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STATE OF NORTH CAROLINA
COUNTY OF WAKE

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
25 DHR ____

THE NORTH CAROLINA MEDICAL SOCIETY; THE NORTH CAROLINA ACADEMY OF FAMILY PHYSICIANS; THE NORTH CAROLINA COLLEGE OF EMERGENCY PHYSICIANS; NCARF, MARC, INC.; THE ARC OF NORTH CAROLINA; BENCHMARKS; THE ADDICTION PROFESSIONALS OF NORTH CAROLINA; NORTH CAROLINA SPEECH, HEARING, AND LANGUAGE ASSOCIATION; PREMIER HEALTHCARE SERVICES, INC.; CORNERSTONE TREATMENT FACILITY, INC.; CORNERSTONE TREATMENT FACILITY PROGRAM, INC.; PQA, INC.; HOMECARE HOLDINGS, LLC; HOMECHOICE OF THE TRIANGLE, LLC; HOMECHOICE OF THE SANDHILLS, LLC; HOMECHOICE OF EASTERN NORTH CAROLINA, LLC; DIVINE FAMILY HOMECARE, LLC; BRICHELYA HEALTHCARE, INC.,

Petitioners,

v.

N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH BENEFITS,

Respondent.

PETITION FOR CONTESTED CASE HEARING AND MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

Pursuant to N.C. Gen. Stat. § 150B-23, Petitioners The North Carolina Medical Society; The North Carolina Academy of Family Physicians; The North Carolina College of Emergency Physicians; NCARF; MARC, Inc.; The Arc of North Carolina; Benchmarks; Addiction Professionals of North Carolina; The North Carolina Speech, Hearing, and Language Association; Premier Healthcare Services, Inc.; Cornerstone Treatment Facility, Inc.; Cornerstone Treatment

Facility Program, Inc.; PQA, Inc.; HomeCare Holdings, LLC; HomeChoice of the Triangle, LLC; HomeChoice of the Sandhills, LLC; HomeChoice of Eastern North Carolina, LLC; Divine Family Homecare, LLC; and Brichelya Healthcare, Inc. (collectively the "Petitioners") hereby request a contested case hearing with regard to the decision of the North Carolina Department of Health and Human Services and the Division of Health Benefits to implement Medicaid rate reductions of 3%, 8%, and 10% for Medicaid services provided by Petitioners in violation of state and federal law.

Pursuant to N.C. Gen. Stat. § 150B-33(b) and Rule 65 of the North Carolina Rules of Civil Procedure, Petitioners also hereby move this Tribunal to issue a Temporary Restraining Order ("TRO") and Preliminary Injunction against Respondents. These requests for injunctive relief are supported by the affidavits concurrently filed with this Petition.

In support of their Petition and Motion for a TRO and Preliminary Injunction, Petitioners state the following:

THE PARTIES

1. Petitioner the North Carolina Medical Society (the "Medical Society) is an association representing over 6,932 physicians and physician assistants in every region of the state, across all specialties and practice settings. The Medical Society's mission is to improve the health of the citizens of North Carolina. Since 1849 it has served as the leading voice for high-quality patient care, advancing healthcare standards, and advocating on behalf of physicians and the patients who depend on them. Members of the Medical Society provide critical care to Medicaid beneficiaries in every specialty and region of the state. Its members are paid for the services they provide to Medicaid beneficiaries by direct payments from North Carolina's Medicaid program, as well as the managed care Standard and Tailored Plans.

2. Petitioner the North Carolina Academy of Family Physicians ("NCAFP") is North Carolina's largest specialty medical association, with a membership of over 4,300 family physicians. The mission of the NCAFP is to advance the specialty of family medicine to improve the health of patients, families, and communities in North Carolina. Eight-two percent (82%) of NCAFP's members serve Medicaid beneficiaries and in many cases these family physicians are the only physicians these beneficiaries see for their healthcare needs on a regular basis.

3. Petitioner The North Carolina College of Emergency Physicians ("NCCEP") represents over 1,100 emergency medicine physicians across North Carolina. NCCEP's mission is to promote excellence in emergency medicine, advocate for emergency care providers and patients, and support the health of the state. Approximately 40% of the emergency room visits provided in North Carolina are paid for by the Medicaid program.

4. Petitioner NCARF is an association of thirty-five (35) member organizations that provide Medicaid services to individuals with disabilities, including individuals with intellectual and developmental disabilities ("IDD"), individuals with autism, and individuals with mild to severe IQ ranges. The services that NCARF's members provide include community rehabilitation programs, innovation waiver services, supported employment, and residential programs including group homes that provide personal care services ("PCS"). NCARF's members serve over 8,000 North Carolinians of which approximately 80% to 90% are Medicaid beneficiaries.

5. Petitioner MARC, Inc. ("MARC) is an association of sixteen (16) 501(c)(3) nonprofit members who provide training, employment, and supports to Medicaid beneficiaries with developmental disabilities. Collectively, MARC's members serve more than 4,700 disabled individuals, of whom 1,450 are served in a facility-based setting. Nearly 100% of the individuals to whom MARC members provide facility-based services are Medicaid beneficiaries.

6. Petitioner Benchmarks is non-profit association of 60 provider agencies who provide a broad array of behavioral health, child welfare, education and developmental disability services to Medicaid beneficiaries. Benchmarks is the largest association in NC representing MH/DD/SA and child welfare providers. These services include enhanced behavioral health services such as ACTT, outpatient therapy, day treatment, therapeutic foster care and community support Its members also provide facility-based services such as psychiatric residential treatment facilities ("PRTFs"). Benchmarks' provider members serve individuals with IDD in outpatient settings as well providing residential services such as intermediate care facilities for IDD individuals ("ICF-IDDs"). Nearly 100% of the individuals served by Benchmarks' provider members are Medicaid beneficiaries.

7. Petitioner The Arc of North Carolina ("The Arc") is the state's largest nonprofit organization that advocates and supports individuals with IDD and their families. In addition to advocacy, The Arc provides a broad range of services to 2,460 Medicaid beneficiaries with IDD and additional 2,957 individuals with other health issues. These services are aimed at promoting independence, community inclusion, and quality of life. These services include residential supports, community living assistance, care coordination, employment services, life skills training, advocacy, and assistance navigating Medicaid and other disability-related programs.

8. Petitioner Addiction Professionals of North Carolina ("APNC") is a statewide nonprofit professional trade association for substance use professionals and providers. APNC represents 10 organizational providers that provide essential substance use prevention, treatment, recovery and harm reduction services to Medicaid beneficiaries. APNC also represents 700 individual substance abuse service providers, many of whom treat Medicaid beneficiaries. A

majority of the Medicaid payments these providers receive are paid by the Tailored Plans and some of the Medicaid services are paid through the Standard Plans and Medicaid Direct.

9. Petitioner the North Carolina Speech, Hearing, and Language Association ("NCSHLA") is a professional association representing over 500 Speech-Language Pathologists and Audiologists. NCSHLA members serve children and adults across North Carolina to help them communicate and ingest food and liquids safely. A large percentage of NCSHLA's members serve Medicaid beneficiaries, especially those beneficiaries from birth to the age of twenty-one (21) whose services are covered Medicaid's Early and Periodic Screening, Diagnostics, and Treatment ("EPSDT") program. NCSHLA's members are paid for the services they provide to Medicaid beneficiaries by direct payments from North Carolina's Medicaid program, as well as the managed care Standard and Tailored Plans.

10. Petitioners Premier Healthcare Services, Inc. ("Premier") Cornerstone Treatment Facility, Inc. ("Cornerstone"), and Cornerstone Treatment Facility Program, Inc. ("CTFP"), are not members of Benchmarks but also provide residential PRTF services. Premier operates a twelve-bed licensed PRTF in rural Hoke County. Cornerstone operates a licensed PRTF in rural Hoke and Anson Counties. CTFP in operates a licensed PRTF in Moore County. Collectively, these four facilities have the capacity to serve 48 children and adolescents with severe behavioral health issues. Almost all of the residents of these PRTFs are Medicaid beneficiaries.

11. PQA, Inc. ("PQA") provides primarily Medicaid reimbursed office-based and community behavioral health services, including assessments, tailored care management, psychiatric services, medication management, substance abuse treatment, community support team services, peer support, intellectual and developmental disabilities services (IDD), and NC Innovations Waiver Services in the rural Piedmont and Yadkin Valley of North Carolina. PQA is

not a member of Benchmarks but provides similar community-based enhanced mental health services.

12. Petitioners HomeChoice of the Triangle, LLC, HomeChoice of the Sandhills, LLC, HomeChoice of Eastern North Carolina, LLC ("Home Choice") are licensed home care agencies which are managed by HomeCare Holdings, LLC. Home Choice provides in-home personal care services ("PCS") to 115 Medicaid beneficiaries in Chatham, Durham, Frankin, Granville, Johnston, Orange, Vance, and Wake Counties. Ninety-seven percent (97%) of the individuals served by Home Choice are Medicaid beneficiaries.

13. Petitioner Divine Family Homecare, LLC ("Divine") is a licensed home care agency that provides in-home personal care services ("PCS") to twelve (12) Medicaid beneficiaries in Cabarrus, Cleveland, Iredell, Lincoln Mecklenburg, Rowan, and Union Counties.

14. Petitioner Brichelya Healthcare, Inc. ("Brichelya") is a licensed home care agency that provides in-home personal care services ("PCS") to approximately 85 Medicaid beneficiaries in and around Mecklenburg County. Some of the individuals served by Brichelya receive Community Alternative Program for Disabled Adult Services ("CAP-DA"). All of the individuals served by Brichelya are Medicaid beneficiaries.

15. Respondent the North Carolina Department of Health and Human Services ("NCDHHS") is the state agency charged with overseeing health care services in North Carolina.

16. Respondent the Division of Health Benefits ("DHB") is a division of NCDHHS. DHB is responsible for the administration of North Carolina's Medicaid Program (collectively NCDHHS and DHB are "Respondents" or "Department").

BACKGROUND

I. The North Carolina Medicaid Program

17. Medicaid is a joint federal–state program that provides healthcare coverage to low-income individuals, including children, adults, the elderly, and people with disabilities. The federal government pays for the majority of the cost of care provided to Medicaid beneficiaries but states are responsible for approximately one third of the cost and are charged with operating the Medicaid program subject to federal laws and oversight from the Centers for Medicare and Medicaid Services ("CMS").

18. North Carolina's Medicaid Program provides healthcare coverage to approximately 3.1 million low-income adults, children and the elderly. An estimated 43% of the Medicaid beneficiaries in North Carolina are children, 26% live in rural areas, and 18% have three or more chronic conditions. *See* Medicaid in North Carolina, Kaiser Family Foundation Fact Sheet, May 2025, attached as **Exhibit A**.

19. North Carolina's Medicaid program is unique in that payments are made by several sources. First, DHB makes direct payments to providers for certain individuals who do not qualify to be enrolled in North Carolina's Managed Care program ("Medicaid Direct"). These include those beneficiaries who are dually eligible for Medicare and Medicaid ("Duel Eligibles") and the medically needy and those who participate in certain Medicaid waiver programs such as Community Alternative Programs for children and disabled adults ("CAP-C" or "CAP-DA") services.

20. The Department also contracts with managed care organizations ("MCOs") to operate two distinct managed care programs known as the "Standard Plan" and the "Tailored Plan" managed care programs. These plans operate under a waiver received from the federal

government. Under the waiver, certain federal regulations that would typically govern the Medicaid program are waived to provide North Carolina more flexibility in how it operates its Medicaid program.

21. Under North Carolina's managed care program, "Standard Plans" are operated by private companies that serve as managed care organizations ("MCOs") otherwise known as prepaid health plans ("PHPs"). These MCOs are paid a fixed (capitated) rate per member per month ("PMPM") to pay for Medicaid services for each enrolled Medicaid beneficiary. The PMPM is determined by the Department at least yearly based on a federally mandated examination of the costs to provide care by a certified actuary that contracts with the Department. The PMPM is required by federal law to be actuarially sound and the Department is required to consider the cost of care, the need for services, payment rates, administrative costs, and other expenses when determining the PMPM. The Department is required to submit its analysis and receive approval each year from CMS that the PMPM is actuarially sound.

22. Most NC Medicaid enrollees are Standard Plan members, and more than 1.8 million Medicaid beneficiaries are enrolled in Medicaid Standard Plans in North Carolina. The Standard Plans cover a broad population, including children, adults, people with certain chronic conditions and some elderly recipients.

23. There are several Standard Plan MCOs operating in North Carolina, including AmeriHealth Caritas, Healthy Blue (Blue Cross Blue Shield), UnitedHealthcare Community Plan, WellCare, and Carolina Complete Health.

24. In addition to Standard Plans, North Carolina operates a separate managed care program known as "Tailored Plans." Tailored Plans are plans intended for individuals with more complex health needs, specifically those with serious mental illness, severe substance use

disorders, IDD, or traumatic brain injuries (TBI). Tailored Plans are also paid a capitated PMPM feed to provide services. The PMPM for these plans must also meet federal standards for actuarial soundness. Tailored Plans are managed by what used to be known as LME/MCOs and include Alliance Health, Partners Health Management, Trillium Health Resources, and Vaya Health.

25. Petitioners also serve Medicaid beneficiaries subject to the NC Innovations Waiver program ("Innovation Waiver Program") and the CAP-C CAP-DA 191(c) Waiver. These programs are North Carolina's primary Home and Community-Based Services (HCBS) waiver for IDD beneficiaries who need a high level of support. Instead of receiving care in an institutional setting, the waiver allows people to receive services in their homes or communities while promoting independence, inclusion, and self-determination. Innovation Waiver services are administered by the Tailored Plans. A defining feature of the Innovations Waiver is that it is capped, meaning there are a limited number of waiver slots statewide. This leads to long waiting lists—known as the Registry of Unmet Needs. People may wait years to receive an Innovations slot.

II. DHB's Unilateral Medicaid Rate Cuts

A. Medicaid Funding Process

26. Each year the North Carolina General Assembly appropriates funds to meet the state's Medicaid spending obligations. It is not unusual for the General Assembly and the Department to differ on the estimated appropriation needed to fund the Medicaid program in a given year. Over at least the last five years, the Governor's projected Medicaid budget has always been higher than what was appropriated by the General Assembly. *See* DHB August 19, 2025 Presentation "NC Medicaid State Budget Reductions," **Exhibit B**.

27. For example, in state fiscal year ("SFY") 2025, under the previous administration of Governor Cooper, the Department, led by then Secretary Kody Kinsley, informed the General Assembly it needed nearly half of billion dollars in additional Medicaid appropriations to fully fund the Medicaid program. *See* "Legislature Approves Medicaid Money-But Not What DHHS Says It Needed," WUNC, September 12, 2024, attached as **Exhibit C**. The General Assembly, however, only appropriated $377 million. *Id.* Despite this difference, the Department did not cut Medicaid provider rates and there was no additional appropriation needed for SFY 2024-25.

28. Because the General Assembly appropriates Medicaid funds based on projected expenditures, it has recognized that its initial appropriation may not always be sufficient to cover the cost of the Medicaid program. One way that it has addressed this concern is through the creation of a Medicaid Contingency Reserve Fund which can only be used for budget shortfalls in the Medicaid program. This fund currently has over $500 million in reserve that can be appropriated by the General Assembly to cover budget shortfalls. *See* N.C. Gen. Stat. § 143C-4-11. The General Assembly has made use of this fund previously, appropriating an additional $136 million to the Medicaid program in 2020. N.C. Sess. Law 2020- 88, Sec. 5.5.

B. Fiscal Year 2026 Funding and DHB Unilateral Medicaid Cuts

29. On July 16, 2025, the Department informed to the General Assembly that it needed an additional $819 million to fully fund the Medicaid program for State Fiscal Year ("SFY") 2025-26, which runs from July 1, 2025, until June 30, 2026.

30. The General Assembly at that time did not agree with the Department's projections and, on July 30, 2025, passed a bill which provided DHB with an additional $600 million in funding to pay for increased Medicaid spending, which was signed into law by Governor Stein on August 6, 2025. *See* N.C. Sess. Law 2025-89.

31. After passage of the $600 million "rebase," Department Secretary Devdutta Sangvai (the "Secretary" or "Secretary Sangvai") wrote to the leaders of the General Assembly on August 11, 2025 (the "August Letter"), informing them that the Department did not believe that the additional $600 million was enough to cover its projected Medicaid expenditures for SFY 2025-26. The Secretary further announced that without immediate additional funding the Department would cut provider Medicaid payment rates by 3%, 8% and 10%. *See* August Letter, attached as **Exhibit D**.

32. In the August Letter, Secretary Sangvai stated that the planned rate reductions would "carry serious and far-reaching consequences. Most immediately, reduced rates and the elimination of services could drive providers out of the Medicaid program, threatening access to care for those who need it most." *Id.*

33. While Petitioners' claims do not hinge on the veracity of the Department's forward-looking budget estimates, it should be noted that legislative leaders do not agree that provider rate cuts are necessary or that the Department lacks sufficient appropriations to fund the Medicaid program.

34. Senator Donny Lambeth (R-Forsyth), co-chair of the Joint Legislative Oversight Committee on Medicaid is quoted as saying: "[w]e've had staff scrub the numbers, we felt like at this point in our process, this was the best number we could go with [$600 million], but we are continuing to look at the rebase number." *See* "NC lawmakers order halt to Medicaid cuts as budget stalemate continues," WRAL News, August 29, 2025, attached as **Exhibit E**. Senator Lambeth has also noted that Department leaders "have the power to hold off on those rate cuts, and in the 12 years I've been here, we have never cut rates. If we were short on Medicaid, we filled that with new money later in the year" and that the General Assembly "reconcile[s] towards

the end of the year, and that's what I thought we would do this year." *See* "NC Republican Lawmakers Criticize State Health Officials For Cutting Medicaid Provider Rates," NC Newsline, October 14, 2025, attached as **Exhibit F** and "Medicaid Rate Cuts Slammed as Health Officials Defend Ruling," The Charlotte Post, October 26, 2025, attached as **Exhibit G**. Speaker Hall has echoed this sentiment stating, "Governor Stein can and should simply stop all Medicaid cuts, since the legislature will be back this spring with more than enough time to add additional funds if needed." See "State Republican Leaders Reject Gov. Stein's Call to Session for Medicaid Funding," WITN, November 13, 2025, attached as **Exhibit H**.

35. Additionally, Senate President Pro Tempore Phil Berger and House Speaker Destin Hall have questioned the Department's budget shortfall projections, noting in a letter to Governor Stein that the Department allocated $100 million of the $600 million appropriated by the General Assembly to administrative costs instead of paying for beneficiary care. November 13, 2025 Letter to Governor Stein, attached as **Exhibit I.** The letter also notes that last year the Department reverted $110 million in Medicaid appropriated funds that went unspent and carried forward $243 million, including $166 million in funds appropriated for last year's Medicaid budget. *Id.*

36. More recently, the State Auditor released a report of findings that the Department would accumulate an estimated $210 million in appropriated funds for "lapse salaries." These are funds that are appropriated and received by the Department for positions that are unfilled. *See* Preliminary DHHS Vacancy and Lapse Salary Analysis, Office of the State Auditor, attached as **Exhibit J**.

37. The Department and the General Assembly both agree that even under the Department's projected budget, current appropriation can fully fund the Medicaid program without provider cuts through at least April of 2026.

C. Department Actions to Implement Provider Rate Cuts

38. In the August Letter, the Secretary stated that the Department would immediately begin taking administrative steps to prepare for potential cuts to Medicaid rates. **Exhibit D**. However, it was not until September 25, 2025 that DHB issued a Medicaid Provider Bulletin on its website officially announcing the cuts it would make beginning on October 1, 2025. In this bulletin, it informed providers that if the General Assembly appropriated more funds it would reverse these cuts. Medicaid Provider Bulletin, Attached as **Exhibit K**.

39. On September 29, 2025 DHB issued a formal public notice entitled "Public Notice (SPA #25-0026) NC Medicaid State Budget Rate Reductions" (the "DHB Notice"), attached as **Exhibit L**.

40. The DHB Notice formally announced DHB's intention to amend the State Plan to implement service rate reductions of 3%, 8%, or 10% for SFY 2025-26, effective October 1, 2025, only two days after the date of the DHB Notice. The DHB Notice asserted that "[t]hese rate reductions are necessary to enable the NC Medicaid program to operate within the funding appropriated by the North Carolina General Assembly (NCGA) for SFY 2025-26." The DHB Notice goes on to list the affected services and their corresponding rate reduction percentages. *Id.* Again the Department informed providers that the rate cuts would be subject to change if the General Assembly appropriated more funds.

41. The DHB Notice also informed providers, beneficiaries, and the public that it could submit comments to the Department regarding these budget cuts by U.S. Mail or email. *Id.* However, the cuts were set to take begin on October 1, 2025, only two days after the DHB notice, which was likely not enough time for letters from U.S. Mail to even arrive at DHB.

42. On October 1, 2025, DHB cut all Medicaid payments by the announced percentages for Medicaid Direct payments.

43. For payments made to providers by the Standard and Tailored Plans, those plans had flexibility to delay the payment cuts until November. As a result, the Standard and Tailored Plans did not implement cuts until November 1, 2025. However because the Department had directed the Standard and Tailored Plans to make cuts effective October 1, 2025, the MCOs are now retroactively recouping funds for services provided in October 2025 in addition to the ongoing rate cuts directed by the Department.

III. The Department's Cuts of Reimbursement Rates Paid to Petitioners

44. The Department's actions have subjected Petitioners to various rate cuts of 3%, 8% and 10%, effective October 1, 2025.

45. Specifically, as it relates to Petitioners, the physician and physician assistant members of the Medical Society, NCAFP, and NCCEP have been subjected to 8% Medicaid rate cuts. Emergency room physician services have been slashed by 10%. **Exhibit L**. The physician members of the Medical Society, NCAFP, and NCCEP are paid for the services they provide to Medicaid beneficiaries by direct payments from North Carolina's Medicaid program, as well as from payments from the Standard and Tailored Plans.

46. Petitioners NCARF and MARC represent providers whose Medicaid rates have been cut by 3% for the Innovation Waiver services and Tailored Plan IDD services they provide. For the NCARF members who provide personal care services ("PCS") and PCS services in Group Homes, their Medicaid rates were also cut by 8% for those services. *Id.* Provider members of NCARF and MARC are primarily paid by the Tailored Plans with some payments from the Standard Plans and from the Innovation Waiver program.

47. Petitioner Benchmarks has members who provided IDD, enhanced mental health services as well as residential services such as group homes. Its provider members received rate cuts of 3% and 8%, for these services. *Id.* Benchmarks' members also provide ICF-IDD residential services to individuals with intellectual disabilities which were cut by 8%. *Id.* Benchmark members who provide residential PRTF services to children and adolescents with severe behavioral health issues received a 10% cut. *Id.* The majority of the payments Benchmarks receives are made by the Tailored Plans but it also receives payments from the Innovation Waiver and Medicaid Direct.

48. Petitioner The Arc of North Carolina, which provides both IDD and Behavioral Health services, was subject to rate cuts of 3% for enhanced behavioral health services, 8% for PCS and ICF-IDD residential services. *Id.* The majority of the payments The Arc receives are made by the Tailored Plans but it also receives payments from the Standard Plans and Medicaid Direct.

49. Petitioner APNC, whose members provide important substance abuse services received a 3% cut to their Medicaid rates. *Id.* The majority of the payments the APNC receives are made by the Tailored Plans but it also receives payments from the Standard Plans and Medicaid Direct.

50. Petitioner NCSHLA's members provide speech-language pathology and Audiology services, which is considered an outpatient specialized therapy, which received a 3% Medicaid rate cut. *Id.* NCSHLA's member providers are paid for services they provide to Medicaid beneficiaries by Medicaid Direct as well as by the Standard and Tailored Plans.

51. Petitioners Premier, Cornerstone, and CTFP, which provide residential PRTF services to children and adolescents with severe behavioral health issues, received a 10% cut. *Id.* Petitioners' PRTF services are paid for by the Tailored Plans.

52. PQA, Inc. ("PQA") provides primarily Medicaid reimbursed office-based and community enhanced behavioral health services and received a 3% cut to its Medicaid payments. PQA's services are paid for by the Tailored Plans as well as the Innovation Waiver program. *Id.*

53. Petitioners HomeCare Holdings, LLC, HomeChoice of the Triangle, LLC, HomeChoice of the Sandhills, LLC, HomeChoice of Eastern North Carolina, LLC, Divine Family Homecare, LLC, and Brichelya, Healthcare, Inc (collectively the "Home Care Petitioners") all provide PCS services as licensed home care providers. These Petitioners received an 8% cut to their Medicaid reimbursements. *Id.* The Home Care Providers Medicaid Services are primarily paid for by Medicaid Direct but also receive payments from the Standard and Tailored Plans as well the CAP waiver.

IV. The Department's Failure to Conduct Rate Cut Analysis

54. The public statements and published communications from the Department as well as affidavits filed with this Tribunal or other tribunals in related Medicaid rate cut cases show that the above Medicaid rate reductions were not based on any individualized analysis of what the appropriate rate for each services should be, and that the Department failed to conduct any analysis to determine if the reduced rates allowed for efficiency, economy, and quality of care before setting the rate. The Department also failed to analyze or determine that the reduced rates were sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that those services are available to the general population. *See* Department Affidavits attached as **Exhibit M**; see also **Exhibits K and L**.

55. The DHB Notice and the Medicaid Bulletin announcing these cuts also did not state whether the Department has determined whether the cuts, which effectively slashed the Standard and Tailored Plans' pre-determined PMPM fees, meet the standard for actuarial soundness as required by federal law governing managed care waiver programs. **Exhibits K and L.**

56. Based on the prior statements of the Department, the reduced rates set forth above were not individualized or based on data and information related to each specific service. Instead, the Department took a three-tiered "shoot, ready, aim" approach to the cuts to meet budgetary concerns without any analysis or individualized review of how the cuts would affect quality or service availability. *See* **Exhibits K, L, and M.**

57. The Department has admitted that it did not consider or analyze whether the reduced rate was appropriate for each specific service but instead based the percentage of a service's Medicaid rate cut on (1) which providers had not received increases over the past several years; (2) minimizing impact to behavioral health; (3) minimizing impact to community based programs; and (4) minimizing impact to children. *See* **Exhibits D, and M**. None of these factors cited by the Department relate to whether the directed reduced rates meets the criteria set forth by state and federal law, namely that rates for a service are based on an individualized service-specific review to ensure they are appropriate for the population served or would allow the service to enlist enough providers to make the service available at least to the extent as that service is available to the general population.

V. The Department Failed to Consider Public Comment Prior to Cutting Rates

58. The DHB Notice, which was published on September 29, 2025, and effective two days later, invites providers and Medicaid beneficiaries to provide feedback to the Department via email or U.S. Mail. Basic logic demands that it would take more than 48 hours for providers or

beneficiaries to draft their comments, communicate their concerns and provide the Department the time necessarily to review and consider each comment. Accordingly, the Department knew when it solicited public feedback that this feedback could not be submitted, compiled, and properly considered prior to the rate cuts taking effect.

59. While the Department in late November acknowledged that it received comments and published a summary of those comments, the purpose of requiring comments is not just that they be read by the Department. Instead. the purpose of the public comment process is that the comments be considered as part of the Department's decision-making process. Here, the cuts were announced and implemented prior to consideration of those public comments.

VI. The Department Has Yet to Submit Any Request for Approval of These Rate Cuts to CMS

60. The Department has failed to submit any request or required analysis to CMS to institute these rate cuts.

61. While the Department has stated that it plans to submit a State Plan Amendment ("SPA") to CMS regarding these cuts by December 31, 2025 that is simply conjecture. The Department has yet to even post a draft of its SPA request to CMS on its Medicaid State Plan Public Notices page, and as a result CMS has not even considered whether it will permit these rate reductions.

62. In addition, under the rules that govern Medicaid managed care, the Department is required to certify and seek approval from the federal government each year that the per member per month ("PMPM") fee provided to the MCOs are actuarially sound.

63. The Department admitted in its August Letter that prior to the rate cuts, it was already using "the lowest rate possible within the actuarially sound rate range" when setting the PMPM. **Exhibit D**. It further announced that the Standard Plans would receive a PMPM cut of

an additional 1.5% and that the Tailored Plans would not receive an additional PMPM cut. Even taken at face value, the Department's cut of 1.5% to the Standard Plans' PMPM is not actuarially sound, since the Secretary has stated that the Department previously set the PMPM at the lowest actuarially sound PMPM possible prior to reducing the rate.

64. The Department's claims that it is only cutting the Standard Plans' PMPM by 1.5% and not cutting the Tailored Plans' PMPM is also disingenuous, or worse, intentionally misleading. The cuts to Medicaid rates directed by the Department have the effect of reducing the PMPM for the Standard and Tailored Plans by well over 5%. This is necessarily true, because ultimately the only way the Department can reduce spending in the Standard and Tailor Plans is to reduce the funds it provides those plans through the PMPM amounts. Accordingly, any pre-rate cut analysis of actuarial soundness required by federal law is no longer valid and must be resubmitted for approval by CMS. Yet the Department has not conducted such an analysis or indicated that it will in the future.

VII. The Department Has Misled Providers and the Public that these Cuts are Reversable.

65. In all of its public communications, the Department has stated that the rates cuts may be reversed if the General Assembly appropriates more funds. **Exhibits D, K and L**. Yet, if the Department submits a SPA, as it has announced it will for these rate cuts, it will start a chain events that will make reversing these cuts impossible and may keep rates lower for the foreseeable future.

66. Assuming that the Department submits a SPA sometime in the future, and CMS approves it (which is far from certain), the Department would have no legal authority to unilaterally reverse these rate cuts without first seeking approval from CMS. Moreover, it would have no legal ability to reverse the cuts in terms of the federal share of the funds for October 1 through December

31, 2025 if a SPA is approved. The Department has seemingly misled the public and the provider community that if or when the General Assembly acts, the cuts will be reversed at the Department's edict.

67. In addition to misstating that these rates cuts are reversible, if the General Assembly appropriates more funds this year, it is far from certain that CMS will allow for rate increases even at that time. CMS has publicly announced its desire to cut federal Medicaid spending and would have no obligation to approve rate increases in the future when North Carolina has voluntarily lowered rates. Thus the Department's communications, for which it has elicited public comment, are at best misleading and have not afforded providers and the public sufficient information on which they can comment as to the long-term effects of these rate cuts.

LAWS GOVERNING MEDICAID RATES AND VIOLATIONS

68. Participation by a state in the Medicaid program is optional, however, once a state elects to participate, the state must comply with federal laws governing Medicaid. Under North Carolina law the state has "accepted and adopted" all of the provisions of the federal Social Security Act providing grants to the states for Medicaid. N.C. Gen. Stat. § 108A-56.

I. The Medicaid State Plan and North Carolina Medicaid Statutes

69. A Medicaid State Plan (the "State Plan") is required by Title XIX of the Social Security Act Medical Assistance Program and 42 CFR § 447.201(a). The State Plan sets forth North Carolina's mechanisms for compliance with various applicable federal laws, including laws governing payment and rates for Medicaid services. The State Plan is created by the Department and must be approved by CMS.

70. State law requires that DHB follow the State Plan and any waivers as approved by CMS. Specifically, N.C. Gen. Stat. § 108A-54(c) requires:

> [t]he Medicaid Program shall be administered and operated in accordance with this Part and the North Carolina Medicaid State Plan and Waivers, as periodically amended by the Department of Health and Human Services in accordance with G.S. 108A-54.1A and approved by the federal government.

(emphasis added)

71. Additionally, N.C. Gen. Stat. § 108A-55(c) goes further as relates to Medicaid payments by stating:

> The Department shall reimburse providers of services, equipment, or supplies under the Medical Assistance Program in the following amounts:
> (1) The amount approved by the Centers for Medicare & Medicaid Services (CMS) of the United States Department of Health and Human Services, if CMS approves an exact reimbursement amount.
> (2) The amount determined by application of a method approved by the Centers for Medicare & Medicaid Services (CMS) of the United States Department of Health and Human Services, if CMS approves the method by which a reimbursement amount is determined, and not the exact amount.
>
> The Department shall establish the methods by which reimbursement amounts are determined in accordance with Chapter 150B of the General Statutes. A change in a reimbursement amount becomes effective as of the date for which the change is approved by the Centers for Medicare & Medicaid Services (CMS) of the United States Department of Health and Human Services

(emphasis added).

72. Under North Carolina law, the State Plan, State Plan Amendments, and Waivers approved by CMS have "the same force and effect as a rule adopted pursuant to Article 2 of Chapter 150B." *See* N.C. Gen. Stat. §108A-54.1B. Given that SPAs have the same effect as Chapter 150B Rules, it is clear that when a SPA is required, the Department cannot act on a potential or proposed SPA until published for comment and approved by CMS.

73. N.C. Gen. Stat. § 108A-55(c), discussed above, contains an additional provision that requires the Department to promulgate rules pursuant to Chapter 150B regarding the methods that the Department will use to establish reimbursement amounts. The plain language of this

provision of the statute does not require the Department to use rulemaking to determine Medicaid rates, but it does require that rules be promulgated to inform the public on the method that the Department uses to establish reimbursement amounts. A review of the rules promulgated pursuant to Chapter 150B regarding the methods that the Department uses to establish reimbursement amounts reveals that these rules either do not exist or have been allowed to expire. *See e.g.* 10A NCAC Subchapter 22G. Failure to promulgate such rules means that the methods used by the Department in determining these rate reductions were not established in accordance with the legal process required by the statute.

74. North Carolina law also expressly regulates when the Secretary can take steps to address budgetary issues with the Medicaid program. Specifically, N.C. Gen. Stat. § 108A-54(e), which sets forth the "powers and duties" of Secretary, states in subpart (6) that the Secretary may:

> [d]evelop midyear budget correction plans and strategies and then take midyear budget corrective actions necessary to keep the Medicaid program within budget.

N.C. Gen. Stat. § 108A-54(e)(6) (emphasis added).

75. North Carolina operates on a state fiscal year that begins on July 1 and ends on June 30. Accordingly, under N.C. Gen. Stat. §108A-54(e)(6), if the Secretary believes that budget corrections are necessary for the Medicaid program, the Secretary is authorized to develop midyear budget correction plans and strategies and then take midyear budget corrective actions necessary to keep the Medicaid program within budget. The Secretary began to develop plans and take action in August of 2025, the second month of the fiscal year and implemented the corrective plan on October 1, 2025, well before the midyear point mandated by the General Assembly.

II. Federal Law Governing Provider Payments

A. Federal Law Related to Medicaid Reimbursements

76. Pursuant to 42 U.S.C. § 1396a(a)(30)(A) and 42 CFR § 447.204, Medicaid rates "must be consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that those services are available to the general population."

77. The Department is required to consider these factors in reviewing payment sufficiency, and is also required to consider provider and recipient feedback of any state plan amendment for CMS approval that proposes to reduce or restructure Medicaid service payment rates.

78. 42 CFR § 447.203 requires the state to undertake an analysis for any SPA that proposes to reduce or restructure provider payments in circumstances when the changes could result in diminished access, and provide written assurance and relevant supporting documentation that each of the following conditions are met in the rate change: (i) Medicaid payment rates in the aggregate following the proposed reduction would be at or above 80 percent of the most recently published Medicare payment rates for the same or a comparable set of Medicare-covered services; (ii) the proposed reduction, including the cumulative effect of all reductions or restructurings taken throughout the current State fiscal year, would be likely to result in no more than a 4 percent reduction in aggregate fee-for-service Medicaid expenditures for each benefit category affected by proposed reduction within a State fiscal year; and (iii) the public processes for beneficiary and provider output mandated by 42 CFR § 447.203(c)(4) and 42 CFR § 447.204 yielded no significant access to care concerns from beneficiaries, providers, or other interested parties regarding the service(s) for which the payment rate reduction is proposed, or if such processes did yield

concerns, the State can reasonably respond to or mitigate the concerns, as appropriate, as documented in the analysis provided by the State pursuant to 42 CFR § 447.204(b)(3).

79. Operating a Medicaid managed care program under a waiver granted by CMS does waive certain Medicaid regulatory requirements. However, the waivers North Carolina received from CMS for its Medicaid Managed Care and the Innovations Waiver programs do not waive these federal regulations.

B. Federal Laws Relating to Managed Care Reimbursement

80. States that operate Managed Care waiver programs, such as North Carolina, must also comply with specific regulations that govern the operation of their managed care program.

81. Under 42 C.F.R. §§ 438.4-438.7 states must pay Medicaid MCOs using actuarially sound capitation rates. This means rates that are developed according to recognized actuarial principles, using reliable claims and encounter data, and are sufficient to cover reasonable and appropriate costs of delivering all covered services to enrolled populations. The regulation requires states to submit detailed actuarial rate certifications, justify all underlying assumptions, and include the financial impact of any state-directed payments or delivery system reforms. CMS reviews these materials annually to ensure the state's rates are adequate, transparent, and compliant with federal standards. The Department's actuarial soundness certification must be re-analyzed under federal law when the data changes. Here the data used by the Department to set the PMPM has changed significantly due to the rate cut and the actual PMPM has been significantly reduced.

82. North Carolina's rate cuts have resulted in a significant cut to the PMPM of both the Standard and Tailored Plans which have not been analyzed and certified as actuarially sound. The Department has not analyzed whether the across the broad rate cuts affect the adequacy of utilization, network access and it has submitted no information to CMS regarding these cuts and

how they will affect the MCOs' ability to operate and fund an adequate network of providers, all of which it is required to do by the regulation. Without CMS approval, the Department has unilaterally reduced expenditures to providers as a directed cut to payments made by the MCOs in violation of its obligation under federal law to ensure an actuarially sound PMPM for the MCOs.

83. Additionally, 42 CFR § 438.6(c) entitled "State Directed Payments under MCO, PIHP or PAHP Contracts" states that unless certain standards are met "the State may not in any way direct MCO's PIHP's or PAHP's expenditures under the contract." Because MCOs are subject to losses if they do not manage their PMPM appropriately, this rule provides MCOs with the ability to pay providers in a manner that takes into account network adequacy and the needs of the population served. Some examples of when federal law allows the Department to direct the MCOs' payments include setting minimum fee schedule for providers and to provide uniform dollar or percentage increases for providers of a service or adopt a maximum fee schedule for providers. The regulation does not provide the Department the ability to provide a uniform dollar or percentage decrease to providers. Thus, the Department has no legal authority to direct the provider rate percentage reductions to the MCOs.

84. Even though this regulation does not allow for direct percentage cuts ordered by the Department, the Department's SPA Notice states that it plans to amend its Managed Care contracts to add State Directed Payment requirements to include a requirement that traumatic brain injury ("TBI") services be paid at 97% of the Innovations Waiver, 1915(i) waiver, and TBI waiver service reimbursement rate paid on September 30, 2025, that PRTF be reimbursed at 90% of the reimbursement rate paid to PRTFs on September 30, 2025, and that advanced medical home fees be reimbursed at no less than $4.85 per assigned member. **Exhibit L**.

85. To the extent that the Department claims some exception exists to allow it to direct payment percentage reductions, 42 CFR § 438.6(c) requires that before a directed payment can be implemented, the Department must conduct an analysis of the directed payment and receive prior written approval from CMS. The Department has not conducted such an analysis nor has it received prior written approval from the Department for any of these directed payments and specifically for the direct payments it specifically outlined in the SPA Notice.

C. North Carolina Innovations And CAP Waiver Representations

86. Under state law, the State Plan, SPAs and Waivers approved by CMS have the same force and effect as a rule promulgated under Chapter 150B. The North Carolina Innovations Waiver contains very specific language regarding how rate setting will be determined. It states:

> The TP/PIHPs are responsible for setting all provider rates for waiver services. The TP/PIHPs set rates based on demand for services, availability of qualified providers, clinical priority or best clinical practices and estimated provider service cost. The TP/PIHPs use the State's Medicaid rates for the same or similar services as a guide in setting rates. Billing codes and Services rates are available on each PIHP/TP webpage for wavier participants to review. All proposed changes to existing rates or for implementing new rates are reviewed internally by the PIHPs and externally by their respective PIHP provider advisory committee. The provider council is comprised of a cross section of the PIHP's provider networks. Rate reviews focus on internal and external equity and consistency. Providers are notified of rate changes by announcement at the provider meetings and online posting on the PIHP's website.
>
> Innovations Waiver Approved Application - NC .0423R04.00 (7/1/24) and 4.03 (8/1/25)

87. Similarly North Carolina's CAP Waiver sets forth how CAP rates will be set stating:

> North Carolina establishes reimbursement rates applicable to services provided by providers and facilities. The rates are based on the costs incurred and reported by the providers with certain limits. Rates are generally set for the rate period based on the historical costs of the facility

> for a prior year (adjusted for inflation), rather than on the actual costs of providing the services for which the rate is claimed
>
> Application for 1915(c) HCBS Waiver NC 4141.R07.00 3/1/23

88. Despite the Innovations and CAP Waiver representation, which have the effect of state rules, the Department has unilaterally reduced the rates providers receive for these services.

THE DEPARTMENT HAS VIOLATED THE STANDARDS OF N.C.G.S. §150(b)(23)

I. Violations of State Law

89. The Department has violated the standards of N.C. Gen. Stat § 150B-23 because it has failed to act as required by law, has failed to use proper procedure, has acted in excess of the Department's authority, and has acted arbitrarily and capriciously.

90. The Department, by implementing rate cuts unilaterally prior to seeking or receiving approval from CMS, has acted in violation of N.C. Gen. Stat. §§ 108A-54, which requires the Medicaid program to be operated and administered in accordance with the State Plan as approved by the federal government. The government has not approved any changes to the State Plan relating to these rate cuts nor has the Department even sought such approval, although it has stated that it will sometime in the future. It is therefore not operating or administering the program as approved by CMS.

91. The Department has further violated the standards of N.C. Gen. Stat § 150B-23 because it has acted contrary to law, and has acted in excess of the Department's authority by implementing rate cuts for PCS providers, when the State Plan specifically provides a rate that must be paid for PCS at $5.96 per 15-minute period, it also states that providers will be paid the rate in effect on January 1, 2024. *See* State Plan Excerpt attached as **Exhibit O**. N.C. Gen. Stat. § 108A-55(c)(1) requires providers to be paid the amount approved by CMS. Furthermore, N.C. Sess. Law 2023-134 Sec. 9E.12A specifically mandates that providers must be paid $5.96 per 15-

minute increment by Medicaid Direct for PCS. The Department's failure to pay PCS at this rate violates the statute and the session law.

92. The Department has also acted contrary to law—and in excess of the Department's authority—by unilaterally implementing rate cuts prior to seeking or receiving approval from CMS. N.C. Gen. Stat. § 108A-55(c) requires that any change in Medicaid reimbursement amounts becomes effective as of the date for which the change is approved by CMS.

93. The Department publicly acknowledges that these payment reductions require a SPA and that it plans to submit a SPA to CMS for approval at some future date. The Department has acted contrary to state law and in excess of its authority because North Carolina law limits the effective date of such changes to the date of approval by CMS. Thus under state law, the Department is not permitted to implement these rate reductions until the date that these reductions are approved by CMS.

94. 108A-54.1B(d) states that State Plans, SPAs and Waivers approved by CMS have the same force and effect as a rule promulgated under Chapter 150B. The Department has therefore violated a state rule by implementing cuts in contradiction to the State Plan and to the approved 1115 Waiver, the Innovation waiver and the CAP waivers which set forth the basis for how rates will be set in North Carolina.

95. The Department also has failed to promulgate rules pursuant to Chapter 150B setting forth the methods that it uses to establish reimbursement amounts. Respondents have violated the standards of N.C. Gen. Stat. §150B-23(a) by failing to follow this statutory requirement.

96. The Department also violated state law when it implemented rate cuts on October 1, 2025 in response to its budgetary concerns. N.C. Gen. Stat. § 108A-54(e)(6) expressly provides

the Secretary the authority to make only mid-year adjustment plans and implement mid-year adjustments to meet Medicaid budgetary needs. Respondents have violated the standards of N.C. Gen. Stat. §150B-23(a) by instituting rate cuts several months before the midyear point in contradiction of the plain language of the statute.

II. Violations of Federal Law

97. Respondents' rate cuts also violate federal statute and regulations and are contrary to established procedures.

98. 42 U.S.C. § 1396a(a)(30)(A) and 42 CFR § 447.204 require the Department to determine that reimbursement rates are "consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that those services are available to the general population." The Department conducted no such analysis considering these factors before implementing the rate cuts. Respondents also have not created or provided a rate impact analysis as required by federal law.

99. DHB failed to comply with the analysis for rate reductions required by 42 CFR § 447.203, which is meant to safeguard against negative impact of payment reductions that could result in diminished access.

100. The rate cuts violate 42 CFR § 447.204 and 42 U.S.C. § 1396a(a)(30)(A) because the basis for the rate cuts was budgetary and not premised on the analysis of the rate on the provision of services as required by federal law. It is impermissible and arbitrary and capricious under established precedent for Respondents to base rates solely on budgetary concerns.

101. The Department failed to conduct an adequate analysis of the impact on quality or access before implementing rate cuts. The new rates are not based on reasonable cost data or provider participation data.

102. Respondents failed to follow proper procedure by not considering these factors when applying rate cuts.

103. The Department has further acted in violation of federal law by directing cuts to payments to the MCO. 42 CFR § 438.6(c) restricts a state from directing MCO expenditures under the contract unless certain criteria are met and the state receives prior written approval from CMS. The Department is directing expenditures in this instance despite of the criteria having been met.

104. Moreover, to the extent that the Department has admitted it is directing expenditures and plans to seek approval from CMS in the future, the regulation requires prior written approval from CMS before the Department can act.

105. Finally, in order to operate a managed care system, the Department must ensure that the PMPM is actuarially sound and that it provides for adequate payments to providers that permits an adequate provider network. The Department has not completed this analysis, has not provided CMS with any data demonstrating that its cuts are actuarially sound, and has admitted that its pre-cut PMPM was set at the lowest level for actuarial soundness. As such, these cuts necessarily force the program to fall below the standards of actuarial soundness which is not allowed under federal law.

III. Violations of Innovations and CAP Waivers

106. Under N.C. Gen. Stat. 108A-54.1B(d) waivers approved by CMS have the same force and effect as a rule promulgated under Chapter 150B. The North Carolina Innovations Waiver and the CAP Waiver contains language regarding how rate setting will be determined,

which was not followed by the Department here. Therefore, the Department has acted in violation of the state regulation in failing to use the proper procedures for setting rates under this program.

PETITIONERS WILL BE IRREPARABLY HARMED BY RATE CUTS

107. Petitioners are requesting a TRO and preliminary injunction enjoining Respondents from reducing reimbursement rates and directing the reduction of reimbursement rates and requiring that DHB pay and direct its MCO contractors to pay Petitioners at the full rate in existence on September 30, 2025, starting from dates of service beginning on October 1, 2025 and going forward.

108. As set forth in the over thirty (30) affidavits filed contemporaneously with this Petition, Petitioners have been and will continue to be immediately and irreparably harmed by the rate cuts if a TRO and preliminary injunction are not granted. Injunctive relief is necessary to maintain the status quo and protect Petitioners, their employees, and the Medicaid beneficiaries they serve from the disastrous effects of the rate cuts during the pendency of this contested case.

109. Those harms to Petitioners include but are not limited to: (1) denial of funds lawfully owed to Petitioners, which cause Medicaid services to be provided at breakeven or at a loss, (2) using reserves, lines of credit and personal savings to finance obligations such as payroll, (3) discharging Medicaid beneficiaries or limiting or deny services to Medicaid beneficiaries, (4) delaying maintenance on facilities, (5) terminating staff and staff attrition due to an inability to offer competitive wages and reduced staff salaries.

110. These harms directly and irreparably harm the individuals Petitioners employ who rely on their salaries to provide and care for their families.

111. Medicaid beneficiaries across the state are also suffering and will continue to suffer irreparable harm absent injunctive relief. The reduced payments rates force longer wait times for

services and increased staff turnover makes it more difficult to receive services from qualified caregivers. Medicaid beneficiaries are being denied admission for certain services or told that providers are limiting services to Medicaid. In some instances such as PRTFs, facilities are prioritizing serving children and adolescents with severe behavioral health problems from other states with higher Medicaid reimbursement rates over providing services to children from North Carolina. These service reductions result in more emergency room visits and longer placement times for these children who will be forced to wait in emergency rooms until a placement can be found. Reduced payments means that beneficiaries who seek emergency room services will experience longer wait times, which leads to poor outcomes, including death. In rural areas, physicians are struggling to continue to accept Medicaid patients and lack of staff means fewer patients are getting the healthcare they need.

112. The over thirty (30) affidavits demonstrate in detail the dire nature of this harm, which grows worse for Petitioners and the Medicaid beneficiaries they serve with each passing day. Without injunctive relief, North Carolina's Medicaid provider network will deteriorate and in some rural areas is on the brink of total collapse.

113. The Department in several public statements has admitted that these rate cuts will irreparably harm Medicaid beneficiaries and the state's most dedicated healthcare providers who serve them. The Secretary has stated that the rate reductions "carry serious and far-reaching consequences. Most immediately, reduced rates and the elimination of services could drive providers out of the Medicaid program, threatening access to care for those who need it most." **Exhibit D**. The Department recently went further to state that "these provider rate cuts are devastating to people, providers and communities that rely on NC Medicaid[.]" *See* Administrative Judge Blocks NC Medicaid Rate Cut For Assisted Living Services, attached as

Exhibit N. The affidavits filed with this Petition confirm the Department's assessment that Medicaid providers and the patients they serve are being devastated by these cuts.

114. The Department, on the other hand, will suffer no substantial injury if the TRO and preliminary injunction are granted because it will be paying the full rates as set according to law. It is undisputed that the Department has the funds to pay the lawfully created Medicaid rates during the pendency of this contested case.

115. Petitioners can also demonstrate a likelihood of success on the merits of the claims set forth herein.

OAH HAS JURISDICTION OVER PETITIONERS CLAIMS

I. The North Carolina APA Provides This Tribunal Jurisdiction to Consider Petitioners' Claims

116. Petitioners are persons aggrieved as defined in N.C. Gen. Stat. § 150B-2(6) because Petitioners have been adversely and directly affected substantially by the Department's actions. The decision to cut Medicaid reimbursement rates for Petitioners has deprived Petitioners of monetary reimbursement for services to which they are lawfully entitled and has threatened the economic feasibility of continuing to provide these services to Medicaid beneficiaries who need Petitioners' services. Petitioners were also denied the opportunity to provide meaningful feedback and to have that feedback considered by the Department prior to the rate cut decision by the Department.

117. OAH has jurisdiction to consider Petitioners' challenge of whether the Department violated the standards of N.C. Gen. Stat. § 150B-23(a) when it made the decision to unilaterally cut Medicaid rates. Under the express statutory authority granted by the APA, a "contested case" is "an administrative proceeding pursuant to this Chapter to resolve a dispute between an agency

and another person that involves the person's rights, duties, or privileges." N.C. Gen. Stat. § 150B-2(2).

118. The APA provides a "person aggrieved" the right to file a contested case to challenge the Department's administrative decisions. The contested case provisions of the APA apply to "all [State] agencies and all proceedings not expressly exempted from the Chapter." N.C. Gen. Stat. § 150B-1(e). N.C. Gen. Stat. § 150B-1(e) sets forth an enumerated list of the agency actions that are exempt from review. The Department's decision to reduce Medicaid reimbursement rates is not listed as an act exempt from OAH review.

II. Petitioners Are Not Required to Exhaust Administrative Remedy Provided by 10A NCAC 22J

119. The General Assembly has designated OAH as the statutory administrative remedy in North Carolina under N.C. Gen. Stat. Chapter 150B.

120. To the extent that Respondents claim that 10A NCAC 22J provides a regulatory administrative remedy through the Department Hearing Office for disputes regarding rates and payments, such administrative remedy is not intended to address the actions taken by the Department in this case, is not mandatory on its face and is nevertheless ineffective.

121. Administrative remedies are ineffective or inadequate when they cannot address the harm alleged and a decision will not grant the relief sought by the party seeking the administrative remedy.

122. In an email communication dated November 4, 2025, the Chief Department Hearing Officer stated that the Department Hearing Office has no authority to grant injunctive relief and therefore the remedy it can provide is ineffective since the irreparable harm that Petitioners are facing cannot be remedied by the Hearing Office. *See* November 4, 2025 Hearing Office email attached as **Exhibit P**.

CONCLUSION

WHEREFORE, the Department has acted in violation of the standards of N.C. Gen. Stat. § 150B-23(a) and has substantially prejudiced Petitioners' rights and denied it property, which are funds owed to it for Medicaid services provided under the lawful Medicaid rates. Accordingly, Petitioners request the following relief:

1. that Petitioners be granted a contested case hearing without undue delay on Respondents' Medicaid rate cuts for the services Petitioners provide;
2. that the Administrative Law Juge enter a TRO and preliminary injunction against Respondents mandating that Respondents reimburse claims and direct their MCO contractors to reimburse claims at the full, non-reduced Medicaid rate that was in effect on September 30, 2025 until such time as the Administrative Law Judge renders a final decision in this contested case;
3. that the Administrative Law Judge enter a decision reversing Respondents' Medicaid rate reductions;
4. that the Administrative Law Judge order the assessment of reasonable attorneys' fees and witnesses' fees pursuant to N.C. Gen. Stat. § 150B-33(b)(11); and
5. for such other relief as the Office of Administrative Hearings deems appropriate.

This the 1st day of December, 2025.

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that he has this day served a filed-stamped copy of the foregoing **VERIFIED PETITION FOR CONTESTED CASE HEARING AND MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION AND ANNEXED EXHIBITS AND AFFIDAVITS** by Certified Mail, Return Receipt Requested and courtesy copy by email, addressed as follows:

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This the 1st day of December, 2025.

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