to handle the number of simultaneous users who would foreseeably attempt to access the provider portal.

58.   The inaccessibility of NCTracks caused foreseeable harm to the providers, including the Plaintiffs and Class Members. Providers who were unable to access the system, for instance, were necessarily prevented from filing Medicaid claims, and therefore could not obtain much-needed reimbursements to which they were entitled. Providers were further prevented from using the system to obtain prior approval to provide services to Medicaid patients. As a result, many patients were forced to reschedule or cancel their appointments. Still other users, seeking to enroll as providers, were unable to do so.

59.   Another manifestation of CSC's negligence was the failure to properly migrate data from the legacy MMIS system to NCTracks prior to go-live. As a result, certain providers whose claims were in process during the migration from the legacy MMIS system to NCTracks were not timely reimbursed or were otherwise forced to resubmit their previously pending claims, because data associated with these claims were lost or corrupted during the migration process.

60.   Some categories of claims, including Pregnancy Medical Home (PMH) claims, could not be processed and paid at go-live for the simple fact that NCTracks was not programmed to handle these categories of claims. Providers were therefore unable to receive reimbursement until NCTracks was updated to support such claims. In the case of PMH claims, for instance, support was not added for nearly four-and-a-half months following go-live. Upon finally adding support, CSC advised that previously denied PMH claims would need to be re-submitted.

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(c) **CSC Set its Own Acceptance Criteria for the Software, Wrongfully Inducing the State to Implement NCTracks**

61.   Furthering its wrongful conduct, CSC induced the State to erroneously declare NCTracks ready for go-live. Specifically, after designing and developing the system, CSC was asked to define the acceptance criteria by which the State would assess NCTracks' operational readiness for go-live. "Acceptance criteria" are crucial to software development. Ordinarily, acceptance criteria are set forth in a contract, statement of work, or other written document, and acceptance criteria are almost always established so that software will meet operational and end-user requirements contemplated by the purchaser of the software. After all, CSC's contract obligated CSC to design and develop NCTracks so that it provided a common, unified, and flexible system meeting DHHS' business requirements regarding Medicaid. Any acceptance criteria therefore should have been set to meet the needs of DHHS and the needs of the known end-users of NCTracks: the Medicaid providers.

62.   In this instance, CSC was allowed to set its own acceptance criteria. In other words, CSC was allowed to establish its own "goal line" for completion of NCTracks.

63.   When CSC was asked by the State to set the acceptance criteria, it could have declined the request based on the obvious conflict of interest, it could have asked another party— such as the supposedly independent Maximus—to set the criteria, or it could have chosen some other method of defining the acceptance criteria to measure objectively the true readiness of the system. Instead, CSC proceeded to define its own acceptance criteria by which its contract completion would be judged.

64.   Upon information and belief, CSC set the acceptance criteria not based upon end users' needs but upon its own desire to complete the project, regardless of the quality of the software. Indeed, acceptance criteria were developed concurrently with User Acceptance

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Testing ("UAT") and Production Simulation Testing ("PST"), indicating that they were written to match the test results, rather than to objectively set the goals toward which testing would be directed. The benefit to CSC, of course, was ensured contract compliance regardless of the software's readiness for go-live.

65. The effect of CSC setting its own acceptance criteria became obvious upon go-live. NCTracks was not ready to timely and reliably accept, process, and pay providers' valid Medicaid claims, and CSC was not able to timely remedy issues uncovered upon go-live before the issues caused harm to providers. CSC knew that this foreseeable harm would result regardless of NCTracks' compliance with the acceptance criteria it proposed. Upon information and belief, CSC further knew that the IV&V vendor, Maximus, did not perform truly independent verification and validation to ensure that testing was properly conducted, and knew that SLI had not adequately performed its testing duties.

66. CSC's setting its own acceptance criteria also robbed DHHS, the Plaintiffs, and the Class Members of a safety net if NCTracks was not ready for go-live. On February 28, 2013, the State decided to terminate the contract for the then-existing MMIS, and the State made this decision based upon NCTracks' having met the acceptance criteria that CSC itself had set. The effective date of the termination, which had been established months before based upon CSC's representations to the State, was just six days after go-live. At that point, NCTracks became the only system available to process reimbursement claims, and no backup was available. As was obvious upon go-live, the CSC-authored acceptance criteria had utterly failed to confirm that NCTracks was ready. NCTracks was a disaster, and the State was beyond the point of no return. It could not process reimbursement claims by any other means, it was stuck with a defective system, and it had no backup. This disaster was directly caused by CSC improperly defining the

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acceptance criteria, which induced the State to terminate the legacy system and accept the system for go-live.

67.   CSC owed a duty of care to users of NCTracks, independent of any contractual requirement that CSC believed it was required to meet upon go-live. By engaging in the conduct described above, CSC failed to exercise reasonable care to the Plaintiffs and the Class Members, who have been foreseeably harmed by the system's failures and by CSC's inability to support the system and timely remedy its many defects.

(2)   CSC's and SLI's Failure to Test the Software

68.   Any software system must be tested prior to its use to ensure that it performs according to defined functional requirements and that it performs adequately given how end users will foreseeably use the system.

69.   The software industry has established standards for testing software systems, and the adequacy of system testing can be readily measured against these standards. And yet, SLI and the other vendors failed to follow such basic industry standards for software testing on NCTracks. In May 2013, the North Carolina State Auditor issued a report in connection with a performance audit the State Auditor had conducted. The audit assessed whether UAT and PST had been adequate and sufficient. The State Auditor's report revealed that, as of May 2013, NCTracks had not been fully tested to confirm that it could produce and support the most critical business functions. Critical priority test cases had not been executed, key user role test cases had not been fully executed, and integrated test documentation did not exist. The State Auditor cautioned that if these issues were not corrected, a high risk existed that critical NCTracks functions would have major errors upon go-live.

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70.   UAT for NCTracks was conducted between August 29, 2012 and March 1, 2013. However, SLI and the other vendors had so utterly failed to test the software that by the end of UAT, 285 of the 834 "critical" test cases—i.e. tests of the main and basic features of the system—had not been performed *at all*. Moreover, 123 of the 834 critical test cases had failed. Importantly for the Plaintiffs and the Class Members, Defendants had neglected to perform 114 critical test cases that related directly to whether Medicaid providers could reliably use NCTracks.

71.   Upon information and belief, SLI knew about these deficiencies in the testing process. Further, while DHHS acknowledged the State Auditor's findings with respect to the inadequacy and incompleteness of UAT as of May 2013 and did not disagree with certain remedial recommendations, SLI did not follow these recommendations. Predictably, not long after go-live, the system experienced numerous catastrophic problems, including access-related issues that caused significant harm to users, including the Plaintiffs and Class Members.

72.   In addition, as discussed above, the testing process was flawed because CSC designed, developed, and implemented NCTracks *and* defined the acceptance criteria while testing was ongoing. Upon information and belief, SLI knew that the testing process was flawed, and nonetheless failed to conduct testing in a reasonable manner that would have avoided foreseeable harm to Medicaid providers.

73.   As the vendor responsible for testing, SLI owed a duty of care to the foreseeable users of NCTracks, including the Plaintiffs and Class Members. Specifically, SLI owed a duty to these users to perform all critical tests, using reliable testing processes prior to approval of NCTracks for go-live. This duty was independent of any contractual requirement that SLI believed it was required to meet during or upon conclusion of UAT and PST.

74.   SLI failed to conduct proper UAT and PST prior to approval of NCTracks for go-live. SLI failed to perform critical tests, failed to document certain test results, and followed highly flawed testing processes, among other things. The substantial harm suffered by users of NCTracks after go-live could have been avoided had SLI performed proper UAT and PST prior to go-live.

(3)   **Maximus' Failure to Conduct Independent Verification and Validation**

75.   The State hired Defendant Maximus to conduct IV&V for NCTracks. However, Maximus did not conduct truly *independent* verification and validation. Instead, Maximus relied almost exclusively on information obtained from SLI and CSC regarding the progress of software design, development, and testing. As a result, Maximus was unaware of critical issues with the testing environment.

76.   As the vendor responsible for oversight of all system testing, Maximus owed a duty of care to the foreseeable users of NCTracks, including the Plaintiffs and Class Members. Specifically, Maximus owed a duty to these users to conduct truly independent verification and validation to ensure that UAT and PST were properly conducted prior to approval of NCTracks for go-live. This duty was independent of any contractual requirement that Maximus may have believed it was required to meet.

77.   It was foreseeable that Maximus' failure to conduct independent verification and validation, and its exclusive reliance on reports and information provided by other vendors, would result in, among other things, an inability to identify and minimize system implementation risks, and a lack of knowledge of key details and issues regarding the testing environment. Upon information and belief, the substantial harm suffered by users of NCTracks after go-live could

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have been avoided had Maximus conducted truly independent verification and validation to ensure that UAT and PST were in fact properly conducted.

E.   The Defendants' Decision to Go-Live on July 1, 2013 and the Disastrous Results

78.   The May 2013 report by the Office of the State Auditor reported serious problems with the NCTracks project and warned against implementation of NCTracks on the July 1, 2013 go-live date unless corrective action was taken.

79.   The State Auditor's findings were sobering. The software had not been properly tested, the testing process was highly flawed, no defined test plan or testing acceptance criteria had been established, CSC was allowed to set its own testing criteria, no independent verification and validation had been performed, and no formal criteria to determine if NCTracks was ready for go-live had been established.

80.   The State Auditor's report unequivocally stated that NCTracks should not be launched on July 1, 2013 without significant and immediate corrective action.

81.   Despite the findings contained in this audit report and despite the clear warning of the harm that would be imposed on Medicaid providers if NCTracks went live without corrective action, Defendants nonetheless went live with the system on July 1, 2013.

82.   As predicted, upon the July 1, 2013 go-live, the Plaintiffs and the Class Members experienced, and continue to experience, catastrophic software errors and design problems with NCTracks. Examples of those errors and design problems include:

      (a)   Physicians and other medical professionals must be re-credentialed in order to maintain eligibility as Medicaid providers. However, errors in NCTracks have prevented many individual providers from being re-credentialed, thus causing them and their practices to be denied Medicaid reimbursements entirely. NCTracks has also erroneously forced certain providers to pay the $100 re-credentialing fee twice.

      (b)   The "electronic remittance advice" feature was purportedly redesigned in NCTracks to be simpler and more provider-friendly, thereby reducing paperwork.

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However, the redesigned feature is flawed, and requires much longer documentation, thereby forcing Medicaid providers to contend with thousands of pages of paper in order to reconcile reimbursement claims. This has imposed extreme administrative burdens on providers.

(c)   NCTracks requires providers to use an electronic signature in order to submit enrollment applications. This is done by a separate, automated, blind validation process using a personal identification number, or PIN. On many occasions, providers have requested PINs, but failed to receive them. This has caused major delays, and stymied providers' efforts to fix even straightforward problems with enrollments. Thousands of providers' attempted enrollments have failed or been delayed, resulting in a large number of reimbursement denials.

(d)   NCTracks has a locator check, so that if the place of service specified on a reimbursement claim does not match up with the location reflected in a provider's records, the claim will be denied. If the locator detects a mismatch, the reimbursement is sent to "pending status" indefinitely. Many times, the locator check has incorrectly sent claims into this status, and as a result providers have not been paid reimbursements that are due and owing.

(e)   "Manage Change" is the NCTracks feature that a provider must use to modify its Medicaid provider enrollment record. Any modification, however minor (even correcting a typographical error in a provider's address), requires the provider to re-enter the *entire* provider enrollment application. Then, once submitted, the request to change an enrollment record must be reviewed and approved by DHHS. This has resulted in a massive backlog of Manage Change requests, which has resulted in denied and delayed reimbursements.

(f)   NCTracks has an "Office Administrator" feature that extends to one person, and one person only per Medicaid provider, full rights to authorize changes in the system. There is some ability to create other users, but those users are restricted from using all features in the program. This has created major administrative burdens for providers.

(g)   NCTracks requires that each individual provider have an individual NPI (a national provider identifier) and that this individual provider be affiliated with a group NPI. As a result of errors in NCTracks, many individual providers were affiliated with the wrong groups, leading to denials of reimbursements.

(h)   The design of NCTracks has no feature that allows a provider to determine what type of Medicaid coverage a patient has, which is very important factor to a provider that is attempting to determine whether to accept the patient for treatment. Medicaid provides many types of coverage, and certain services are excluded depending upon the type of coverage a patient has. Without knowing the type of Medicaid coverage, providers are placed in a position of having to treat patients at the risk of not being paid for their services. For example, Plaintiff Nash treats patients for OB-GYN-

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specific matters and for general health care matters, such as upper respiratory infections. However, NCTracks does not indicate a patient's type of Medicaid coverage, and when Nash calls the State for information about coverage, no one is able to answer questions. Nash is therefore faced with a choice of not accepting a patient for treatment who could have an emergent condition or treating the patient at the risk of not being reimbursed. Providers such as Nash treat such patients, and as a result are not reimbursed when Medicaid does not cover the services.

83.   In addition to experiencing these software errors and design problems, the

Plaintiffs and the Class Members were denied reimbursements simply because of errors in

NCTracks, and they continue to be denied reimbursements because of the faulty system.

Examples of specific reimbursements that have been denied include:

(a)   NCTracks incorrectly applied the co-pay amount for Medicaid patients. Immediately upon go-live, providers began receiving reimbursements in which they were "shorted" $2 per Medicaid claim because NCTracks calculated a Medicaid recipient's deductible as $5 instead of $3. In other words, providers were collecting a $3 co-pay from patients, as required by Medicaid, but NCTracks directed reimbursements based upon a $5 co-pay, resulting in the $2 short-pay to providers.

(b)   Reimbursement for Medicare "Crossover" claims were reduced over $10 per claim or eliminated entirely. Prior to the implementation of NCTracks, when a patient had coverage by both Medicare and Medicaid, the Medicare coverage would pay the allowable under Medicare. Medicaid would then pay a portion of the remainder. When NCTracks was implemented, this Medicaid payment was reduced or eliminated.

(c)   NCTracks failed to pay for Pregnancy Medical Home services. The Pregnancy Medical Home program pays OB-GYN practices extra fees in order to accept an expectant mother who is a Medicaid patient and to retain her for the entire pregnancy. NCTracks simply failed to pay these extra fees that were required by the Medicaid program, and the system also failed to pay additional incentive payments for health history forms and health risk assessments.

(d)   NCTracks failed to implement reimbursement increases mandated by the Affordable Care Act. Beginning January 1, 2013, Medicaid primary care services must be paid at Medicare rates for two years. However, NCTracks simply did not implement this change, and primary care physicians were shorted the difference between Medicare and Medicaid reimbursement rates.

(e)   NCTracks, without explanation, rejected claims for injections and vaccines, including "17P" injections (progesterone injections that help prevent pre-term births in high-risk pregnancies), T-DAP vaccines (an important vaccine administered to expectant mothers), adult vaccines, vaccines administered to children during Well Child

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Visits, and allergy injections. Prior to NCTracks, reimbursements for these injections and vaccines were paid regularly. However, NCTracks rejected these claims as of July 1, 2013. The Plaintiffs and the Class Members were not paid for providing these important services, they were not paid for the injections/vaccines that they had purchased to administer to their patients, and in some cases they were not paid for the office visits at which these vaccines and injections were administered.

(f)   NCTracks rejects reimbursement claims for ultrasounds and other procedures, even though authorization has been obtained. Without explanation, NCTracks rejects reimbursement claims for these procedures on the basis of lack of authorization, when the provider is plainly entitled to reimbursement. Moreover, system errors have prevented providers from submitting authorization forms and from receiving authorization confirmations from DHHS. The authorization errors have resulted in total denials of reimbursement.

(g)   Similar to the authorization problem, numerous reimbursement claims have been denied due to a supposed lack of patient consent forms on file. This has been particularly prevalent with providers who perform sterilizations and hysterectomies. These providers have had thousands of reimbursement claims denied for a supposed lack of consent forms, when the forms have actually been submitted.

(h)   Data files containing certain providers' enrollment data were not properly converted for use in NCTracks, resulting in total denial of reimbursements to these providers. When NCTracks went live, certain providers were not properly enrolled in Medicaid simply because their data had not been converted correctly. This error manifested itself in a number of ways, including wrong NPIs appearing in NCTracks, a physician's affiliation with a practice being dropped when it should not have been, and physicians or groups being terminated from the Medicaid program. The impact was the same, with none of the providers receiving payment because they were not properly enrolled.

(j)   Carolina Access patients were improperly assigned by NCTracks. "Carolina Access" is a program that is part of Community Care of North Carolina. Patients who participate in this program are assigned to specific doctors. When NCTracks went live, thousands of patients were assigned to the wrong doctors. As a result, the properly-assigned physician could not get reimbursed for treating a Carolina Access patient unless a separate authorization was received, and many physicians have had reimbursement claims rejected entirely.

84.   When the Plaintiffs and Class Members began to use NCTracks, it was apparent that the pre-implementation training that CSC had conducted was completely inadequate to prepare Medicaid providers for NCTracks. For example, CSC hosted a webinar weeks prior to go-live, which included screen shots and other specific examples of how NCTracks would

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operate. However, when NCTracks went live, the features that had been demonstrated to the Plaintiffs and the Class Members were not included in the operating version of the software. Furthermore, during pre-implementation training, errors in the software were apparent, and CSC told the Plaintiffs and the Class Members that these errors would be corrected in the live version. CSC did not, in fact, correct these errors.

F.   Negligent Operation of NCTracks and Failure to Correct Defects

85.   The wrongful acts committed by Defendants have been greatly compounded by CSC's negligent operation of NCTracks and its failure to correct the defects in the system.

86.   One of the primary problems with CSC's operation of NCTracks is its negligent operation of the Call Center. The Call Center was intended to be a hotline for Medicaid providers who ran into problems with NCTracks. Ostensibly, the Call Center would answer the Plaintiffs' and the Class Members' questions and resolve the problems they encountered.

87.   In reality, the Call Center staff is inexperienced and simply cannot address the vast majority of problems that the Plaintiffs and the Class Members have encountered. Call Center personnel typically respond to questions with "that's a known problem, with no known solution," "that's a problem I'm unable to assist you with," "I'm going to escalate this," or some equally unhelpful response. Call Center representatives often do little or nothing more than create "tickets" (written records of the problems), escalate them to a senior representative, and promise that someone will call back about the problems.

88.   It is apparent that Call Center personnel have not received even the most basic training in medical reimbursement processing. For example, terms such as "allowable" and "deductible" are simple concepts in medical billing and reimbursement, but Call Center personnel frequently are unfamiliar with basic terms such as these. Moreover, these personnel

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are plainly unknowledgeable about Medicaid reimbursement, the operation of NCTracks, and related issues that are needed to address providers' problems.

89.   The problems with the Call Center have not improved, despite CSC's attempts to portray progress. For example, one of the main problems with the Call Center was CSC's failure to timely answer calls, which resulted in a nearly 63.9% "call abandon" rate (i.e. the Plaintiffs and the Class Members would simply hang up because they were put on hold for too long). Instead of improving the underlying service, CSC just changed the way it handled calls to reduce this "call abandon" rate. CSC now answers calls promptly and tells providers that it will call them back. These callbacks rarely occur, and no substantive help is offered. However, by using this method, CSC superficially reduced its "call abandon" rate to 0.49% by early October, 2013, despite failing to improve Call Center services.

90.   Some of the "fixes" to the software have been merely temporary. In numerous cases, the Plaintiffs and the Class Members have complained about NCTracks' denying legitimate reimbursement claims due to software errors, and CSC has ostensibly fixed the errors. After processing reimbursements properly for a short period, however, NCTracks would again begin denying claims due to the same errors. And, many times, new problems have arisen even as old problems have been addressed.

91.   Moreover, even when software errors have actually been fixed, DHHS has failed to pay the Plaintiffs and the Class Members for reimbursements that were improperly denied between July 1, 2013 and the date the error was fixed. As a result, the Plaintiffs and the Class Members have not been paid reimbursements that are due and owing to this day. For example, beginning on July 1, 2013, Plaintiff Abrons and other members of the Co-Pay Subclass (as defined below in paragraph 143(h)) began receiving reimbursements in which they were

"shorted" $2 per Medicaid claim because NCTracks calculated a Medicaid recipient's deductible as $5 instead of $3. CSC then corrected this error, and Abrons began receiving reimbursements based upon the properly-applied $3 co-pay. However, DHHS has not paid the $2 per claim that it failed to pay Abrons between July 1, 2013 and the time it began paying reimbursements as required by law. This same problem has occurred with several other categories of reimbursements.

92.   Defendants' wrongful acts not only have caused harm to the Plaintiffs and the Class Members but have also adversely affected North Carolina citizens who are eligible for Medicaid. For example, as a direct result of the financial harm that Defendants inflicted on providers, Plaintiff Nash was forced to stop accepting new Medicaid patients as of January 1, 2014. Because of the NCTracks problems, Plaintiff Nash, which is a major Ob-Gyn practice in Rocky Mount, simply cannot serve Medicaid patients as it has in the past. Upon information and belief, Defendants' wrongful acts have caused and will continue to cause limitation of health care resources to North Carolina's citizens who are Medicaid eligible.

G.   The Reckless and Intentional Harm to Plaintiffs and the Class Members by CSC, Maximus, and SLI

93.   The facts alleged above reveal that CSC, Maximus, and SLI were fully aware that NCTracks was not ready for implementation upon go-live and that Medicaid providers would suffer severe harm if NCTracks were implemented in its existing condition on July 1, 2013. Nonetheless, these defendants intentionally and willfully implemented a software system they knew would cause harm to the Plaintiffs and the Class Members.

94.   The facts alleged also reveal that CSC, Maximus, and SLI made reckless decisions regarding the NCTracks project and disregarded the rights of the end users of NCTracks. Indeed, the facts show that these defendants knew that they were following a highly

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flawed testing process, knew that no independent verification and validation had been conducted, knew that CSC could manipulate acceptance criteria to deliver a system that was not ready for implementation, and knew that NCTracks indeed was not ready for implementation on July 1, 2013. These defendants nonetheless proceeded with developing and implementing the highly unstable and flawed system, directly causing serious harm to the Plaintiffs and Class Members.

95.   Upon information and belief, CSC also misrepresented the then-existing status of the software by informing the State that NCTracks met acceptance criteria, when CSC knew that the acceptance criteria was not in fact a reflection of the readiness of NCTracks for actual operation. This misrepresentation caused the State to terminate the HP contract and approve NCTracks for the July 1, 2013 go-live.

96.   Upon further information and belief, these defendants provided other false information to the State about the readiness of NCTracks which resulted in the implementation of the system before it was ready.

IV.   THE DAMAGE CAUSED BY DEFENDANTS' WRONGFUL CONDUCT

A.   The Harm Suffered by the Plaintiffs and Sought in Their Individual Capacity

97.   The Plaintiffs have suffered significant harm as a result of Defendants' actions. This harm consists of reimbursements that have been improperly denied or underpaid, and damage to the Plaintiffs' businesses. In some circumstances, DHHS has not paid reimbursements that have been due and owing since June 20, 2013, which was the last checkwrite prior to NCTracks go-live. The specific categories of damages that the Plaintiffs have suffered and seek in their individual capacities are as follows:

(a)   Reimbursements were not paid because CSC did not properly convert enrollment data for certain of the Plaintiffs' individual providers, and the individual providers were therefore not enrolled in Medicaid. These damages are comprised of the

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total of reimbursement claims since July 1, 2013 that have not been paid as a result of this data conversion error.

(b)   Reimbursements were not paid for treatment of properly-assigned Carolina Access patients who were incorrectly re-assigned due to NCTracks. The damages are comprised of the total of reimbursement claims for these Carolina Access patients that were denied because of the incorrect assignment of its patients.

(c)   Reimbursements were not paid because NCTracks errors prevented re-credentialing of physicians and resulted in denial of all reimbursement claims for these physicians. The damages are comprised of the total of reimbursement claims for these physicians that were unpaid due to a lack of credentialing.

(d)   Reimbursements were not paid for treatment of Medicaid patients for whom type of Medicaid coverage was unknown and unascertainable. The damages are comprised of the total of reimbursement claims that were denied because the type of treatment was not covered by the patient's Medicaid.

(e)   Reimbursements were not paid due to PINs being unavailable, and enrollment applications could not be submitted. The damages are comprised of the total of reimbursement claims that were denied because a provider was not enrolled.

(f)   Reimbursements were not paid because NCTracks incorrectly assigned individual providers to the wrong group NPI. The damages are comprised of the total of reimbursement claims that were denied because individual providers were assigned to the wrong group NPI.

(g)   Reimbursements were not paid because NCTracks' use of taxonomy codes is unworkable. The damages are comprised of the total of reimbursement claims that were denied because providers entered the wrong taxonomy codes for reimbursement.

(h)   The Plaintiffs have also suffered harm to their businesses as a result of Defendants' conduct. Among other things, the Plaintiffs have suffered damages in the form of salaried employee time diverted to addressing the problems imposed by NCTracks; hiring of additional employees; additional wages and overtime paid for employees to contend with NCTracks; interest on loans taken to cover cash flow shortages due to non-payment of reimbursements; lost clinical time; lost profits for services they have been unable to perform; and similar harm to the Plaintiffs' businesses.

B.   **The Harm Suffered by the Class Members and Claims Brought on a Class Basis**

98.   The Plaintiffs bring claims on behalf of themselves and the Class Members and Subclass Members (as defined below in paragraphs 142 through 143) for certain claims that are susceptible to and best resolved on a class-wide basis.

(1) $2 Co-Pay "Short"

99.   A Medicaid recipient is required to pay a $3 co-pay for specified services. However, CSC negligently designed NCTracks so that the co-pay applied to such services was $5. So, when NCTracks went live on July 1, 2013, Medicaid claims were submitted with the proper $3 co-pay having been collected from the patient, but NCTracks paid the reimbursable amount at the $5 co-pay level. This assumed that the provider had collected $2 more from the Medicaid recipient than had actually been collected. As a result of this error, the Plaintiffs Abrons, Capital Nephrology and Children's Health and the Co-Pay Subclass Members (as defined below in paragraph 143(a)) were "shorted" by $2 for each of these claims.

100.   The software error that caused the $2 short-pay was ultimately fixed, but the error has recurred, causing more short-pays. For example, for the December 4, 2013 payments from DHHS, Plaintiff Abrons discovered that NCTracks had apparently begun randomly applying a $5 co-pay again.

101.   Plaintiffs Abrons, Capital Nephrology and Children's Health and the Co-Pay Subclass Members have been underpaid on Medicaid reimbursement claims by being "shorted" $2 on claims to which a $3 co-pay applied.

102.   The damages suffered by the Plaintiffs Abrons, Capital Nephrology and Children's Health and the Co-Pay Subclass Members can be calculated by a common methodology and in a single, uniform, and mechanical manner. To establish the damages, one need only identify the claims for which NCTracks incorrectly applied the $5 co-pay amount, then multiply those claims by $2.

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(2)   Medicare Crossover

103.   When a patient is "dual eligible" for Medicare and Medicaid, a provider submits the claim to Medicare. Medicare pays its portion of the claim, then submits the claim to Medicaid for payment of the remainder of the allowable portion of the claim. Medicaid then must pay the provider the Medicaid portion.

104.   By way of example, for a service that is billed at a total amount of $100, a provider would submit the $100 bill to Medicare. Medicare would then pay the Medicare allowable amount, in this example $80, leaving $20 unpaid to the provider. Medicaid would then pay a portion of the $20 remainder. These amounts are based upon established payment rules that existed prior to July 1, 2013.

105.   As of July 1, 2013, DHHS began paying providers using a new payment methodology for Medicare Crossover claims. However, DHHS did not follow applicable procedures for changing the payment methodology for these Medicare Crossover claims and the newly-imposed payment methodology is invalid.

106.   As a result of DHHS's improper payment of Medicare Crossover claims, each of the Plaintiffs and the Medicare Crossover Subclass Members (as defined below in paragraph 143(b)) has been underpaid specified amounts for the services they have provided to Medicaid recipients.

107.   The Plaintiffs and the Medicare Crossover Subclass Members have also been improperly denied reimbursement entirely for certain Medicare Crossover claims.

108.   The amount of damages suffered by the Plaintiffs and the Medicare Crossover Subclass Members can be calculated by a common methodology and in a single, uniform, and mechanical manner. Specifically, for each underpayment or non-payment, one can refer to the

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Current Procedural Terminology ("CPT") code for the service provided, the amount Medicare pays for that CPT Code, the amount that Medicaid pays for that CPT Code, and the amounts applicable to payment of Medicare Crossover claims. Using this information, one can thereby calculate the amount per claim that was either underpaid or not paid at all.

(3)   **Pregnancy Medical Home**

109.   "Pregnancy Medical Home" is a special program run by DHHS that pays OB-GYN practices extra fees and incentive payments in order to accept Medicaid recipients who are expectant mothers. The program incentivizes providers to retain Medicaid recipients as patients for the duration of their pregnancies and post-partum, thus increasing the quality of healthcare provided to these Medicaid recipients and their children.

110.   Among the specific fees and incentive payments to which Medicaid providers are entitled under the Pregnancy Medical Home program are a total payment for the entire pregnancy, which is due after delivery, an incentive payment to complete a health history form, and an incentive payment to complete a health risk assessment.

111.   When NCTracks went live on July 1, 2013, it simply failed to pay these extra fees and incentive payments that were required by the Medicaid program.

112.   Plaintiff Highland and other PMH Subclass Members (as defined below in paragraph 143(c)) have not been paid reimbursement claims for the fees and incentive payments that are due to them under the Pregnancy Medical Home program.

113.   The amount of damages suffered by Plaintiff Highland and the PMH Subclass Members can be calculated by a common methodology and in a single, uniform, and mechanical manner. Specifically, for each non-payment, one can refer to the CPT Codes for the unpaid fees

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and incentive payments and identify the amount due, refer to the total number of unpaid fees and incentive payments under these CPT Codes, and thereby calculate the damages.

(4)   ACA-Required Payment Rates

114.   The Affordable Care Act requires that Medicaid providers be paid at Medicare rates for primary care services beginning on January 1, 2013.

115.   In accordance with its obligation to pay at the higher rates, DHHS has published a fee schedule stating the reimbursement amounts for which it will pay Medicaid providers for primary care services.

116.   Despite this published fee schedule, DHHS has failed to pay reimbursement claims in accordance with the fee schedule.

117.   Plaintiffs Abrons, Children's Health and Halifax and the ACA Rate Subclass Members (as defined below in paragraph 143(d)) have been underpaid on such reimbursement claims because DHHS has not paid them in accordance with the published fee schedule since January 1, 2013.

118.   The amount of damages suffered by Plaintiffs Abrons, Children's Health and Halifax and the ACA Rate Subclass Members who have provided primary care services can be calculated by a common methodology and in a single, uniform, and mechanical manner. Specifically, for each non-payment, one can refer to the CPT Codes for primary care services, refer to the State's published rate schedule for those CPT Codes, refer to the Medicaid reimbursement rate for those CPT Codes, and identify the total number of reimbursement claims for those CPT Codes. One can then calculate the damages mechanically.

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(5)   <u>**Injections and Vaccines**</u>

119.   Medicaid providers are entitled to reimbursement for administering vaccines and injections to their Medicaid-eligible patients.

120.   However, when NCTracks went live on July 1, 2013, the system simply rejected claims for specific injections and vaccines. These included "17P" injections (progesterone injections that help prevent pre-term births in high-risk pregnancies), T-DAP vaccines (an important vaccine administered to expectant mothers), adult vaccines, vaccines administered to children during Well Child Visits, and allergy injections. NCTracks also paid some of the claims for injections and vaccines, but then denied reimbursements for the office visits at which the injections and vaccines were administered.

121.   Plaintiffs Nash, Highland, Abrons, Children's Health, Halifax and Hickory and the Injections/Vaccines Subclass Members (as defined below in paragraph 143(e)) have not been reimbursed for providing these vaccines and injections or for the office visits at which these vaccines and injections were administered.

122.   The amount of damages suffered by the Plaintiffs Nash, Highland, Abrons, Children's Health, Halifax and Hickory and the Injections/Vaccines Subclass Members can be calculated by a common methodology and in a single, uniform, and mechanical manner. Specifically, one need only refer to the CPT Codes for each of the vaccines and injections, refer to the amount to be paid for each, and identify the total number of unpaid vaccines and injections. One can thereby calculate the damages.

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(6)   Patient Consents

123.   Medicaid reimbursements for certain procedures require signed, written consent from the patient to perform a procedure. Examples of these procedures include sterilizations and hysterectomies.

124.   Plaintiffs Nash and Highland and other Patient Consent Subclass Members (as defined below in paragraph 143(f)) have submitted reimbursement claims for procedures with proper consent from the patients. However, without explanation, NCTracks has rejected reimbursement for these procedures supposedly for lack of consent, when the provider is plainly entitled to reimbursement. Moreover, system errors have prevented providers from submitting consent forms. This has resulted in total denials of reimbursement.

125.   The amount of damages suffered by Plaintiffs Nash and Highland and the Patient Consent Subclass Members can be calculated by a common methodology and in a single, uniform, and mechanical manner. Specifically, one need only refer to the CPT Codes for each of the properly consented-to procedures, refer to the amount to be paid for each of these procedures, and identify the total number of unpaid reimbursements. One can thereby calculate the damages.

(7)   Prior Approvals

126.   Similar to patient consents, Medicaid reimbursements for certain procedures require prior authorization from DHHS. An example of such procedures includes ultrasounds, among others.

127.   Plaintiffs Nash, Highland, Halifax, and Hickory and other Prior Approval Subclass Members (as defined below in paragraph 143(g)) have submitted reimbursement claims for procedures with proper prior authorization. However, without explanation, NCTracks has rejected reimbursement for these procedures supposedly for lack of authorization, when the

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provider is plainly entitled to reimbursement. Moreover, system errors have prevented providers from submitting authorizations and from receiving authorization confirmations from DHHS. This has resulted in total denials of reimbursement.

128.   The amount of damages suffered by Plaintiffs Nash, Highland, Halifax, and Hickory and the Prior Approval Subclass Members can be calculated by a common methodology and in a single, uniform, and mechanical manner. Specifically, one need only refer to the CPT Codes for each of the properly approved procedures, refer to the amount to be paid for each of these procedures, and identify the total number of unpaid reimbursements. One can thereby calculate the damages.

(8)   Time Value of Money

129.   The Defendants' wrongful conduct caused massive delays in payment of reimbursements that were due and owing but simply were not paid due to errors in NCTracks. By one estimate, the State failed to pay nearly $700 million in the first 90 days of NCTracks' operation alone.

130.   Each of the Plaintiffs and the Time Value Subclass Members (as defined below in paragraph 143(h)) has suffered damages as a result of delays in payment of reimbursement claims. Such payments were delayed but ultimately paid, albeit late, and the amounts due, having been paid, are not subject to a claim of damages in this case. However, the Plaintiffs and the Time Value Subclass Members are entitled to recover the time value of the money that was owed, was paid, but was paid late as a result of errors in NCTracks.

131.   The amount of damages suffered by the Plaintiffs and the Time Value Subclass Members can be calculated by a common methodology and in a single, uniform, and mechanical manner. To calculate the time value of money that is owed to the Plaintiffs and the Time Value

Subclass Members, one need only identify the time period of the delayed payments, the total monetary amount of the delayed payments, and apply an acceptable interest rate, thereby deriving the total amount due.

C.   Continuing Harm to the Plaintiffs and the Class Members

132.   The damages described above resulted from errors in NCTracks, and many of CSC's fixes to NCTracks have not been permanent. For example, after Plaintiff Abrons struggled with an improper NPI designation and CSC purportedly fixed this problem, NCTracks again mis-designated Plaintiff Abrons' NPI number, resulting in denials of reimbursement claims. Upon information and belief, the Plaintiffs and the Class Members have suffered additional damages in like manner. Any damages arising in the future as a result of a recurrence of software errors are also subject to this suit.

133.   Additional problems with NCTracks and CSC's operation of NCTracks are ongoing and are arising anew, and as a result the Plaintiffs and the Class Members continue to suffer harm from Defendants' ongoing negligence. The Plaintiffs and the Class Members are entitled to recovery for damages resulting from Defendants' acts of negligence that are identified at a later date.

D.   Futility and Inadequacy of Administrative Remedies

134.   Although administrative procedures are provided for appealing the underpayment or denial of Medicaid reimbursement claims, those procedures do not provide a means for the Plaintiffs and the Class Members to compel the State to follow Medicaid reimbursement rules or to recover certain damages sought in this civil action. In addition, the administrative procedures are futile and inadequate. Accordingly, the Plaintiffs and the Class Members are not required to exhaust their administrative remedies.

135.   Administrative procedures cannot compel the State to follow Medicaid reimbursement rules. One of the primary causes of action in this lawsuit addresses the fact that NCTracks has placed the State out of compliance with Medicaid reimbursement rules, and Plaintiffs seek to compel the State's compliance with the law. No administrative procedures exist that could grant such a remedy.

136.   Administrative procedures cannot award certain damages sought by the Plaintiffs and the Class Members. The administrative procedures only allow Medicaid providers to appeal the amount of the wrongfully denied reimbursement. No procedures exist to recover for damage to the Plaintiffs' businesses, to recover for payment of the $100 re-enrollment fee that was paid when not actually due, and to recover damages in the form of time value of money.

137.   Administrative remedies are futile and inadequate because they are entirely impractical in light of the amount per claim owed. To appeal underpayment or non-payment of a reimbursement claim, a Medicaid provider must obtain a final determination by DHHS for each individual claim that the amount paid or the non-payment is correct, according to DHHS. The provider then must appeal each determination by initiating a contested case under the Administrative Procedures Act. The amounts at issue in this lawsuit, on an individual basis, make such procedures entirely impractical, and administrative remedies are therefore futile and inadequate. For example, Plaintiff Abrons' claim for the $2 co-pay short totals approximately 150 to 200 reimbursement claims at $2 each. Plaintiff Abrons, the other Plaintiffs, and the Class Members should not be expected to pursue contested cases under the APA for individual claims totaling approximately $400 each. Moreover, if each of the Plaintiffs and the Class Members pursued administrative remedies for each of the reimbursement claims at issue in this civil action on an individual basis, there would be no effective relief because the sheer volume of appeals

could not be effectively administered. Finally, as detailed above, determination of liability and

damages for such claims does not need to be determined on an individualized basis.

138.   Administrative remedies are also futile and inadequate because DHHS and CSC

have acted in a manner that makes pursuing administrative remedies impractical or impossible.

For example:

(a)   DHHS cannot even process certain claims because NCTracks strictly adheres to the use of taxonomy codes, and claims prior to July 1, 2013 were submitted through the legacy system, which did not require taxonomy codes. Without the taxonomy codes, DHHS cannot process the claims, and the providers are left with no remedy at all. Moreover, the manner in which DHHS requires providers to obtain the correct reimbursement for improperly denied reimbursements would require providers to review each and every claim in detail, thereby making receipt of reimbursement entirely impractical.

(b)   DHHS and CSC have also prevented Medicaid providers from submitting claims for reimbursement. A Medicaid provider has one year after the service is provided to submit a claim. Providers have submitted claims in NCTracks for services that were provided prior to Go Live, but NCTracks caused these claims to appear as not having been submitted. Then, when the providers were informed that the claims were appearing as not submitted, they resubmitted them, only to be told the claim submissions were not timely.

(c)   DHHS and CSC have also placed thousands of reimbursement claims in "limbo" by failing to issue decisions on reimbursement claims. The providers have been informed by DHHS and CSC that they must resubmit the claims, and providers' claims have been resubmitted as many as a dozen times, with no reimbursement and no final determination that the amount is or is not payable. The providers therefore have no administrative remedies available to them for such claims because they have no agency decision from which to appeal.

139.   Finally, the Plaintiffs and the Class Members are left with no administrative

remedies because the implementation of NCTracks has led to a complete breakdown of

reimbursement procedures throughout North Carolina's Medicaid system. The administrative

remedies provided by statute and regulation envision a Medicaid provider having the right to

dispute reimbursement denials and underpayments within DHHS, through the Office of

Administrative Hearings, then ultimately in Superior Court. But the first step in this process—

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disputing with DHHS—is not available to Medicaid providers because of the overwhelming number of reimbursement errors and because of DHHS' utter inability to address providers' issues. Simply put, NCTracks has caused the reimbursement system and appeals of reimbursement errors to break down, and providers have no redress in DHHS. Because providers cannot initiate the process of administrative appeals in DHHS, there are no administrative remedies available to these providers.

140. The above examples describe some of the aspects of the administrative process that ultimately provides no adequate remedies to the Plaintiffs and the Class Members.

V.   CLASS ACTION ALLEGATIONS

141. Plaintiffs bring this action pursuant to Rule 23 of the North Carolina Rules of Civil Procedure.

A.   Definitions of the Class and the Subclasses

142. As detailed above in paragraphs 1 through 140, North Carolina Medicaid providers assert specific categories of claims based upon harm suffered as a result of the implementation of NCTracks. All Medicaid providers who have suffered those damages and who assert those claims are defined as the "Class Members" in this Complaint. Each of the Class Members are persons or entities who are (a) Medicaid providers (b) who have entered into Medicaid provider contracts with DHHS and (c) who have used the NCTracks system to submit claims for reimbursement or who have been owed reimbursement payments since July 1, 2013.

143. The Class Members are further defined and divided into Subclasses based upon the types of claims and harm suffered. Specifically, these Subclasses are defined as follows:

(a)   The "Co-Pay Subclass" is defined as all persons and entities who meet the definition of a Class Member as stated in paragraph 142 above and additionally who have submitted Medicaid reimbursement claims for services to which a $3 co-pay applies but

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for which NCTracks reimbursed the providers based upon the assumption that a $5 co-pay applied.

(b)   The "Medicare Crossover Subclass" is defined as all persons and entities who meet the definition of a Class Member as stated in paragraph 142 above and additionally who have submitted Medicaid reimbursement claims for services provided to dual-eligible patients and who have not been reimbursed by Medicaid at the proper rates, which existed prior to July 1, 2013.

(c)   The "PMH Subclass" is defined as all persons as all persons and entities who meet the definition of a Class Member as stated in paragraph 142 above, and additionally who are OB-GYN practices, who participate in the Pregnancy Medical Home program, who have provided services to Medicaid patients in the Pregnancy Medical Home program, who have submitted reimbursement claims under the Pregnancy Medical Home program, and who have either been paid less than owed or who have not been paid at all for these claims.

(d)   The "ACA Rate Subclass" is defined as all persons and entities who meet the definition of a Class Member as stated in paragraph 142 above and additionally who have provided primary care services to Medicaid patients for which DHHS is obligated to pay at the higher scheduled rates but for whom reimbursements have been paid at the existing Medicaid rates.

(e)   The "Injections/Vaccines Subclass" is defined as all persons and entities who meet the definition of a Class Member as stated in paragraph 142 above and additionally who have administered injections and vaccines to Medicaid patients but who have not been paid in full for the service of administering the injection/vaccine, the injection vaccine itself, and/or the office visit at which the injection/vaccine was administered.

(f)   The "Patient Consent Subclass" is defined as all persons and entities who meet the definition of a Class Member as stated in paragraph 142 above and additionally who have performed procedures for which signed, written patient consent is required, who have submitted reimbursement claims for these procedures, but who have not been paid in full for such procedures.

(g)   The "Prior Approval Subclass" is defined as all persons and entities who meet the definition of a Class Member as stated in paragraph 142 above and additionally who have performed procedures for which prior DHHS approval is required, who have submitted reimbursement claims for these procedures, but who have not been paid in full for such procedures.

(h)   The "Time Value Subclass" is defined as all persons and entities who meet the definition of a Class Member as stated in paragraph 142 above and whose reimbursement payments were late, but ultimately paid, as a result of the implementation of NCTracks.

B.   Numerosity

144.   Approximately 70,000 health care and other professionals provide services to Medicaid-eligible recipients in North Carolina, and nearly all North Carolina Medicaid providers have been harmed by the implementation of NCTracks. The majority of the 70,000 Medicaid providers have suffered some form of the damages that are sought to be recovered as class damages, and these providers are therefore within the definition of the Class and the Subclasses. Members of the Class and the Subclasses are therefore so numerous that joinder of all members is impracticable.

C.   Common Questions of Law and Fact

145.   There are questions of law and fact which are common to members of the Class and the Subclasses and which predominate over any questions affecting only individual members. Specifically:

(a)   Whether CSC, Maximus, and SLI were negligent in the design, development, implementation, and operation of NCTracks and thereby damaged the Plaintiffs, the Class Members, and the Subclass Members.

(b)   Whether CSC, Maximus, and SLI acted intentionally, recklessly, and deceptively in harming the Plaintiffs, the Class Members, and the Subclass Members and therefore committed unfair or deceptive trade practices in violation of N.C. Gen. Stat. 75-1.1.

(c)   Whether CSC, Maximus, and SLI are jointly and severally liable to the Plaintiffs, the Class Members, and the Subclass Members for their negligence and for their unfair or deceptive trade practices.

(d)   Whether DHHS breached the provider contracts it entered into with the Plaintiffs, the Class Members, and the Subclass Members.

(e)   Whether the State violated the constitutional rights of the Plaintiffs, the Class Members, and the Subclass Members.

(f)   Whether the Plaintiffs, the Class Members, and the Subclass Members are entitled to declaratory and injunctive relief against the State.

(g)   Whether as a result of Defendants' wrongful acts the Plaintiffs, the Class Members, and the Subclass Members have suffered damages, and if so the amount of damages to which they are entitled.

D.   Typicality

146.   The claims of the Plaintiffs are typical of the claims of the other members of the Class and the Subclasses. The Plaintiffs and each of the other Class Members and Subclass Members have been harmed by the same wrongful acts of the Defendants. The Plaintiffs' claims arise from the same wrongful conduct that give rise to the Class Members' and the Subclass Members' claims and are based upon the same legal theories.

E.   Other Class Considerations

147.   The Plaintiffs are committed to prosecuting this action and have retained counsel competent and experienced in litigation of this nature. The Plaintiffs are adequate representatives of the Class and the Subclasses and will fairly and adequately protect their interests. The Plaintiffs have no interests that are adverse or antagonistic to the interests of the Class and the Subclasses.

148.   A class action is superior to all other available methods for the fair and efficient adjudication of the class claims because individual litigation of the class claims is economically infeasible and procedurally impracticable. While the damages suffered by the Class Members and the Subclass Members in the aggregate are substantial, the individual damages sought under the class claims are too small to warrant the expense of individual suits. The likelihood of individual Class Members and Subclass Members prosecuting their own separate claims is remote, and even if every Class Member and Subclass Member could afford individual litigation, the court system would be unduly burdened by individual litigation of such cases. Further, individual Class Members and Subclass Members do not have a significant interest in

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individually controlling the prosecution of separate actions, and individualized litigation would also result in varying, inconsistent, or contradictory judgments and would magnify the delay and expense to all of the parties and the court system because of multiple trials of the same factual and legal issues. The Plaintiffs know of no difficulty to be encountered in the management of this action that would preclude its maintenance as a class action.

149.   Moreover, Defendants have acted or refused to act on grounds generally applicable to the Class and the Subclasses and, as such, final injunctive relief and corresponding declaratory relief with regard to the Class Members and the Subclass Members as a whole is appropriate.

150.   The Plaintiffs do not anticipate any difficulty in the management of this litigation. Any manageability concerns can be adequately addressed through various means available to the Court.

VI.   CLAIMS FOR RELIEF

FIRST CLAIM FOR RELIEF
(Negligence against CSC, Maximus, and SLI)

151.   The allegations in Paragraphs 1 through 150 above are realleged and incorporated herein by reference.

152.   At all times relevant, Defendants CSC, SLI, and Maximus had a duty, independent of their contracts and owed to the Plaintiffs and the Class Members, to design and develop NCTracks, test the software, and conduct IV&V prior to go-live. CSC had additional duties to operate NCTracks and fix software errors.

153.   Defendants CSC, SLI, and Maximus, as more particularly described above, were negligent in that they failed to exercise due care in the design and development of NCTracks, in

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the testing of NCTracks, in the conduct of IV&V, in the operation of NCTracks, and in the attempts to fix defects found in NCTracks after go-live.

154.   The negligent conduct of Defendants CSC, SLI, and Maximus was a direct and proximate cause of damage to the Plaintiffs and the members of each Subclass, except for the Medicaid Crossover Subclass.

155.   As a direct and proximate result of Defendants CSC's, SLI's, and Maximus' negligence, the Plaintiffs and the above identified subclass members have suffered damages in excess of $10,000.

SECOND CLAIM FOR RELIEF
(Unfair and Deceptive Trade Practices against CSC, Maximus, and SLI)

156.   The allegations in Paragraphs 1 through 155 above are realleged and incorporated herein by reference.

157.   At all relevant times, Defendants CSC, Maximus, and SLI were engaged in commerce as defined by Chapter 75 of the North Carolina General Statutes.

158.   The wrongful conduct of Defendants CSC, Maximus, and SLI, as alleged above, constitutes unfair or deceptive acts or practices, which has injured and will continue to injure the Plaintiffs and the members of each Subclass, except for the Medicaid Crossover Subclass, and which has resulted and will continue to result in damages to them.

159.   As a direct and proximate result of this unfair and deceptive conduct, the Plaintiffs and the above identified subclass members have been damaged and are entitled to a judgment against Defendants CSC, Maximus, and SLI for actual damages, and those damages are to be automatically trebled pursuant to N.C. Gen. Stat. § 75-16. The Court should also award attorney fees pursuant to N.C. Gen. Stat. § 75-16.1.

THIRD CLAIM FOR RELIEF
(Breach of Contract against DHHS)

160.   The allegations in Paragraphs 1 through 159 above are realleged and incorporated herein by reference.

161.   Each of the Plaintiffs and the Class Members has entered into contracts with the State to be Medicaid providers. Each of these contracts is identical.

162.   The State has breached its contracts with each of the Plaintiffs and the members of each Subclass, except for the Time Value Subclass, by failing to pay Medicaid reimbursements that are due and owing.

163.   As a direct and proximate result of DHHS' breach of contract, the Plaintiffs and above identified subclass members have suffered damages.

FOURTH CLAIM FOR RELIEF
(Declaratory Judgment)

164.   The allegations in Paragraphs 1 through 163 above are realleged and incorporated herein by reference.

165.   Certain categories of unpaid reimbursements described above have not been paid because DHHS changed the methodology for payment.

166.   DHHS' methodology, adopted effective July 1, 2013, is not in accordance with Medicaid reimbursement rules established by statute and regulation.

167.   The Plaintiffs and the Class Members are entitled to an order under the Declaratory Judgment Act that DHHS' payment methodology, effective July 1, 2013, violates Medicaid reimbursement rules.

FIFTH CLAIM FOR RELIEF
(Violation of Article I, Section 19 of the North Carolina Constitution)

168. The allegations in Paragraphs 1 through 167 above are realleged and incorporated herein by reference.

169. The Plaintiffs and the Class Members have a contractual right to receive payment for reimbursement claims that are due and payable under Medicaid law. This contractual right was and is a property right that could not be taken without just compensation under the North Carolina Constitution, Article I, Section 19.

170. DHHS' conduct as described above constitutes a taking of the Plaintiffs' and the Class Members' property without just compensation.

171. Article I, Section 19 of the North Carolina Constitution guarantees the Plaintiffs and the Class Members the fundamental right to due process. DHHS has unlawfully deprived the Plaintiff and the Class Members of their due process rights by law by acting in the manner described above.

172. As a direct and proximate result of DHHS' violations of the Plaintiffs' and the Class Members' constitutional rights under Article I, Section 19 of the North Carolina Constitution, the Plaintiffs and the Class Members have suffered damages in excess of $10,000.

VII. PRAYER FOR RELIEF

WHEREFORE, the Plaintiffs respectfully pray:

1.   That the Court certify the Class and the Subclasses and appoint the Plaintiffs and their counsel to represent the Class and the Subclasses;

2.   That the Court declare that the Defendants are financially responsible for notifying all Class Members and Subclass Members about all matters for which the they are entitled to notice;

3.   That the Court award damages caused by Defendants' wrongful conduct, in an amount to be proved at trial;

4.   That, as to Defendants CSC, SLI, and Maximus, the Court treble actual damages as required by N.C. Gen. Stat. § 75-16;

5.   That the Court enter a judgment holding Defendants CSC, SLI, and Maximus jointly and severally liable;

6.   That the Court enter a declaratory judgment that the State is violating Medicaid reimbursement rules;

7.   That the Court order the State to comply with Medicaid reimbursement rules;

8.   For a jury trial on all issues so triable;

9.   That the Court award pre- and post-judgment interest in accordance with the North Carolina General Statutes;

10.   That the costs of this action be taxed against the Defendants;

11.   That the Court award Plaintiffs' attorney fees for bringing this action; and

12.   That the Court grant such further relief as the Court may deem just and proper.

This the 16th day of January, 2014.

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