IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA
WESTERN DIVISION
Civil Case No.: 5:17-cv-00581-FL

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| MARCIA ELENA QUINTEROS HAWKINS, ALICIA FRANKLIN, VANESSA LACHOWSKI, and KYANNA SHIPP on behalf of themselves and all others similarly situated, | ) |
| Plaintiffs, | ) |
| v. | ) |
| MANDY COHEN, in her official capacity as Secretary of the North Carolina Department of Health and Human Services, | ) |
| Defendant. | ) |

**MEMORANDUM IN SUPPORT OF**
**PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

## INTRODUCTION

The Medicaid Act establishes several categories of eligibility through which an individual with low income may qualify for Medicaid coverage of her health care. Some of the eligibility pathways were created for children and their caretakers and for pregnant women, while others are based on being aged, blind, or disabled. Once an individual has been determined eligible, the state Medicaid agency cannot terminate her benefits without taking the following steps: first, the state Medicaid agency must determine whether the beneficiary remains eligible for Medicaid under any eligibility category and, if so, continue Medicaid coverage uninterrupted; second, if the individual is determined ineligible, the state Medicaid agency must provide the

beneficiary with a proper written notice and opportunity for a fair, pre-termination hearing. These steps ensure continuity of coverage and fairness in the administration of the Medicaid program, and they are at issue in this case.

Tens of thousands of low-income children, parents, and aged, blind and disabled adults in North Carolina have been or in the near future will be terminated from Medicaid by the Defendant without a determination they are no longer eligible for Medicaid and without adequate, timely notice and the opportunity for a fair, pre-termination hearing. Lacking prior notice and the opportunity to be heard, they cannot understand or challenge the termination. These terminations are the result of written policies and procedures and systemic practices that are inconsistent with the federal Medicaid Act and the Due Process Clause of the Fourteenth Amendment.[1]

Terminations of Medicaid coverage have placed the health of Plaintiffs and the proposed plaintiff class at immediate risk. Without Medicaid, Plaintiffs and proposed class members are unable to afford to pay for care and are unable to timely access medically necessary treatment, prescription drugs, and other services. In addition, thousands of current Medicaid beneficiaries, including at least one of the named plaintiffs, are threatened with the loss of their health coverage in the immediate future as a result of these ongoing violations of federal law. DHHS's challenged policies, procedures, and practices thus are causing and threatening irreparable harm to Plaintiffs and the plaintiff class.

[1] Plaintiffs do not seek preliminary relief on the basis of allegations in paragraphs 65 and 70-76 of the Amended Complaint or on the basis of their claims under the Americans with Disabilities Act or Section 1557 of the Affordable Care Act but reserve those allegations and claims for discovery and trial. Plaintiffs also reserve for discovery and trial their request to reinstate coverage to those who have been illegally terminated since January 2014.

Plaintiffs have moved the Court for a classwide preliminary injunction pursuant to Rule 65, Fed. R. Civ. P.[2] Pending a final determination of the merits, Plaintiffs seek the injunction to preserve the status quo by preventing those Plaintiffs and proposed class members who currently receive Medicaid from being terminated in the future until Defendant has determined them ineligible under all Medicaid categories and provided then with adequate, timely notice of the right to a *de novo* pre-termination hearing.

## LEGAL STANDARD

In cases such as this one, brought under 42 U.S.C. § 1983 to enforce provisions of the Medicaid Act and Constitution, district courts are invested with broad equitable powers to fashion appropriate remedial relief. *Doe v. Kidd*, 419 Fed. Appx. 411 (4th Cir. 2011). "A plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits and to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Winter v. Natural Res. Def. Council Inc.*, 129 U.S. 365, 374 (2008)); *Real Truth About Obama, Inc. v. Fed. Elec. Comm.*, 575 F.3d 342 (4th Cir. 2009). Plaintiffs meet this test.

## LEGAL FRAMEWORK

The Medicaid Act, Title XIX of the Social Security Act, 42 U.S.C. § 1396-1396w-5, establishes a medical assistance program cooperatively funded by the federal and state

[2]Although plaintiffs have filed a motion for class certification, "[d]istrict courts are empowered to grant preliminary injunctions regardless of whether the class has been certified." *Brantley v. Maxwell-Jolly*, 656 F. Supp. 2d 1151, 1178 n.14 (N.D. Cal. Sept. 10, 2009) (quotation marks omitted) (on appeal). *See also* 2 NEWBERG ON CLASS ACTIONS, § 9:45, at 411 n.3 & 413-14 (4th ed. 2002) (interim injunctive relief should be awarded on class-wide basis where "activities … are directed generally against a class of persons"; collecting cases ordering class-wide preliminary injunctive relief pending class certification).

governments. A state's participation in Medicaid is voluntary. Once a state elects to participate, however, it must adhere to federal legal requirements, as provided by the United States Constitution, the Medicaid Act, and the rules promulgated by the federal Medicaid agency. 42 U.S.C. § 1396, *et seq.*; *Antrican v. Odom*, 290 F.3d 178, 183 n.2 (4th Cir. 2002) (noting that if a state elects to participate in Medicaid, it must "comply with detailed federally mandated standards"). The Centers for Medicare & Medicaid Services (CMS) of the United States Department of Health and Human Services is the agency that administers Medicaid at the federal level, including publishing rules and guidelines set forth in 42 C.F.R. §§ 430.0-483.480 and in the CMS *State Medicaid Manual*. States are required to administer Medicaid "in the best interests of recipients." 42 U.S.C. § 1396a(a)(19).

North Carolina has elected to participate in the Medicaid program. N.C. Gen. Stat. §§ 108A-54, 108A-56. As required by federal law, 42 U.S.C. § 1396a(a)(5), North Carolina has designated the North Carolina Department of Health and Human Services (DHHS) to be the single state Medicaid agency. N.C. Gen. Stat. §§ 108A-25(b), 108A-54; Def. Mem. Supp. Mot. to Dismiss at 3. Defendant Mandy Cohen is the Secretary of DHHS. *Id*. While many duties for processing Medicaid eligibility determinations have been delegated by DHHS to county Departments of Social Services (DSSs), the single state agency is required, as a condition of participation in the Medicaid program, to ensure that federal Medicaid rules are followed by its county agents. *Id.*; 42 U.S.C. § 1396a(a)(5); 42 C.F.R. § 431.10. The Fourth Circuit has made clear that the DHHS Secretary is responsible for assuring that the actions of her agents comply with federal law. *DTM v. Cansler*, 382 Fed. App'x 334, 338 (4th Cir. 2010); *K.C. v. Wos*, 716 F.3d 107 (4th Cir. 2013).

Once an individual is determined to be eligible for Medicaid coverage, medical assistance must be provided promptly, 42 U.S.C. § 1396a(a)(8), and eligibility is required to be redetermined every twelve months, unless there is a change in circumstance affecting eligibility before then, in which case the redetermination must occur as soon as the change is known. 42 C.F.R. § 435.916(a)(1), (b), (d). Before Medicaid coverage is terminated, the agency must determine the beneficiary to be ineligible under all Medicaid categories. 42 C.F.R. §§ 435.930(b), 431.916(f)(1). The agency must then send timely, adequate written notice of the right to a pre-termination hearing. 42 C.F.R. §§ 431.210-212, 231, 435.917.

## ARGUMENT

### I. PLAINTIFFS ARE LIKELY TO SUCCEED ON THE MERITS OF THEIR CLAIMS.

#### A. Defendant Is Automatically Terminating Medicaid Coverage Without First Determining Ineligibility Or Providing Timely Written Notice of the Right to a Pre-Termination Hearing.

1. Defendant's Procedure and Practice:

Plaintiffs seek preliminary relief to halt the process by which Defendant and her agents are imposing automatic computer-generated terminations of Medicaid coverage for Plaintiffs and tens of thousands of proposed class members without first determining the beneficiary to be ineligible and without providing timely written notice of the right to a pre-termination hearing. Absent timely action by the county DSS worker to prevent it, DHHS's eligibility computer system, NC FAST, is programmed to automatically terminate Medicaid coverage, without determining whether the beneficiary is still eligible for Medicaid, in at least three circumstances: (1) at the end of a twelve-month Medicaid "certification period"; (2) for a parent or other caretaker at the end of the month in which the youngest child in the home becomes age eighteen; (3) for a child at the end of the month in which that child turns age nineteen. Dec. 21, 2017 Douglas Sea Decl. Exs. 17, 18, 20; Feb. 9, 2018 Sea Decl. Exs 7, 9 (pp. 2, 3), 19 (pp. 1, 2), 22;

Madison Hardee Decl. Exs 1, 2; Cassidy Estes-Rogers Decl. Exs. 1, 2, 4; Nan Allison Decl. Exs. 3-7; Elizabeth Garcia Decl., Ex. 1; Feb. 9, 2018 Marcia Quinteros Hawkins Declaration, ¶¶ 9-12; Feb. 9, 2018 Vanessa Lachowski Decl. ¶¶ 8-10; Leroy Rivers Decl. ¶¶ 20-22; Tarren Turrubiates Decl. ¶¶ 4, 7, 9, Ex. 1; Alma Miranda Reyes Decl. ¶¶6-9, 12. When these automatic terminations occur, no written notice is provided to the beneficiary. *Id*.; Dec. 21, 2017 Sea Decl. Ex. 21; Feb. 9, 2018 Sea Decl. Exs. 7, 8 (p. 8), 9 (p 2).

These automatic terminations began in 2014. As noted above, Medicaid eligibility for Medicaid beneficiaries is required under federal law to be reviewed and redetermined every twelve months, or sooner if there is a change in circumstance. 42 C.F.R. § 435.916(a)(1), (b), (d). In North Carolina, county DSSs are responsible for obtaining the information needed to review continuing eligibility and then entering that data into the state agency's computer system. Dec. 21, 2017 Sea Decl. Ex. 24. During 2014, DHHS required county DSSs to convert all Medicaid cases to a new computer system called NC FAST. Feb 9, 2018 Sea Decl. Ex. 1 (p. 2). The conversion to NC FAST resulted in hundreds of thousands of cases in which county DSSs have failed to timely complete the review of continuing eligibility required by federal regulations (called "recertification" in DHHS reports). *Id*., Dec. 21, 2017 Sea Decl. Exs. 3-16; Feb. 9, 2018 Sea Decl. Exs. 3-6, 11-13. For example, as of May 20, 2015, the number of Medicaid cases for families and children overdue for recertification was 124,372. Feb. 9, 2018 Sea Decl. Ex. 20 (p. 1). Because NC FAST is programmed to automatically terminate Medicaid if the county DSS does not timely complete this eligibility review and then enter the results of that review into NC FAST, tens of thousands of beneficiaries have lost their Medicaid with no notice even though they remained eligible for Medicaid. Dec. 21, 2017 Sea Decl. Exs. 3-16; Feb. 9, 2018 Sea Decl. Exs. 3-6, 11-13.

Beginning in early 2014, Defendant responded to the recertification backlog by temporarily programming NC FAST to extend eligibility for Medicaid for families and children (referred to in DHHS reports as "MAGI" cases)[3] for one additional month to prevent Medicaid termination by NC FAST when the eligibility redetermination had not been completed by the county DSS by the end of the month it was due. Dec. 21, 2017 Sea Decl. Ex. 20 (p. 2). However, this programming to provide eligibility extensions excluded "medically needy" families and aged, blind, and disabled Medicaid beneficiaries (who receive Medicaid under "traditional" categories).[4] *Id.*; Feb. 9, 2018 Sea Decl. Exs. 10 (pp. 4, 6), 19 (p. 2). Eligibility extensions by NC FAST also did not prevent termination notices from being mailed less than ten days before the termination occurred, as the extension only applied to cases not processed by the end of the month. *Id.*; Dec 21, 2017 Sea Decl. Ex. 20; Feb. 9, 2018 Sea Decl. Ex. 9 (p.2). Moreover, beginning in July 2015, Defendant required county DSSs to specifically request eligibility extensions by NC FAST for cases where the eligibility review had not been timely completed. Dec 21, 2017 Sea Decl. Exs. 18, 19; Feb. 9, 2018 Sea Decl. Ex. 16. By early 2016, only a handful of DSSs were seeking and obtaining NC FAST extensions. Dec. 21, 2017 Sea Decl. Exs. 18, 19. Absent an extension by the computer, the only way Medicaid eligibility can be extended when the eligibility redetermination is not timely completed is for the DSS worker to manually force NC FAST to do so, which must be done one case at a time. Dec. 21, 2017 Sea Decl. Exs. 17, 18, 21, 24 (p.4); Feb. 9, 2018 Sea Decl. Ex 10 (p. 6).

NC FAST generates reports showing the number of "past due" Medicaid eligibility recertifications for each county DSS as of the date of the report. Dec. 21, 2017 Sea Decl. Exs. 3-

[3] "MAGI" is an acronym for Modified Adjusted Gross Income, which is an income counting methodology used in determining Medicaid eligibility for families and children under federal law. 42 C.F.R. § 435.603(e).

[4] "Traditional" refers to categories of Medicaid that do not use the "MAGI" methodology.

16, 22; Feb. 9, 2018 Sea Decl. Exs. 3-6, 14. "Past due" means that as of the date the report is generated, DSS has not completed the review of continuing Medicaid eligibility that was due in the previous month *and* that eligibility was not extended beyond the previous month by the DSS worker or by NC FAST. Dec. 21, 2017 Sea Decl. Ex 22. A sample of these reports provided to Plaintiffs' counsel confirm that, at least since July 2016, DHHS and its county DSS agents across the state have in hundreds of cases per month failed to either timely complete the eligibility review that was due or to extend Medicaid coverage until the review was completed. Dec. 21, 2017 Sea Decl. Exs. 3-16, 22; Feb. 9, 2018 Sea Decl. Exs. 3-6, 14. The number of such "past due" cases in this sample of reports alone includes tens of thousands of N.C. Medicaid beneficiaries. *Id.* In each of these cases, DHHS's computer system NC FAST automatically terminated Medicaid coverage without determining ineligibility for Medicaid and without any notice to the family, let alone the opportunity for a hearing before Medicaid ended. *Id.*

For example, two NCFAST reports show that, as of September 21, 2017, 100 of 100 county DSSs had failed to complete eligibility reviews for a total of 30,595 Medicaid cases (21,328 MAGI plus 9,267 traditional) that were due to be terminated automatically by NC FAST on September 30, 2017. Feb. 9, 2018 Sea Decl. Exs. 5, 6. In each of these cases, the last day to mail timely notice of termination was September 20, the day *before* these reports were generated. 42 C.F.R. § 431.211. Two more NCFAST reports show that, as of October 5, 2017, review of 1,272 (840 MAGI plus 432 Traditional) of these cases due for review in September still had not been completed. Dec. 21, 2017 Sea Decl. Exs. 3-4. This means at least 1,272 families lost Medicaid coverage with no notice at all on September 30, 2017.

A large number of automatic Medicaid terminations have been ongoing for many months. Dec. 21, 2017 Sea Decl. Exs. 3-16; Feb. 9, 2018 Sea Decl. Exs. 3-6, 11-13. Reports

generated on September 8, 2016 show that at least 7,490 families (6593 MAGI plus 897 traditional) lost Medicaid without notice on August 31, 2016 and were still without Medicaid eight days later. Dec. 21, 2017 Sea Decl. Exs. 13-14. Reports generated January 5, 2017 include 5,884 (3,784 MAGI plus 2,100 traditional) families who lost Medicaid without notice on December 31, 2016. Dec. 21, 2017 Sea Decl. Exs. 5-6.

Automatic Medicaid terminations without notice have continued unabated after this suit was filed. Two reports generated by Defendant on December 22, 2017 show that as of that day a total of 15,687 Medicaid recertifications statewide had not been completed by the deadline to send timely notice of termination. Feb. 9, 2018 Sea Decl. Exs. 3-4, 14. Every county DSS had cases still due to be processed the day after the deadline; some DSSs had thousands of cases not processed by the deadline. *Id*. Equally troubling, there were still 540 cases where the recertification had been due in November 2017 but had not been completed as of December 22. *Id*. Every one of these 540 families lost Medicaid coverage on November 30, 2017 with no notice at all. Every one of these 540 families was still without Medicaid over three weeks later.

These numbers significantly understate the extent of this systemic, ongoing deprivation of essential Medicaid coverage. First, Plaintiffs' counsel were provided only a sample of reports. Second, these are "point in time" reports which means cases that were processed late but before the date the report is generated are not shown, even though timely notice of termination was not mailed. Feb. 9, 2018 Sea Decl. Ex. 14. Third, even after the county DSS completes its eligibility review, DHHS (through NC FAST) does not mail a notice of termination to the beneficiary until the following work day, and these reports do not capture that delay of one to four days (in the case of an intervening weekend and Monday holiday). Dec. 21, 2017 Sea Decl. Ex. 17; Feb. 9, 2018 Sea Decl. Ex. 23 (p. 15).

Three of the named plaintiffs and five proposed class members have filed evidence that they suffered automatic terminations without any notice. On July 31, 2017, NC FAST terminated Plaintiff Quinteros Hawkins' Medicaid coverage (except family planning coverage) because her youngest daughter turned age 18 in July. DSS made no effort to determine if Ms. Hawkins was still eligible for Medicaid before the termination occurred. Hardee Decl. Ex. 2. No written notice was sent to Ms. Quinteros Hawkins informing her that her Medicaid was being stopped. Feb. 9, 2018 Hawkins Decl. ¶¶ 9-12; Hardee Decl. Ex. 2. Plaintiff Vanessa Lachowski lost her Medicaid without notice on December 31, 2016 even though she remained eligible, because DSS did not timely complete her annual redetermination, causing her to lose her personal care services. Feb. 9, 2018 Lachowski Decl. ¶¶ 8-11; Allison Decl. Exs. 6-7. Plaintiff Kyanna Shipp lost her Medicaid with no notice on November 30, 2017 because she turned 19-years-old in November and DSS failed to review her eligibility. Allison Decl. Exs. 4-5. Class member Dequavius Bowman lost Medicaid without notice in July 2014 when he turned age nineteen and his Medicaid was not reinstated until February 2015. Hardee Decl. Ex. 1. Class member Tarren Turrubiates and her children lost Medicaid without notice on three different occasions in 2016 because DSS had not reviewed their eligibility before the computer automatically terminated coverage at the end of certification periods. Turrubiates Decl. ¶¶ 4, 7, 9, Exs. 1-3. Class member Leroy Rivers lost his Medicaid without notice due to an automatic termination, which caused him to lose his personal care services. Rivers Decl. ¶¶ 20-22. Estes Rogers Decl. Exs. 1-2. NC FAST automatically terminated Medicaid for class member Arianna Ruiz because she turned age 19. Reyes Decl. ¶¶ 6-9, 12; Garcia Decl. ¶¶ 3-5. Class member and minor child S.S. lost her Medicaid without notice at the end of her 12-month certification period because DSS did not

timely complete her review. Estes-Rogers Decl. Ex. 4. DSS did not reinstate her Medicaid until more than four months later. *Id.*

Defendant has repeatedly instructed county DSSs to complete recertifications by the end of the month they are due or manually force the computer to extend eligibility in that case. Dec. 21, 2017 Sea Decl, Exs. 17, 18, 19, 21, 24 (p. 4); Feb. 9, 2018 Sea Decl. Exs. 8 (p.8), 9 (pp.2, 3), 10, 15, 16, 17, 18, 19, 20. The evidence proves this has been a woefully inadequate remedy. Until Defendant is ordered to change its computer programming to prevent automatic terminations, hundreds of thousands of Medicaid beneficiaries in North Carolina will remain threatened with the termination of their Medicaid coverage without timely notice and regardless of their continuing eligibility.

2. Defendant's Practice Violates the Medicaid Act.

Defendant's procedure violates the federal Medicaid statute, which requires states to provide Medicaid "with reasonable promptness to all eligible individuals." 42 U.S.C. § 1396a(a)(8). In addition, states must make Medicaid available to all qualifying individuals. 42 U.S.C. § 1396a(a)(10). The regulations implementing these statutory provisions specify that the agency must continue providing Medicaid until the beneficiary is determined to be ineligible under all Medicaid eligibility categories. 42 C.F.R. §§ 435.930(b), 431.916(f)(1). Courts have repeatedly enforced this requirement to determine ineligibility under all Medicaid categories before Medicaid can be terminated. *See, e.g.*, *Crippen v. Kheder*, 741 F.2d 102, (6th Cir. 1984), *rev'g Crippen v. Dempsey*, 549 F. Supp. 643 (W.D. Mich. 1982); *Mass. Ass'n of Older Ams. v. Sharp*, 700 F.2d 749 (1st Cir. 1983), *same case sub nom., Mass. Ass'n of Older Ams. v. Comm'r of Pub. Welfare,* 803 F.2d 35 (1st Cir. 1986); *Stenson v. Blum*, 476 F. Supp. 1331, 1339-42 (S.D.N.Y. 1979), *aff'd mem.*, 628 F.2d 1345 (2d Cir. 1980); *Crawley v. Ahmed*, No. 08-14040,

2009 U.S. Dist. LEXIS 40794 (E.D. Mich. May 14, 2009). Here, Defendant's computer is programmed to automatically terminate Medicaid regardless of continuing eligibility, simply because the DSS worker did not timely review the case.

3. Defendant's Practice Violates Due Process.

It is well-established that Medicaid beneficiaries have a statutory entitlement to benefits that is protected by the Due Process Clause of the Fourteenth Amendment. In *Goldberg v. Kelly*, 397 U.S. 254 (1970), the Court noted that termination of welfare benefits for the poor (a category which includes the Medicaid program) "pending resolution of a controversy over eligibility may deprive an *eligible* recipient of the very means by which to live while he waits." *Id.* at 264. Thus, the Court held that such individuals are entitled, under due process, to an evidentiary hearing before benefits can be discontinued. *Id.* at 267.

Such recipients must also be given "timely and adequate notice detailing the reasons for a proposed termination . . . ." *Goldberg*, 397 U.S. at 268. *See also Mullane v. Central Hanover Bank & Trust Co.*, 339 U.S. 306, 314 (1950) (requiring "notice reasonably calculated, under all circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections."); *Board of Regents v. Roth*, 408 U.S. 564, 577 (1972); *Gray Panthers v. Schweiker*, 652 F.2d 146, 168 (D.C. Cir. 1981) (without adequate notice of reasons for denial "hearing serves no purpose"); *Vargas v. Trainor*, 508 F.2d 485, 490 (7th Cir. 1974) (notice especially important because of "human tendency, even among those more experienced and knowledgeable in the ways of bureaucracies than . . . disabled persons . . . to assume that an action taken by a government agency in a pecuniary transaction is correct").

These rights are guaranteed not only by the Constitution, but also the Medicaid Act. The state Medicaid agency must provide the "opportunity for a fair hearing before the State agency to

any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness." 42 U.S.C. § 1396a(a)(3). This includes the right to written notice of the right to a pre-termination hearing provided at least ten days (with a few exceptions not relevant here) before Medicaid is terminated, including the specific reasons for the termination, the specific law or regulation supporting the action, and an explanation of the right to a hearing and the right to continue receiving benefits pending that hearing. 42 C.F.R. §§ 431.210-212, 231, 435.917.

Here, Defendant is terminating Medicaid with no notice at all, let alone timely notice that permits the beneficiary to challenge the action at a pre-termination hearing. Plaintiffs therefore move the Court to preliminarily enjoin Defendant to cease automatic computer-generated terminations of Medicaid coverage without first determining ineligibility and sending timely written notice.

**B. Defendant Is Violating Both the Medicaid Statute and Due Process by Terminating Medicaid Without Redetermining Eligibility Based on an Alleged Disability.**

1. Defendant's Policy:

Plaintiffs also seek preliminary relief to require Defendant to cease terminations of Medicaid without determining ineligibility under all Medicaid categories for persons alleging disability who have not yet been determined disabled. These terminations occur even when the county DSS *does* timely review the case and sends timely written notice of termination. This is because Defendant's written policy prohibits consideration of Medicaid eligibility based on an alleged disability prior to termination, fails to provide adequate notice of the termination, and fails to provide the right to a pre-termination hearing on the issue of disability.

One category of Medicaid eligibility is for persons who meet the Social Security definition of disability. Feb 9, 2018 Sea Decl. Ex. 24 (p. 1); 42 U.S.C. § 1396(a)(m). In North Carolina, this category includes all disabled persons who have income under 100% of the federal poverty line. Session Law 2015-241 § 12H.2(b)(1). The individual need not have been determined disabled by Social Security before receiving Medicaid under this category. Feb. 9, 2018 Sea Decl. Ex. 24 (p. 1). The Medicaid agency may adopt a recent Social Security denial of disability if there is no new or worsened impairment since the Social Security denial but otherwise must make its own disability determination. *Id.* (p 5); 42 C.F.R. § 435.541(c). Either way, a Medicaid disability denial triggers the right to a state hearing where Medicaid can be approved based on a finding of disability without waiting for the outcome of a pending Social Security appeal. Feb. 9, 2018 Sea Decl. Exs. 23 (p. 23), 24 (p. 16), 25 (p. 24); N.C. Gen. Stat. § 108A-79(i). This right is critical to persons with disabilities who need access to medical care because the wait for a disability hearing decision from the Social Security Administration (SSA) averages almost twenty-two months after a hearing is requested. Feb. 9, 2018 Sea Decl. Ex. 27 (showing average of 650 days wait for decision in four N.C. SSA hearing offices in 2017). This delay does not include the time needed for SSA's reconsideration of a disability denial before a hearing can be requested, which averaged 111 days in 2017. Feb. 9, 2018 Sea Decl. Ex. 28; 20 C.F.R. § 404.907.

Medicaid is often approved for persons alleging disability under categories which do not require proof of disability, for example, because the disabled person is pregnant or a parent or caretaker of a minor child or is herself under age 19. Feb. 9, 2018 Sea Decl. Ex. 29. When the person alleging disability loses her eligibility for Medicaid in that non-disability category and has not yet been determined disabled by Social Security, DHHS policy instructions prohibit

determination of whether the individual is eligible for Medicaid based on disability before terminating her Medicaid benefits. Dec. 21, 2017 Sea Decl. Ex. 24 (pp. 21-22); Feb. 9, 2018 Sea Decl. Exs. 8 (pp. 4-5), 26 (p. 3) (limiting review to whether person losing non-disability Medicaid has already been determined disabled).

Two named Plaintiffs and one proposed class member have filed evidence that they were terminated from Medicaid without any consideration of their eligibility for Medicaid based on their alleged disabilities. Plaintiff Marcia Quinteros Hawkins received Medicaid as the parent of a minor child with very low income and assets. Feb. 9, 2018 Hawkins Decl. ¶ 6. Ms. Quinteros Hawkins notified Mecklenburg County DSS that she is experiencing a lot of pain, taking several medications, and is unable to work on a substantial basis due to her medical problems. *Id*. at ¶ 7. In addition, her DSS worker had access to Ms. Hawkins' record to verify her pending Social Security disability claim. Feb. 9, 2018 Sea Decl. Ex. 24 (p. 5). On September 20, 2017, DSS sent a written notice to Ms. Quinteros Hawkins that her Medicaid would stop on October 31, 2017 because her youngest child had turned age eighteen. Feb. 9, 2018 Hawkins Decl. Ex. 2. Following DHHS instructions, DSS made no effort to determine whether Ms. Quinteros Hawkins is disabled before notifying her that her Medicaid would be terminated. Hardee Decl. Ex. 2. Ms. Hawkins is still without health coverage. Feb. 9, 2018 Hawkins Decl. ¶ 15.

Plaintiff Kyanna Shipp was terminated from Medicaid without any notice on November 30, 2017 because she turned 19-years-old in November and thus was no longer eligible under the Medicaid category for low-income infants and children. Allison Decl. Exs. 4-5; Feb 9, 2018 Sea Decl, Ex. 29. DSS made no effort to determine if she is eligible for Medicaid based on her alleged disability before terminating her coverage. Allison Decl. Ex. 5. After this suit was filed and her attorneys contacted DSS, DSS reinstated Ms. Shipp's Medicaid because no termination

notice had been sent to her. *Id.* However, on January 11, 2018, DSS sent Ms. Shipp notice that her Medicaid will again terminate effective February 28, 2018. *Id.* DSS again made no inquiry into Ms. Shipp's eligibility under Medicaid based on her alleged disability before doing so. *Id.* The January 11th notice of termination provides no information about her potential eligibility for Medicaid based on her alleged disability. *Id*.

In 2016, class member Jerry Hedger told DSS he was disabled but then lost his Medicaid when DSS considered his eligibility only under the category for parents of minor children. Jerry Hedger Decl. ¶¶ 3-4. The notice of termination told him only that his family's income was too high for Medicaid for families. Hedger Decl. Ex. A. When he went to DSS to ask about this, the worker told him he would have to file a new application for Medicaid based on his disability. Hedger Decl. ¶ 5.

2. Defendant's Policy Violates the Medicaid Statute.

Defendant's policy of prohibiting determination of disability prior to Medicaid termination violates the Medicaid Act. As discussed above, *supra* at pp. 11-12, 42 U.S.C. §§ 1396a(a)(8) and 1396a(a)(10) prohibit termination of Medicaid until the individual has been determined to be ineligible under all Medicaid categories, which includes Medicaid based on disability. The federal Medicaid agency (CMS) has amended one of its regulations to address this precise issue. 42 C.F.R. § 435.916(f)(1)(2012). In its preamble explaining this change, CMS stated:

> We have added a new paragraph to § 435.916(f)(1), to clarify that, in accordance with longstanding policy the agency must consider all bases of eligibility when conducting a renewal of eligibility. To meet this requirement, renewal forms will need to include basic screening questions, similar to those that will need to be on the single streamlined application, *to indicate potential eligibility based on disability* or other basis other than the applicable MAGI standard.

77 Fed. Reg. 17181 (March 23, 2012) (emphasis added). In response to the federal agency's direction, Defendant recently amended the state agency's Medicaid eligibility redetermination form for families and children to ask whether anyone in the household alleges disability. Feb. 9, 2018 Sea Decl. Ex. 30 (p. 4). However, if the family answers this question affirmatively, this does not trigger a disability determination under Defendant's unchanged eligibility redetermination procedure. Dec. 21, 2017 Sea Decl. Ex. 24 (p. 22); Feb. 9, 2018 Sea Decl. Exs. 8 (p.5) & 26 (p.3).

Even before the federal Medicaid agency clarified its regulation, a federal court in Michigan squarely addressed the same issue, preliminarily enjoining, as a violation of 42 U.S.C. §§ 1396a(a)(8) and (a)(10), the state agency's practice of terminating Medicaid benefits of individuals losing eligibility under family-related Medicaid categories without first determining whether they are eligible for Medicaid based on an alleged disability. *Crawley v. Ahmed*, No. 08-14040, 2009 U.S. Dist. LEXIS 40794 (E.D. Mich. May 14, 2009).

3. Defendant's Policy Violates Due Process by Providing Inadequate Notice.

Defendant's policy of terminating Medicaid coverage without first determining ineligibility under all categories, including based on alleged disability, also violates plaintiffs' and class members' due process rights because Defendant's termination notice is constitutionally inadequate.

Due process requires a notice "detailing the reasons for a proposed termination" and including "the legal and factual bases" for the decision. *Goldberg*, 397 U.S. at 267-68. *See also, e.g., Hamby v. Neel*, 368 F.3d 549 (6th Cir. 2004); *Ortiz v. Eichler*, 794 F.2d 889 (3d Cir. 1986); *Turner v. Walsh*, 574 F.2d 456 (8th Cir. 1978); *Vargas v. Trainor*, 508 F.2d 485 (7th Cir. 1974); *Baker v. Alaska DHHS*, 191 P.3d 1005 (Alaska 2008). As one district court has explained:

> At a minimum, due process requires the agency to explain, in terms comprehensible to the claimant, exactly what the agency proposes to do and why the agency is taking this action . . . . This detailed information is needed to enable claimants to understand what the agency has decided, so that they may assess the correctness of the agency's decision, make an informed decision as to whether to appeal, and be prepared for the issues to be addressed at the hearing.

*Ortiz v. Eichler*, 616 F. Supp. 1046, 1061, 1062 (D. Del. 1985)(citations omitted).

Similarly, the Alaska Supreme Court has explained the role of the notice as follows:

> Due process notices are designed to protect recipients from erroneous deprivation of benefits by allowing them to assess whether or not the agency's calculations are accurate . . . . [A]gencies make mistakes. If a major purpose served by benefit change or denial notices is protecting recipients from agency mistakes, then it stands to reason that such notices should provide sufficient information to allow recipients to detect and challenge mistakes.

*Allen v. Alaska Dep't of Health & Soc. Servs.*, 203 P.3d 1155, 1167-68, n.61 (Alaska 2009) (collecting cases). *See also, e.g., Kapps v. Wing*, 404 F.3d 105, 124 (2d Cir. 2005) ("Claimants cannot know *whether* a challenge to an agency's action is warranted, much less formulate an effective challenge, if they are not provided with sufficient information to understand the basis for the agency's action. [citation omitted]. Thus, in the absence of effective notice, the other due process rights afforded a benefits claimant … are rendered fundamentally hollow."); *Weaver v. Dept. of Social Servs.*, 791 P.2d 1230 (Colo. Ct. App. 1990) (Medicaid notice reducing services was constitutionally inadequate because it did not furnish accurate information to allow recipients to ascertain the standards governing coverage). *See Walters v. Reno,* 145 F.3d 1032 (9th Cir. 1998) (due process violated where notices "created an unacceptable risk of confusion").

Here, Defendant's notice of termination fails to satisfy due process because it fails to inform the person alleging disability that her Medicaid eligibility based on disability was not considered before termination of benefits, nor of the right to appeal and obtain a pre-termination hearing on whether she is disabled, nor even of the right to reapply for Medicaid based on

disability. Dec 21, 2017 Sea Decl. Exs. 23, 25; Feb. 9, 2018 Sea Decl. Ex. 25 (pp. 11-14); Allison Decl. Ex. 5; Hedger Decl. Ex. A. Defendant's notice provides as the reason for termination only why the individual is not eligible for Medicaid under Family and Children categories. *Id.* In *Crawley*, the court held that such a Medicaid termination notice is inadequate because it fails to explain that disability was not considered before termination. 2009 U.S. Dist. LEXIS 40794 at *76.

4. Defendant's Practice Violates Due Process by Denying a Hearing on the Issue of Disability.

Under Defendant's ongoing practice, where Medicaid is terminated under a category not requiring proof of disability, any appeal of that termination is also limited to non-disability issues. Feb 9, 2018 Sea Decl. Ex. 23 (pp. 2, 23, 24) (limiting right to state disability hearing to appeals of denials that were based on disability). In other words, if the beneficiary requests a hearing to appeal the Medicaid termination under a non-disability category, her alleged disability will not be considered by the hearing officer. This also means the beneficiary cannot continue receiving Medicaid until a hearing is held on whether she is disabled. This violates the beneficiary's constitutional right to a *de novo* pre-termination hearing.

In *Goldberg v. Kelly*, 397 U.S. 254 (1970), the Court held that "the decisionmaker's conclusion as to a recipient's eligibility must rest solely on the legal rules and evidence adduced at the hearing." *Id*. at 271. The hearing must include "an effective opportunity [for the recipient] to defend by confronting any adverse witnesses and by *presenting his own arguments and evidence* orally." *Id.* at 267-68 (emphasis added). The Court explained, "the pre-termination

hearing has one function only: to produce an *initial determination* of the validity of the [agency's] grounds for discontinuance of payments . . ." *Id*. at 267 (emphasis added).[5]

The federal Medicaid regulations explicitly incorporate the due process requirements of *Goldberg*. 42 C.F.R. § 431.205(d). Those regulations also specifically require that Medicaid hearings be "*de novo*," 42 C.F.R. §§ 431.205(b)(2), 431.232(c), 431.233, and define "*de novo"* as "a hearing that starts over from the beginning." 42 C.F.R. § 431.201. *See also* 42 C.F.R. § 431.244 (requiring that Medicaid hearing decisions be based solely on the evidence introduced at the *de novo* hearing).

Defendant is denying class members a *de novo* Medicaid termination hearing by denying the right to introduce evidence of disability at the hearing and to have the appeal decided based upon that evidence. As the court in *Crawley* stated, "A truly fair hearing would allow plaintiffs an opportunity to prove that they are eligible for Medicaid based on disability." 2009 U.S. Dist. LEXIS 40794 at *77.

As shown by the above-cited evidence, two named plaintiffs and other proposed class members have already lost or are threatened with the loss of their health coverage as a result of these ongoing violations of federal law. Plaintiffs request that the court preliminarily enjoin Defendant to cease Medicaid terminations without first considering eligibility based on alleged disability, providing adequate notice of the basis for the decision, and providing the right to a

[5] Following *Goldberg*, courts have consistently required a *de novo* evidentiary hearing prior to the termination or reduction of Medicaid and other public assistance. *See, e.g., Heckler v. Campbell*, 461 U.S. 458, 471 n.1, (1983) (Brennan concurring); *Roche v. Turner*, 186 Misc. 2d 581, 719 N.Y.S. 2d 436 (Sup. Ct. N.Y. Cty. 2000); *Md. Dep't of Health & Mental Hygiene v. Brown*, 177 Md. App. 440, 470, 935 A.2d 1128, 1145 (Md. Ct. Spec. App. 2008) *aff'd* 406 Md. 466, 959 A.2d 807 (2008); *Lawson v. Penn. Dep't of Public Welfare*, 744 A.2d 804 (Pa. Comwlth. 2000); *Urban v. Meconi*, 930 A.2d 860 (Del. 2007); *Curtis v. Roob*, 891 N.E.2d 577, 579-81 (Ind. Ct. App. 2008); *In re Houston*, 180 VT 59, ¶10, 180 Vt. 535, 538, 904 A.2d 1174, 1178 (Vt. 2006).

pre-termination hearing on the issue of whether the individual is eligible for Medicaid based on disability.

## II. PLAINTIFFS AND PROPOSED CLASS MEMBERS ARE THREATENED WITH IRREPARABLE HARM.

Defendant's challenged policies and practices threaten the Plaintiff class with irreparable harm. Terminations of Medicaid coverage place the health of those losing Medicaid at immediate risk. Without Medicaid coverage, Plaintiff and proposed class members are unable to timely access medically necessary treatment, prescription medications, and essential in-home services.

Numerous courts have found irreparable harm where Medicaid beneficiaries face loss of Medicaid coverage for necessary health care services. In *Pashby v. Delia*, 709 F.3d 307 (4th Cir. 2013), the Fourth Circuit held that the threat of losing needed medical care through Medicaid coverage constituted irreparable harm. In *LS. v. Delia*, 2012 U.S. Dist. LEXIS 43822, this court held that loss of in-home Medicaid services constituted irreparable harm. In *Benjamin H. v. Ohl*, 1999 WL 34783552 (S.D. W.Va. July 15, 1999), the court granted a preliminary injunction, finding the plaintiffs were suffering irreparable harm because they were being denied access to Medicaid services they needed, and families and caregivers were experiencing unnecessary stress due to the lack of appropriate services. *Id.* at *12. *See also Knowles v. Horn,* 2010 WL 517591 (N.D. Tex. Feb. 10, 2010) (finding irreparable harm where Medicaid services terminated without due process); *Cota v. Maxwell-Jolly*, 688 F. Supp.2d 980 (N.D. Cal. 2010) (finding that "the reduction or elimination of public medical benefits is sufficient to establish irreparable harm to those likely to be affected by the program cuts."); *Crawley v. Ahmed*, 2009 WL 1384147 at *28 (E.D. Mich. May 14, 2009) (finding that irreparable harm existed because "it is undeniable that the unpaid bills, loss of needed medical assistance, and ultimately poor health suffered by Plaintiffs, cannot be adequately addressed by the promise of future Medicaid coverage"); *Newton*

*Nations v. Rogers*, 316 F. Supp. 2d 883, 888 (D. Ariz. 2004) (finding irreparable harm existed where Medicaid beneficiaries could be denied medical care); *Bizjak v. Blum*, 490 F. Supp. 1297, 1303 (N.D.N.Y. 1980) (finding irreparable harm in due process case, stating "It is not at all inconceivable that the inability to review the case record prior to a 'fair hearing' could result in the further inability to prepare properly for the hearing with the result being an erroneous denial of benefits. Thus, it is clear that the possibility of irreparable injury in this case is neither remote nor speculative but, in fact, highly likely."); *see also Beltran v. Meyers*, 677 F.2d 1317, 1322 (9th Cir. 1982) (holding irreparable injury is established when enforcement of a Medicaid policy "may deny needed medical care"); *Mass. Ass'n of Older Americans v. Sharp*, 700 F.2d 749, 753 (1st Cir. 1983) ("Termination of [Medicaid] benefits that causes individuals to forego such necessary medical care is clearly irreparable injury."); *Caldwell v. Blum*, 621 F.2d 491, 498 (2nd Cir. 1980) (finding harm where Medicaid applicants would "absent relief, be exposed to the hardship of being denied essential medical benefits"); *Becker v. Toia*, 439 F. Supp. 324, 336 (S.D.N.Y. 1977) (enjoining Medicaid copayments, finding that "injury to those whose health is maintained on the slenderest chemical balance provided through medication is not merely irreparable, it is ultimate.").

Plaintiff Quinteros Hawkins has been without Medicaid coverage since October 31, 2017. Feb. 9, 2018 Hawkins Decl. ¶ 15. She missed at least three scheduled doctors' appointments in November and December because she did not have Medicaid to pay for them. *Id*. at ¶ 16. She has not been able to get the physical therapy her doctor prescribed to help her recover from recent shoulder surgery. *Id.* She is worried that without treatment, her conditions will worsen and soon she will not be able to work at all. *Id.* If that happens, she will have no income and will to be able to afford the $12.00 per month she has to pay for her numerous medicines through a sliding-scale

clinic. *Id.* The stress of being without health insurance coverage and not being able to afford the care she needs is adversely affecting her health. *Id.*

When Plaintiff Vanessa Lachowski lost Medicaid without notice on December 31, 2016, her personal care services were interrupted for over ten days. Feb. 9, 2018 Lachowski Decl. ¶ 11. Her safety and health were placed at serious risk, and the termination caused significant hardship and extreme stress for her and her family. *Id.* She and her mother were again concerned and stressed when they received no review paperwork or other contact from DSS in November and December of 2017 because if she loses her Medicaid coverage again, Ms. Lachowski will be terminated from the CAP-DA program, which provides her critically needed in-home care. *Id*. at ¶¶ 13, 14. If that occurs, she is likely to have to wait another year or more on the waiting list to get CAP-DA services again. *Id*. Though her Medicaid has not stopped again since this suit was filed, the constant threat of losing her Medicaid coverage continues to cause her ongoing stress. *Id*. at ¶ 14.

Proposed class member Leroy Rivers lost his personal care services three different times because his Medicaid was terminated under policies or practices challenged in this lawsuit. Rivers Decl.; Estes-Rogers Decl. Exs. 1-2. As a result, he was unable to take care of his personal needs, putting his health and safety at risk. Rivers Decl. ¶ 33. He continues to suffer stress from the fear that he will again lose his Medicaid coverage when review of his Medicaid eligibility next becomes due. *Id*. Until written notice of Medicaid termination was obtained for Arianna Ruiz as proof of her loss of health coverage, she could not enroll in coverage under the Affordable Care Act. Reyes Decl. at ¶ 10.

Plaintiffs and proposed class members are suffering or imminently threatened with direct, serious harm. Beneficiaries are losing access to essential medical services, putting their health at

serious risk. In addition, the reductions and terminations are causing unnecessary stress on beneficiaries and their families. Hundreds of thousands of current N.C. Medicaid beneficiaries are at risk. For these reasons the requirement for irreparable harm has been met.

## III. THE BALANCE OF EQUITIES FAVOR PLAINTIFFS.

The Defendant will need to change some administrative procedures if the injunction is issued. However, she must show that proposed injunctive relief poses more than mere fiscal and administrative inconvenience to tip the balance of equities away from Plaintiffs, who are suffering physical, emotional, and financial harm in the absence of relief. The Supreme Court has held that a state Medicaid agency's claim of economic harm does not outweigh the harm posed to a plaintiff facing the threat of having to forgo necessary medical care:

> On the other side of the balance are the life and health of the members of this class: persons who are aged, blind, or disabled and unable to provide for necessary medical care because of lack of resources. The District Court noted that some of the members of the class have already died since this suit was filed, and the denial of necessary medical benefits during the months pending filing and disposition of a petition for writ of certiorari could well result in the death or serious medical injury of members of this class. The balance of equities therefore weighs in favor of the respondents.

*Blum v. Caldwell,* 446 U.S. 1311, 1316 (1980); *see also Todd v. Sorrell,* 841 F.2d 87, 88 (4th Cir. 1988) ("[H]arm to the plaintiff would have been enormous, indeed fatal, were the injunction denied, and harm to the Commonwealth if granted, while it may not have been negligible, was measured only in money and was inconsequential by comparison."); *L.J. v. Massinga,* 838 F.2d 118 (4th Cir. 1988) (monetary costs and administrative inconvenience to city from preliminary injunction was outweighed by preventing continuing harm to plaintiffs caused by defendants' mismanagement of foster care system); *accord LS. v. Delia,* 2012 U.S. Dist. LEXIS 43822; *Daniels v. Wadley*, 926 F. Supp. 1305, 1313 (M.D. Tenn. 1996); *Kansas Hosp. Ass'n v. Whiteman*, 835 F. Supp. 1548, 1552-53 (D. Kan. 1993); *see generally Multi-Channel TV Cable*

*Co. v. Charlottesville Quality Cable Operating Co.*, 22 F.3d 546 (4th Cir. 1994). The balance of equities thus favors injunctive relief.

## IV. THE PUBLIC INTEREST FAVORS ISSUANCE OF THE INJUNCTION.

An injunction is also in the public interest. The public interest is served when laws passed by Congress and the U.S. Constitution are enforced. *See LS. v. Delia*, 2012 U.S. Dist. LEXIS 43822; *Glenwood Bridge, Inc. v. City of Minneapolis*, 940 F.2d 367, 372 (8th Cir. 1991); *Kansas Hosp. Ass'n*, 835 F. Supp. at 1553; *see also Nat'l Wildlife Fed. v. Nat'l Marine Fisheries Serv.*, 235 F. Supp. 2d 1143, 1162 (W.D. Wash. 2002); *Haskins v. Stanton*, 794 F.2d 1273, 1277 (7th Cir. 1986) (where an injunction seeks to require defendants to comply with existing law, the injunction imposes no burden but "merely seeks to prevent the defendants from shirking their responsibilities"); *White v. Martin*, 2002 U.S. Dist. LEXIS 27281, 22-23 (W.D. Mo. 2002).

Courts also routinely find that lawful administration of the Medicaid act is in the public interest. *Texas Children's Hosp. v. Burwell*, 76 F. Supp. 3d 224, 246 (D.D.C. 2014); *Edmonds v. Levine*, 417 F. Supp. 2d 1323, 1342 (S.D. Fla. 2006) ("Issuance of an injunction to enforce the federal Medicaid Act is without question in the public interest"); *Children's Mem'l Hosp. v. Ill. Dep't of Pub. Aid*, 562 F. Supp. 165, 174 (N.D. Ill. 1983). "[T]here is a robust public interest in safeguarding access to health care for those eligible for Medicaid, whom Congress has recognized as 'the most needy in the country.'" *Texas Children's Hosp.*, 76 F. Supp. 3d at 246 .

In determining whether the public interest will be served by the granting of a request for preliminary injunction, courts may look to the intent in enacting the law sought to be enforced. *Johnson v. U.S.D.A.*, 734 F.2d 774, 788 (11th Cir. 1984). Among the stated purposes of the Medicaid Act is "to furnish . . . services to help [low income] families and individuals attain or retain capacity for independence or self-care." 42 U.S.C. § 1396(2). Preserving Plaintiffs' health,

well-being, and independence is thus squarely in the public interest. *See also., Temple Univ. v. White*, 941 F.2d 201, 220 n. 27 (3d Cir. 1991) ("Public Policy under [federal law governing state modification of Medicaid programs] mandates that parties in fact adversely affected by improper administration of programs pursuant thereto be strongly encouraged to correct such errors.").

Importantly, Plaintiffs do not seek a ruling from this Court that they are entitled to Medicaid benefits, but only that Defendant and her agents must follow fundamental due process and statutory requirements before terminating those benefits. Long term fiscal interests thus are not threatened by issuance of the injunction. Also, Plaintiffs do not seek reinstatement of those previously terminated under these procedures at this preliminary stage, but rather seek only to preserve the status quo for those currently receiving and eligible for Medicaid coverage.

## V. THIS COURT SHOULD REQUIRE ONLY A NOMINAL BOND.

Plaintiffs request that the amount of the bond required under Federal Rule of Civil Procedure 65 be a nominal amount. This Court has discretion to set the amount of the bond for a a preliminary injunction. *LS. v. Delia*, 2012 U.S. Dist. LEXIS 43822 (setting amount of bond at $100). The same amount is appropriate here both because Plaintiffs are enforcing important federal rights and because the plaintiffs are indigent public assistance recipients. *See Barahona-Gomez v. Reno*, 167 F.3d 1228, 1237 (9th Cir. 1999); *Doctor's Assoc., Inc. v. Stuart*, 85 F.3d 975, 985 (2d Cir. 1996); *Moltan Co. v. Eagle-Picher Indus., Inc*., 55 F.3d 1171, 1176 (6th Cir. 1995); *Stockslager v. Carroll Elec. Co-op. Corp*., 528 F.2d 949, 951 (8th Cir. 1976); *Bass v. Richardson*, 338 F. Supp. 478, 490 (S.D.N.Y. 1971); *Denny v. Health and Soc. Servs. Bd. of State of Wisconsin*, 285 F. Supp. 526, 527 (E.D. Wis. 1968).

## CONCLUSION

For the reasons stated above, Plaintiffs respectfully request that this Court issue an order preliminarily enjoining Defendant from terminating Medicaid benefits to the named plaintiffs and all others similarly situated until Defendant first determines ineligibility under all Medicaid categories and provides adequate and timely written notice and the opportunity for a *de novo* fair hearing prior to the termination of services. Plaintiffs also request that the court require only a nominal amount for security on the part of the plaintiffs.

Dated: February 13, 2018

Respectfully submitted,

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## CERTIFICATE OF SERVICE

I certify that on this day, I served a true copy of the Plaintiffs' Memorandum in Support of Motion for Class Certification upon the Defendant's attorney via electronic means through the CM/ECF system to:

Thomas Campbell
Special Deputy Attorney General
N.C. Department of Justice

Rajeev K. Premakumar
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N.C. Department of Justice

This the 13th day of February 2018.

/s/ Douglas Stuart Sea