UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA
WESTERN DIVISION
Case No. 5:11-CV-273

| | |
|---|---|
| HENRY PASHBY, *et al*, individually and on behalf of all others similarly situated,<br><br>Plaintiffs<br>v.<br><br>LANIER CANSLER, in his official capacity as Secretary of the North Carolina Department of Health and Human Services,<br><br>Defendant. | **MEMORANDUM OF LAW IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION** |

## INTRODUCTION

This suit challenges the legality of N.C. Medicaid Clinical Policy 3E establishing the In-Home Care for Adults program (hereinafter "IHCA Policy 3E"). On June 1, 2011, pursuant to this policy, personal care services (PCS) to 3,500 to 4,000 elderly, blind, or disabled North Carolina citizens will be terminated. Each of these individuals rely on PCS to remain safely in their homes and have been determined by Defendant's agent to need the services he currently receives.

IHCA Policy 3E establishes criteria for receipt of PCS that are significantly more restrictive than those applied under the pre-June 2011 PCS program. These criteria also are much more stringent than Defendant's criteria for persons who live in assisted living facilities, mostly large institutions with the misnomer of Adult Care Homes (ACHs), to receive PCS under Medicaid. As a result, the named Plaintiffs and those similarly situated are imminently threatened with the choice of being institutionalized or suffering irreparable harm to their health and safety.

Defendant has sent notices of termination of PCS under IHCA Policy 3E to each of the named Plaintiffs and to 3,500 to 4000 other proposed Plaintiff class members with an effective date of June 1, 2011. Plaintiffs seek a preliminary injunction to temporarily halt these PCS

terminations pending a determination by this Court of their legality. Unless enjoined, the PCS terminations will cause irreparable harm by placing Plaintiffs and other members of the proposed class at imminent and serious risk of harm to their health and safety, as well as of unnecessary and unwanted institutionalization. The public interest and balance of equities strongly favor Plaintiffs because Defendant's only interest is in temporary, minimal budgetary savings, whereas the proposed Plaintiff class faces life or death consequences.

Plaintiffs are highly likely to prevail on their legal claims. IHCA Policy 3E contravenes federal law by terminating necessary health care services based on criteria that substantially discriminate against Medicaid recipients living at home and in favor of those who reside in facilities such as ACHs. Thus, IHCA Policy 3E violates the requirement of Title XIX of the Social Security Act, 42 U.S.C. § 1396a-1396w-5 ("the Medicaid Act") that states cover comparable Medicaid services for individuals with similar needs. IHCA Policy 3E also violates the Title II of the Americans with Disabilities Act, 42 U.S.C. § 12312 ("ADA"), and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 ("Section 504"), by placing PCS recipients at imminent risk of unnecessary and unwanted out-of-home placement, including in ACHs. Finally, Defendant's failure to provide adequate and meaningful notice to the plaintiffs of the proposed PCS terminations violates the federal Due Process Clause and the Medicaid Act.

## BACKGROUND AND FACTS

### A. Medicaid and PCS.

Title XIX of the Social Security Act establishes the federal-state Medicaid program. See 42 U.S.C. §§ 1396–1396w-5. The purpose of Medicaid is to furnish, as far as practicable, "medical assistance on behalf of . . . aged, blind or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services" and "to help such families and individuals to attain or retain capability for independence or self-care." 42 U.S.C. § 1396-1. Participation in the Medicaid program by states is voluntary. If a state elects to

participate in the Medicaid program, it must "comply with detailed federally mandated standards." *Antrican v. Odom*, 290 F.3d 178, 183 n.2 (4th Cir. 2002). North Carolina has elected to participate in Medicaid. N.C.G.S. § 108A-56. Participating states are reimbursed by the federal government for a majority of the costs of Medicaid benefits. *See* 42 U.S.C. § 1396b. Participating states must designate a "single state agency" to administer the Medicaid program. 42 U.S.C. § 1396a(a)(5). In North Carolina, the single state agency is the North Carolina Department of Health and Human Services ("DHHS" or "Department"). N.C.G.S. 108A-54. The Defendant, Lanier Cansler, is Secretary of DHHS.

Participating states must cover certain mandatory services. 42 U.S.C. §§ 1396a(a)(10), 1396d(a). In addition, a state may choose to provide certain optional services, including PCS. *Id.* §§ 1396d(a)(24). Once a state chooses to provide an optional service, it must fully adhere to the applicable requirements of federal law and regulations. *See Lankford v. Sherman,* 451 F.3d 496, 504 (8th Cir. 2006) North Carolina has decided to cover PCS. Affidavit of Kathie Smith, RN (Smith Aff.) Exh.3.

**B. In-Home PCS and IHCA Policy 3E**

At the heart of this lawsuit is the fact that Defendant provides PCS in two different settings under two different sets of rules; restrictive rules governing coverage of PCS in the home but much more liberal rules for covering PCS in large, institutional ACHs. Prior to the implementation of IHCA Policy 3E, eligibility for in-home PCS in North Carolina already required hands-on assistance with two or more out of five listed activities of daily living (ADLs): bathing, dressing, toileting, mobility, and eating. DMA 4/16/10 Clinical Coverage Policy 3C, pp. 7, 10; Affidavit of Barbara A. Barat (Barat Aff.), Exh. G. IHCA Policy 3E and 3F replace In-Home PCS with two new programs: In-Home Care for Children ("IHCC") and In-Home Care

for Adults ("IHCA"). Although renamed and split into two programs, IHCA and IHCC still provide PCS in the home and have been approved as PCS by the federal Medicaid agency, Centers for Medicare and Medicaid (CMS). Apr. 18, 2011 State Plan Amendment 10-31 Approval letter; Barat Aff., Exh. N. The IHCA program limits eligibility for in home PCS for adults to those requiring limited hands-on assistance with three or more Activities of Daily Living (ADLs) (increased from two ADLs) or requiring assistance with two or more ADLs, one of which is at the extensive or dependent level. IHCA Policy 3E, p. 10; Smith Aff, Ex. 3.

Certain services may not be covered under IHCA: skilled nursing services provided by an LPN or RN, respite care, money management, non-essential errands and shopping, medical and nonmedical transportation, yard or home maintenance work, and continuous monitoring or ongoing recipient supervision. There must be no available, willing, and able household member to provide the authorized services on a regular basis. The in home PCS needed must be directly linked to a documented medical condition(s). The recipient must be under the ongoing direct care of a physician for the medical condition(s) causing the functional limitations. The maximum covered amount of in home PCS for adults is 3.5 hours per day and 60 hours per month. Defendant contracts with the Carolinas Center for Medical Excellence (CCME) to perform initial in-home assessments prior to approval of IHCA. Once approved, IHCA recipients are required to be reassessed by CCME at least annually. Also, the recipient's treating physician must attest that the authorized hours of service are medically necessary. IHCA Policy 3E, Smith Aff. Exh. 3.

During May 2011, CCME used the results of the most recent assessment already on file for those already receiving in-home PCS to approve or disqualify them under the new criteria. May 2011 DMA Provider Bulletin, Smith Aff. Exh. 4. For example, if an adult in home PCS recipient's last assessment showed a need for hands on assistance with 2 ADLs, the individual

was sent notice the services would be terminated on June 1, 2011, even though the assessment may be a year old and no longer accurate. Recipients thus were not given an opportunity to request a new CCME assessment prior to termination if the recipient's needs have increased since the last assessment. *See id;* Smith Aff. ¶30. DHHS has projected that 3,500 to 4,000 In-Home PCS recipients in N.C. will be terminated under the new program. Smith Aff. ¶ 24, Exh. 2.

**C. ACH PCS**

Medicaid-funded PCS is also provided in adult care homes (ACHs). However, in-home PCS and ACH PCS differ markedly in their setup, scope, amount, and structure. According to Defendant's website, ACHs "are residences for aged and disabled individuals who *may* require 24-hour supervision and assistance with personal care needs. People in adult care homes typically need a place to live, *some* help with personal care (such as dressing, grooming, and keeping up with medications), and *some limited* supervision. N.C. Div. of Aging and Adult Services, Adult Care Homes webpage (emphasis added), Barat Aff. Exh. L. *See generally*, N.C.G.S. § 131D-2.2(a); 10A NCAC 13F.0701. Admission to an ACH requires only "the opinion of the resident, physician, family or social worker, and the administrator [that] the services accommodations of the home will meet his particular needs." 10A NCAC 13F.0701(a). There are few other restrictions on admission. *See id*. at (b); N.C.G.S. 131D-2.2(a).

North Carolina operates the State-County Special Assistance Program to pay for room and board for low-income individuals (with monthly income less than $1,182) living in ACHs and other congregate settings. N.C.G.S. 108A-40. Seventy percent (70%) of all ACH residents are eligible for Special Assistance. Rpt. of DHHS Task Force on ACH, p. 6, Barat Aff. Exh. M. To be medically qualified to receive Special Assistance, the only requirement is certification by a physician of "the need for care in an adult care home…." 10A NCAC 71P .0906. All ACH

residents receiving Special Assistance are automatically eligible for Medicaid. 10A NCAC 21B.0102(2). About 19,300 N.C. residents of ACHs receive Special Assistance and Medicaid. Rpt. of DHHS Task Force on ACH, p. 8, Barat Aff. Exh. M.

Defendant has not published any clinical coverage policy to state the eligibility requirements to receive PCS in ACHs, but, under currently existing rules and policies, all or almost all Medicaid recipients in ACHs apparently qualify for PCS. See generally, 10A NCAC 13F.0901. Unlike in home PCS, there is no prior approval process by DHHS or any DHHS agent before an ACH resident can begin receiving PCS covered by Medicaid. Smith Aff. ¶19. Defendant's Special Assistance (SA) Manual flatly states: "SA recipients are eligible for Medicaid funded personal care services provided by the facility." SA-3220, VII, Barat Aff. Exh. P. The care plan submitted to obtain approval for Medicaid-funded PCS in an ACH merely requires a physician's certification that the resident "has a medical diagnosis with associated physical/mental limitations warranting the provision of personal care services in the above care plan." DMA-3050-R (Exh. I); 10A NCAC 13F .0802. The ADLs for which an individual living in an adult care home may obtain personal care assistance are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating. 10A NCAC 13F .0801. In SPA 10-31, Defendant assured CMS that, in the future, residents of ACHs will have to meet more strict criteria to receive PCS. Barat Aff. Exh. N. However, the criteria in SPA 10-31 are also more liberal than those applicable to in home PCS recipients. *Id*. In any event, Defendant has not implemented any of the new restrictions on ACH PCS required by CMS's approval of SPA 10-31. Smith Aff. ¶ 26.

To summarize, the above descriptions demonstrate that there are substantial differences between in-home PCS and ACH PCS: (1) To be eligible for PCS in the home, an individual must

require limited assistance with *three* out of *five* listed ADLs, or require limited assistance with one of those five ADLs and extensive assistance for another, while eligibility for ACH PCS requires only some assistance with *one* out of *seven* listed ADLs. Thus, a Medicaid recipient who requires limited assistance with dressing only is eligible to receive PCS in an ACH but another recipient who requires limited assistance with personal hygiene, transferring, eating, and bathing would be ineligible for PCS because the individual chose to remain in a private residence. (2) In-home PCS requires the need for "hands-on" assistance with ADLs but ACH PCS only requires the need for "some" assistance with an ADL. In fact, Form DMA-3050R lists "supervision" as a means of providing PCS in an ACH. Barat Aff. Exh. H. Thus, an individual requiring supervision of five different ADLs and hands-on limited assistance with 2 ADLs would be ineligible to receive PCS in the home, but a person in an ACH needing only supervision of one ADL would be eligible to receive PCS in that setting. (3) Assessments for Medicaid recipients seeking in-home PCS are performed by Defendant's agent, CCME, while assessments for ACH PCS are performed by staff of the facility that will be paid by Medicaid. 10A NCAC 13F. 0801. Also, unlike in-home PCS, there is no prior approval process to delay or deny receipt of PCS for residents of an ACH. (4) ACH PCS does not impose additional restrictions on eligibility such as the unavailability of an informal caregiver, a link between a documented medical condition and the assistance needed, and the recipient being under the direct care of a physician for that condition, all of which are required for in-home PCS.

**D. Institutional Nature of ACHs**

ACH residents live in mostly large institutions, not in "homes." As of January 2011, there were 602 Adult Care Homes in North Carolina with a total of 36,159 beds (an average of 60.6 beds per facility). One hundred sixty five ACHs in N.C. have 80 or more beds, and 40 ACHs

have 120 beds or more, up to 201 beds in the largest facility. Jan 2011 DHHS Report, Barat Aff. Exh. Q. Nor are these beds empty: the average occupancy rate for ACHs is 87%. Barat Aff. Exh. M, p. 6.

CMS has recently proposed regulations to define what constitutes a community based setting in the context of home and community-based waiver programs. Such a setting

> must be integrated in the community; must not be located in a building that is also a publicly or privately operated facility that provides institutional treatment or custodial care; must not be located in a building on the grounds of, or immediately adjacent to, a public institution; or, must not be a housing complex designed expressly around an individual's diagnosis or disability [such as age or disability] . . . . In addition, we propose that the settings must not have qualities of an institution, as determined by the Secretary. Such qualities may include regimented meal and sleep times, limitations on visitors, lack of privacy and other attributes that limit individual's ability to engage freely in the community.

Home and Community-Based Waivers, 76 Fed. Reg. 21311, 21312-13 (Apr. 15, 2011). *See also* 42 C.F.R. 435.10 (defining "institution" as "an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor").

By CMS's proposed or any rational standard, ACHs are not community settings. ACHs are licensed and regulated by the N.C. Division of Facility Services. N.C.G.S. 131D-2.4. The physical layout of most ACHs is institutional. Declaration of Misty Annarino ¶¶ 6, 8, 10, 11, 13, 14 ("Annarino Decl."); 10A NCAC 13F .0305, .0306. Many ACHs have special locked units. See 10 NCAC 13F .1303, .1304. Significantly, almost 5,000 ACH beds in N.C. are actually in nursing homes and 195 of the 400 licensed nursing homes in N.C. also have licensed ACH beds. N.C. 2011 State Medical Facilities Plan, Table 11A, Barat Aff. Exh. ?.; N.C. DHHS Report (5/16/11), *available at* http://www.ncdhhs.gov/dhsr/data/nhlist_a.pdf. There is no lease or landlord/tenant protections from eviction; instead residents are "discharged" by the facility. 10A NCAC 13F .0702. *See also*, *Henry Korman Draft Memo to Technical Assistance Collaborative*

(2008), Declaration of Susan H. Pollitt (Pollitt Decl.) Exh. A.

ACH residents are isolated from the community. In most ACHs, residents have little interaction with the outside world and rarely go out into the community. Annarino Decl. ¶16. Many of these facilities are in rural areas or located in areas with little to no access to public transportation. 2011 State Facilities Plan, Barat Aff. Exh. Q. There are few activities or opportunities and a resident's time may often be spent standing in line for medication. Annarino Decl. ¶14-16, 18. Visits with family and friends may be regulated. Annarino Decl. ¶12; 10A NCAC 13F.0906(f)(2).

By their nature, ACHs are designed to provide custodial care and supervision, limiting residents' autonomy. Privacy is very limited because residents are subject to 24 hour supervision. 10A NCAC 13F.0901. They have little control over their daily schedule and activities are done in a group. Annarino Decl. ¶13-15. Schedules are regimented for the convenience and efficiency of ACH staff rather than resident-centered. *Id.* Meals are served in groups at set times. *Id.* Residents generally are prohibited from managing their own activities such as cooking, taking medication, cleaning, budgeting and handling their own money. *Id* at ¶9, 13, 18, 21. The facility can receive the resident's Social Security, Supplemental Security Income (SSI), or Veterans' Administration (VA) check directly and apply it to the facility's charges. 10A NCAC 13F .1103(b); .1104. Residents are entitled to locked storage space only if the ACH administrator or supervisor has access. N.C.G.S. § 131D-21(12). Chemical and physical restraints may be ordered against the resident's will. N.C.G.S. § 131D-21(5); 10A NCAC 13F .1501. Medications are administered by staff unless a doctor orders otherwise. 10A NCAC 13F .1005. The resident has no right to smoke tobacco inside the ACH, even in his own room. N.C.G.S. 131D-4.4. Residents are required to be immunized annually. N.C.G.S. 131D-9.

Residents may be assigned a roommate not of their choice. Annarino Decl. ¶8.[1]

**E. Needs of the ACH Population**

The needs of Medicaid recipients in ACHs are no greater than the needs of the recipients of in-home PCS. As discussed above, admission to an ACH and receipt of Medicaid-funded PCS in an ACH required *less* severe medical needs than the requirements to receive in-home PCS, even prior to the implementation of IHCA Policy 3E. *See discussion, supra* at C. According to Defendant's own assessments, on average, in home PCS recipients have as high a level of need for assistance with ADLs as ACH residents.[2] Many individuals in ACHs who could live at home with appropriate supports are instead placed in these institutional settings. *See*, N.C. Institute of

[1] Defendant's own reports and other recent studies also demonstrate the institutional nature of ACHs. *See, e.g*., *Technical Assistance Collaborative, Inc*., *Draft Study of Adult Care Homes, Family Care Homes, Group Homes, and Permanent Supportive Housing for People with Disabilities in North Carolina, DRAFT Report*, p. 13 (2009), Pollitt Aff. Exh. B (concluding that many Adult Care Home "placements are inconsistent with *Olmstead* and other disability rights laws for those people whom, with the support of their treatment professional[s], desire to live in more integrated places," that ACHs share many characteristics with more traditional institutional settings such as developmental disability centers and State psychiatric hospitals, and that "When people enter ACHs they surrender a number of personal rights and expectations for personal control and autonomy"); *N.C. Institute of Medicine Report on Co-Location*, p. 34 (Jan, 2011) Pollitt Aff. Exh. C ("Although these types of living arrangements [ACHs] do help people who might otherwise be institutionalized live closer to their home communities, these residences are not optimal for community integration. Residents of ACHs may be cut off from active participation in the local community due to lack of transportation and the structured format (i.e. when meals and personal care are scheduled) of many residential care homes"); *Welcome Home!, Commission on MHDDSAS Task Force on Housing*, p. 10 (2004) (Exh. D (describing need for "housing to return people with disabilities to their communities and to prevent their having to leave their communities for more restrictive environments"); *Study of Issues Related to Persons with Mental Illness in Long-Term Care Facilities*, *N.C. Study Commission on Aging*, p. 4(2005), Pollitt Aff. Exh E ("many with mental illness continue to live in long term care settings because there are not yet more appropriate alternatives available to them in their communities"); *Final Report of DHHS and N.C. Housing Finance Agency*, p. 10 (2009), Pollitt Aff. Exh. F (notes that state funding supports individuals with "residential services in congregate settings" but there are few state services to support "independent community living").

[2] ACH residents have an average ADL score of 6 out of 18 on the study's classification system. An individual with a score of 4 was considered independent; an individual with a score of 18 totally dependent. 63 percent of the ACH population fell into the most independent category. In comparison, persons living at home and receiving adult day health services also had an average score of 6. N.C. DHHS *Assessment on Long Term Care Popul. Project Report* (Sept. 2005), Barat Aff. Exh. I.

Medicine, *Short and Long-Term Solutions for Co-Location in Adult and Family Care Homes,* (Jan. 2011), Pollitt Aff. Exh. C. .

**F. Named Plaintiffs**

The facts regarding each named plaintiff are set out in the Complaint and in their declarations and will not be repeated here. Each of the named Plaintiffs has received notice his or her PCS will be terminated June 1, 2011 because of IHCA Policy 3E. As a result, each Plaintiff is likely to suffer harm to his or her health and safety and to be at significant risk for institutionalization in an ACH or other setting. *See, generally*, Plaintiff Decls.

**G. Description of Plaintiff Class**

About 28,000 people depend on the in-home PCS program. Smith Decl.¶ 3. Experts confirm that these seniors and people under 65 with disabilities are healthiest and happiest living more independently at home. Smith Decl. ¶ 10; Webb Decl. ¶ 4. The in-home PCS program has been remarkably successful in stabilizing elderly and disabled Medicaid recipients at home. *Id*. Assistance with the personal care tasks of bathing, dressing, eating, mobility, and using the toilet are core PCS tasks. Smith Decl. ¶ 4. Many in-home PCS recipients with arthritis or the symptoms of a stroke depend on PCS for assistance taking a bath, and without this help they would not be able to bathe at all. *Id.* Other in-home PCS recipients need personal care assistance because, for example, they are paralyzed, have traumatic brain injury, or have seizure disorders. *Id*.

Many PCS recipients need assistance with simple domestic chores such as cooking. Smith Decl. ¶5. When balance is poor, help with cooking and meal clean-up ensures that individuals do not risk a fall, which can trigger a "downward spiral" that ends in a nursing home. *Id*. Other PCS recipients need assistance with meal preparation because they have dementia or

cognitive impairments. *Id.* at ¶6. Whatever the reason, in-home PCS services ensure their safety, continued health, and nutrition. *Id*. (regular, nutritious meals slow the dementia process and make individuals more alert). Other recipients need help with special diets because of suppressed immune systems or because they are dialysis patients. *Id.* PCS recipients may also need help with cleaning and laundry. Those with poor balance and weakness often cannot manage a broom or mop and risk falls if they attempt to clean house themselves. Smith Decl. ¶7. PCS providers also offer support and prompting to remind recipients to take prescription medication at the right time and in the right amounts. Smith Decl. ¶ 8 (many recipients have taken either too much or too little medication in absence of provider). Others hav mental disabilities and need direction and reminders to clean because of their level of confusion, disorientation, or self-neglect. *Id.* For frail seniors and people with mental disabilities who lack family supports and may otherwise be very isolated, the presence of a PCS provider in the home also monitors deterioration or changes in condition that may otherwise go unnoticed until it is too late. Smith Decl. ¶9.

**LEGAL STANDARD**

In actions brought under Section 1983 to enforce the Medicaid Act, district courts are invested with broad equitable powers to fashion appropriate remedial relief. *Doe v. Kidd*, No. 10-1191, 2011 U.S. App. LEXIS 6067, at * 20 (4th Cir. Mar. 24, 2011). "A plaintiff seeking a preliminary injunction must establish that he is: likely to succeed on the merits, that he is likely 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, as here there is both a likelihood of severe

irreparable harm and a strong likelihood of success on the merits.[3]

## ARGUMENT

### I. The Termination of PCS Will Cause Irreparable Injury.

Unless this Court acts, as a result of the major changes to the PCS program that will take effect June 2011, thousands of individuals relying upon PCS will be unable to survive in their homes. Many will be forced into adult care homes in order to receive PCS. Others' conditions will deteriorate until the point that they need placement in a nursing facility. Many will attempt to remain in their homes until they are forced into a hospital or die. The loss of PCS services will put Plaintiffs at imminent risk of illness, injury, institutionalization, and even death, as well as harm to their family ties, independence and dignity. An injunction should issue to preserve the status quo while the merits of the legal challenge are adjudicated.

#### A. The Termination of PCS Will Place Recipients at Great Risk of Injury at Home, Homelessness and Institutionalization.

##### 1. Risk of Injury and Effect on Health and Safety

The irreparable injury resulting from the loss of PCS services will be severe. Those who work with PCS recipients predict that Plaintiffs and class members will risk harm resulting from failure to take medications properly; isolation without food, medicine, and other necessities; development of decubitis ulcers and poor hygiene resulting in a high risk of infection; injury from attempts to cook food themselves; illness from eating inadequately prepared food;poor diet which exacerbates their medical conditions; illness due to unsanitary conditions; falls from

[3] Although plaintiffs will shortly be filing 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). Class certification is unnecessary when, as here, granting relief to any class member will effectively grant relief to the entire class. *See* 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).

attempts to bathe or clean without assistance; and premature death as a result of neglect and injuries. Smith Decl. ¶36; Webb Decl. ¶ 17; Declaration of Brenda Hutchens ¶ 13.

**2. Risk of Institutionalization**

If IHCA Policy 3E is implemented, Plaintiffs and those they represent also risk unnecessary institutionalization. Without PCS, family members who must work outside the home will have no choice but to place their loved ones in institutions or to hospitalize them after health declines. Smith Decl. ¶37; Webb Decl. ¶18. Treating professionals warn that the lack of affordable home care services is a primary factor driving the need for placement in nursing homes or assisted living facilities. *Id.* The named plaintiffs are greatly concerned they will be unable to remain in their homes without PCS. *See generally*, Pl. Decls. Moreover, Defendant's agent CCME has already determined that there are no other available, willing, and able adult to provide services to Plaintiffs or they would not be receiving PCS in their homes. 4/16/10 Clinical Coverage Policy 3E, p. 5, Barat Aff. Exh. G

Institutionalization will be detrimental to Plaintiffs' quality of life and care. Placement in an institution can destabilize already compromised mental or physical functioning, and it is extremely difficult for individuals to later move out of institutions and back into the community. Smith Decl. ¶ 39; Webb Decl. ¶ 19. Institutionalized individuals may become habituated to institutional structures, and lose the skills necessary to live in a community-based setting. *Id*. As ACH residents, they will suffer a substantial loss of dignity, independence, privacy, connection to their communities, and control over their lives. *See generally*, Annarino Decl. If Plaintiffs and others in the proposed class lose PCS services, they will imminently face the prospect of institutionalization or hospitalization. This will cause Plaintiffs emotional, psychological, and physical harm that cannot be compensated by an award of monetary damages.

**3. Plaintiffs Will Suffer Irreparable Injury.**

Courts addressing the issue have concluded that recipients would suffer irreparable harm if they were to lose in-home assistance similar to the N.C. in-home PCS program. As one Court recently wrote:

> The consumers' quality of life and health-care will be greatly diminished, which will likely cause great harm to disabled individuals. For instance, the declarations submitted by Plaintiffs describe harms ranging from going hungry and dehydration, to falls and burns, to an inability ever to leave the home. Institutionalizing individuals that can comfortably survive in their home with the help of [PCS] providers will "cause Plaintiffs to suffer injury to their mental and physical health, including a shortened life, and even death for some Plaintiffs."

*Martinez v. Schwarzenegger*, No. C 09-02306 CW, 2009 U.S. Dist. LEXIS 57960, at *17 (N.D. Cal. June 26, 2009); *aff'd sub nom Dominguez v. Schwarzenegger,* 596 F.3d 1087 (9th Cir., 2010), *certiorari granted on other grounds sub nom Maxwell-Jolly v. Cal. Pharmacists' Ass'n,* 131 S.Ct. 192 (2011). *Accord: Mayer v. Wing*, 922 F. Supp. 902, 905, 909 (S.D.N.Y. 1996) (preliminary injunction prohibiting reduction of personal home care services and stating "reduc[tion] or terminati[on of] home care services . . . would result in the deprivation of life-sustaining medical services. This certainly constitutes irreparable harm."); *Crabtree v. Goetz*, No. Civ.A. 3:08-0939, 2008 U.S. Dist. LEXIS 103097, at *82 (home care service cuts will cause irreparable injury because "institutionalization will cause Plaintiffs to suffer injury to their mental and physical health, including a shortened life, and even death for some Plaintiffs"); *Long v. Benson*, No. 4:08cv26-RH/WCS, 2008 U.S. Dist. LEXIS 109917 (N.D. Fla. Oct. 14, 2008); *aff'd* No. 08-16261, 2010 U.S. App. LEXIS 12826 (11th Cir. 2010) (similar); *LaForest v. Former Clean Air Holding Co.*, 376 F.3d 48, 55-56 (2nd Cir. 2004) (denial of needed medical care constitutes irreparable harm); *Massachusetts Ass'n, of Older Americans v. Sharp*, 700 F.2d 749, 753 (1st Cir. 1983) ("Termination of benefits that causes individuals to forego such necessary medical care is clearly irreparable harm."); *Caldwell v. Blum*, 621 F.2d 491, 498 (2nd Cir. 1980) *cert. denied* 452 U.S. 909 (1981) (Medicaid applicants established harm where they would "absent relief, be exposed to the hardship of being denied essential medical benefits); *Cota v. Maxwell-Jolly*, 688 F. Supp.2d 980 (N.D. Cal. 2010) (on appeal); *V.L. v. Maxwell-Jolly*,

669 F.Supp.2d 1006 (N.D.Cal. 2009) (on appeal); *Me. Ass'n of Interdependent Neighborhoods v. Petit,* 647 F. Supp. 1312, 1315 (D. Me. 1986); *Comancho v. Tex. Workforce Comm'n*, 326 F. Supp. 2d 794, 802 (W.D. Tex. 2004) (loss of Medicaid benefits constitutes irreparable harm); *McMillan v. McCrimon*, 807 F. Supp. 475, 479 (C.D. Ill. 1992) ("The nature of [the] claim – a claim against the state for medical services – makes it impossible to say that any remedy at law could compensate them.").

## II. PLAINTIFFS ARE LIKELY TO SUCCEEED ON THE MERITS OF THEIR CLAIMS.

### A. IHCA Policy 3E Violates the Medicaid Act's Comparability Requirement by Providing Differing Levels of Medical Assistance to Individuals with Comparable Needs.

The "comparability" requirement of the Medicaid Act provides "that medical assistance made available to any individual described in subparagraph (A) [describing categorically needy recipients] — (i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and (ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A)."[4] 42 U.S.C. § 1396a(a)(10)(B). In effect, the comparability requirement mandates "comparable services when individuals have comparable needs," and it is violated "when some recipients are treated differently from other recipients where each has the same level of need." *Jenkins v. Washington State Dep't Social & Health Servs.*, 157 P.3d 388, 392 (Wash. 2007); *see also Samantha A. v. Wash. Dep't of Socials Servs. & Health Servs.,* No. 84325-2, 2011 WL 2054645

[4] *See* 42 C.F.R. § 440.240 ("(a) The state must provide that the services available to any categorically needy recipient under the plan are not less in amount, duration, and scope than those services available to a medically needy recipient; and (b) The plan must provide that the services available to any individual in the following groups are equal in amount, duration, and scope for all recipients within the group: (1) The categorically needy. (2) A covered medically needy group.").

(Wash. May 26, 2011) (holding rule violated comparability because "on its face [it] treats similarly situated individuals differently . . . based not on need" but upon who a [beneficiary] lives with."); *Hodgson v. Bd. of County Comm'rs, Hennepin County*, 614 F.2d 601, 608 (8th Cir. 1980) ("Once a state designates services it will subsidize, it may distinguish between eligible and ineligible recipients only on the basis of their degree of medical need."); *Sobky v. Smoley*, 855 F. Supp. 1123, 1139 (E.D. Cal. 1994) (comparability requirement "creates an equality principle by which all categorically needy individuals must receive medical assistance which is no less than that provided to any other categorically or medically needy individual").

Courts have thus found that states violate the Medicaid Act when they fail to offer the same service to all with the same need. *See*, *e.g.*, *White v. Beal*, 555 F.2d 1146, 1151 (3d Cir. 1977) (optional state Medicaid services must be "distributed in a manner which bears a rational relationship" to underlying federal purpose of helping those in greatest need; provision of glasses only to recipients with eye diseases, but not refractive error, violated comparability requirement); *Conlan v. Bonta*, 102 Cal. App. 4th 745, 753-54 (2002) (comparability violated where state Policy resulted in some Medicaid recipients incurring unreimbursed expenses); *Parry v. Crawford*, 990 F. Supp. 1250, 1257 (D. Nev. 1998) (comparability violated where state provides intermediate care facility services only to those with mental retardation, not those with "related conditions" and no basis on which to infer difference in medical need); *V.L. v. Wagner*, 669 F.Supp.2d 1106, 1114-17 (N.D. Cal. 2009) (cuts in home support services violated likely violated comparability) (on appeal); *Cota v. Maxwell-Jolly*, 688 F. Supp. 2d 980, 993 (N.D. Cal. 2010) (same, addressing cuts in adult day health services) (on appeal).

Here, the June 2011 eligibility requirements for PCS provided to Medicaid recipients in their private residences are not comparable to those for PCS provided to Medicaid recipients in

ACHs. This causes discrimination against those trying to remain in their homes as opposed to moving to an ACH. Under the above-described eligibility criteria, anyone eligible to receive PCS in their home would also be eligible for admission to an ACH. The needs of the populations are the same but the eligibility rules are far from comparable. *See*, *discussion* at pp. 5-7, 10, *supra*.

The federal Medicaid agency, CMS, has repeatedly informed Defendant that the differences between in home PCS and ACH PCS violate the comparability requirement in the federal Medicaid statute. *See, e.g*., Jan 20, 2011 CMS Ltr. To Craigan Gray, Barat Aff. Exh. A. As early as 2006, DMA assured CMS it was taking steps to make the two PCS programs comparable. August 16, 2006 Dobson Ltr. to CMS; September 12, 2006 CMS Ltr. to Dobson, Barat Aff. Exhs. B, C. However, instead of making the eligibility requirements for in home PCS and ACH PCS comparable, Defendant has instead made the requirements in its clinical coverage policies for In-Home PCS much more stringent, while not changing the requirements for ACH PCS. *See*, *discussion* at pp. 5-7, *supra*.

CMS has approved a state plan amendment authorizing ICHA Policy 3E. However, CMS approved the more restrictive In-Home PCS criteria at the same time that it approved more restrictive criteria for PCS in an ACH. Apr. 18, 2011 SPA 10-31 Approval letter, pp. 19-23, Barat Aff. Exh. N. Defendant has implemented none of the ACH PCS changes and no one has been terminated from ACH PCS. Smith Decl. ¶22. In addition, the CMS approval was based upon misstatements and incomplete information from Defendant about the two programs and the populations receiving them. Defendant misstated the needs of the two groups as being different in the areas of need for supervision, need for PCS on a 24/7 basis, need for medication management, and ability to live safely alone. *Compare*, Discussion at pp. 5-7, 10, *supra* and DHHS Nov.15, 2010 Resp. to CMS Questions, p.10, Barat Aff. Exh. D. Defendant also

misstated to CMS the requirements for admission to an ACH. *Compare,* Discussion at pp. 5-7 and Oct. 8, 2010 DMA Response to Informal Coverage Questions, p.3, Barat Aff. Exh. E. Defendant also has omitted important information in its communications with CMS about the differences between the two services, such as the differences in covered ADLs, covered tasks, eligilibity requirements and hourly limits in the two settings. *See, e.g*., Oct, 8, 2010 DHHS Responses to Informal Coverage Questions, Barat Aff. Exh. E; Feb. 10, 2010 DHHS Ltr. to CMS, Barat Aff. Exh.F.

Even if CMS knowingly approved Defendant's lack of comparable treatment, its decision would not be entitled to deference because Defendant's PCS eligibility criteria, on their face, violate the statute's requirement of comparability and because the approval contradicts CMS's own previously stated position. A determination by the agency does not warrant deference when its "reasoning couples internal inconsistency with conscious disregard for statutory text." *Ark. Dep't of Human Servs. v. Ahlborn,* 547 U.S. 268, 292 (2006). *See also Rehab. Ass'n v. Kozlowski*, 42 F.3d 1444 (4th Cir. 1994) (rejecting federal agency's interpretation of Medicare and Medicaid Acts as contrary to language and intent of statute); *Detsel by Detsel v. Sullivan,* 895 F.2d 58 (2d Cir. 1990) (reversing federal agency's decision to deny Medicaid payment to state because Secretary's decision contradicted previous guidance on the same issue).

All of the individuals scheduled to be terminated from In-Home PCS services have been previously found to need such services through an individualized, independent assessment. The proposed termination of all recipients with need for assistance with 2 ADLs are less will deprive thousands of PCS recipients of services that they need just as critically as the ACH PCS recipients. This violates the comparability requirement.

### B. IHCA Policy 3E Violates the ADA and the Rehabilitation Act.

Title II of the ADA states that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. Regulations clarify that Title II requires public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d).[5] The preamble discussion of the "integration regulation" explains that "the most integrated setting" is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible . . . ." 28 C.F.R. Pt. 35, App. A (2010) (addressing § 35.130).

In *Olmstead v. L.C.*, 527 U.S. 581 (1999), the Supreme Court applied these authorities and held that title II prohibits the unjustified segregation of individuals with disabilities. *Olmstead*, 527 U.S. at 596. The Court held that public entities are required to provide community-based services to persons with disabilities when (a) such services are appropriate; (b) the affected persons do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of others who are receiving disability services from the entity. *Id.* at 607. The Court explained that this holding "reflects two evident judgments." *Id*. at 600. "First, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of

[5] Section 504 of the Rehabilitation Act similarly prohibits disability-based discrimination. 29 U.S.C. § 794(a) ("No otherwise qualified individual with a disability … shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance … ."). Claims under the ADA and the Rehabilitation Act are treated identically unless one of the differences in the two statutes is pertinent to a claim. *Kemp v. Holder*, 610 F.3d 231, 234-35 (5th Cir. 2010); *Henrietta D. v. Bloomberg*, 331 F.3d 261, 272 (2d Cir. 2003).

participating in community life." *Id.* "Second, confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." *Id.* at 601.

To comply with the ADA's integration requirement, a state must reasonably modify its policies, procedures or practices when necessary to avoid discrimination. 28 C.F.R. § 35.130(b)(7). The obligation to make reasonable modifications may be excused only where a state demonstrates that the requested modifications would "fundamentally alter" the programs or services at issue. *Id.*; *see also Olmstead*, 527 U.S. at 604-07.

To establish a violation of Title II of the ADA, a plaintiff must prove that he or she (1) is a "qualified individual with a disability;" (2) was either excluded from participation in or denied the benefits of a public entity's services, programs, or activities or was otherwise discriminated against by the public entity; and (3) such exclusion, denial of benefits, or discrimination was by reason of his disability. *See Raines v. Florida*, 983 F. Supp. 1362, 1371 (N.D. Fla. 1997). Here, Plaintiffs are qualified individuals with disabilities in that they receive Medicaid services due to their disabilities. Further, as demonstrated by their current living arrangements, they are capable of living independently in their own homes with assistance.

A plaintiff need not wait for institutionalization to occur in order to pursue a claim for violation of the integration mandate. The risk of institutionalization itself is sufficient to demonstrate a violation of Title II. *Fisher v. Oklahoma Health Care Auth.*, 335 F.3d 1175 (10th Cir. 2003). In *Fisher*, the Tenth Circuit rejected defendants' argument that plaintiffs could not make an integration mandate challenge until they were placed in the institutions. The Court reasoned that the protections of the integration mandate "would be meaningless if plaintiffs were required to segregate themselves by entering an institution before they could challenge an

allegedly discriminatory law or policy that threatens to force them into segregated isolation." *Id.* at 1181. *See also Marlo M. v. Cansler*, 679 F. Supp. 2d 635, 637 (E.D.N.C. 2010) (granting a preliminary injunction in case where plaintiffs faced an increased risk of institutionalization).[6]

Plaintiffs are likely to prevail in showing that PCS violates the "integration mandate" of the ADA by placing them at serious risk of having to move out of their homes to less integrated settings and institutionalization. Plaintiffs have shown that implementation of IHCA Policy 3E will place them at risk of unnecessary confinement in institutional settings, including ACHs, in violation of the ADA's integration mandate. The evidence establishes that the elimination of these essential services for the plaintiffs will place them at risk of institutionalization. *See, discussion supra* at pp. 13-15. When approving IHCA Policy 3E, CMS specifically instructed the state agency that its approval of the new service did not relieve the state of its obligations under *Olmstead*. Barat Aff. Exh. N.

In circumstances that are similar to the present case, courts have found violations of the ADA's integration mandate. For example, in *Fisher*, the Tenth Circuit held that recipients of community-based Medicaid services could challenge a state-imposed limitation (enacted for budgetary reasons) of five prescriptions per month, which did not apply to residents of nursing

[6] *See also Makin v. Hawaii*, 114 F. Supp. 2d 1017, 1034 (D. Haw. 1999) (holding that individuals in the community on the waiting list for community-based services offered through the State's Medicaid program, could challenge administration of the program as violating Title II's integration mandate because it "could potentially force Plaintiffs into institutions"); *M.A.C. v. Betit*, 284 F. Supp. 2d 1298, 1309 (D. Utah 2003) (ADA's integration mandate applies equally to those individuals already institutionalized and to those at risk of institutionalization); *Crabtree v. Goetz*, No. 3:08-0939, 2008 WL 5330506, at *30 (M.D. Tenn. Dec. 19, 2008) (unpublished decision) ("Plaintiffs have demonstrated a strong likelihood of success on the merits of their [ADA] claims that the Defendants' drastic cuts of their home health care services will force their institutionalization in nursing homes."); *Brantley v. Maxwell-Jolly*, 656 F. Supp. 2d 1161,1164 (N.D. Cal. 2009); *Cota v. Maxwell-Jolly*, 688 F. Supp. 2d 980, 985 (N.D. Cal. 2010) (on appeal); and *V.L. v. Wagner*, 669 F. Supp. 2d 1106, 1109 (N.D. Cal. 2009) (all granting preliminary injunctions where plaintiffs were at risk of institutionalization due to cuts in community-based services) (on appeal).

homes, because they "st[oo]d imperiled with segregation" under the new Policy. 335 F.3d at 1178-79, 1181-82; *see also Crabtree*, 2008 WL 5330506 at *25 (enjoining state from reducing allowable hours of home health services because it would "eliminate services that enable Plaintiffs to remain in their community placement" and thereby "cause their institutionalization into nursing homes"); *V.L.*, 669 F.Supp.2d at 1119-20 (cuts in home support services resulting in increased risk of institutionalization violated the ADA); *Cota*, 688 F.Supp.2d at 993-95(same).

Maintenance of current PCS eligibility standards constitutes a reasonable modification that would not require fundamental alteration of the program. Even assuming that requiring Defendants to maintain current standards *could* constitute a fundamental alteration, it is well-established that "budgetary constraints alone are insufficient to establish a fundamental alteration defense." *Penn. Protection & Advocacy, Inc. v. Penn. Dept. of Public Welfare*, 402 F.3d 374, 380 (3d Cir. 2005); *see also Frederick L. v. Dept. of Public Welfare of Com. Of Penn.*, 364 F.3d 487, 495-96 (3d Cir. 2004); *Fisher*, 335 F.3d at 1182-83. Moreover, if even a small proportion of the 3,500 to 4,000 In-Home PCS recipients at risk here end up in hospitals, emergency rooms, nursing homes, or ACHs, the cost to taxpayers is likely to be greater than the savings the state hopes to realize. *See, Discussion* at 13-15, *supra.*

Defendant's actions constitute illegal discrimination under *Olmstead*. Plaintiffs' community-based placements are appropriate as demonstrated by the fact they are all living safely in their own homes. Community-based treatment is especially appropriate for Plaintiffs as it guarantees them a level of independence that is unavailable to them in an institutional setting. Smith Decl. ¶10; Annarino Decl. Plaintiffs' desire to continue living in their homes can be reasonably accommodated through continuation of their PCS. Indeed, it is cheaper to care for Plaintiffs in their own homes than in ACHs. Smith Decl. ¶ 20. Despite Plaintiffs' successful

integration into their communities and the cost-effectiveness of their community-based care, Plaintiffs are likely to be forced to leave their homes if the Court does not enjoin Defendant's action. The failure of Defendant Cansler to authorize in-home PCS for Plaintiffs and his attendant failure to make reasonable modifications to the PCS program to allow Plaintiffs to remain in the community violates Plaintiffs' rights to be free from discrimination based on their disability under the ADA and *Olmstead*.

### C. The PCS Termination Notices Violate Due Process Because They Are Not Reasonably Calculated to Apprise PCS Recipients of Their Rights.

Prior to an action that will affect an interest in life, liberty, or property protected by the Due Process Clause, a State must provide "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." *Mullane v. Central Hanover Bank & Trust Co.*, 339 U.S. 306, 314 (1950). Thus, recipients of Medicaid services must receive a "timely and adequate notice detailing the reasons for termination and an effective opportunity to defend" against it at a pre-termination, administrative hearing. *Goldberg v. Kelly*, 397 U.S. 254, 262-63, 269 (1970); *O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 787 (1980). That notice must provide recipients with information they can use to decide whether the agency has made mistakes in terminating their benefits and, if so, how they can contest those mistakes at a hearing. *Goldberg*, 397 U.S. at 266, 268; *see also 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 is especially important because of "human tendency, even among those more experienced and knowledgeable in the ways of bureaucracies than the aged, blind and disabled persons . . . to assume that an action taken by a government agency in a pecuniary transaction is correct").

Whether notice comports with constitutional requirements depends upon whether it is "tailored to the circumstances" of the recipients who must decide whether to request a hearing.

*Goldberg*, 397 U.S. at 268. Thus, when the government is on notice of an individual's impairment, "even notice that complied fully with the statutory requirements [may] nonetheless not [be] reasonably calculated to provide her adequate notice." *Covey v. Town of Somers,* 351 U.S 141, 146-47 (1956); *see also Memphis Light, Gas & Water Div. v. Craft*, 436 U.S. 1, 13-15 (1978) ("[P]articularly extensive efforts to provide notice may often be required when the State is aware of a party's inexperience or incompetence."); *Evans v. Chater*, 110 F.3d 1480, 1483 (9th Cir. 1997) (holding fact that disability benefits applicant was incompetent at the time he received notice of denial or termination of benefits relevant to whether due process right to meaningful opportunity to be heard was violated); *Steiberger v. Apfel*, 134 F.3d 37, 40-41 (2nd Cir. 1997) (due process violated by notice of termination of benefits that recipient was unable to understand and act upon due to mental impairment); *David v. Heckler*, 591 F.Supp. 1033, 1042 (E.D.N.Y 1984) (when notice was technical and confusing it was not comprehensible to class of disability recipients); *accord Doston v. Duffy*, 732 F.Supp. 857, 872-73 (N.D. Ill. 1988).

The termination notice in this case is three single-spaced pages. Each notice contains verbatim the same content and contains no information about the individual facts of the individual recipient's case (except the number of hours of PCS to be terminated). The stated reason for PCS termination on each notice reads as follows:

> Medicaid did not approve the request to transfer to IHCA because your assessed activities of daily living do not meet the minimum IHCA program requirements of hands on assistance for unmet needs with three qualifying activities of daily living, or with two qualifying activities of daily living, at least one of which requires extensive hands-on assistance.

*See,* Pl. Decls. The notices say nowhere for which ADLs the individual has been determined to need direct hands-on help or for ADLs which he or she does not need such help. Thus, for example, a recipient who believes he needs direct hands on assistance with bathing has no way of knowing whether Defendant's agent CCME agrees so does not know what if any issues are in dispute that could be the basis for an appeal. In addition, CCME only performed assessments for

the first time in the last month for up to 2281 cases. Smith Decl. Exh 2. In these cases, the recipient cannot even determine from the notice whether CCME determined he or she needs direct hands-on help with two, one, or zero ADLs.

Defendant specifically assured CMS prior to approval of SPA 10-31 that the CCME assessment results containing recipient-specific information would be included in the notice of termination. Draft Response to CMS RAI (Jan. 20, 2011), p. 2, Barat Aff. Exh. K. CMS approval of the SPA was conditioned on a termination notice "that explains the reason(s)…" Barat Aff, Exh. N, p. 2. Defendant failed to do so. 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, Hamby v. Neel*, 368 F.3d 549 (6th Cir. 2004); *Ortiz v. Eichler*, 794 F.2d 889 (3d Cir. 1986); *Vargas v. Trainor*, 508 F.2d 485 (7th Cir. 1974); *Turner v. Walsh*, 574 F.2d 456 (8th Cir. 1978); *Baker v. Alaska DHHS*, 191 P.3d 1005 (Alaska 2008).

Moreover, the above-quoted boilerplate language giving the reason for termination of PCS is not written so that PCS recipients can understand and act upon it, and so is not "reasonably calculated" to provide PCS recipients with the meaningful and comprehensible information that due process requires. To expect disabled and aged recipients, many with cognitive impairments, to understand this very long and complex sentence (and other confusing parts of the notice) is a cruel hoax. To be meaningful, the notice would need to put the recipient on notice, in language these recipients can be expected to understand, that in order to retain PCS services he or she would need to present evidence to show need for hands-on help with additional ADLs, how many additional ADLs, and which additional ADLs that could be. Because of its confusing, technical content, the notice does not convey this key information to PCS recipients. As the U.S. District Court for the District of Delaware 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 t**o** *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. at 1061, 1062 (citations omitted) (emphasis added).

The notice is defective in another way as well. The specific legal authority cited to support the decision in each notice is the "In-Home Care for Adults Clinical Coverage Policy found at http://www.dhhs.state.nc.us/dma/mp/index.htm." However, that webpage does not list ICCA Policy 3E, but instead includes a link to the prior PCS clinical Policy. Smith Aff. ¶ 27; Barat Aff. ¶ 9. Thus plaintiffs who received this notice and who were seeking to find the specific legal authority for the notice were unable to do so.

This termination notice thus fails to include the specific legal authority for the decision as required by procedural due process standards. *See Goldberg*, 397 U.S. at 268. In *Weaver v. Dept. of Social Services*, 791 P.2d l230 (Colo. App. l990), the court held that a Medicaid notice reducing services was inadequate constitutionally because the notice did not furnish the recipient with accurate information as to the applicable regulations that would allow the recipient to ascertain the regulatory standards governing his right to benefits. *See also*, *Ortiz v. Eichler*, 794 F.2d 889 (3d Cir. 1986); *Frank v. Kizer*, 213 Cal. App. 3d 919, 261 Cal. Rptr. 882, 884 (Cal. App. l989); *Thompson v. Roob*, 105-cv-0636-SEB-VSS, 2006 U.S. Dist. LEXIS 76303 (S.D. Ind. 2006).[7]

## II. THE BALANCE OF EQUITIES FAVOR PLAINTIFFS.

Defendants must show that proposed injunctive relief pose more than mere fiscal and administrative problems for Defendants to tip the balance away from Plaintiffs, who will suffer physical and emotional harm in the absence of relief. The Supreme Court has held that a state

[7] In addition to violating procedural due process, the notice of termination, because it is written in complex technical language, also violates the ADA and Section 504 because it is not reasonably accessible to people with cognitive disabilities. *See Alexander v. Choate*, 469 U.S. 287, 301 (1985); *see also Henrietta D. v. Gulliani*, 119 F. Supp. 2rd 181 (E.D.N.Y. 2000), *aff'd*, 331 F.3d 261 (2nd Cir. 2003) (state must make process to obtain benefits meaningfully accessible to individuals with disabilities).

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) ("harm 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: 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).

**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 are enforced. *Glenwood Bridge, Inc. v. City of Minneapolis*, 940 F.2d 367, 372 (8th Cir. 1991). Budgetary savings are in the public interest; however those measures must give way when they are in conflict with federal substantive law. *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).

In determining whether the public interest will be disserved by the granting of a request for preliminary injunction, courts may look to the legislative intent in enacting the statute 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 program is "to furnish . . . services to help [low income] families and individuals attain or retain capacity for independence or self-care." 42 U.S.C. § 1396-1. Preserving Plaintiffs' health, well-being, and independence is thus squarely in the public interest.

Long term fiscal interests also support issuance of the injunction. The State may pay less for In-Home PCS if IHCA Policy 3E is implemented, but it will pay more for more expensive institutional care for its citizens. It costs more money to care for a person in an ACN than if the individual remains in a private residence. Smith Decl. ¶ 20. PCS thus saves the State money by allowing individuals to remain in their homes longer without requiring more restrictive and more costly living settings, such as ACHs, nursing homes, and hospitals. Plaintiffs each need only a few hours of assistance per day or week. However, this assistance makes all the difference in a recipient's ability to live safely at home. *See generally*, Pl. Decls. Without PCS, Plaintiffs and many other proposed class members will end up needing to seek more expensive services in emergency rooms and other settings. Smith Decl. ¶ 37; Webb Decl. ¶18. Michigan made a series of cuts to Medicaid home and community-based services. These cuts led to increases in more expensive services, specifically, hospitalization, emergency room use, and permanent nursing facility placement. Smith Decl. ¶38, Exh. 5.

## III. THIS COURT SHOULD WAIVE THE BOND.

Plaintiffs request that they not be required to post any cash bond. This Court has the

discretion to issue a preliminary injunction without requiring Plaintiffs to give security. *See, e.g.*, *Baldree v. Cargill,* Inc., 758 F. Supp. 704 (M.D. Fla. 1990), *aff'd*, 925 F.2d 1474 (11th Cir. 1991). Federal courts routinely waive bond requirements in suits to enforce important federal rights of public interest. *See, e.g., Barahona-Gomez v. Reno*, 167 F.3d 1228, 1237 (9th Cir. 1999); *Doctor's Associates, Inc. v. Stuart*, 85 F.3d 975, 985 (2d Cir. 1996); *Moltan Co. v. Eagle-Picher Industries, Inc*., 55 F.3d 1171, 1176 (6th Cir. 1995); *Stockslager v. Carroll Elec. Co-op. Corp*., 528 F.2d 949, 951 (8th Cir. 1976). Courts also have used their discretion to waive the bond requirement for indigent Plaintiffs. *See, e.g*. *Bass v. Richardson*, 338 F. Supp. 478, 490 (S.D.N.Y. 1971) ("It is clear that indigents, suing individually or as class Plaintiffs, ordinarily should not be required to post a bond under Rule 65(c)."); *Denny v. Health and Social Services Board of State of Wisconsin*, 285 F. Supp. 526, 527 (E.D. Wis. 1968) ("Poor persons . . . are by hypothesis unable to furnish security as contemplated in Rule 65(c), and the court should order no security in connection with this preliminary injunction.").

Important federal rights are at stake in this litigation. *See, e.g., 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"). Given the high likelihood of success on the merits, Plaintiffs' status as public assistance recipients, as well as the fact that the injunction seeks merely to require DHHS to comply with federal law, no bond should be required.

## CONCLUSION

For all the foregoing reasons, Plaintiffs request that this Court schedule on an expedited basis an evidentiary hearing to determine whether to issue a preliminary injunction prohibiting

Defendant from implementing IHCA Policy 3E.

Dated: May 31, 2011 Respectfully Submitted,

/s/ Douglas Stuart Sea
Douglas Stuart Sea
State Bar No. 9455
LEGAL SERVICES OF SOUTHERN PIEDMONT, INC.
1431 Elizabeth Avenue
Charlotte, North Carolina 28204
Telephone: (704) 971-2593
Telefax: (704) 376-8627
dougs@lssp.org

/s/ Sarah Somers
Sarah Somers
N.C. State Bar No. 33165
Jane Perkins
N.C. State Bar No. 9993
NATIONAL HEALTH LAW PROGRAM
211 N. Columbia Street
Chapel Hill, NC 27514
Telephone: (919) 968-6308
Telefax: (919) 968-8855
somers@healthlaw.org
perkins@healthlaw.org

/s/ John R. Rittelmeyer
John R. Rittelmeyer
N.C. State Bar No. 17204
Jennifer L. Bills
N.C. State Bar No. 37467
Elizabeth D. Edwards
N.C. State Bar No. 35262
DISABILITY RIGHTS NC
2626 Glenwood Avenue, Suite 550
Raleigh, NC 27608
Phone: (919) 856-2195
Fax: (919) 856-2244
john.rittelmeyer@disabilityrightsnc.org
jennifer.bills@disabilityrightsnc.org
elizabeth.edwards@disabilityrightsnc.org