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' REPLY MEMORANDUM IN SUPPORT OF THEIR MOTION FOR A PRELIMINARY INJUNCTION CONCERNING DISTRICT OF COLUMBIA MEDICAID APPLICATIONS AND RENEWALS

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INTRODUCTION

In their opposition to Plaintiffs' Motion for a Preliminary Injunction (ECF No. 2077, January 15, 2016 (Def. Opp.)), defendants reject the relief requested by plaintiffs—to approve all applications pending more than 45 days and to continue the eligibility of all Medicaid recipients due to renew until defendants are able to comply with the Constitution, federal law and applicable regulations—as unnecessary, unwarranted, and extraordinary. Yet despite defendants' admissions that many errors have occurred in the processing of Medicaid renewals throughout the implementation of the Affordable Care Act (ACA), that 2,655 Medicaid applications are currently pending over 45 days, and that many individuals have improperly lost coverage as a result of these failures, the District claims widespread success. In fact, when defendants' arguments are closely analyzed, it is clear that despite all of the District's mitigation plans and temporary fixes, systemic issues persist that make it impossible for the District to ensure that timely and accurate eligibility decisions are made for a significant number of Medicaid applicants and recipients in the near future.

Plaintiffs show below that defendants' procedural arguments are without merit and that plaintiffs are entitled to the relief they seek.

ARGUMENT

I. THE COURT HAS JURISDICTION TO PROVIDE RELIEF TO MEDICAID APPLICANTS AND RECIPIENTS

Defendants claim that the Court has no authority to enter the preliminary injunction sought by plaintiffs. Def. Opp. 16-22. First, defendants argue that because the provisions of the Settlement Order relating to applications and recertifications have been terminated, "[t]here is nothing left for plaintiffs to monitor or enforce * * *". Def. Opp. 16. However, plaintiffs do not seek to reinvigorate the terminated provisions in the Settlement Order. Instead, plaintiffs are seeking injunctive relief, based on the original claims in the Second Amended Complaint (ECF No. 133 paras. 72-81), for two of the five sub-classes which remain certified: (1) individuals whose

applications for Medicaid have been pending for over 45 days and (2) Medicaid recipients who have or will lose their coverage without adequate and timely notice at the time of periodic recertification. *See* ECF No. 100, Pl. Ex. 43.

These claims and their related legal requirements are not new, as defendants argue (Def. Opp. 17), but are the very same claims and requirements that led to the lawsuit in the first place. Simply put, defendants are subject to the same legal requirements as they were when plaintiffs first filed their complaint: they must make a determination on Medicaid applications within 45 days and provide adequate and timely notice to Medicaid recipients before benefits can be terminated. U.S. Constitution, 5th Am.; 42 U.S.C. 1396a(a)(8); 42 C.F.R. 435.911, 42 C.F.R. 435.919, 42 C.F.R. 435.930(b), D.C. Code 4-205.26, 4-205.55(a); *see also Salazar v. District of Columbia*, 954 F. Supp. 278, 324-326 (D.D.C. 1996).

The passage of the Affordable Care Act did not change these core obligations.[1] The 13 declarations submitted in support of plaintiffs' motion demonstrate that defendants are violating the very same provisions at issue when this lawsuit was first filed, often in strikingly similar ways. *See e.g., Salazar*, *supra*, 954 F. Supp. at 289, 296-297 (Alvarez waits from April to October for decision on application; Cruz-Diaz Alavrez waits 90 days for decision on application; Argueta benefits are cut off even though they received no notice of the obligation to recertify; Guardado has a lapse in benefits even though the recertification form was timely returned). The essential aspects of the legal claims are unchanged: as to non-disability Medicaid applications, the applicant is entitled to a

[1] Defendants erroneously claim (p. 21) that plaintiffs' motion is based on a "new law" citing *Shepard v. Madigan*, 958 F. Supp. 2d 996, 1000-1001 (S.D. Ill. 2013). However, *Shepard* found that an action by gun owners was moot because under a new law, the owners were no longer subject to a *per se* ban on concealed weapons. Here, the ACA did not change the underlying federal and constitutional requirements and defendants' violations persist.

written decision in 45 days; as to Medicaid renewals, the recipient may not be terminated without adequate pre-termination notice.[2]

Second, defendants argue that both the Court's jurisdiction and the application and recertification subclasses terminated when the relevant provisions of the Settlement Order were terminated. Def. Opp. 18-19.[3] Defendants' argument has no support in the terms of the Settlement Order. Paragraph 79 expressly provides that "[t]he Court shall retain jurisdiction of this matter to make any necessary orders enforcing or construing this Order." ECF No. 663. The exit provisions (paras. 74-78) do not state that the Court's jurisdiction will end upon termination of the obligations in a given section of the Order. To the contrary, paragraph 78 of the Settlement Order makes clear that "[a]ll other provisions of this Order shall conclude at the same time as the *last* of the sections identified in paragraphs 74-77 above" (emphasis added), and some of these sections remain active. Moreover, the Order certifying the class provides that the "five subclasses" consist of (ECF No. 100, Pl. Ex. 43, p. 1):

> 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: * * * [emphases added]

By its terms, the Court's Order contemplated continued existence of the subclasses for the entire "pendency of this litigation." *Ibid.* There has been no subsequent Order decertifying the subclasses. The Court's relevant Orders relieving defendants from compliance with certain

[2] Defendants cite (p. 18) *Barcia v. Sitkin*, 367 F.3d 87 (2d Cir. 2004) in which the court of appeals reversed the grant of a motion to enforce a consent judgment because, *inter alia*, there was no pre-existing federal constitutional right to the relief requested. *Id*. at 105-110. Here, in contrast, plaintiffs have pre-existing federal and constitutional rights to the relief requested.

[3] Defendants argue that (Def. Opp. 19) that the application and recertification subclasses "do not share anything meaningful in common with the remaining provisions in the Settlement Order * * *[,]" but overlook the most basic of facts: children in subclass V cannot begin to enforce their claim for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services under the Medicaid program if they cannot apply for or renew such benefits.

provisions of the Settlement Order did not decertify the subclasses and, in fact, contemplated continuing monitoring and enforcement of the rights of the recertification subclass by plaintiffs' counsel, stating that members of the plaintiff class could obtain legal assistance from plaintiffs' counsel pursuant to paragraph 64 of the Consent Order. ECF No. 1886, p. 9, n. 1. Although defendants argue (p. 19) that this reference to legal assistance contemplated only representation of other clients "in other fora or litigation," this is inconsistent with the language of paragraph 64, which contemplated assisting "members of the plaintiff class" and stated that such legal assistance would be considered "compensable monitoring of this Order," giving rise to attorney's fees in the litigation. ECF No. 663, para. 64. Thus, although the Court's Order relieved defendants from compliance with certain provisions of the Settlement Order, it expressly contemplated the continued existence of—and continued assistance to—the relevant subclass.[4]

Third, defendants argue that "plaintiffs may not impose new requirements on the District that are not memorialized in the Settlement Order * * *." Def. Opp. 17. In fact, when new circumstances require it, courts can and do impose new requirements "not memorialized in the Settlement Order" in order to effectuate the objectives of consent decrees. *See Brown v. Neeb*, 644 F.2d 551 (6th Cir. 1981)(in post-judgment stage, district court had inherent authority to enter preliminary injunction to benefit class of minority firefighters to meet the underlying goal of the consent decree); *Hadix v Caruso*, 461 F. Supp. 2d 574 (W.D. Mich. 2006), remanded, 248 Fed. Appx. 678 (6th Cir. 2007)(in ongoing Section 1983 class action, court reopened terminated section

[4] Defendants cite *Local No. 93, Int'l Ass'n of Firefighters*, 478 U.S. 501 (1986) for the proposition that "the existence or non-existence of a class is irrelevant to the scope of the case once the parties agree to and the Court enters a consent decree." Def. Opp. 18. The case makes no findings concerning the existence or non-existence of a class. In *Local No. 93*, a Title VII class action for race and national origin discrimination, the Court interpreted a specific enforcement provision in Title VII as not limiting a court's power to provide additional relief under a consent decree. 478 U.S. at 515. The Court authorized broader relief than that provided under Title VII, finding that it was "the agreement of the parties, rather than the force of the law upon which the complaint was originally based, that creates the obligations embodied in the consent decree." *Id*. at 522. In contrast, here, no party has argued that any provision of the Medicaid statute limits the Court's power to order relief for the class.

of consent decree and entered preliminary injunction setting forth new requirements concerning psychiatric treatment of prisoners).[5] Here, as in those cases, the Court has authority to order the relief sought by plaintiffs in order to further the underlying goal of the consent decree: the protection of the statutory and constitutional rights of Medicaid applicants and recipients.

Fourth, contrary to defendants' claim that the terms of a consent decree (Def. Opp. 18), "provide the sole source of plaintiff's rights in the action[,]" a court always retains inherent authority to impose new terms, whether through its continuing jurisdiction of the case, through the terms of the order itself, or through a procedural device, such as Rule 60(b)(5) or 60(b)(6). *See Rufo v. Inmates of the Suffolk County Jail*, 502 U.S. 367, 384 (1992) ("Modification of a decree may be warranted when * * * enforcement of the decree without modification would be detrimental to the public interest" (internal citations omitted)); *United States v. Western Electric Co., Inc.*, 46 F. 3d 1198, 1202 (D.C. Cir. 1995)("'The power of a court of equity to modify a [consent] decree of injunctive relief * * * is long-established, broad, and flexible'")(internal citations omitted); *see also e.g.*, *Brown v. Neeb*, *supra*, 644 F.2d at 557 ("A consent decree is a strange hybrid in the law. It is a contract that has been negotiated by the parties. It is also a court order which can be changed by a court if circumstances warrant").[6]

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[5] In 2009, after a hearing, the district court found that the State had complied with the terms of the preliminary injunction and dissolved it. *Hadix v. Caruso*, 2009 WL 891709 (W.D. Mich. 2009).

[6] The cases cited by defendants (pp. 20-21) do not compel dismissal of this motion. In *Bobby M. v. Chiles*, 907 F. Supp. 368, 371, 371 n. 8 (N.D. Fla. 1995), the court terminated a consent decree when, unlike here, "there is universal agreement that its underlying purpose has been achieved." In *United States v. Overton*, 834 F. 2d 1171, 1174 (5th Cir. 1987), the court analyzed the preliminary injunction factors, despite the expiration of the consent decree. On appeal, the Fifth Circuit affirmed the denial of a preliminary injunction because plaintiffs could not rely on the expired consent decree and because the district court did not err in finding no substantial likelihood of success on the merits. *Hadix v. Johnson*, 2014 WL 4678252, at *2 (E.D. Mich. Sept. 18, 2014) is unavailing since the Court refused to reopen the consent decree, *inter alia*, because, unlike here, the plaintiff was no longer part of the plaintiff class. The EEOC was not permitted to pursue contempt proceedings in *EEOC v. Local 40*, 76 F. 3d 76, 80 (2d Cir. 1996), because the consent decree had expired by its own terms based on the passage of time. In contrast, here, plaintiffs do not seek contempt findings based on violations of an expired decree, but rather new temporary relief to protect two of the subclasses.

Here, the Court has authority to effectuate plaintiffs' rights in this action. The Court has continuing jurisdiction over the subclasses because they remain certified. Defendants admit that they are once again violating the statutory rights of thousands of persons to a decision on a Medicaid application within 45 days. Schlosberg Decl., paras. 71-73. Under the explicit authority of this Court, plaintiffs' counsel continues to provide assistance to individuals seeking help in the recertification subclass. ECF No. 1886, p. 9, n. 1. Moreover, the Court has inherent authority to modify the terms of the Settlement Order under Rule 60(b)(6), which provides for relief from a final judgment or order for "any reason that justifies relief" provided that "extraordinary circumstances are present." Fed. R. Civ. P. 60(b)(6); *Salazar ex rel. Salazar v. Dist. of Columbia*, 633 F.3d 1110, 1119 (D.C. Cir. 2011). As discussed in greater detail in the Rule 60(b) motion which will be submitted on or about February 8, 2016, such relief is warranted here because defendants are not processing Medicaid applications within 45 days, nor have they shown that the alleged improvements of the ACA have prevented violation of the rights of Medicaid recipients at renewal, *See* ECF No. 1870; *Hadix*, *supra*, 461 F. Supp. 2d at 588-589 (finding extraordinary circumstances warranting Rule 60(b)(6) relief present and reopening terminated provisions of Settlement Order where new evidence of violations surfaced).

II. THE FEDERAL GOVERNMENT IS NOT AN INDISPENSABLE PARTY

Contrary to defendants' arguments (pp. 42-44), the United States is not a necessary party under Rules 65 and 19 of the Federal Rules of Civil Procedure.

In accordance with Rule 65, plaintiffs seek relief only from defendants, not from CMS or any other party. Rule 19(a)(1)(A) requires joinder if, "in that person's absence, the court cannot accord complete relief among existing parties." Since plaintiffs seek relief only from defendants the Court can "accord complete relief among existing parties." *See Ralabate v. Bane*, 1993 WL 232338, at *1 (W.D.N.Y. June 22, 1993)(denying joinder of the Secretary of HHS because plaintiffs challenged the state's "compliance with such laws and not the validity of such laws"); *Jones v.*

Blinziner, 536 F. Supp. 1181, 1195 (N.D. Ind. 1982)(same); *Wilson v. Gordon*, 2014 WL 4347807, at *3-5 (M.D. Tenn. Sept. 2, 2014)(United States is not a necessary party in a case challenging untimely Medicaid application processing even though the federal government was processing the state's Medicaid applications on an interim basis; injunction granted requiring a state fair hearing in any delayed adjudication of an application).

Defendants claim that because federal funds partially pay for Medicaid, and may be available under 42 C.F.R. 250(b)(2) or 42 C.F.R. 435.1002(c), to offset the costs of compliance with the injunction, the federal government is a necessary party. Def. Opp. 43. Defendants cite no authority in support of this proposition. Under federal law, "[t]he single State agency is responsible for determining eligibility for all individuals applying for or receiving benefits * * *" (42 C.F.R. 431.10(b)(3); *see also* 42 U.S.C. 1396a(a)(5)) and the single State agency must take appropriate measures if federal laws are not being followed (42 C.F.R. 431.10(c)(3)). In the District of Columbia, "DHCF is the single state agency for the administration of Medicaid." Schlosberg Decl., para. 4. Therefore, defendants, not the United States, are responsible for ensuring the statutory and Constitutional rights of Medicaid applicants and recipients in the District of Columbia.[7]

III. INJUNCTIVE RELIEF IS WARRANTED TO PREVENT IRREPARABLE HARM TO MEDICAID APPLICANTS AND RECIPIENTS

A. Plaintiffs Are Likely to Succeed on the Merits

1. Preliminary Injunctions Are Not Barred at the Post-Judgment Stage of a Case

Defendants claim that plaintiffs' motion should be denied on procedural grounds because a preliminary injunction is only available in a pre-trial stage of a case and "the trial in this case occurred twenty years ago in 1996." Def. Opp. 23. Although preliminary injunctions are frequently employed prior to a trial, there is no rule or case law prohibiting their use after trial. To the contrary, courts have entered such injunctions in post-judgment cases in a variety of contexts. *See*

[7] Rule 19(a)(1)(B) only applies when a non-party "claims an interest relating to the subject of the action." Since the United States has not claimed an interest, sub-part (B) does not apply.

e.g., *Meyers v. Moody*, 723 F. 2d 388, 389-390 (5th Cir. 1984)(approving use of post-judgment preliminary injunction to freeze assets of debtor); *Brown v. Neeb*, *supra*, 644 F.2d at 560 (in post-judgment phase, district court granted preliminary injunction to benefit class of minority firefighters); *Hadix v. Caruso*, *supra*, 461 F. Supp. at 589-599 (preliminary injunction warranted in post-consent decree case to provide prisoners with necessary medical services).

2. Defendants Offer No Persuasive Response to Plaintiffs' Evidence of Widespread Delays in Application Processing

(a) Defendants Admit that a Backlog of Thousands of Applications Exists that Cannot Presently Be Eliminated

Plaintiffs' motion demonstrated that thousands of Medicaid applications have been pending for well beyond 45 days. Pl. Br. 10-13. The application backlog has been in existence since March or April of 2015. Pl. Ex. 1, p. 3. This means that many Medicaid applicants have been waiting up to a year for needed medical care, often with devastating results. *See, e.g.*, Whitman-Walker Decl., Pl. Ex. 27, paras. 5, 6; Bread for the City Decl., Pl. Ex. 24, 7, 10, 11, 12.

Defendants do not contest these key facts. They admit that 2,655 Medicaid applicants have been waiting well beyond 45 days for an eligibility determination. *See* Schlosberg Decl., paras. 72, 73. They also admit (Def. Opp. 13-14) that many of the technological problems giving rise to the backlog are not resolved, so that new cases could continue to fall into the backlog. *See also id.* at 31 ("there are not simple solutions to these complex problems; technical analysis is underway to * * * conduct manual review of each [malformed application] case * * *"). In addition, defendants admit (p. 14) that the *earliest* the backlog could be resolved is June 2016, when a system upgrade will occur, more than a year after the discovery of the backlog. Schlosberg Decl., para. 75.

Defendants attempt to downplay their clear violation of the 45-day processing requirement by claiming that they have made great progress in reducing the backlog. However, defendants have had more than nine months to eliminate the backlog and have been unable to do so, despite their representations that they are "working tirelessly." Def. Opp. 32. Indeed, among the

"stuck/malformed" application group, defendants have only been able to reduce the backlog by a few hundred cases (from 2,112 to 1,408 since March 2015). Def. Opp. 31. The fact that thousands of Medicaid applications remain in the backlog, despite defendants "taking every conceivable step" to resolve the problem over a nine-month period (Def. Opp. 35), shows that defendants' solutions have failed and court intervention is necessary to remedy these violations in a timely manner.

Defendants also argue that court intervention is unnecessary because they are following "strategies that have been reviewed and approved by [CMS]." Def. Opp. 32. However, defendants submit no guidance authored by CMS regarding the backlog, only a set of instructions drafted by DHCF. Def. Ex. G; Schlosberg Decl., para. 67. Although defendants represent that CMS approved these instructions (*ibid.*), no written approval has been submitted. Nor do defendants submit any document that evaluates whether defendants are timely complying with the instructions set forth at Exhibit G. Evidence suggests that defendants have been unable to comply timely with certain of these instructions. For example, the relevant instructions require that, for "Bucket 6" of the backlog, consisting of individuals "determined eligible for Medicaid * * * [with] no outstanding verifications," defendants must "enroll these individuals immediately" in Medicaid. Def. Ex. G at 1. Defendants assert that these instructions were approved by CMS in August 2015. Schlosberg Decl., para. 67. In September 2015, Bucket 6 contained 112 applications. Pl. Ex. 17, p. 3. At the December 2015 MCAC meeting, defendants admitted that Bucket 6 had grown since September to encompass 146 applications as of December 2015.[8] Thus, although defendants argue that court intervention is unnecessary because CMS has sanctioned its progress in reducing the backlog, the evidence actually shows that defendants have failed to comply timely with the instructions approved by CMS[9] and will be unable to eliminate the backlog fully until June 2016 at the earliest.[10]

[8] The Declaration of Chelsea Sharon, if accepted by this Court, provides testimony of this admission by defendants' representative at the December 10, 2015, MCAC meeting. *See* ECF No. 2082.

[9] Even if defendants were timely complying with the CMS instructions, this would not cure violations of the 45-day processing requirement. CMS mitigation plans do not *cure* violations of

Moreover, as plaintiffs showed in their opening brief, the statistics about delayed pending applications in DC Health Link do not take into account applications that defendants have not registered because they have been lost or misplaced at service centers. *See* Pl. Br. 13-15.[11] The testimony of Medicaid advocates who assist beneficiaries on a daily basis demonstrates that lost or misplaced paperwork is a substantial problem. *See, e.g*., Loubier Decl., Pl. Ex. 27, para. 9; Bread for the City Decl., Pl. Ex. 24, para. 11; Legal Aid Decl., Pl. Ex. 26, paras. 5, 17. The advocates' experiences are supported by independent reviews of DHS service centers showing systemic document-processing problems. *See* Pl. Exs. 5, 6, 7, 9, 10. Although these reports focus on the processing of Food Stamp applications and renewals, defendants acknowledge that the same Document Imaging Management System (DIMS) reviewed in these reports, is used for scanning and uploading Medicaid documents. Schlosberg Decl., para. 59.

(b) Defendants' Claim of Improved Renewals Processing Is Contradicted by Substantial Evidence

Defendants claim that "the overall response rate for renewals is higher than ever before," increasing from a historical rates of about 60% of beneficiaries responding to renewal notices before the ACA, to a "response rate" of 86.3% in 2015. Def. Opp. 25. Defendants' use of the term "response rate" is misleading. A "response rate" implies that individuals took some action to renew their coverage, yet most of the claimed 86.3% response rate is made up of the 53% of beneficiaries who were not required to make any response at all in 2015, since they were able to be passively

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federal law but rather, as their name suggests, aim to *mitigate* the resulting harm to beneficiaries when such violations occur.

[10] Defendants boast that they were able to process 33,000 online Medicaid applications "on the same day they were submitted." Def. Opp. 7. However, this places defendants in the lowest category of state performance on this metric. According to the 2016 Kaiser Commission Report (Pl. Ex. 53, Table 6, p. 38), of the 37 states that can make real-time decisions on Medicaid applications, the District of Columbia is among the 12 states that can do so only in fewer than 25% of the cases.

[11] The Declaration of Chelsea Sharon, if accepted by this Court, provides testimony of a recent example of a Medicaid application submitted in September 2015 which was not registered as received until after a lawyer intervened for the client in November 2015. *See* ECF No. 2082.

renewed. *See* ECF No, 2070-2, p. 5; ECF No. 2077-1, Schlosberg Decl., para. 44. The District cannot take credit for increasing response rates, when none is required.

Second, the 86.3% number is inflated because it includes individuals who lost coverage at some point, including some who lost coverage through no fault of their own, but who regained it after the District of Columbia utilized the 90-day grace period allowed under 42 C.F.R. 435.916(a)(3) and (b).[12] Rivers Decl., Pl. Ex. 33, para. 15(c). These individuals are counted by the District of Columbia as having been successfully renewed, despite having been unable to access medical care or incurring out-of-pocket expenses during the gap in coverage. *Ibid*. Defendants' own data show that of the 36,897 Medicaid households who had to manually renew in 2015 (*i.e*., return a renewal form) roughly 30% lost coverage due to defendants' alleged non-receipt of the form. Rivers Decl., Pl. Ex. 33, para. 15 and Tables 1 and 2 attached thereto. Plaintiffs provided evidence that in many instances, this widespread loss of coverage, is attributable not to inaction by the beneficiary, but to defendants' systemic errors in processing renewals. *See* Pl. Br. 17-32 and exhibits cited therein. Plaintiffs provided declarations of individuals who suffered injuries during a gap in coverage, despite having timely returned their renewal forms. *See* Pl. Exs. 29, 31, 32, 48, 49. Yet, with one exception, defendants provide no response to these declarations. *See* Def. Opp. 36.

Defendants also dismiss the testimonies provided by the major Medicaid advocacy organizations in the District of Columbia, including the DC Legal Aid Society, Whitman Walker Health, Bread for the City, Legal Counsel for the Elderly, and the DC Fiscal Policy Institute, describing examples of clients who suffered harm as accounting for "relatively few cases * * *

[12] The 90-day grace period permitted post-ACA provides no greater benefit to recipients than they had pre-ACA. Prior to the ACA, recipients who were terminated could also receive retroactive coverage if they submitted a new application. Under both cases, the recipient loses benefits if the renewal form is not recorded as having been timely returned. The maximum retroactive coverage period is 90 days under either scenario. *Compare* 42 C.F.R. 435.916(a)(3)(iii) with 42 C.F.R. 435.915 (formerly 42 C.F.R. 435.914, re-designated at 77 FR 17209, March 23, 2012). Under both scenarios, the recipient loses coverage for a period of time and cannot access Medicaid benefits during this period.

[which] comprise a small fraction of the approximately 250,000 individuals on Medicaid." Def. Opp. 36.[13] These organizations, which collectively assist thousands of Medicaid clients in the District of Columbia, state that a significant proportion of their clients are losing coverage as a result of systemic processing issues. Bread for the City Decl., Pl. Ex. 24, para. 6, 13-22; Whitman Walker Decl., Pl. Ex. 25, para. 5; Legal Aid Decl., Pl. Ex. 26, paras. 1, 2, 21; Loubier Decl., Pl. Ex. 27, para. 1; Legal Counsel for the Elderly Decl., Pl. Ex. 30, paras. 3-4. *See, e.g.*, Loubier Decl., Pl. Ex. 27, para. 11 ("[W]e routinely see consumers whose benefits have lapsed or have not been processed, despite having submitted paperwork.").[14] It is contrary to common sense that the dozens of violations recounted in these declarations could all be the result of anomalous instances of human error, rather than evidence of systemic problems.

(c) Defendants Do Not Provide Adequate Notice prior to Terminating Beneficiaries' Coverage

In their motion and supporting declarations, plaintiffs showed that defendants fail to provide timely and adequate notice of the need to renew and fail to send timely and adequate notice in advance of the termination of coverage to Medicaid beneficiaries. Pl. Br. 30-32. As to the first, defendants claim that there is no longer an issue because an error resulting in 1,188 notices being sent to the incorrect address has been resolved. Def. Opp. 30. But defendants' narrow focus on one technological error, which affected renewals from May to October 2015 (Pl. Ex. 1, p. 3), does not

[13] Defendants' attempt to portray plaintiffs' evidence of their poor performance in 2015 as a drop in the bucket of 250,000 Medicaid recipients is not the correct comparison. Not all 250,000 recipients were up for renewal in 2015. Based on defendants' own data, there were 77,942 MAGI beneficiaries (69,844 M1 beneficiaries and 8,098 D1 beneficiaries) up for renewal in 2015. ECF No. 2072-2, Pl. Ex. 1, p. 5. Even if the cases cited by plaintiffs represent only a small fraction, 5% to 10%, of the Medicaid beneficiaries who are subject to renewal (Whitman-Walker Decl., Pl. Ex. 25, para. 5), it would still constitute an extremely large number of people whose rights are being violated.

[14] Defendants claim ignorance of the specifics of the cases set forth in plaintiffs' declarations (*see* Def. Opp. 36) despite the fact that, in many instances, the advocates testify that they worked directly with District of Columbia staff to resolve the numerous representative individual examples cited by these organizations. *See* Bread for the City Decl., Pl. Ex. 24, para. 5; Whitman-Walker Decl., Pl. Ex. 25, para. 2; Legal Aid Decl., Pl. Ex. 26, para. 6; Loubier Decl., Pl. Ex. 27, para. 10.

account for advocates' overall experience in 2015 that "DHS frequently terminates Medicaid coverage without providing recipients with any notice that they are required to renew their coverage" (Pl. Ex. 24, para. 13) or for the examples of individuals who did not receive notices prior to these dates (*id*., para. 15; Pl. Ex. 26, para. 6(b)).

With regard to defendants' failure to send a notice when a beneficiary's coverage is terminated, defendants argue that no law requires the District to send an additional notice of termination when coverage has been terminated. Def. Opp. 29-30. This may be correct for beneficiaries who receive a renewal form and do not take the action required to renew their coverage. However, when a beneficiary either receives no notice of the obligation to renew or timely submits a renewal form, and nevertheless receives a notice that her coverage will be terminated for failure to submit the form, notice is inadequate because it fails to state accurately the reason for termination, as required by federal and District law. 42 C.F.R. 431.210(b); D.C. Code 4-205.55(a)(2); *see also Salazar v. District of Columbia, supra*, 954 F. Supp. at 527.[15]

3. <u>Defendants Cannot Resolve Many Critical Issues in the Near Future</u>

(a) Defendants' Efforts to Reduce Wait Times and Solve Document Processing Issues at Service Centers Will Not Yield Results in the Near Future

Defendants admit that beneficiaries "can experience long wait times" at the ESA Service Centers," but argue that the steps they are taking have or will improve wait times. Def. Opp. 33. Unfortunately, none of the steps they are taking will help a significant number of beneficiaries now or in the near future. First, defendants claim that "[r]enewal documents regularly are scanned into DIMS to ensure preservation." *Ibid*. Defendants do not state how often documents are scanned into DIMS ("regularly" could mean every day, every week, or less frequently) or provide any evidence that documents are being promptly registered and scanned upon receipt. Nowhere do defendants

[15] The Declaration of Chelsea Sharon, if accepted, demonstrates that these renewal problems for Medicaid recipients are continuing in December 2015 and January 2016. *See* ECF No. 2082-3.

claim that scanning a renewal form into DIMS means that receipt of the renewal form is entered into defendants' computer systems so that the Medicaid recipient's coverage will not be terminated unless the District of Columbia determines the recipient to be no longer eligible for Medicaid. *See* Schlosberg Decl., paras. 59-65. Moreover, the evidence submitted by plaintiffs shows that case workers are not timely scanning documents into DIMS. *See* Pl. Exs. 5, 6, 7, 9, 10; Pl. Ex. 24, para. 11; Pl. Ex. 26, paras. 5, 17.

Second, defendants claim they have improved wait times at service centers and "hired a business processing consulting team to review Service Centers and recommend changes to * * * minimize wait times." Def. Opp. 33. Defendants claim they have reduced waiting times at service centers by an average of 11 minutes (*ibid*.), but this claimed improvement in waiting times pales in comparison to the hours long wait times that beneficiaries regularly endure. *See* Pl. Ex. 8 (testimony of advocates' monitoring of 3 service centers over 12 visits at which they spoke to 550 people in line revealing long wait times, with a third of those interviewed lining up between 4 and 5 a.m.).[16] As to the changes to be made by the business processing consulting team, defendants provide no timeline as to when these changes will become effective. In any event, since service centers must first be evaluated, processes developed and approved, and across-the-board training conducted before any successful implementation of business processes can take place, it is highly unlikely that this effort will yield results in the near future.

Third, defendants state that "the District has acted to obviate the need for individuals to appear at Service Centers by implementing self-help renewal centers and a new interactive voice response system." Def. Opp. 33. Defendants provide no information about when the self-help renewal centers were implemented or how many people have been assisted. Defendants' interactive

[16] Defendants claim the average wait time at service centers is only 50 minutes (Schlosberg Decl., para. 84), but provide no support for this figure. Based on plaintiffs' evidence that beneficiaries line up as early as 4 or 5 a.m., it is unlikely that defendants are including in their average the wait times for those who arrive at the service centers before the opening hour.

voice response (IVR) system is in a pilot stage, with no timeline for full implementation. *See* Schlosberg Decl., para. 80. Indeed, defendants have claimed to be piloting such a system in the past, but it never came to fruition. Pl. Ex. 19B, p. 3 (in May 2014 defendants were working to implement the IVR system). However, even if the IVR system becomes fully functional, it will still not assist individuals who never receive a renewal notice, those that need to submit additional documents, or those whose renewals are "stuck" or "malformed."

Finally, defendants state that they have hired more call center workers who will be able to process Medicaid renewals over the telephone (Schlosberg Decl., paras. 81, 82), but in practice this is not always occurring. Beneficiaries and advocates report that "ESA Customer Service Line Staff indicate that they are not authorized to complete the renewal process over the phone but customers must walk into a service center." Whitman-Walker Decl., Pl. Ex. 25, para. 10.

(b) Technological Issues Resulting from the Implementation of the ACA Will Persist until June 2016 and Later

Defendants acknowledge that many of the underlying technological problems they are facing will not be resolved for some time. First, defendants acknowledge that many of the underlying issues causing "stuck" renewals and applications will require a major technology upgrade not scheduled until June 2016. Schlosberg Decl., para. 75; Def. Opp. 14.[17] Moreover, the

[17] Defendants' incorrectly claim (p. 31) that they have reduced "stuck" renewals from an initial count of 999 to 10 over a short period of time. First, the initial count was actually 361 rather than 999. Schlosberg Decl., para. 65. Second, although defendants claim they discovered the "stuck" renewals in October 2015 and quickly resolved them, their own documents suggest the issue was discovered in May 2015 and defendants simply did not have capacity to address the problem. *See* Pl. Ex. 55, p. 6 (identifying problems with "stuck renewals" in May 2015 and noting that team in charge of resolving the issue "ha[s] a process to follow but too much on their plates").

Defendants similarly claim that they identified the problem with "stuck/malformed" applications in October 2015 and reduced the problem "drastically" in a short time period. Def. Opp. 31. However, according to defendants' documents, they had identified the problem prior to January 23, 2015: "Apps are still frequently becoming 'malformed' cases * * * but we have a much better understanding of the underlying issues and new reports to track them." Pl. Ex. 56, p. 18. Thus, far from acting quickly, it took defendants a year to reduce this one group of applications pending more than 45 days to 1,408 cases.

simultaneous use of ACEDS (the District's pre-ACA eligibility system) and DCAS (the post-ACA eligibility system) means that data in one system must be in the other. Pl. Ex. 21, FOIA 003-004, Response 2(e). Although in theory this should happen automatically, defendants admit that case workers must input data manually when this does not occur. *Ibid*. Plaintiffs provided evidence of defendants' admissions that data were not matching between the two systems, which defendants do not dispute.[18] *See* Pl. Ex. 11, DHCF 388; Pl. Ex. 13, p. 6. Defendants admit that ACEDS, the old eligibility system, will not be retired until all beneficiaries are transferred to the new system, which is not expected until DCAS is fully implemented in 2018. Schlosberg Decl., paras. 15, 57. Thus, as long as ACEDS is in operation, the risk exists for communication problems between the two systems to occur and for beneficiaries to lose coverage as a result.

Defendants also acknowledge that many of the underlying issues leading to untimely eligibility determinations for applications will require a major technology upgrade not scheduled until June 2016. Schlosberg Decl., paras. 65, 75.

Defendants represent that passive renewals have begun to function again.[19] However, the data show that, even when passive renewals were underway in 2015, a significant percentage of recipients lost coverage over the course of the year. Rivers Decl., Pl. Ex. 33, para. 15 and Tables 1 and 2 attached thereto. Indeed, in its opposition (p. 10), defendants provide the percentage of Medicaid recipients who could passively renew, but not the percentage among recipients required to renew manually who lost coverage.

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[18] Defendants respond only to concerns from MCO's made in April 2015 indicating that they were losing beneficiaries by the thousands because information was not passing from ACEDS to DCAS, and explain that "MCO's were initially misinterpreting renewals as terminations in their data systems." Def. Opp. 25.

[19] Defendants claim that plaintiffs were informed prior to filing the motion that "the requisite functionality to accomplish passive renewals was added to DCAS in December 2015." Def. Opp. 24. However, plaintiffs were informed only that the District was "*targeting* the end of February certification" for passive renewals, "barring any technical issues" (emphasis added) (Pl. Ex. 1, p. 6) a fact that plaintiffs acknowledged in their brief. Pl. Br. 9.

Furthermore, although passive renewals have apparently restarted, recipients are still unable to renew Medicaid online. *See* Pl. Ex. 21, DCHF FOIA Response 1(e); Schlosberg Decl., para. 82 (defendants are "working with IBM to complete improvements to the DC Health Link system needed to make online benefit renewal available to Medicaid beneficiaries * * *"). Defendants offer no timeline for when this option, required under the ACA (*see* Pl. Br. 9), will be available for the renewal of Medicaid benefits. *Ibid*. When online renewals were functioning, 85% or more of those who submitted renewal forms each month from January to September 2015 did so online. Pl. Ex. 41, p. 4. Now, paperwork for all these cases that previously renewed online—sometimes numbering close to 2,000 cases per month, *ibid.*—will have to flow through already crowded service centers.

Moreover, defendants are providing incorrect notices to Medicaid recipients instructing them that they can submit their form online – when, in fact, they cannot. *See* Def. Ex. D, p. 3 ("You can submit the Medicaid Renewal Form either online, through U.S. postal mail, in person, or by phone"). In addition, nearly all of those who were sent renewal forms in the D1 group in December 2015 (31% out of 37%) were sent an incorrect due date and will have to be sent and asked to submit a second renewal form. Schlosberg Decl., para. 55. Even if these recipients are given additional time to submit the second form, it will inevitably lead to confusion and loss of coverage for many.

In sum, defendants admit that several technological defects persist and that they have been forced to adopt manual workarounds to mitigate the adverse effects of these defects. *See* Schlosberg Decl., paras. 65, 67 (manually processing each "stuck" renewal and application case); para. 94 (manually adding newborns to cases); para. 31 (manually making immigration determinations); Pl. Ex. 21, FOIA 003-004, Response 2(e) (manually transferring data from DCAS to ACEDS when data breakdown occurs). Yet these workarounds are just temporary fixes that do nothing to resolve the underlying technological problems and that draw staff away from other crucial tasks like document processing.

B. Plaintiffs Will Continue to Experience Irreparable Harm because Defendants' Violations Persist

1. Plaintiffs Rely on Substantial Evidence Demonstrating that Medicaid Applicants and Recipients Are Suffering and Will Suffer Irreparable Harm in the Absence of Immediate Relief

Defendants accuse plaintiffs of improperly relying on evidence showing harm suffered by individuals who enroll or attempt to enroll in the District's Health Care Alliance or Food Stamps program and not on the harm suffered by Medicaid applicants and recipients. Def. Opp. 34-35.

To demonstrate irreparable harm, plaintiffs submitted declarations of the major Medicaid advocacy organizations in the District of Columbia, which collectively assist thousands of Medicaid applicants and beneficiaries, and individuals' declarations, demonstrating that defendants' violations of the constitutional and statutory rights of Medicaid applicants and recipients cause them irreparable harm. *See* Pl. Exs. 24-27, 29-32, 48, 49.

Defendants cite (Def. Opp. 34) a chart from legal services providers with examples of application and recertification cases provided to defendants in April 2015 (Pl. Ex. 18) and a report and related testimony (Pl. Exs. 8, 19) submitted by Medicaid advocates to the DC City Council, which summarizes the monitoring of long lines at three ESA service centers and include accounts of those waiting in line to apply or renew Food Stamps, Alliance, and/or Medicaid benefits. The report and testimony show that long lines at service centers impair defendants' ability timely and accurately to process applications and renewals for Medicaid applicants and recipients. Pl. Exs. 8, 9. The composition of those waiting in line is irrelevant since the end result is the same—long lines and waiting times at service centers which cause delays in processing Medicaid applications and renewals. As to the chart (Pl. Ex. 8) provided to defendants in April 2015 with examples of systemic issues in the processing of Medicaid applications and renewals, defendants cite a single example of a non-Medicaid case out of 38 examples of problems with the processing of Medicaid renewals. Def. Opp. 34 (citing Pl. Ex. 18, p. 20).

Defendants similarly claim that plaintiffs improperly rely on independent reports relating to the SNAP (Food Stamps) program. Def. Opp. 35. However, these reports found systemic problems in processing applications and renewals for SNAP benefits due to backlogs in scanning paperwork using the District's Document Imaging Management System (DIMS) (*see* Pl. Ex. 5, ESA 2949; Pl. Ex. 6, ESA 2599; Pl. Ex. 7, ESA 2648-49; Pl. Ex. 9, ESA 2989)—the same system that defendants acknowledge is used for scanning and uploading Medicaid documents (Schlosberg Decl., para. 59). Defendants do not dispute that the same case workers assist both Medicaid and Food Stamp recipients. *Ibid*.

Thus, the evidence of long lines at the ESA service centers, and the independent findings that there are substantial problems with ESA workers processing documents using the DIMS system, supports the other substantial evidence submitted by plaintiffs that Medicaid applicants and recipients are suffering harm due to defendants' failures to process Medicaid applications and renewals.

2. <u>The Relief Requested Will Remedy the Current and Imminent Harm Suffered by Medicaid Applicants and Recipients</u>

(a) Applicants and Beneficiaries Are Currently Suffering Irreparable Harm

Defendants completely ignore the very real harm currently being suffered every day by at least 2,655 applicants whose applications are pending more than 45 days and by Medicaid recipients who remain without coverage following improper termination of their benefits on renewal. Def. Opp. 36; s*ee* Schlosberg Decl., paras. 72, 73; Pl. Ex. 24, paras. 10, 11, 16, 17, 19; Pl. Ex. 25, para. 6; Pl. Ex. 49. Since the examples provided by plaintiffs were merely representative examples of systemic issues, there are many more individuals who remain without coverage.[20] *See, e.g*., Pl. Ex.

[20] Defendants dismiss many of the examples cited by plaintiffs because they have been resolved. Def. Opp. 36. However, since many of the underlying problems will not be resolved for some time (*see* pp. 13-17), the same problems are capable of repetition. Moreover, it is well established that "[p]ast wrongs" suffered by members of the class "may serve as evidence bearing on whether there is a real and immediate threat of repeated injury." *City of Los Angeles v. Lyons*, 461 U.S. 95, 102 (1983) (alteration and internal quotations omitted); *see also N.B. ex rel. Peacock v. District. of*

24, para. 6 ("below are examples of typical issues"); Pl. Ex. 25, para. 3 ("the following provides some examples of the issues we've identified").[21] Courts have routinely found that a deprivation of medical benefits constitutes irreparable harm. *Massachusetts Ass'n of Older Americans v. Sharp*, 700 F.2d 749, 753 (1st Cir. 1983) ("Termination of benefits that causes individuals to forgo such necessary medical care is clearly irreparable injury")(internal citation omitted); *Crawley v. Ahmed*, 2009 WL 1384147 at *28 (E.D. Mich. May 14, 2009)("it is undeniable that unpaid bills, loss of needed medical assistance, and ultimately poor health suffered by Plaintiffs, cannot be adequately addressed by the promise of future Medicaid coverage"); *M.K.B. v. Eggleston*, 445 F. Supp. 2d 400, 437 (S.D.N.Y. 2006)("Given the often perilous economic circumstances of the plaintiffs [being denied Medicaid benefits], and those similarly situated, the denial of public benefits to such individuals unquestionably constitutes irreparable harm"); *Markva v. Haveman*, 168 F. Supp. 2d 695, 718 (E.D. Mich. 2001), affirmed, 317 F.3d 547 (6th Cir. 2003)("delay or denial of Medicaid benefits can amount to irreparable harm").

Contrary to defendants' suggestion that the harm is cured when (and if) a recipient obtains retroactive benefits during the 90-day grace period following the termination of his benefits (*see* Def. Opp. 8), recipients are not made whole if they obtain retroactive coverage (*see* p. 11 above). To qualify for Medicaid, one has limited income. Plaintiffs have demonstrated that a significant number of Medicaid applicants and recipients have foregone and are foregoing medical care or incurring out-of-pocket expenses and liability for unpaid bills during the period when they lack current Medicaid coverage. Pl. Exs. 8, 18, 19, 24-32, 48, 49.

Columbia, 682 F.3d 77, 84 (D.C. Cir. 2012) (past Medicaid coverage denials without notice showed a likelihood of such coverage denials occurring in the future).

[21] The Declaration of Chelsea Sharon, if accepted by the Court, sets forth three recent examples of harm to Medicaid applicants and recipients from improper processing of Medicaid renewals and an application. *See* ECF No. 2082-3.

(b) The Steps Being Taken by Defendants Are Not Sufficient to Prevent Imminent Harm to Medicaid Applicants and Beneficiaries

Defendants claim that court intervention is not necessary because: (1) they are "already taking every conceivable step to prevent or mitigate any harm to beneficiaries" (Def. Opp. 35); and (2) they are proactively self-identifying ongoing problems in collaboration with advocates (*id*., p. 12). Both claims are unpersuasive.

First, defendants have essentially conceded that they are violating the law and cannot remedy these violations on their own. They say they are doing everything they can, but thousands of Medicaid applications have been pending for months and a significant percentage of Medicaid recipients are improperly losing coverage each month at renewal. Plaintiffs submit that the appropriate response to defendants' assertion that they can do no more is for the Court to intervene to protect Medicaid applicants and recipients.

Second, contrary to defendants' claim (p. 12) that they "continually self-identif[y] problems" in close consultation with advocates, the evidence is to the contrary. The opposition's treatment of Plaintiff Exhibit 18 is illustrative. In this exhibit, three different legal services providers compiled 38 cases in April 2015 presenting "systemic recertification and application problems," organized this list into several recurring patterns of violations, and asked the agency to analyze these cases to "figure out what went wrong." Pl. Ex. 18 at 1. However, the opposition (p. 29) explains that the agency simply identified that most of these cases had already been resolved by advocates and apparently did not investigate them further. For "[t]he one or two cases that were not resolved," the District concluded, without explanation, that these resulted from "routine processing errors" rather than systemic errors. *Id.* This response shows no effort by the agency to self-identify the root cause of recurring patterns of violations.

Moreover, although defendants claim (p. 21) that the District's Medical Care Advisory Committee (MCAC) meetings provide a forum for advocates to "obtain information regarding the

District's implementation of the ACA or raise concerns about compliance,"[22] defendants began taking steps this month to reconstitute the membership of the MCAC and to discuss certain matters in closed Executive Sessions. Pl. Ex. 51. In addition, the Director of DHCF, Wayne Turnage, dismissed Wesley Rivers of the District of Columbia Fiscal Policy Institute (DCFPI), who submitted a declaration in support of plaintiffs' motion (Pl. Ex. 33), from his role as chair of the MCAC. Pl. Ex. 51. The January 27, 2016, MCAC meeting did not address Medicaid application or renewal processing at all. *See* Pl. Ex. 52. These measures severely limit the claimed utility of MCAC as a means for information sharing and proactive engagement between advocates and the District.

C. The Balance of Equities Favors Plaintiffs

1. <u>Defendants' Claim of Substantial and Irreparable Harm to Themselves Is Grossly Exaggerated</u>

Defendants argue that the "injunctive relief sought by plaintiffs would cause *the District* substantial harm that is likely irreparable" (emphasis in original). Def. Opp. 38. Defendants mischaracterize the scope of the relief sought by plaintiffs as one that would permit "everyone who asks for it Medicaid coverage and continue that coverage into perpetuity." *Id.*, pp. 37-38. This is not the case. Under the relief sought by plaintiffs, only those individuals whose Medicaid applications are pending more than 45 days would be granted temporary coverage. ECF No. 2079-1, Proposed Order. Defendants already know how many applications are pending more than 45 days: 2,655. Schlosberg Decl., paras. 72, 73. Any further backlog in pending applications is entirely within the District's control.

The second part of plaintiffs' relief, continuing the eligibility of Medicaid recipients due to be renewed, will similarly affect only a subgroup of the Medicaid population—those that are due to

[22] Defendants also argue (p. 22) that plaintiffs can obtain information through the District's FOIA law, but they have asserted privilege to shield critical documents from plaintiffs' review. *See, e.g.*, Pl. Ex. 22, p. FOIA 047.

be renewed now. Based on defendants' data concerning the D1 group now subject to passive renewal, from September to December 2015, there is an average of 2,024 recipients who are up for renewal every month. Pl. Ex. 1, p. 5. In addition, "the non-MAGI population represents approximately 30% of enrollees." Schlosberg Decl., para. 57. This is far fewer than the 250,000 recipients that make up the total Medicaid population.

The relief that plaintiffs seek is exactly the same as the District acknowledges it already provided to the entire M1 population of about 135,000 Medicaid recipients when it deferred renewals and extended their eligibility for two years. Schlosberg Decl., paras. 34-37. The District did this without verifying that these recipients were eligible for Medicaid. *Id.*, para. 86. The only difference now is that defendants would be providing this relief under the direction of the Court, rather than CMS.

Finally, plaintiffs have not sought an injunction that would last in perpetuity. The injunction will end on defendants' showing that it its processes for processing Medicaid applications and renewals comply with applicable federal and local laws and the Constitution. ECF No. 2070-1 (proposed order).

2. <u>A Preliminary Injunction to Continue the Eligibility of Recipients due to Renew Will Not Contravene the Authority of CMS</u>

Defendants argue that because CMS "has approved the District's plans to remedy remaining [renewal] issues," any further extensions of eligibility "would contravene the instructions the District has been given by CMS." Def. Opp. 39. However, there is no evidence that CMS was aware of the ongoing and persistent problems with Medicaid recipients losing their coverage (*see* Pl. Br. 17-30 and exhibits cited therein) when it approved only a limited continuation of Medicaid eligibility and reportedly denied the District's request to waive the renewal process for more

recipients. *See* Schlosberg Decl., para. 48.[23] Thus, defendants have shown no reason why the relief sought by plaintiffs would contravene the authority of CMS.

3. A Preliminary Injunction Will Not Lead to Waste, Fraud or Abuse, and even if it Did, the Balance of Equities Favors Plaintiffs

Defendants claim that the temporary authorization of all applications pending beyond 45 days will "lead to governmental waste and enable fraud." Def. Opp. 38. Yet, defendants cite no evidence to suggest that the percentage of backlogged applications ultimately determined to be ineligible is likely to be high. And, even for those ultimately determined ineligible, the cost to the District would be reduced by regulations permitting the federal government to pay a portion of the benefits provided to those granted provisional eligibility when a court orders it (42 C.F.R. 431.250(b)(2)) and for certain categories of applicants (42 C.F.R. 435.1102, 42 C.F.R. 1103(a)). *See Dozier v. Haveman*, 2014 WL 5480815, at *13 (E.D. Mich. Oct. 29, 2014) (the equities favored granting a preliminary injunction in a Medicaid action against state officials because, *inter alia*, "it appears that at least some of these expenses can be reimbursed by the federal government [under] 42 C.F.R. § 431.250"). In any event, if the District is able to move swiftly to eliminate the backlog, as it claims it will, there will be no need to expend large amounts on provisional eligibility.

Defendants further claim (Def. Opp. 39) that continuing the eligibility of those due to be renewed will lead to "waste on a massive scale," but the facts contradict this statement. By defendants' own estimate, about 63% of current renewal cases are being passively renewed (Schlosberg Decl., para. 54), leaving only 37% who would benefit from deferred renewal. Defendants cite no evidence to suggest that a high percentage of these individuals are likely to be found ineligible. Indeed, defendants cite no massive waste or fraud resulting from its past decisions to defer renewals, which granted continued eligibility to 135,000 Medicaid recipients over a period of two years.

[23] The request by defendants and denial by CMS were apparently both done orally, since plaintiffs' FOIA request encompassed such documents (Pl. Ex. 20, p. 2, No. 3(c)) and none were produced.

Moreover, even if there is some fraud, waste, or abuse, the Supreme Court has determined that when the potential loss of medical care is involved, the balance of equities favors plaintiffs. *See Goldberg v. Kelly*, 397 U.S. 254, 266 (1970)("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). Defendants' claims of economic harm to taxpayers (Def. Opp. 38-39) are especially unwarranted when the District is failing to comply with the federal requirements of the Medicaid program with which it voluntarily chose to participate.

D. A Preliminary Injunction Is in the Public Interest

With respect to the public interest factor, plaintiffs showed (Pl. Br. 44) that the injunctive order they seek would be in the public interest because it would protect the rights of Medicaid applicants and recipients until defendants achieve full compliance with the laws governing the processing of applications and renewals.

CONCLUSION

For the reasons set forth in plaintiffs' opening memorandum and above, this Court should grant plaintiffs' motion and issue effective preliminary injunctive relief to protect applicants for Medicaid and Medicaid recipients at the time of renewal.

Respectfully submitted,

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Counsel for Plaintiffs

LIST OF EXHIBITS SUBMITTED WITH THE REPLY BRIEF

Number	Description
50	Cancellation Notice of ESA Business Process Enhancement Stakeholder Group, January 13, 2016
51	Electronic mail to Kathleen Millian from Wayne Turnage re MCAC Changes, January 27, 2016
52	MCAC Agenda Provided by DHCF, January 27, 2016
53	2016 Kaiser Commission Report, Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies as of January 2016: Findings from a 50-State Survey
54	Not attached, Proposed Declaration of Chelsea Sharon of the DC Legal Aid Society, subject to the Motion for Leave filed as ECF No. 2082
55	DHCF Response to DC Legal Aid Society FOIA Request, DCAS Powerpoint, May 26, 2015
56	DHCF Response to DC Legal Aid Society FOIA Request, DC Access System, CMS Year 2 Consult, January 23, 2015