UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

OSCAR SALAZAR, *et. al.*, on behalf of themselves and all others similarly situated, Plaintiffs, vs. THE DISTRICT OF COLUMBIA, *et al.*, Defendants.	Civil Action No. 93-452 (GK) *In Forma Pauperis*

PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION CONCERNING DISTRICT OF COLUMBIA MEDICAID APPLICATIONS AND RENEWALS

Pursuant to Rule 65 of the Federal Rules of Civil Procedure, plaintiffs respectfully move this Court to issue a preliminary injunction ordering defendants: (1) to provisionally approve all Medicaid applications pending over 45 days until a final determination can be made; and (2) to continue the eligibility of all Medicaid recipients due to be renewed, until defendants can demonstrate to the Court, based on substantial evidence, that their technology and business processing systems for making timely eligibility determinations on applications and renewals, and providing adequate notice to Medicaid recipients and applicants of such decisions, are functioning as required to ensure and protect the rights of Medicaid recipients and applicants under the United States Constitution and applicable federal law and regulations.

As set forth in the accompanying Plaintiffs' Brief in Support of Their Motion for a Preliminary Injunction Concerning District of Columbia Medicaid Applications and Renewals, plaintiffs are entitled to a preliminary injunction because they are likely to succeed on the merits of their claims, they are suffering and will continue to suffer irreparable injury in the absence of the requested relief, the balance of equities tips in their favor, and the issuance of such an injunction is in the public interest.

A supporting memorandum of points and authorities and proposed order are attached.

STATEMENT PURSUANT TO LOCAL CIVIL RULE 7(m)

Plaintiffs' counsel conferred with defendants' counsel, Elizabeth Gere, concerning this motion on December 22, 2015. Ms. Gere stated that defendants oppose this motion.

Respectfully submitted,

/s/ Zenia Sanchez Fuentes

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December 22, 2015

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MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUCTION CONCERNING DISTRICT OF COLUMBIA MEDICAID APPLICATIONS AND RENEWALS

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BACKGROUND

I. Procedural History

In 1993, plaintiffs filed this class action to enforce portions of Title XIX of the Social Security Act, 42 U.S.C. 1395, *et seq.,* and accompanying regulations, 42 C.F.R. 430, *et seq.*, regarding the District of Columbia's practices and procedures concerning its Medicaid program, alleging, among other things, that defendants were depriving them of their statutory and constitutional rights by failing to (1) issue decisions and provide Medicaid coverage within 45 days after initial applications were submitted, and (2) provide advance notice of the termination, discontinuance or suspension of Medicaid benefits and an opportunity for a hearing to contest the adverse action at the time of recertification for Medicaid.[1]

Following a seven-day trial, this Court agreed with plaintiffs and issued a memorandum opinion ("1996 Memorandum Opinion") finding that, as to the 45-day deadline for Medicaid applications (*Salazar v. District of Columbia*, 954 F. Supp. 278, 324-325 (D.D.C. 1996)):

> The District of Columbia is required, under federal law, to "furnish [ ] [Medicaid] with reasonable promptness to all eligible individuals." 42 U.S.C. § 1396a(a)(8) (1996). Implementing regulations further provide:
>
> > The [state Medicaid] agency must establish time standards for determining eligibility and inform the applicant of what they are. These standards may not exceed-(1) Ninety days for applicants who apply for Medicaid on the basis of disability; and (2) Forty-five days for all other applicants. 42 C.F.R. § 435.911(a) (1995).
>
> The District of Columbia has adopted the 45-day deadline for processing non-disability Medicaid applications. * * * while a state's participation in the Medicaid program is purely voluntary and its acceptance of substantial funds uncoerced, once electing to

[1] "Recertification" for Medicaid is now generally referred to as "renewal" for Medicaid. It is the process to which Medicaid recipients are subject once a year to review their income and family status and determine whether they continue to be eligible for Medicaid. DC Health Link MAGI Medicaid Processing MCAC Update, October 28, 2015 ("October MCAC Presentation"), Pl. Ex. 23, p. MCAC 009.

> participate, it must *fully comply* with federal statutes and regulations in its administration of the program. (emphasis in original; internal quotations and citations omitted)

The Court further found that, with respect to the protection of recipients' due process rights at Medicaid recertification (*id.* at 326):

> The District of Columbia is required, under federal law, to "give [Medicaid] recipients timely and adequate notice of proposed action to terminate, discontinue, or suspend their eligibility" and to provide an opportunity for a hearing if it takes such action. 42 C.F.R. §§ 435.919(a) and 431.200 (1995). * * *[T]he District must "[c]ontinue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible."
>
> * * *
>
> Notice and an opportunity for a hearing prior to termination of Medicaid benefits are also required by the Due Process Clause of the Fifth Amendment. *See Goldberg v. Kelly*, 397 U.S. 254, 265-67, 90 S.Ct. 1011, 1019-20, 25 L.Ed.2d 287 (1970) (holding that notice and evidentiary hearing are required before state may terminate welfare benefits) * * *. (other citations omitted)

By failing to process large numbers of Medicaid applications within 45 days of receipt and by wrongly terminating Medicaid benefits for substantial numbers of Medicaid recipients around the time of recertification, the Court found that defendants had been and were continuing to deprive Medicaid applicants and recipients of these statutory and constitutional rights. *Salazar v. District of Columbia*, *supra* 954 F. Supp. at 324-328. These failures, the Court found, are not "simply an abstract bureaucratic irregularity. Rather, it [defendants' failure to process applications within 45 days] has concrete and often-times devastating effects on poor, sick, vulnerable people." *Id*. at 325.

After the trial, and while the judgment was pending an appeal by defendants, the parties entered into a settlement agreement with specific provisions concerning the appropriate relief for defendants' violations of the Constitution, federal law, and District of Columbia law. Order Modifying the Amended Remedial Order of May 6, 1997 and Vacating the Order of March 27, 1997, January 25, 1999, ECF No. 663 (the "Settlement Order"). For many years, under the terms

of the Settlement Order, plaintiffs' counsel monitored defendants' compliance with those provisions and represented individual Medicaid applicants and recipients at administrative hearings whose applications were not decided in 45 days or whose eligibility was wrongly terminated at the time of recertification.

Eventually, these provisions of the Settlement Order were vacated. The provisions related to timely application processing contained in Section II of the Settlement Order remained in force until February 2009, when the Court granted defendants' motion to vacate Section II of the Settlement Order. ECF No. 1443; Minute Order, February 29, 2009. The provisions related to timely recertification processing in Section III of the Settlement Order remained in force until October 17, 2013, when the Court granted a motion by defendants to terminate Section III and ordered "that Defendants are relieved from complying with Section III * * *." Amended Memorandum Opinion and Order, ECF No. 1886 ("2013 Memorandum Opinion"), p. 11.

In its 2013 Memorandum Opinion, the Court ruled that Section III of the Settlement Order, should be vacated under Federal Rule of Civil Procedure 60(b)(5) because a significant change in the law, the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat 119, *et seq*. ("ACA"), and its implementing regulations, made it inequitable, confusing, and burdensome for defendants to continue simultaneously to adhere to the recertification processing requirements of both the Settlement Order and the ACA, which was scheduled to take effect on October 1, 2013. *Id*., p. 10. The Court also rejected plaintiffs' request to seek discovery so that they could suggest appropriate modifications to Section III of the Settlement Order, in order to protect Medicaid recipients' due process rights during the time of transition under the ACA, finding that "Plaintiffs' counsel has failed to identify any tangible fact or law that suggests those rights will not be adequately protected in this transitional year." *Id*., pp. 7-8.

However, the Court held that counsel for the plaintiff class could continue to assist individual class members whose due process rights are violated at recertification/renewal: "[M]embers of the plaintiff class can also contact Plaintiffs' counsel, as they have been doing over the years, to obtain legal assistance. Consent Order, ¶ 64." ECF No. 1886, p. 9, n. 1.

Unfortunately, as plaintiffs show below, since the entry of the Court's 2009 Minute Order and the 2013 Memorandum Opinion, extensive evidence shows that a combination of technological and business process failures have led to and will lead to thousands of District of Columbia Medicaid applicants waiting more than 45 days for an eligibility determination and Medicaid recipients losing their Medicaid coverage around the time of recertification/renewal without adequate notice.

II. Medicaid Applications and Renewals since Implementation of the ACA

Starting on October 1, 2013, defendants began processing Medicaid applications using new income eligibility and identification verification rules required under implementing regulations of the ACA. 42 U.S.C. 1396a(e)(14); 42 C.F.R. Sections 435.603, 457.315(a). Individuals applying for medical assistance should be able to complete a single streamlined application for state health insurance programs, subsidies, and private insurance. *See* 42 U.S.C. Sections 18083(b)(1)(A), 1396w-3(b)(3). Under a "no wrong door" approach, individuals should be able to apply online, on paper, via telephone, or in person. *See* 42 C.F.R. 435.907(a). In addition, under the ACA, the applicants' ability to complete the application was to be maximized, while the burden was to be minimized. 42 U.S.C. 18083(b)(1), 42 C.F.R. 435.1200(b)(3)(i).

Defendants established DC Health Link (also referred to as "DCAS" or "DCHL"), the District's health insurance online exchange that contains the rules engine for making Medicaid

eligibility determinations under the ACA. DC Health Link was intended to replace the District's legacy eligibility processing system, the Automated Client Eligibility Determination System (ACEDS). In September 2013, defendants informed the Court that they would "fully transition and integrate[] [all Medicaid recipients] into the DC Health Link" by October 1, 2014 and retire ACEDS. *See* ECF No. 1870, p. 9. However, this has not occurred. Instead, ACEDS remains "the system of record for the DC Medicaid program * * * that is connected to MMIS [the Medicaid Management Information System]. Without this connection, a beneficiary could not file claims for services." DHCF FOIA Response, December 3, 2015 ("DHCF FOIA Response"), Pl. Ex. 21, FOIA 003, Response 2(e).

As a result of the ACA and its implementing regulations, starting on October 1, 2013, defendants have also been required to adopt new methods of renewing or recertifying existing Medicaid recipients. The first method, called "renewal," applies to "individuals whose Medicaid eligibility is based on modified adjusted gross income methods (MAGI)." 42 C.F.R. 435.916(a). Most Medicaid recipients fall into categories which would make them eligible for renewal under the MAGI methodology, *i.e.*, non-disabled parents/caretaker relative, infants, children and youth, childless adults (21-64 years old), and pregnant women. *See* October MCAC Presentation, Pl. Ex. 23, MCAC 010. The second method, called "redetermination," applies to "individuals whose Medicaid eligibility is determined on a basis other than modified adjusted gross income. 42 C.F.R. 435.916(b). This group of individuals is commonly referred to as the "non-MAGI" group and is made up of Medicaid recipients whose eligibility is based on a disability, blindness, being over 65 years of age, or receiving long-term care services. ECF No. 1967-1. Non-MAGI recipients in the District of Columbia continue to be subject to the pre-ACA recertification

process, using the pre-ACA recertification form. *See* DHCF Response, Pl. Ex. 21, No. 1(c); *see also* Declaration of Jeremy Padow ("Padow Decl."), Pl. Ex. 34, paras. 2-7.

ACA regulations provide for passive renewal of MAGI and non-MAGI recipients. The "passive renewal" process entails renewing or redetermining eligibility, without requiring any information from the Medicaid recipient, "if able to do so based on reliable information contained in the individual's account" or otherwise available to the agency through federal and local databases and other sources. *See* 42 C.F.R. 435.916(a)(2). If sufficient information is available to the agency to permit an eligibility determination, the Medicaid recipient cannot be required to take any action. *Ibid*. If sufficient information is not available to passively renew an individual, the agency must mail a form—that is pre-populated with information already available to the agency—and ask the Medicaid recipient to complete the missing portions and return the form by telephone, e-mail, online, or in person. 42 C.F.R. 435.916(a)(3). This process may be referred to as "manual" renewal.

For manual renewals, Medicaid recipients are given at least a 30-day deadline for submission of the form, after which Medicaid coverage will terminate. 42 C.F.R. 435.916(a)(3)(B); *see* ECF No. 1870, p. 8 ("the District will allow sixty (60) days"). Recipients also have a 90-day "grace period" following their termination, during which they can return the renewal form or requested information and receive retroactive coverage back to the date of termination. 42 C.F.R. 435.916(a)(3)(C)(iii). However, during the grace period, recipients cannot use their Medicaid benefits until their renewal form is processed by the agency and coverage is restored.

Under a timetable approved by the federal government through the Centers for Medicare & Medicaid Services ("CMS"), the District of Columbia was to "implement the passive renewal

process in stages, with full implementation for all beneficiaries by October 2014." ECF No. 1879, p. 12. Defendants anticipated implementing passive renewals first for MAGI beneficiaries and then for non-MAGI beneficiaries. *Id*., pp. 12-15. This has not occurred. Only a subset of MAGI Medicaid recipients have gone through the passive renewal process.[2] October MCAC Presentation, Pl. Ex. 23, MCAC 011. These recipients, referred to as the "M1 population," are those who first applied for Medicaid in ACEDS prior to implementation of the ACA and thus never had an eligibility determination using MAGI methodology. *Ibid.* M1 renewals began in January 2015 and are scheduled to be completed by December 31, 2015. *Ibid*.

With M1 renewals, a significant percentage of Medicaid recipients—53%--were able to renew passively, *i.e.*, without having to complete and submit a renewal form. *See* DC Health Link MCAC Presentation, December 10, 2015 ("December MCAC Presentation"), Pl. Ex. 1, p. 5. However, out of the remaining 47% who still needed to manually renew, a significant percentage—approximately 3 in 10 per month—lost Medicaid coverage due to defendants' alleged non-receipt of the renewal form. Rivers Decl., Pl. Ex. 33, para. 15, Table 2. As will be discussed below (pp. 22-26), substantial evidence shows defendants regularly fail timely and accurately to process Medicaid renewal paperwork submitted by beneficiaries.

Apart from the M1 population, all remaining Medicaid recipients have yet to be transitioned to passive renewal. These include two groups. First is the "D1 population," which consists of those MAGI beneficiaries who applied for Medicaid after the implementation of the ACA and have thus already had an eligibility determination using MAGI methodology. Rivers

[2] Passive renewals for the M1 group were scheduled to begin in January 2014, but were postponed a number of times and finally began a year later, in January 2015. ECF No. 1967-1; Pl. Ex. 23, MCAC 011.

Decl., Pl. Ex. 33, para. 9; Pl. Ex. 23, MCAC 011. The second group is all non-MAGI beneficiaries, *i.e*., the elderly and disabled.

With the exception of a few M1 renewals, whose "population * * * is expected to dwindle out of existence in January 2016[,]" defendants do not currently have the technical capability to passively renew any Medicaid recipients. DHCF FOIA Response, Pl. Ex. 21, FOIA 001, No. 1(c),(d); *see also* Waiver Request from Claudia Schlosberg to CMS, June 4, 2015, Pl. Ex. 37, FOIA 041 ("D.C. Health Link does not have the functionality required to determined [sic] Medicaid renewals accurately * * *"). This means that, for D1 renewals, which have been ongoing since August 2015, no Medicaid recipients will be able to passively renew. Instead, Medicaid recipients will be required to fill out either a "short" 14-page renewal form or a full 19-page renewal form. *Ibid*, p. 2; Short Renewal Form, Pl. Ex. 35; Sample Renewal Full Renewal Form, Pl. Ex. 36. These forms ask a series of yes or no questions and require immigrants to answer detailed questions about their immigration status. *Id*. The forms are not pre-populated with information already available to the agency (beyond the name of the Medicaid recipient). *Id.* If the recipient fails to return the form, Medicaid coverage is terminated. Accordingly, from January 2016 onwards, all Medicaid recipients will be required to submit a renewal form or else lose coverage, even if the information sought on the form is already available to the agency through its own files or federal or local databases.

In addition, for D1 renewals, Medicaid recipients will not be able to submit the renewal form online, *see* Pl. Ex. 21, DHCF FOIA Response 1(e), which contravenes federal regulations. 42 C.F.R. 435.907(a)(1) (providing that Medicaid recipients must be able to submit renewal forms "[v]ia the internet Web site" the state agency uses).

Although CMS has provided temporary authorization that the District of Columbia may stop passive renewals, it has noted that these technological defects prevent the District from "accomplish[ing] the redetermination and renewal of Medicaid eligibility in accordance with Medicaid and CHIP regulations at 42 CFR 435.916 and 457.343." Letter from CMS to Claudia Schlosberg, November 20, 2015, Pl. Ex. 38, p. 1. CMS emphasized that the authority to cease passive renewals "are granted only to the extent to which the District requires additional time to build and test critical renewal functionality and are contingent upon regular updates from the District on the status of its systems development and capacity." *Ibid.*

Defendants have provided no firm timeline for reinstating passive renewals and online renewals. As of December 10, 2015, defendants report that they "are targeting the end of February certification for the first D1 cycle to have passive renewals," but that this plan is "barring any technical issues." Pl. Ex. 1, p. 6. Non-MAGI recipients will continue to be subject to the pre-ACA recertification process, using the pre-ACA recertification form, for an indefinite period of time. DHCF FOIA Response, No. 1(c); *see also* Padow Decl., Pl. Ex. 34, paras. 2-7.

Unlike in the past, defendants did not seek permission from CMS to continue individuals' eligibility while they worked to get their computer systems in order. Instead, defendants sought and obtained permission to implement a patchwork approach that places the burden of renewing coverage on Medicaid recipients, rather than on the District of Columbia. Data provided by defendants show that, in the first three months of D1 renewals, without passive technology, only between 21 to 38% of renewals have retained coverage each month. Rivers Decl., Pl. Ex. 33, para. 16, Table 3.

ARGUMENT

I
SUBSTANTIAL EVIDENCE SHOWS THAT DEFENDANTS ARE FAILING TO ISSUE TIMELY DETERMINATIONS ON MEDICAID APPLICATIONS AND RENEWALS IN LARGE NUMBERS

A. DEFENDANTS ARE DEPRIVING THOUSANDS OF MEDICAID APPLICANTS OF THEIR RIGHT TO HAVE THEIR APPLICATIONS PROCESSED WITHIN 45 DAYS

The District of Columbia is required to make an eligibility determination on all non-disability Medicaid applicants within 45 days after submission. 42 C.F.R. 435.912(c)(3); D.C. Code 4-205.26 (2014). As shown below, it is failing to do so.

1. As of December 10, 2015, Defendants Admit that There Is a Backlog of Approximately 4,500 Medicaid Applicants in the Online System who Have Been Waiting More Than 45 Days for a Decision

Defendants admit that, around March or April 2015, they became aware of a backlog of close to 12,000 applications that had been pending in DC Health Link for more than 45 days. December MCAC Presentation, Pl. Ex. 1 p. 3. According to defendants, they had previously been unaware of this backlog until they ran new queries as part of their backlog reports. *Ibid.* In August 2015, defendants reported that there were 5,263 applications that had been pending in DC Health Link for more than 45 days. DCAS Top Priorities and Risks, August 8, 2015 ("August 2015 DCAS Update"), Pl. Ex. 2,[3] DHCF 32. Despite the District "working overtime to resolve these cases as soon as possible," as of November 23, 2015, there were still 5,215 Medicaid applications in DC Health Link pending over 45 days. DHCF FOIA Response, Pl. Ex. 21, No. 5(d), FOIA 005. In December 2015, defendants reported that they had reduced the

[3] Plaintiffs' Exhibits 2-7, 9-17, 41, 42, and 45-47 are documents provided by the District of Columbia's Department of Health Care Finance and Department of Human Services in response to a Freedom of Information Act ("FOIA") request made by the Legal Aid Society of the District of Columbia ("Legal Aid") on August, 2015. *See* Declaration of Jennifer Mezey (hereafter "Legal Aid Decl."), Pl. Ex. 26, para. 16-17.

number of pending applications to 4,497.[4] *See* DC Health Link MCAC Update, December 10, 2015 (hereafter "December MCAC Presentation"), Pl. Ex. 1, p. 3.

Defendants have categorized the backlog of applications into two main groups, based on the source of the problem. The first group of backlogged applications, the "malformed application" group, consists of approximately 1,970 cases.[5] December MCAC Presentation, Pl. Ex. 1, p. 3. According to defendants, "[a] malformed case is a case that did not generate all the information to create a full formed case when it was entered into the system [case worker portal] because of a technical system issue." *See* October MCAC Presentation, Pl. Ex. 23, p. 6. As the District of Columbia Department of Human Services explains, "[w]hat this means * * * [is that] [t]here are individuals who are not getting Medicaid that should be." August 2015 DCAS Update, Pl. Ex. 2, DHCF 34. There has been very little reduction in the backlog of this group since the problem was discovered, with the number of affected cases decreasing only from 2,112 to 1,970. December MCAC Presentation, Pl. Ex. 1, p. 3.

The second group of backlogged applications, referred to by defendants as the "case processing backlog," consists of 2,527 individuals.[6] Pl. Ex. 1, p. 3.[7] The backlog of applications in the second backlog group is due to defendants' inability to verify income, residency, or some

[4] Plaintiffs calculated this number by adding the numbers, 2,527 and 1,970, under the "Remaining Count" column for applications defined as pending applications and stuck/malformed applications. Pl. Ex. 1, p. 3.

[5] Defendants are tracking malformed applications by cases, and not the number of individuals affected. DHCF FOIA Response, Pl. Ex. 21, Response 5(b). A household consisting of various individuals could submit a single application. Therefore, it is possible that the number of total affected individuals may be larger.

[6] Defendants estimate that a few hundred of these individuals are duplicates, such that there are an estimated 2,022 affected individuals. December MCAC Presentation, Pl. Ex. 1, p. 3.

[7] Page numbers in Plaintiffs' Exhibit 1 refer to the page number, not the slide number in the presentation.

other type of required verification and to other "[computer] system performance issues." *Ibid.* Defendants have broken down the second group into sub-groups for which they use the term "buckets." August 2015 DCAS Update, Pl. Ex. 2, DHCF 31. Over 1,500 of these Medicaid applicants were not notified that their applications could not be processed because of an outstanding verification. *Id.*, DHCF 32. These individuals were not notified that they had a right to an administrative hearing to show their eligibility. As of August 2015, defendants reported, with regard to individuals in 12 of the 15 "buckets," that "[a]s of now we are not able to implement the manual sending of these notices." *Id.*, DHCF 31.

Given that the backlog was discovered in March or April of 2015, it is possible that many of the backlogged applications have been pending for nine months or even longer. Indeed, Medicaid advocates report helping applicants forced to wait for several months or even years without a decision on their Medicaid applications. For instance, according to Dr. Randi Abramson, the Chief Medical Officer at Bread for the City (Pl. Ex. 24, para. 12):

> Patient E submitted a Medicaid application and all required verifications through the DC Health Link website in October 2014. Although her application was recorded as received on that day, she remained uninsured in May 2015 when she returned to Bread for the City for a medical appointment. Our enrollment coordinator contacted DC Health Link and was told to resubmit Patient E's proofs. These verifications were submitted again, but Patient E's coverage was not approved until November 2015, nearly one year after her application was first submitted. During this time, Bread for the City was providing Patient E with medications to manage her chronic high blood pressure. However, she repeatedly ran out of these medications because she found it difficult to travel to Bread for the City to pick them up while also attempting to maintain her employment. Her lack of medical insurance directly contributed to instability in both her employment as well as her overall health.

See also id., para. 8 (Patient A, who has uncontrolled diabetes, had a pending application for over four months, due to a "technical glitch"); para. 9 (Patient B, who has heart failure, had a pending application for nearly two years, received medication from Bread for the City); para. 10

(Patient C applied online in March 2014 and, after almost three years of attempts, is still waiting for an eligibility determination).

Whitman-Walker Health reports that approximately 10% of their application cases submitted online through DC Health Link remain unresolved after 45 days due to these system glitches described above. Declaration of Katie Nicol ("Whitman-Walker Decl."), Pl. Ex. 25, para. 5. For example, one patient applied in February 2015, but due to technical problems verifying his citizenship, was not approved until nine months later. *Id*., para. 6(a). Another patient who applied online in March 2015 and has provided requested income verification six times is still waiting for a decision. *Id*. para 6(b).

According to defendants, the technological problems causing the backlogs will continue until a major upgrade is made to their eligibility and case management computer system, which is planned for March 2016. December MCAC Presentation, Pl. Ex. 1, p.4.

2. <u>There is an Additional Backlog of Paper Applications</u>

District of Columbia documents produced in response to FOIA requests show that by August 2015, defendants recognized that "there is a paper application backlog in addition to the current DC Health Link related issues." August 2015 DCAS Update, Pl. Ex. 2, DHCF 35. The "plan" was that "DHCF leadership will meet with DHS operations leadership to get statistics on this process." *Ibid.* In October 2015, plaintiffs requested more recent versions of the August 2015 report to ascertain what these statistics showed about the backlog of paper Medicaid applications. Plaintiffs' FOIA Request, October 27, 2015, Pl. Ex. 20, p. 3, No. 4 and attachment at pp. DHCF30-DHCF38 (attached as Pl. Ex. 2). However, DHCF stated that it had "no responsive documents." DHCF FOIA Response, Pl. Ex. 21, FOIA 005, No. 4. DHS refused to produce responsive documents on the grounds that relevant documents pertaining to Medicaid

application were "stored on secure OCTO [Office of Chief Technology Officer] servers" and relevant documents pertaining to renewals were "exempt from disclosure" under District of Columbia law. DHS FOIA Response, December 4, 2015, Pl. Ex. 22, FOIA 047, No. 4.i., 4.ii. Because defendants have refused to provide responsive documents that could bear on the size of the paper application backlog, plaintiffs' counsel cannot provide an estimate of the number of affected cases.

3. Defendants Routinely Lose or Fail to Process Application Paperwork, Depriving Medicaid Applicants of a Timely Eligibility Determination

(a) Independent Reviews of the DHS Service Centers Show Systemic Document Processing Problems

In addition to the processing delays described above, an untold number of applications are never processed at all because they are lost or misplaced in DHS service centers. Five independent external audits or reviews of the Department of Human Services' administration of the SNAP (Food Stamps) program—three conducted by the federal government (Pl. Exs. 5, 6, 7) and two conducted by the DC Office of Quality Assurance and Analysis (Pl. Exs. 9, 10)—have found systemic problems in processing applicants' documentation. Although these reviews concerned the SNAP program, such deficiencies likely extend to Medicaid paperwork, which is processed by the same staff in the same service centers.

These oversight reports found widespread failures to track and maintain beneficiaries' documentation. At the H Street service center, the review found that "[o]ver 40% of applications and supportive case documentation sampled for the review was not scanned into DIMS [Document Imaging Management System]" and noted "a backlog of scanning" to be performed. Program Access Review Findings of H Street Service Center, FY 2015, July 2, 2015, Pl. Ex. 5,

ESA 2949. At the Anacostia Service Center (Anacostia Service Center Management Evaluation Report, FY 2014 ("Anacostia Report"), Pl. Ex. 9, p. ESA 2989):

> Out of the seventy (70) cases randomly selected, only thirty (30) case were available for our analysis (i.e. relevant documents were found in DIMS). This is not an Anacostia [service center] problem; we have found this to be an ESA problem. [emphasis added]

The other oversight reports reached similar conclusions. *See* Pl. Ex. 6, ESA 2599 (noting "a disproportionate amount of cases [that] had no supporting case file documentation in DIMS" and criticizing the lack of supervisors at service centers "to directly the daily workflow" of document processing); Pl. Ex. 7, ESA 2648-49 (imposing a fine on the District for its failure to maintain case documentation and noting that remedial measures adopted by ESA, such as hiring new staff, had yet to prove effective).

According to defendants' documents related to Medicaid, even when documents are scanned into DIMS, this paperwork does not always get transferred to DC Health Link for use in Medicaid eligibility determinations. As a result, Medicaid recipients' documents may be effectively lost because Medicaid caseworkers cannot see the documents in DC Health Link. *See* ESA Operations and Data Cleanup Dashboard, June 3, 2014, Pl. Ex. 42, p. 20 (noting that files scanned into DIMS could not always be found in DC Health Link, resulting in "ESA staff asking customers to send in documentation that has already been provided"); Federal Status Check Presentation, May 18, 2015, Pl. Ex. 45, p. 4 ("[n]eed to improve caseworker access to submitted verification documents * * *").

(b) Monitoring of DHS Service Centers by Medicaid Advocates also Found Systemic Document Processing Problems

A review of DHS service centers conducted by Medicaid advocates in February 2015 observed widespread problems with document processing. *See* Legal Aid Decl., Pl. Ex. 26, paras. 2(b)-(c), 7-15, 18. As part of this review, Medicaid advocacy organizations, including

plaintiffs' counsel, made 12 visits to three DHS service centers in February 2015 and spoke with approximately 550 people in line. *Id*., para. 7. In March 2015, the DC Fiscal Policy Institute and the Legal Aid Society of the District of Columbia provided testimony to the District of Columbia Council's Committee on Health and Human Services that analyzed the data from these visits. The testimony found that consumers were often required to "make return trips to Service Centers to correct improper benefits terminations and denials caused by ESA failing to process their paperwork." Pl. Ex. 8, p. 2; *see also* Pl. Ex. 19. Subsequent visits by these same organizations to the service centers in June 2015 again found numerous individuals standing in line to re-submit documentation they had already provided, many now facing denial or termination of benefits due to defendants' failure to process the paperwork in the first instance. *See* Legal Aid Decl., paras. 13(a), (c), (d), (e), (g), (h); 15(a), (c).

Erin Loubier of Whitman-Walker Health, who participated in the service center monitoring, explains (Loubier Decl., Pl. Ex. 27, paras. 9, 10):

> One common issue involved consumers bringing in verification documents that the agency had requested. Consumers reported having brought in the documents multiple times, but they continued to receive notices that the documents were not received or benefits were terminated. The system for uploading documents into a consumer's case and then processing the case reflect delayed, manual processes. There is a backlog and often documents never reach the case file until we begin our advocacy efforts and email copies of the documents to the ESA SWAT Team.

Indeed, the stories of individual Medicaid recipients illustrate defendants' inability to track and manage paperwork. Bread for the City provides the following example: (Bread for City Decl., Pl. Ex. 24, para. 11)

> Patient D is a young teenager, and our enrollment coordinators have helped him to submit Medicaid applications on five separate occasions. Our enrollment coordinator first submitted an application for Patient D and his parents in January 2014. Though no notices were received, Patient D's parents later learned that the application was denied in March 2014. A new paper application was submitted for Patient D and his mother in December 2014. After receiving no response for months, a third application was

submitted just for Patient D in May 2015. In June 2015, Patient D's mother came back to Bread for the City and learned that she had Medicaid coverage, but Patient D did not. Another application was faxed to DHS in July 2015, with no response. A fifth application was submitted, again including all verifications, in November 2015. As of December 9, 2015, nearly two years after his first application, Patient D remains without insurance.

B. AT RENEWAL, DEFENDANTS DEPRIVE MEDICAID RECIPIENTS OF THEIR RIGHT TO RECEIVE MEDICAID UNTIL FOUND TO BE INELIGIBLE AND TO RECEIVE ADVANCE NOTICE AND AN OPPORTUNITY FOR A HEARING PRIOR TO TERMINATION OF THEIR BENEFITS.

In its 1996 Memorandum Opinion, this Court found that defendants unlawfully terminated Medicaid recipients' benefits by: (1) "allow[ing] many Medicaid recipients' benefits to lapse by failing to process recertifications * * * due to expire that month"; and (2) failing to provide advance notice and an opportunity for a hearing prior to termination of benefits. *Salazar v. District of Columbia*, *supra*, 954 F. Supp. at 326-28. The evidence discussed below shows that these violations continue to be widespread.

1. The District Improperly Allows Medicaid Recipients' Benefits to Lapse

As noted in this Court's 1996 Memorandum Opinion (954 F. Supp. at 326), defendants must "[c]ontinue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible." 42 C.F.R. 435.930(b). Here, defendants routinely violate this obligation by allowing Medicaid recipients' benefits to lapse due to: (a) technological errors; (b) failure to timely and accurately process submitted renewal paperwork; and (c) failure to screen Medicaid recipients for alternative categories of coverage prior to termination.

(a) Technological Problems Routinely Cause Improper Termination of Medicaid Benefits

(i) Medicaid Recipients Have Lost and Are Losing Coverage Due to Defendants' Inability to Transfer Data between Systems

As noted above (p. 5), defendants have been unable to retire ACEDS, the District's legacy processing system. The result is that, although DC Health Link contains the rules engine for MAGI eligibility determinations, ACEDS remains "the system of record" necessary to actually activate benefits. DHCF FOIA Response, Pl. Ex. 21, FOIA 003-004, Response 2(e). In other words, for MAGI Medicaid recipients to have active coverage, their information must be transferred from DC Health Link to ACEDS. *Ibid.* Defendants recognize that, although DC Health Link "is programmed to transfer the information automatically to ACEDS," caseworkers must "input [the data] into ACEDS manually" if "the District discovers an issue that prohibits the automatic transfer" of such data. *Ibid.* (emphasis added). Defendants explain that the need to transfer data from DC Health Link to ACEDS will not end until "the District sunsets the ACEDS system," which is not expected to happen for some time. *Ibid.*

Defendants' documents show that the District has been experiencing problems with automatic transfer of this data, causing Medicaid recipients' benefits to lapse when their eligibility information does not pass to ACEDS to activate benefits. In April 2015, defendants began receiving reports from the managed care organizations ("MCOs") that their enrollment numbers were declining by the thousands, even where beneficiaries received a passive renewal approval letter or timely returned the renewal form. *See* District of Columbia Agency E-mail Communications, April 2015, Pl. Ex. 12, DHCF 12. Defendants expressed "concern[] that the passive renewals information and completed pre-populated renewal information may not be fully transmitted" to ACEDS and MMIS from DC Health Link and stated that "[t]his is a major

problem. We need to address immediately." *Ibid.* After briefly looking into a small sample data, DHCF staff concluded that they needed to "compare all of the passive renewals to the MMIS file before we can conclude that we do not have a systemic problem with passive renewals" information transferring to ACEDS. *Id.*, DHCF 6. That same month, defendants noted reports "that passive cases are not actually passing to MMIS," which "would mean that individuals that were passively renewed do not have benefits." DCAS Top Priorities and Risks, April 21, 2015 ("April 2015 DCAS Update"), Pl. Ex. 4, DHCF 16. Defendants explained that "[m]ost likely, there is a breakdown in the transmission of eligibility spans and data from system to system," with cases "falling through" either from "DCHL to ACEDS or ACEDS to MMIS." *Ibid.*

In May 2015, defendants again reiterated this concern about data failing to transfer between the two systems, noting that "[r]ecords in DCHL need to match ACEDS. We currently have a project underway to make this happen prior to execution for the DCHL renewals." *See* DCHL MAGI Renewals: Contingency Plan, Pl. Ex. 11, DCHF 388. In June 2015, defendants again noted "[d]iscrepancies between DCAS and ACEDS" and emphasized that "[t]he status of a Medicaid case in DCAS must match ACEDS, and vice versa—at a minimum, in time for D1 renewals." *See* DCAS Improvement Team Status, June 24, 2015, Pl. Ex. 13, p. 6. Defendants identified 1,149 cases in which the information in DC Health Link was not automatically transferring to ACEDS, meaning that these Medicaid recipients had active coverage in DC Health Link yet were not actually receiving benefits in ACEDS. *Ibid.*

As long as problems exist with the automatic transfer of data between DC Health Link and ACEDS, recipients with active coverage in the former system are in danger of losing benefits due to a failure to transfer eligibility information to the latter.

(ii) Medicaid Recipients Have Lost and Are Losing Coverage Due to a Computer Error Resulting in "Malformed Cases"

In early October 2015, defendants discovered that due to the same "malformed" case technological defect affecting applications in DC Health Link (see p. 11 above), many renewal "cases were not populated correctly in the DC Health Link system and thus lost coverage." *See* DHCF FOIA Response No. 2(d), FOIA 003. Data provided at an MCAC meeting on December 10, 2015 indicates that this defect affected 361 renewal cases (and likely more individuals, as a case often includes multiple household members). Pl. Ex. 1, p. 3. As of November 23, 2015, defendants had identified 86 renewal cases that had lost coverage at the time of renewal due to this defect and had only restored coverage to a subset of these cases. *See* DHCF FOIA Response 2(c), FOIA 003 (indicating restoration of coverage to only 68 individuals). By December 10, 2015, 131 cases remained to be reviewed to determine, in the first instance, whether coverage had been lost. Pl. Ex. 1, p. 3. Accordingly, over 100 affected households may currently lack Medicaid coverage due to these technological defects. This number is likely to grow, because the technological defect is ongoing and continues to impact current renewal cases. Pl. Ex. 1, p. 3 (noting that additional work is needed to resolve these technological errors)].

(iii) Other Technological Errors Lead to Incorrect Determinations and Loss of Coverage

Defendants' documents make reference to numerous other technological errors preventing correct case processing and eligibility determinations.

First, defendants' documents acknowledge problems making accurate immigration eligibility determinations in DC Health Link. For instance, in May 2014, defendants identified "incorrect immigration cases" as a "burning issue" (*see* Pl. Ex. 15, ESA Operations and Data Cleanup Dashboard, p. 5) and noted an undetermined number of asylees who should have

received Medicaid but did not (*id*., p. 2, item 6). Defendants explained that DC Health Link's "rules engine was incorrectly denying these cases." Pl. Ex. 42, p. 8. In 2015, defendants continued to recognize that many new immigration cases "are still getting [the] wrong determination" and that certain immigration verification databases were not functioning properly.[8] *See* DCAS Improvement Team Status, May 19, 2015, Pl. Ex. 14, p. 1.

Second, Medicaid recipients with certain life event changes, such as the birth of a newborn, also may have lost coverage due to system defects. Defendants have recognized DC Health Link's "inability to accurately redetermine eligibility once a life event has been reported due to system defects." E-mail Communications between CMS and DHCF, January 2015, Pl. Ex. 16, DHCF 1850; *see also id.*, DHCF 1955 ("We are having major challenges with processing change in circumstances for all reported changes."). Defendants explained that they needed to "manually add[] newborns and additional household members to the case by using our old legacy system" to avoid a loss of coverage. *Id*., DHCF 1850. As of August 2015, defendants reported "a significant backlog in * * * life event processing." E-mail Communications Between DHS and DHCF, August to September 2015, Pl. Ex. 17, DHCF 51. Due to these defects with life event processing, newborns or additional household members may go without Medicaid coverage due to an inability to timely add them to the household's case.

Defendants did not report at the October or December MCAC meetings or in their FOIA responses whether the underlying defects leading to incorrect immigration eligibility determinations for inability to process life events have been resolved. *See* Pl. Exs. 1, 23.

[8] Even without these technological errors, asylees may not receive benefits since poorly trained staff at service centers sometimes incorrectly discourage them from applying for Medicaid. *See* Moise Decl., Pl. Ex. 28.

(b) Defendants Fail to Timely and Accurately Process Renewal Paperwork, Causing Medicaid Benefits to Lapse

For some time, Medicaid advocates have been alerting defendants that large numbers of Medicaid recipients are losing coverage at the time of renewal as a result of defendants' inability to timely process their paperwork. In April 2015, Medicaid advocates informed defendants that a high number of Medicaid recipients were being wrongly terminated at the time of renewal and provided numerous examples. E-mail from Legal Services Providers to ESA with Examples, Pl. Ex. 18; *see also* August 2015 DCAS Update, Pl. Ex. 2, DHCF 37 ("advocates are stating that there is widespread termination of benefits for beneficiaries"). Defendants' data on the processing of M1 renewals shows that, in 2015, about 3 in 10 of those Medicaid recipients who had to manually renew (*i.e.*, return a renewal form) lost coverage due to defendants' alleged non-receipt of the form. Rivers Decl., Pl. Ex. 33, para. 15 and Table 2 attached thereto. The evidence below demonstrates that this widespread loss of coverage, many times, is attributable not to inaction by the beneficiary but to defendants' systemic errors in document processing.

(i) Medicaid Advocates Provide Numerous Examples of Medicaid Recipients Who Lost Coverage Despite Timely Submission of Renewal Paperwork

Testimony from those assisting Medicaid recipients shows recipients frequently lose coverage at the time of renewal due to defendants' failure to track and process documents received from Medicaid recipients. Legal Aid Decl., Pl. Ex. 26, paras. 6, 10, 13, 17; Whitman-Walker Decl., Pl. Ex. 25, para. 9; Loubier Decl., Pl. Ex. 27, para. 9, 10; Bread for City Decl., Pl. Ex. 24, paras. 18-21; Declaration of Tina Nelson, ("Legal Counsel for Elderly Decl."), Pl. Ex. 30, paras. 10-16.

For instance, the Legal Aid Society of the District of Columbia describes the experiences of several families whose Medicaid benefits were terminated following timely submission of

their renewal forms. Legal Aid Decl., Pl. Ex. 26, paras. 6(a), (c), (d), (e). As one example (*id*., para. 6(e)):

> One client, a mother of seven with severe disabilities, submitted her Medicaid renewal form in January 2015. She got a notice in late February stating that the form had not been received. She then got a notice in early March stating that the form had been received. She went to a service center in April to renew her SNAP benefits and was told that there was nothing more that she needed to do to renew her Medicaid. Then she received another notice in April telling her that she needed to verify District residency for herself and one of her children. The client had not recently moved, and all of her children live with her. After Legal Aid got involved, the client's benefits were restored in May 2015. The client and her son – who both have serious health conditions – were unable to receive needed treatment during the weeks that they went without coverage.

Dr. Abramson of Bread for the City testified that (Pl. Ex. 24, para. 18):

> Even when individuals receive renewal notices and timely submit the required information, delays and failures in document processing often result in termination of benefits. Bread for the City enrollment coordinators often need to intervene to correct an improper termination, even where Bread for the City assisted the patient in submitting the renewal form and retains proof of submission.

Dr. Abramson at Bread for the City cites examples in which her patients' coverage is terminated despite having timely submitted all the required renewal documents. *See e.g.*, *id*., para. 19 (Patient I, a Spanish speaker who managed to submit a timely renewal form, despite it being sent in English, received verbal confirmation of receipt, but was terminated in October 31, 2015, and remains without coverage); para. 20 (Patient J, who is incontinent, completed and timely submitted her renewal form, but nevertheless experienced a temporary loss in coverage resulting in her going without needed incontinence supplies, limiting her ability to fully function); para. 21 (Patient K, who suffers from prostate cancer, submitted his renewal form and proofs twice, but "was left to cope with a demeaning situation because he could not afford to pay for incontinence supplies out-of-pocket" during the lapse in coverage).

Whitman-Walker Health, a community health clinic with special expertise in LGBT and HIV care, recounts similar instances of termination of coverage following timely submission of

renewal paperwork. Whitman-Walker Decl., Pl. Ex. 25, para. 9(a) (patient was informed by ESA staff that his form had been received, yet his coverage was still terminated); para 9(b) (patient was unable to access life-saving medications after coverage was terminated following completion of form at service center).

The problem affects the elderly and disabled in particularly harmful ways. For instance, Tina Nelson of Legal Counsel for the Elderly offers that they often assist clients who lose their eligibility despite having "submitted Medicaid recertification documents, either on their own or through their EPD Waiver case managers." *See* Pl. Ex. 30, para. 10. When these individuals are improperly terminated, the Social Security Administration deducts their Medicare Part B premiums, which the District's medical assistance program covers, from their much-needed Social Security check. *Ibid.* It often takes months to resolve these coverage lapses, during which these recipients face an extremely heavy financial burden. *Id.*, para. 13.

Plaintiffs' counsel also sees these types of improper terminations with some frequency. For example, when defendants failed to renew the Medicaid coverage of Terri Jackson and her family, despite the fact that they timely submitted the form first online and then at a service center, Ms. Jackson and her family lost their Medicaid coverage. Among other problems, this resulted in Ms. Jackson's Medicare Part B premiums being withheld from her Social Security check for six months. Jackson Decl., Pl. Ex. 32, paras. 1-3, 8-12. Ms. Jackson's husband and son, who suffer from chronic health conditions, also lost coverage, forcing Ms. Jackson to purchase medications out-of-pocket for them and causing the family a great deal of stress. *Id.*, paras. 6, 12. *See also* Declaration of Vera Edmonds ("Edmonds Decl."), Pl. Ex. 48 (Ms. Edmonds, who timely mailed renewal forms for her family, found out her coverage had lapsed

when she went to doctor following a car accident; as a result, she has been unable to attend rehabilitation therapy or pay for needed medication).

These individuals and families ultimately received help from legal advocates, but many more Medicaid recipients do not. As demonstrated by the results of the advocates' service center monitoring project, many people are struggling on their own to try to regain coverage, having been improperly terminated after submission of their renewal forms. *See* Legal Aid Decl., Pl. Ex. 26, para. 13(c) (Medicaid termination following mailing of renewal form); para. 13(e) (elderly woman in wheelchair waiting in line after receiving 30-day notice that coverage would expire, despite having mailed Medicaid renewal form); para. 13(h) (Medicaid termination following mailing of renewal form); para. 15(b) (termination of infant's Medicaid despite efforts to renew on DC Health Link).

(ii) Defendants' Documents Reveal Systemic Problems with Timely and Accurate Processing of Renewal Paperwork

As noted above, independent external audits of DHS performance under the SNAP program reveal systemic problems with scanning and tracking beneficiaries' documents (pp. 14-15 above), deficiencies that likely contribute to widespread loss of Medicaid renewal paperwork. In addition, defendants note technological difficulties that may interfere with their ability to register a renewal form as received. Specifically, a May 2015 report notes a "medium" level of risk associated with the "caseworker functionality" of DC Health Link, the functionality that allows "registration of receipt of the renewal form." DCHL MAGI Renewals Contingency Plan, Pl. Ex. 11, DHCF 384-394. If the computer system is unable to correctly register receipt of the renewal form, beneficiaries will be terminated for failure to return their renewal forms when, in fact, they had already done so. Even when defendants are able to locate renewal paperwork and register it as received, they struggle to process it quickly enough to avoid a lapse in benefits. E-

mail exchanges between DHCF and CMS in January 2015, indicate that defendants were regularly taking 90 days to process renewals, which CMS considered too long. Pl. Ex. 16, DHCF 1847-1849. *See id.*, 1849 ("The agency should be working to process the returned form as expeditiously as possible and * * * the whole process ordinarily should not take 90 days * * *."). *See also* Pl. Ex. 17, DHCF 47-48 (referring to a "backlog renewal").

(iii) Beneficiaries See Long Lines and Wait Times at DHS Service Centers

In addition to processing paperwork, DHS staff must serve the large number of beneficiaries who come to service centers each day. Service Center monitoring conducted by Medicaid advocacy organizations (pp. 15-17 above), shows that beneficiaries begin lining up as early as 4 a.m. or 5 a.m. to be seen, with lines prior to opening numbering 50 or more people on a majority of the visits and 100 on one visit. Many applicants reported that they were back in line for a second or third time because the lines had been so long on a previous visit that they had been turned away. Pl. Ex. 8, p. 2-3, Appdx. A. Whitman-Walker Health explains that (Pl. Ex. 25, para. 8):

> We hear from consumers that they must line up as early as 4 am for an opening time of 7:45 am or 8 am in order to be seen * * * Consumers reported to me * * * that they wait for many (often more than 4) hours to meet with a case worker to get help.

See also Declaration of Danielle Moise ("Moise Decl."), Pl. Ex. 28, para. 12 (reporting difficulty for client to be seen at service center in fall 2015); Declaration of Karla Ayala-Carranza ("Ayala-Carranza Decl."), Pl. Ex. 29, para. 10 (same).

(iv) The Cessation of Passive Renewals and Online Renewals Will Exacerbate These Systemic Problems with Accurate and Timely Processing of Renewal Paperwork

As shown above, pp. 7-9, beginning in January 2016 and continuing for an indefinite period of time, no Medicaid recipients will be able to passively renew, nor will they be able to

renew online due to technological defects. *See also* Pl. Ex. 33, Rivers Decl., Exhibit 2 thereto, p. 2. The lack of passive renewals and online renewals will likely compound defendants' problems with timely and accurate document processing.

When passive renewals were functioning, 53% of cases were able to passively renew (see p. 7 above), meaning that defendants only had to devote resources to processing less than half of all recipients' renewals. Now, without passive renewals, defendants will have to devote even more resources to processing renewals because 100% of Medicaid recipients will need to submit a renewal form in order to renew their coverage. Specifically, defendants will have to track and manage paperwork for 100% of beneficiaries and process this paperwork quickly enough to avoid a lapse in benefits. *See* Renewals Metrics Report, Pl. Ex. 41, p. 1 (discussing challenges arising from cessation of passive renewals, including the fact that "[o]ur staff have to process all cases manually (as we did before in ACEDS days)"). For months defendants have recognized they will have problems processing these renewals due to limited operational capacity. *See* Pl. Ex. 3, June 15, 2015, DHCF 22, 28 (noting that "ESA will have serious resource issues during implementation of D1" and listing "ESA resource overload" as the number 1 risk and priority); *see also* Pl. Ex. 4, April 21, 2015, DHCF 17 ("The PMO [Project Management Office] and ESA have serious resource issues and are not on the same page.").

Further taxing defendants' resources is the fact that Medicaid recipients can no longer renew online, which means that all paperwork must flow through already crowded ESA service centers.[9] Thus, not only must more beneficiaries return a renewal form due to the cessation of

[9] In addition to the problems with over-crowded service centers, recipients will likely be confused about the inability to renew online, as they have been able to do so in the past. Moreover, the 30-day notice that defendants provided in response to plaintiffs' FOIA request incorrectly informs D1 Medicaid recipients that they can submit the renewal form online. Sample D1 30-Day Notice, Pl. Ex. 46.

passive renewals, but they must do so primarily by in-person submission of forms or by mail and fax to the service centers.[10] Based on data provided by defendants and analyzed by Wesley Rivers, an analyst at the D.C. Fiscal Policy Institute, ESA service centers are likely to experience a huge demand in services, starting in January 2016 (Exhibit 2 to Rivers Decl., p. 2):

> when about 3,765 families and individuals * * * will need to come into a service center * * *. Another 3,500 or so cases that applied for the first time through DC Health Link last year, will also need to come in – meaning ESA will face more than 7,000 renewals.

Additional data analyzed by Mr. Rivers suggests that the cessation of passive renewals has already resulted in widespread termination of coverage for the D1 population. Since September 2015, defendants have only successfully received and processed between 21 to 38% of renewal forms each month, with the remaining D1 beneficiaries having their coverage terminated. Rivers Decl., Pl. Ex. 33, para. 16, and Table 3. This sharp rise in the number of terminations suggests that defendants are struggling to accurately and timely process renewals for this larger group of recipients, who must all manually renew.

(c) Defendants are Improperly Terminating Coverage of Medicaid Recipients Who Are Eligible under a Different Coverage Category

The Medicaid statute's requirement to furnish medical assistance with "reasonable promptness," 42 U.S.C. 1396a(a)(8), entails an obligation for a state Medicaid agency to determine whether recipients are eligible for other categories of medical assistance prior to terminating them. *See, e.g.*, 42 C.F.R. 435.916(d)(2) ("If the agency has information about

[10] Although Medicaid recipients can purportedly renew over the telephone, the testimony of Medicaid advocates shows that such renewals do not function in practice, either because staff tell recipients they cannot renew on the telephone or because recipients cannot get through to a live representative. *See* Whitman-Walker Health Decl., Pl. Ex. 25, para. 10 (reporting that ESA Customer Service Line regularly informs customers "that they are not authorized to complete the new renewal process over the phone but * * * must walk into a service center"); Legal Aid Decl., Pl. Ex. 26, para. 13(e) (elderly woman tried to check on status of renewal form on phone but line was always busy).

anticipated changes in a beneficiary's circumstances that may affect his or her eligibility, it must redetermine eligibility at the appropriate time based on such changes."); *Crippen v. Kheder*, 741 F.2d 102, 106-107 (6th Cir. 1984) (when an individual loses Medicaid eligibility due to termination of SSI, state Medicaid agency must determine eligibility for medical assistance under other categories prior to terminating coverage).

Medicaid advocates report systemic failures by defendants to screen Medicaid recipients for other potential categories of Medicaid eligibility before terminating their coverage.[11] For example, Legal Counsel for the Elderly reports recurring issues with defendants terminating Medicaid coverage based on recipients' slight change in income, even when these same recipients are eligible for Medicaid under another coverage category. *See* Pl. Ex. 30, paras. 5-8. When these individuals experience a loss of coverage, they are unable to access needed medical care, such as personal care aide services, and are at an increased risk of institutionalization. *Id*., para. 6. Often, these individuals are forced to re-apply for Medicaid and face delays of over 90 days. *Id*., para. 4.

For example, when Fonda Carroll's husband died and she became eligible for a widow's benefit, she lost her Medicaid coverage, which she had obtained due to a disability, because she was considered over-income. Carroll Decl., Pl. Ex. 31, paras. 1-6, 9. Although Ms. Carroll was eligible for Medicaid under a different category (as a childless adult under 65) despite her income increase, she was not screened for eligibility under that category prior to termination. Instead, her coverage was terminated and she was informed that she should re-apply through DC Health Link. *Id*., paras. 10-11. She now has a pending Medicaid application, but, while she waits

[11] Medicaid recipients are improperly losing coverage when they may be otherwise be eligible. For example, defendants are failing to renew Medicaid coverage for some children who live in households with non-citizen parents. *See* Whitman-Walker Decl., Pl. Ex. 25, para.11.

for a determination, she cannot obtain needed doctor's appointments or her COPD (chronic obstructive pulmonary disease) medication because she cannot afford the hundreds of dollars to pay for even a single inhaler. *Id*., paras. 12-13.

2. Defendants Fail to Provide Advance Notice to Medicaid Recipients Prior to Terminating Their Benefits

This Court held that (954 F. Supp. at 326): "The District of Columbia is required, under federal law, to 'give [Medicaid] recipients timely and adequate notice of proposed action to terminate, discontinue, or suspend their eligibility" and to provide an opportunity for a hearing if it takes such action [citations omitted].'"

Defendants routinely violate these requirements by: (a) failing to send renewal forms notifying recipients of the need to renew; and (b) failing to send termination notices when recipients' coverage lapses.

(a) Failure to Provide Notice of the Need to Renew Medicaid

In many cases, Medicaid recipients have their coverage wrongfully terminated because they never receive notice of the need to renew in the first place. Bread for the City's medical director, Dr. Abramson, explains that "DHS frequently terminates Medicaid coverage without providing recipients with any notice that they are required to renew their coverage" and recounts the stories of several individuals who had their Medicaid coverage terminated without receiving any advance notice of the need to renew. Pl. Ex. 24, paras. 13-14; *id*., para. 15 (Patient F, who never received a renewal form and found out her coverage had been terminated at doctor's office, was unable to receive needed mammogram); para. 16 (Patient G, who never received a renewal form, had coverage terminated and could not obtain needed orthopedic care); para. 17 (Patient H, who never received a renewal form for herself and her son, found out their coverage was terminated when she attempted to obtain medication).

The loss of coverage arising from defendants' failure to send the renewal form is particularly difficult for advocates or service providers to correct (Bread for the City Decl., Pl. Ex. 24, paras. 13-14):

> [T]he new "M1" renewal forms that DHS began sending in December 2014 contain a unique code that is required before an individual can complete the renewal online or on paper. Only DHS can generate this code, and there are no blank versions of the M1 renewal form that an individual can complete if they lose or do not receive the original form. Without this code, even if a recipient becomes aware that they need to renew their coverage, they must contact DHS in person or by phone to complete the necessary forms.

Thus, if a Medicaid recipient cannot access the renewal code because they never received the renewal form on which it appeared, they must go to great lengths to obtain a replacement form or face an indefinite period without coverage. *See id.* para. 15 (Patient F was only able to activate coverage after visiting a service center twice to obtain her pre-populated renewal form); para. 16 (Patient G is still unable to renew because he cannot obtain his renewal code); para. 17 (patient H remains without coverage because she is unable to reach DC Health Link to obtain the necessary renewal form and code).

Defendants admit that they have experienced significant problems with renewal forms being sent to incorrect addresses. As early as 2014, the District noted a concern about "incorrect addresses" appearing on notices and "a lot of returned mail * * * coming in for Medicaid cards." ESA Operations and Data Cleanup Dashboard, June 5, 2014, Pl. Ex. 47, p. 7. Defendants explained that "[b]ad addresses are getting through DCAS and appearing on Notices," causing returned mail. *Ibid.* More recently, in October 2015, defendants discovered a computer error that garbled the mailing addresses of Medicaid recipients from May to October 2015, preventing many recipients from receiving the form. December MCAC Presentation, Pl. Ex. 1, p. 3. Defendants' documents report various numbers of affected cases, ranging from 1,188 cases total, *see ibid.*, to nearly 900 cases *per month* over the six-month period, *see* Pl. Ex. 41, p. 1. Although

defendants claim to have remedied the cases (Pl. Ex. 1, p. 3), the specific cases discussed above show the lingering effects of the problem since families remain without coverage.

(b) Failure to Send Notice of the Termination of Medicaid

Defendants send no notice when a Medicaid recipient's coverage actually expires for failure to submit a renewal form. Instead, they send only a 30-day notice informing the recipient that coverage will terminate for failure to submit the required renewal paperwork unless the beneficiary takes further action. If an individual takes action and submits their renewal paperwork within the time specified, they receive no further notice if defendants subsequently terminate their coverage due to an alleged failure to receive the renewal form.

The failure to send termination notices interferes with recipients' ability to regain coverage following termination. Many show up at the pharmacy, doctor, or hospital several months later only to discover that they do not have coverage after all. *See e.g.*, Pl. Ex. 24, paras. 18-21; Edmonds Decl., Pl. Ex. 48 (submitted renewal form before deadline, yet coverage was terminated with no notice); Declaration of Melisa Rizio ("Rizio Decl."), Pl. Ex. 49 (child's coverage terminated with no notice after timely submitting renewal form and receiving assurances that it was being processed).

II
THE COURT SHOULD ISSUE EFFECTIVE PRELIMINARY INJUNCTIVE RELIEF TO PROTECT APPLICANTS FOR MEDICAID AND MEDICAID RECEIPIENTS AT RENEWAL

A plaintiff seeking a preliminary injunction must establish (*Winter v. Natural Resources Defense Council*, *Inc*., 555 U.S. 7, 20 (2008)):

> [1] that he is likely to succeed on the merits, [2] that he is likely to suffer irreparable harm in the absence of preliminary relief, [3] that the balance of equities tips in his favor, and [4] that an injunction is in the public interest.

Before *Winter,* the Court of Appeals for this Circuit "allowed that a strong showing on one factor could make up for a weaker showing on another." *Sherley v. Sebelius*, 644 F.3d 388, 392 (D.C. Cir. 2011). Post-*Winter*, the court of appeals has stated that (*Aamer v. Obama*, 742 F.3d 1023, 1043 (D.C. Cir. 2014)):

> [I]t remains an open question whether the "likelihood of success" factor is "an independent, free-standing requirement," or whether, in cases where the other three factors strongly favor issuing an injunction, a plaintiff need only raise a "serious legal question" on the merits. (citations omitted)

However, in at least one decision following *Aamer*, the court of appeals appeared to move back towards a sliding scale approach, citing a pre-*Winter* decision for the proposition that "the movant has the burden to show that all four factors, taken together, weigh in the favor of the injunction." *Abdullah v. Obama*, 753 F. 3d 193, 197 (D.C. Cir. 2014)(internal quotations and citation omitted).

In any event, plaintiffs show below that they satisfy all four factors, whether they are analyzed under the sliding scale approach or treated as independent factors.

A. PLAINTIFFS ARE LIKELY TO SUCCEED ON THE MERITS

1. <u>The Court Retains Jurisdiction over Applications and Recertifications</u>

(a) The Plaintiff Class Includes Individuals whose Rights Are Violated with Respect to the Timely Processing of Medicaid Applications and with Respect to Lack of Notice prior to Termination of Benefits at Recertification/Renewal

In 1994, the Court certified the plaintiff class to consist of five subclasses. Order, November 3, 1994, ECF No. 100, Pl. Ex. 43, attached. Two of these subclasses relate to applications and recertifications, now referred to as renewals (*id*. at 1-2):

> All persons who have applied, have attempted to apply, or will apply in the future during the pendency of this litigation, for medical assistance pursuant to Title 19 of the Social Security Act ("Medicaid"), and all persons who have received, are receiving, or will receive in the future during the pendency of this litigation, Medicaid in the District of Columbia with respect to the following claims:

* * *

> Any claims for declaratory, injunctive, or other relief premised on an alleged delay in excess of 45 days in the processing of Medicaid applications [Sub-class III]

* * *

> Any claims for declaratory, injunctive, or other relief premised on an alleged lack of advance notice of the discontinuance, suspension or obligation to recertify Medicaid benefits, after being found eligible [Sub-class IV]

The Court has never decertified these sub-classes and defendants have never sought to have these subclasses decertified.

As to applications processing, defendants filed a motion to vacate Section II of the Settlement Order, but did not move to decertify the subclass of Medicaid applicants. ECF No. 1443; *see* Defendants' Proposed Order, *id*., p. 6. The Court entered a Minute Order granting defendants' motion to vacate Section II, but it did not decertify the subclass of Medicaid applicants. Minute Order, February 24, 2009, Pl. Ex. 44, attached.

With respect to the subclass regarding Medicaid recertifications, defendants moved to vacate Section III of the Settlement Order, but also did not move to decertify the subclass of Medicaid recipients. ECF No. 1870. The Court granted defendants' motion, but did not decertify the subclass of Medicaid recipients. ECF No. 1886. Moreover, the Court's memorandum opinion terminating Section III of the Settlement Order explicitly recognized the continued existence of the plaintiff subclass related to recertifications. The Court stated: "[M]embers of the plaintiff class can also contact Plaintiffs' counsel, as they have been doing over the years, to obtain legal assistance. Consent Order, ¶ 64." ECF No. 1886, p. 9, n. 1.

Since the subclasses relating to timely application processing and lack of notice prior to termination of benefits at recertification/renewal remain certified under this Court's Order of November 3, 1994, plaintiffs submit that this Court has jurisdiction over those issues that arise

related to defendants' violation of the statutory and constitutional rights of the individuals belonging to those subclasses. Plaintiffs emphasize that they are not asking the Court to subject defendants to the provisions in Section II and III of the Settlement Order. Rather, based on recent factual developments, plaintiffs seek preliminary injunctive relief to protect the Constitutional and statutory rights of the plaintiff class.

(b) The Court's 1996 Findings as to Defendant's Constitutional and Statutory Violations Remain Good Law

This Court has found that under federal and local law, the District of Columbia is required to make decisions on Medicaid applications within 45 days. *Salazar v. District of Columbia, supra*, 954 F. Supp. at 324. The Court found defendants to be in violation of these provisions in its 1996 decision on the merits. *Id*. at 325-326.

The Court also found that, at the time of recertifying Medicaid benefits, the Constitution, federal and local law require defendants to continue Medicaid recipients' benefits until they are found ineligible and, if they determine they are ineligible, must give them advance notice before terminating their benefits, including the opportunity for a hearing prior to termination of their benefits. 954 F. Supp. at 326. The Court further found that District of Columbia law required 15 days' advance notice before Medicaid benefits can be terminated (*id*. at 326, n. 96):

> *See also* D.C.Code Ann. §§ 3-205.55(a) and 3-201.1 (1994) (requiring notice of "intended action to discontinue, withhold, terminate, suspend, [or] reduce" Medicaid to be "postmarked at least 15 days before the date upon which the action would become effective").

The Court concluded in its 1996 decision that defendants were in violation of these constitutional and statutory provisions. *Id*. at 327-328.

These legal findings remain good law today.

2. Defendants Are Depriving Thousands of Medicaid Applicants of Their Statutory Right to a Decision within 45 Days and Are Very Likely to Continue to Do So in the Near Future

Defendants' admissions through data and other materials provided by them, declarations of the legal and medical organizations that assist a broad range of applicants, including Legal Aid for the District of Columbia, Bread for the City, and Whitman Walker Health, and Legal Counsel for the Elderly, overwhelmingly demonstrate that defendants are currently failing to make decisions on Medicaid applications within 45 days. *See* Pl. Ex 1, p. 3; Pl. Ex. 2, DHCF 30-36; Pl. Ex. 3, DHCF 23-24; Pl. Ex. 4, DHCF 15-16; Pl. Ex. 17-18, 24-27. Defendants admit that about 4,500 Medicaid applicants who applied through the DC Health Link have been waiting for a decision for over 45 days in order to begin utilizing needed medical treatment, services and medications. December MCAC Presentation, Pl. Ex. 1, p. 3. An unknown number of Medicaid applicants who submitted paper applications have similarly been waiting for over 45 days for a decision. Defendants admitted in August 2015, that: "DHCF leadership has been made aware that there is a paper application backlog in addition to the current DC Health Link related issues. Plan * * * [is that] DHCF Leadership will meet with DHS operations leadership to get statistics on this process" (emphasis added). August 2015 DCAS Update, Pl. Ex. 2, DHCF 35. However, defendants refused to update this information in response to FOIA requests sent in October 2015 and answered in December 2015. *See* pp. 13-14 above. Based on the knowledge and experience of non-profit organizations who serve District of Columbia Medicaid recipients, the number of individuals who wait over 45 days for a decision after submitting paper applications is likely to be significant. *See* Pl. Ex. 8; Pl. Ex. 24, paras. 5-7, 9-10; Pl. Ex. 26, para. 2(b), 5, 10, 13, 17-18.

Plaintiffs have shown that many of the underlying problems causing a backlog in applications processing and defendants' inability to track and timely process applications (*see*

pp. 10-17 above and exhibits cited therein), have not been resolved. Therefore, it is extremely likely that a significant number of applicants will continue to have to wait longer than 45 days for an eligibility determination.

3. Defendants Are Improperly Terminating Medicaid Recipients without Notice at the Time of Renewal and are Very Likely to Continue to Do So in the Near Future

Plaintiffs have also shown that defendants have and are continuing improperly to terminate the Medicaid eligibility of recipients without adequate notice due to a variety of technological, document processing, and other problems. *See* pp. 17-32 and exhibits cited therein. Many of these problems have not and will not be resolved for some period of time. For example, while the backlog of renewals has reportedly decreased over time, the underlying technological problems causing them will not be fixed until the spring of 2016. *See* December MCAC Presentation, Pl. Ex. 1, p. 4. Thus, Medicaid recipients will continue to experience a loss of coverage due to these problems.

Moreover, the technological issues are only one aspect of the problems causing improper terminations. *See* pp. 18-21 above. Separate from the technological issues causing a backlog, defendants' inability to track and timely process renewal documents for many Medicaid recipients, constitutes a significant problem that will continue to exist until it is adequately addressed. Numerous Medicaid advocacy and provider organizations in the District of Columbia have submitted testimony explaining the ongoing and persistent problems with Medicaid recipients losing their coverage for a variety of improper reasons: in some cases, the District of Columbia repeatedly seeks documents that have already been submitted; others lose coverage because they did not receive a renewal form and therefore never had an opportunity to renew; still others are denied as a result of incorrect eligibility determinations. Pl. Ex. 24, paras. 5-6,

13-21; Pl. Ex. 25, paras. 9, 11-13; Pl. Ex. 26, paras. 5-6, 9-10, 13, 17-18, 20-21; Pl. Ex. 27, paras. 7, 9-11; Pl. Ex. 30, paras. 4-8, 10-13; *see also* Pl. Exs. 29, 31, 32, 48 and 49. While defendants have engaged the services of a contractor to address and resolve some of these problems as part of a "Business Process Reengineering" project (*see* December MCAC Presentation, Pl. Ex. 1, p. 4), it will likely be many months for the solutions to be developed and implemented, even assuming that the proposed solutions prove to be effective.

The combination of these circumstances—continued technical problems, staffing constraints, long wait times at service centers, inadequate document processing procedures, and the temporary cessation of passive renewals—substantially increases the likelihood that a significant number of Medicaid recipients will continue to lose coverage without adequate notice and the opportunity for a hearing.

* * *

Plaintiffs have shown that the 1994 Order certifying the sub-classes for timely application processing and protection against termination without notice at renewal remains in effect. Plaintiffs have shown that this Court's 1996 holdings that defendants may not delay decisions on Medicaid applications beyond 45 days and may not terminate Medicaid recipients without adequate advance written notice at recertification remain good law. Plaintiffs have further shown based on the evidence submitted with this motion that defendants admit that there is a backlog of the processing of Medicaid applications within 45 days due to problems with their computer systems and that there is a separate backlog in the processing of paper Medicaid applications. Pl. Ex. 1, p. 3; Pl. Ex. 2, DHCF 32, 35; Pl. Ex. 21, FOIA 005. With respect to the processing of Medicaid renewals, plaintiffs have shown that defendants will cease passive renewals for all Medicaid recipients for a period of time beginning on January 1, 2016. DHCF

FOIA Response, No. 1(c), 1(d). Plaintiffs have further shown that there are widespread and systemic problems with the processing of submitted paperwork at the DHS service centers. *See* pp. 14-15 and 22-26 and exhibits cited therein. Plaintiffs have shown that defendants admit that there are on-going computer system problems which adversely affect the processing of Medicaid renewals. *See* pp. 18-21 and exhibits cited therein. Therefore, plaintiffs submit that they are likely to succeed on the merits of their claims that Court oversight and injunctive relief are necessary to protect the interests of the plaintiff class.

B. PLAINTIFFS WILL SUFFER IRREPARABLE INJURY IF THE PRELIMINARY INJUNCTION IS NOT GRANTED

This Court needs no reminder that Medicaid is essential to a great many poor, sick, and vulnerable residents of the District of Columbia who rely on it to meet their basic health needs. As this Court stated in 1996 (*Salazar v. District of Columbia*, *supra*, 954 F. Supp. at 281):

> This case is about people -- children and adults who are sick, poor, and vulnerable-for whom life, in the memorable words of poet Langston Hughes, "ain't been no crystal stair".

Without Medicaid coverage, people are forced into making the difficult choice of whether to pay for needed services and medicines out-of-pocket or some for some other necessary item, like food, clothing, utilities, or rent. If the costs of medical care are prohibitive, these individuals go without it. Every day that an eligible adult or child has to wait for a doctor's visit, a prescription drug, a vaccination, a surgery, life-saving treatment, or some other needed therapy is one that she cannot have back. Illnesses do not wait for a person's coverage to be approved or reinstated. Retroactive Medicaid eligibility and financial reimbursement will not cure the harm. The real life consequences of the problems that defendants have encountered in 2015 in processing Medicaid applications in a timely manner and in processing renewals so that

there is no loss of coverage without advance notice are set forth in the attached Declarations of Medicaid recipients and Medicaid providers. Pl. Ex. 24-27, 29-32, 48, 49.

Moreover, termination of benefits without notice and an opportunity for a hearing deprives individuals of an important benefit, the loss of which can cause irreparable harm. As the Supreme Court stated in *Goldberg v. Kelly*, 397 U.S. 254 at 264, 267-268 (1970):

> [W]hen welfare is discontinued, only a pre-termination evidentiary hearing provides the recipient with procedural due process. * * * Thus the crucial factor in this context—a factor not present in the case of the blacklisted government contractor, the discharged government employee, the taxpayer denied a tax exemption, or virtually anyone else whose governmental entitlements are ended—is that termination * * * may deprive an eligible recipient of the very means by which to live while he waits.

These are the real and irreparable harms that affect the thousands of Medicaid applicants who are suffering and will continue to suffer from defendants' failure to process their applications within 45 days and Medicaid recipients whose eligibility is improperly terminated without notice and an opportunity for hearing. For example, Karla Ayala-Carranza, mother of XA and six-year-old DA, who suffers from serious kidney problems, lost coverage despite having timely submitted her renewal form at a service center. Ayala-Carranza Decl., Pl. Ex. 29, paras. 1-5. Ms. Ayala-Carranza found out that her children did not have Medicaid coverage when she took her daughter to the doctor a month later. *Id*., para. 5. When she took the day off work to go back to a DHS service center, where she waited for several hours—a wait that was prolonged because there were few Spanish-speaking staff available—she was informed that her children's coverage was active. *Id*., paras. 7, 10. Despite this, Ms. Ayala-Carranza discovered that her children did not have coverage when she took DA to the hospital. *Id*., paras. 7-8. As a result of the months-long gap in coverage, DA did not receive treatment from his kidney specialist; Ms. Ayala-Carranza was forced to pay out-of-pocket for expensive medications to treat a kidney infection; and her family accumulated thousands of dollars in medical bills. *Id*.,

paras. 6, 9, 11. The children are due to renew again at the end of January 2016, but Ms. Ayala-Carranza is extremely worried the same errors will occur at a time when her son has a scheduled operation. *Id*., para. 14. *See also* Bread for the City Decl.,Pl. Ex. 24, para. 22)("Based on the experience of myself and my staff, it is my opinion that Medicaid-eligible individuals are often unable to secure or maintain Medicaid coverage for themselves and their families due to administrative failures of DHS"); Loubier Decl. for Whitman-Walter Health, Pl. Ex. 27, para. 11)("The systemic challenges shared in our observations during our monitoring at the service centers and our individual cases * * * illustrate a very high level of WWH staff involvement to get applications and renewals processed. Even with that level of expertise and investment, we routinely see consumers whose benefits have lapsed or have not been processed, despite having submitted their paperwork").

The additional testimony from Medicaid recipients and legal advocacy organizations in the District of Columbia who serve them demonstrate that defendants' violations of the constitutional and statutory rights of Medicaid recipients cause irreparable injury that should be remedied by the granting of a preliminary injunction. *See* Pl. Exs. 24-32, 48, 49.

C. THE BALANCE OF EQUITIES FAVORS PLAINTIFFS

The harm posed to poor, sick, and vulnerable individuals outweighs any potential harm that could be caused to defendants. As shown above, pp. 39-41, the real harm that plaintiffs are suffering and will suffer from defendants' violation of their constitutional and statutory rights if relief is not granted is irreparable.

Plaintiffs seek an order requiring defendants to grant provisional eligibility to all persons whose Medicaid application has been pending longer than 45 days and to continue the eligibility of all Medicaid recipients due for renewal. *See Alexander v. Hill*, 707 F.2d 780, 782-784 (4th

Cir. 1983) (affirming injunction requiring 100% compliance with 45-day rule for processing Medicaid applications and paying applicants $50 per week if their application is delayed beyond 45 days); *KW, ex rel. DW v. Armstrong*, 789 F.3d 962, 968-969, 976 (9th Cir. 2015) (affirming preliminary injunction restoring Medicaid benefits to class of beneficiaries who received inadequate notice). The order would remain in effect until defendants can show, based on substantial evidence, that the District of Columbia is able to process all Medicaid applications within 45 days, that it is able to renew Medicaid in accordance with the due process standards of the Constitution, and that it is able to passively renew Medicaid for the MAGI population under the ordinary requirements of the ACA and its implementing regulations.

Provisional eligibility would allow applicants to temporarily access Medicaid coverage without waiting more than 45 days for their application to be processed. *See generally* 42 C.F.R. 435.1100, *et seq*. (federal regulations permitting states to screen individuals for eligibility and grant temporary access to Medicaid). A continuation of eligibility for individuals due to be renewed would reinstate the District's 2014 policy under which it extended recipients' eligibility and stated that recipients "will have additional months of Medicaid coverage * * *." DHCF FAQ Renewal Changes, Pl. Ex. 40. With these remedies in place, defendants will be able to devote more of their resources to fixing the underlying technological problems and systemic document processing issues that are causing the delays and mistakes that affect so many individual class members, rather than making these fixes at the same time as they attempt to timely process applications and renewals (all of which must now be processed "actively," *i.e*., not passively, and without online access for recipients).

To the extent that the relief sought by plaintiffs results in individuals temporarily receiving benefits who may not be eligible for Medicaid benefits, causing some financial costs to

defendants, federal financial participation may be available. Federal regulation 42 C.F.R. 431.250(b)(2) allows federal financial participation payments to be made "[f]or services provided within the scope of the Federal Medicaid program and made under a court order." Federal regulations also provide for federal financial payments "for services covered under the [State] plan that are furnished * * * (2) [d]uring a period of presumptive eligibility * * *." 42 C.F.R. 435.1002(c). Because the relief sought by plaintiffs aims to effectuate the requirements of the federal Medicaid program, such federal assistance may be available under these regulations. Any remaining financial or administrative cost directly incurred by defendants is more than outweighed by the harm suffered by plaintiffs.

In any event, the Supreme Court has weighed these considerations and ruled that the harm posed to persons who face the loss of medical care is not outweighed by any claim of economic harm caused to the state by providing uninterrupted care pending an eligibility determination. In *Goldberg v. Kelly*, the Court reasoned that (*supra*, 397 U.S. at 266):

> [T]he stakes are simply too high for the welfare recipient, and the possibility for honest error or irritable misjudgment too great, to allow termination of aid without giving the recipient a chance, * * * [to receive notice and opportunity to contest the termination]." (internal quotations and citations omitted)

A few years later, in a case denying an application to stay a preliminary injunction allowing certain Medicaid applicants to receive benefits pending the filing of a petition for writ of certiorari, Justice Marshall noted that (*Blum v. Caldwell*, 446 U.S. 1311, 1316 (1980)):

> [T]he economic harm * * * is only the additional expenditure during the time in which the petition for certiorari is pending. * * * On the other side of the balance are the life and health of the members of this class: persons who are aged, blind, disabled and unable to provide for necessary medical care because of lack of resources. * * * [T]he denial of necessary medical benefits during the months pending * * * [disposition of 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 respondents.

Similarly, here where defendants would only experience some potential financial cost, the balance of equities heavily favors plaintiffs, who are experiencing and will continue to experience an irreparable loss of medical care, and all the social and financial consequences that come with it, without the relief they seek.

D. THE PUBLIC INTEREST WOULD BE SERVED BY A PRELIMINARY INJUNCTION

Access to timely medical services, treatments, and medications for poor, sick, and vulnerable people in the District of Columbia is manifestly in the public interest. It is in the public interest to have the medical needs of the most vulnerable of its members met. Here, in the District of Columbia, one out of every three residents receives Medicaid. DHCF Medical Assistance Information Webpage, Pl. Ex. 39. The public interest is served when one third of the city's residents have access to needed medical care and when their constitutional and statutory rights are upheld and enforced.

III

CONCLUSION

For the foregoing reasons, plaintiffs request that the Court grant their request for preliminary injunction and to enter the attached proposed order**.**

Respectfully submitted,

/s/ Zenia Sanchez Fuentes

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December 22, 2015

LIST OF EXHIBITS

Number	Description
1	DC Health Link MCAC Update, December 10, 2015 ("December MCAC Presentation")
2	DHCF Response to DC Legal Aid Society FOIA Request, DCAS Top Priorities and Risks, dated August 8, 2015 ("August 2015 DCAS Update")
3	DHCF Response to DC Legal Aid Society FOIA Request, DCAS Top Priorities and Risks, dated June 15, 2015 ("June 2015 DCAS Update")
4	DHCF Response to DC Legal Aid Society FOIA Request, DCAS Top Priorities and Risks, dated April 21, 2015 ("April 2015 DCAS Update")
5	ESA Response to DC Legal Aid Society FOIA Request, Food and Nutrition Service Program Access Review of H Street Service Center, July 2, 2015
6	ESA Response to DC Legal Aid Society FOIA Request, Food and Nutrition Service Program Management Evaluation Process FY 2015 Review, April 2, 2015
7	ESA Response to DC Legal Aid Society FOIA Request, Food and Nutrition Service Audit Report, March 23, 2015
8	Wesley Rivers and Chelsea Sharon Testimony to the District of Columbia Council's Committee on Health and Human Services on March 12, 2015
9	ESA Response to DC Legal Aid Society FOIA Request, District of Columbia Office of Quality Assurance and Analysis, Anacostia Service Center FY 2014 Management Evaluation Report, November 6, 2014
10	ESA Response to DC Legal Aid Society FOIA Request, District of Columbia Office of Quality Assurance and Analysis Program Access Review, H Street Service Center, September 23, 2014
11	DHCF Response to DC Legal Aid Society FOIA Request, DCHL MAGI Renewals: Contingency Plan Presentation, May 22, 2015
12	DHCF Response to DC Legal Aid Society FOIA Request, Internal Agency E-mail Communications, April 2015
13	ESA Response to DC Legal Aid Society FOIA Request, DCAS Improvement Team Status, June 24, 2015
14	ESA Response to DC Legal Aid Society FOIA Request, DCAS Improvement Team Status, May 19, 2015
15	ESA Response to DC Legal Aid Society FOIA Request, ESA Operations and Data Cleanup Dashboard, May 13, 2014
16	DHCF Response to DC Legal Aid Society FOIA Request, E-mail Communications Between CMS and DHCF, January 2015
17	DHCF Response to DC Legal Aid Society FOIA Request, E-mail Communications Between DHS and DHCF, August to September 2015
18	E-mail from Legal Services Providers to ESA Staff with Examples

19	Closing the Gap Between Policy and Reality: Preventing Wrongful Denials and Terminations of Public Benefits in the District of Columbia, DC Legal Aid, May 22, 2015
20	Plaintiffs' FOIA Request to DHCF, October 27, 2015
21	DHCF FOIA Response ("DHCF FOIA Response"), December 3, 2015
22	DHS FOIA Response, December 4, 2015
23	Health Link MAGI Medicaid Processing MCAC Update, October 28, 2015 ("October MCAC Presentation")
24	Declaration of Dr. Randi Abramson, December 17, 2015 ("Bread for the City Decl.")
25	Declaration of Katie Nicol, December 17, 2015 ("Whitman-Walker Decl.")
26	Declaration of Jennifer Mezey, December 18, 2015 ("Legal Aid Decl.")
27	Declaration of Erin Loubier, December 17, 2015 ("Loubier Decl.")
28	Declaration of Danielle Moise, December 17, 2015 ("Moise Decl.")
29	Declaration of Karla Ayala-Carranza, December 16, 2015 ("Ayala-Carranza Decl.")
30	Declaration of Tina Nelson, December 21, 2015 (Legal Counsel for the Elderly Decl.")
31	Declaration of Fonda Carroll, December 16, 2015 ("Carroll Decl.")
32	Declaration of Teri Jackson, December 14, 2015 (Jackson Decl.")
33	Declaration of Wesley Rivers, December 21, 2015 ("Rivers Decl.")
34	Declaration of Jeremy Padow, December 21, 2015 ("Padow Decl.")
35	Short Medicaid Renewal Form, provided in FOIA Response from DHCF to Plaintiffs' Request No. 2, December 3, 2015 ("Short Renewal Form")
36	Sample Medicaid Renewal Form, M1, provided in FOIA Response from DHS to Plaintiffs, December 4, 2015
37	Waiver Request from Claudia Schlosberg to CMS, June 4, 2015, provided in FOIA Response from DHCF to Plaintiffs, December 3, 2015
38	Letter from CMS to Claudia Schlosberg to CMS, November 20, 2015, provided in FOIA response from DHS to Plaintiffs, December 4, 2015
39	DHCF Medical Assistance Information Webpage, available at http://dhcf.dc.gov/page/medical-assistance-programs-information-and-eligibility, downloaded on December 14, 2015
40	DHCF FAQ Renewal Changes for Medicaid Members in 2014
41	Response to DC Legal Aid Society FOIA Request Renewal Metrics Report, October 2015
42	ESA Response to DC Legal Aid Society FOIA Request, ESA Operations and Data Cleanup Dashboard, June 3, 2014
43	Order Defining Plaintiff Class, November 3, 1994, ECF No. 100
44	Minute Order, February 24, 2009

45	ESA Response to DC Legal Aid Society FOIA Request Federal Status Check Presentation, May 18, 2015
46	ESA Response to DC Legal Aid Society FOIA Request, Sample D1 30-Day Notice
47	ESA Response to DC Legal Aid Society FOIA Request, ESA Operations and Data Cleanup Dashboard, June 5, 2014
48	Declaration of Vera Edmonds, December 21, 2015 (“Edmonds Decl.”)
49	Declaration of Melissa Rizio, December 22, 2015 (“Rizio Decl.”)