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

ALICIA FRANKLIN and REINA GUZMAN, on behalf of herself and minor child E.L., on behalf of themselves and all others similarly situated, Plaintiffs, v. KODY KINSLEY, in his official capacity as Secretary of the North Carolina Department of Health and Human Services, Defendant.	)	**MEMORANDUM IN SUPPORT OF MOTION TO ENFORCE SETTLEMENT AGREEMENT**

INTRODUCTION

This class action lawsuit was filed November 21, 2017, challenging terminations and reductions of Medicaid benefits by the N.C. Medicaid agency and its agents, 100 county Departments of Social Services (DSSs). On August 9, 2018, this Court granted Plaintiffs' motions for a preliminary injunction and class certification. On October 14, 2022, the parties filed a joint motion for approval of a Settlement Agreement (hereinafter "Agreement"). [DE 120]. On January 13, 2023, following a fairness hearing, the Court issued an order approving the Agreement [DE 132].

JURISDICTION

Under Section V.C of the Agreement, the Court retains jurisdiction "to enter such orders as may be necessary to enforce this Agreement." [DE 122, p. 4.] Section V.C also provides that

"class counsel may at any time give notice to Defendant of evidence suggesting substantial noncompliance with the Settlement Agreement." *Id.* If Defendant fails "to correct the noncompliance… Plaintiffs may apply to the Court for further relief." *Id.* In its final order of approval of the Agreement, this Court specified: "The Court will retain jurisdiction for the period described in the Settlement Agreement for the purpose of enforcing the terms of the Settlement Agreement, which is incorporated by reference into this Order." [DE 132 p. 4.] "District courts have inherent authority, deriving from their equity power, to enforce settlement agreements." *Hensley v. Alcon Labs., Inc.*, 277 F.3d 535, 540 (4th Cir. 2002); *Kokkonen v. Guardian Life Ins. Co.*, 511 U.S. 375 (1994) (finding that if the explicit terms of the settlement agreement are incorporated into the order or if the order provides for continued jurisdiction over the settlement, then the federal district court has the authority to enforce the agreement.)

ARGUMENT

I. DEFENDANT AND ITS COUNTY AGENTS HAVE BEEN IN SUBSTANTIAL NONCOMPLIANCE WITH THE AGREEMENT SINCE APRIL 2023.

Once an individual has been determined eligible for Medicaid, the state Medicaid agency cannot terminate or reduce their Medicaid benefits without taking the following steps. First, the state Medicaid agency must determine *ex parte* whether the beneficiary can be renewed for Medicaid under any eligibility category and, if so, continue Medicaid coverage uninterrupted. 42 C.F.R § 435.916(a)(2), (b); Agreement § III.E. Second, if the agency cannot renew Medicaid based on *ex parte* information, the agency must request information needed to verify whether the individual is eligible under any Medicaid category. 42 C.F.R § 435.916(a)(3), (b); Agreement § III.E. Third, if the beneficiary is ineligible or if coverage is reduced to less than full Medicaid, the state Medicaid agency must provide the beneficiary with a proper written notice and opportunity for a fair, pre-termination hearing. 42. C.F.R. §§ 431.211-431.236; Agreement, §

III.D. These steps ensure continuity of coverage and fairness in the administration of the Medicaid program, and they are the subject of the Agreement.

A court-approved settlement must be construed as it is written, because this preserves the positions for which the parties bargained. *United States v. Armour & Co.*, 402 U.S. 673, 681-82 (l97l). A defendant who has obtained the benefits of a settlement cannot then be permitted to ignore the affirmative obligations imposed by the agreement. *Berger v. Heckler*, 77l F.2d l556, l568 (2nd Cir. l985). *See also*, *U.S. v. ITT Continental Baking*, 420 U.S. 223 (1974).

Although Defendant delegates many duties for Medicaid eligibility redeterminations to county DSSs, both the Agreement and the law in this Circuit make clear that Defendant remains fully responsible for the actions of these agents. Section III.N of the Agreement specifies that "Defendant remains ultimately responsible as the single state Medicaid agency for assuring statewide substantial compliance with this Agreement." [DE 122 p. 7.] The Fourth Circuit has repeatedly told Defendant that, under 42 U.S.C. § 1396a(a)(5), the state Medicaid Secretary is responsible for assuring that the actions of his agents comply with federal law. *DTM v. Cansler*, 382 Fed. App'x 334, 338 (4th Cir. 2010); *K.C. v. Wos*, 716 F.3d 107 (4th Cir. 2013).

Before detailing the basis for this motion, Plaintiffs wish to explain their delay in filing and why much of Plaintiffs' evidence comes from the months of June through September 2023. As discussed in Plaintiffs' January 9, 2024 Motion to Compel Production of Documents [DE 136], Section III.Q of the Settlement Agreement created class counsel's primary means of monitoring Defendant's compliance with the Agreement by requiring Defendant to provide three key documents, the reenrollment form (NCFAST 20020), request for information (DHB 5097), and the notice of termination or reduction (DSS 8110), for each of 582 cases selected in a random quarterly sample. Agreement § III.Q. After review of these documents, class counsel

may request to review the complete DSS and NC FAST eligibility files for 374 cases in the sample. *Id.* However, as detailed in the prior motion and supporting evidence, Defendant has delayed producing the required information, 1/9/24 Mot. ¶¶ 7, 10, 11, 25, 16, 20, 21, 24, 28, and when produced, information has proven to be substantially incomplete. *Id*. at ¶¶ 9-11, 15-17, 22, 25, 27. After that motion was filed, Defendant on January 23, 2024 finally provided a significant majority of the documents from the June 2023 sample, including the DSS and NCFAST files requested, and, on January 29, additional documents for the July-Sept sample. Sea 2nd Decl. Ex. 74, 75. However, class counsel's January 16, 2023 request for the entire DSS and NCFAST files from the July-September 2023 sample has not been met. Sea Decl. Ex. 76, ¶ 79. In addition, Defendant has provided no documents required for the October through December 2023 sample. *Id*. Nonetheless, as shown below, Plaintiffs now have more than sufficient evidence to demonstrate substantial noncompliance requiring relief from the Court. [1]

Regarding this Motion and as described more fully below, from the implementation of the Agreement through the present, a steady stream of noncompliance has been uncovered by class counsel's monitoring and other sources, exposing wrongful terminations and reductions of Medicaid coverage for tens of thousands of class members. In April and May 2023, the first two months of eligibility redeterminations after the Settlement Agreement took effect, class counsel identified so many improper terminations and reductions that Defendant agreed to reopen almost

[1] Beginning in February 2023 and continuing through February 2024, class counsel repeatedly notified Defendant of substantial noncompliance on numerous issues and requested corrective action, including reinstatement of Medicaid to those whose coverage was improperly terminated or reduced in noncompliance with the Settlement Agreement. Sea 2nd Decl. Exs. 1, 2, 3, 4, 6, 7, 8, 13, 17, 18, 27, 39, 41 46, 48, 47, 55, 56, 58; Sea Jan. 9, 2024 Decl. Ex. 22. However, Defendant has not cured the substantial noncompliance even prospectively in most areas and, with the exception of the April and May cases and two other narrow groups, has refused to reinstate coverage for class members whose Medicaid was improperly terminated or reduced. Sea 2nd Decl. ¶ 62, Exs. 9, 30, 31, 32, 40; Sea Jan. 9, 2024 Decl. Ex. 22.

all of them. Sea Jan. 9 Decl. Exs 1,2. [DE 138]; 2nd Sea Decl. Exs. 1, 2. As a result of this widespread noncompliance, Defendant conducted remedial training for all 100 county Departments of Social Services (DSSs). However, the training did not take place until June 27, 28, and 29, 2023, *after* all but a tiny fraction of the June notices of termination and reduction had already been sent. Sea 1/9/24 Decl. Ex. 2 [DE ??]; Summary of Evid. #9.

Terminations of eligibility continue at an alarming rate. Many of these terminations are for procedural reasons (called "procedural terminations"), meaning that Medicaid is terminated, not because Defendant has determined the person no longer qualifies for Medicaid, but due to something that occurred while the agency was processing the case, for example terminating coverage because the beneficiary did not provide information requested by DSS (which could be because the DSS request was sent to the wrong address, or the information sent by the beneficiary was lost after being dropped off at a local office or failed to upload online). Effective June 30, 2023, 49,159 class members were terminated. Summary of Evid. #9. Seventy-eight percent of the June terminations were procedural terminations. *Id.* These numbers did not improve in the months of July through September, when tens of thousands of class members continued to have their Medicaid terminated, mostly for procedural reasons. *Id.*

As detailed below, 11 of the 12 areas of substantial noncompliance with the Agreement raised herein directly relate to these procedural terminations, because Defendant (1) should never have requested the information at all; (2) failed to consider other Medicaid categories for which the requested information was not needed; (3) terminated for failure to provide information that was never requested; (4) requested information that was not needed to redetermine eligibility; (5) did not provide enough time to return the information; (6-7) so limited phone access and online access to DSS that beneficiaries were unable to provide the information or request assistance or

update their address; (8) communicated in English with beneficiaries with limited English proficiency; (9) failed to copy the authorized representative on communications with disabled beneficiaries; and (10-11) terminated or reduced benefits without providing sufficient advance notice or without permitting the required sixty days to appeal the decision.

A. Failure to Renew Medicaid *Ex Parte* When Information Available to the Agency Shows Continuing Medicaid Eligibility

42 C.F.R. § 435.916(a)(2) and (b) (incorporated by Agreement, § III.E) require Defendant to begin the redetermination process by attempting to renew eligibility *ex parte*, based on information in agency files and online matches, before asking the beneficiary for additional information. The instructions to DSSs (incorporated by Section III.I) confirm this. *See, e.g.,* Agreement Ex. D p.101-02.

Violations of this requirement are rampant. In the June and July-September samples, in 336 out of 736 (45%) relevant terminations and reductions, the renewal form sent to the beneficiary included information the agency had obtained *ex parte* which indicated that one or more of the family members whose benefits were reduced or terminated should have been renewed *ex parte* for the benefits being received. Summary of Evid. #2.[2] In 254 of those 336 cases, the beneficiaries were terminated for procedural reasons. In most of these cases, between one and six children were improperly stripped of their Medicaid although the agency's renewal

[2] For most Medicaid renewals (parents, pregnant women, children), the information obtained by the agency during the renewal process from electronic matches is required to be prepopulated on the enrollment form mailed to the beneficiary. 42 C.F.R. § 435.916(a)(3) (incorporated into Agreement § III.E) requires that a "prepopulated renewal form" be sent to the beneficiary if eligibility cannot be renewed *ex parte*. The federal Medicaid agency has defined "prepopulated" as "the most recent and reliable information about the beneficiary which is known by the agency and relevant to the redetermination." Sea 2nd Decl. Ex. 57 p.4 (CMS Bulletin Dec. 4, 2020). Defendant's renewal form confirms this is a requirement: "Your information currently on file is displayed below." Sea 2nd Decl. Ex. 45. See also, Sea 2nd Decl. Ex. 5, slide 58.

form showed that the children were still eligible. *Id.* In several cases in the samples, pregnant women whom the form showed were still eligible, had their coverage terminated or reduced. *Id.* In several other cases, the enrollment form indicates ineligibility only because the form includes income that is not properly countable when determining eligiblity (*e.g.*, income of grandparent or Social Security benefits received by a child). *Id.* Finally, not counted in the above numbers are cases where DSSs did not check other agency records (*e.g.*, Food Stamp files) that may have provided recent information establishing continuing eligibility so that benefits could be renewed *ex parte*. While no count is available, review of the June DSS files showed evidence of checking other agency records to be rare. Summary of Evidence #8. This is despite instructions to DSSs (incorporated by Agreement, § III.I) specifying this must occur. *See e.g.*, Agreement Ex. D p. 71.

B. Failure to consider eligibility under all Medicaid categories

The Settlement Agreement prohibits termination of Medicaid "unless and until DSS has considered the beneficiary's eligibility for Medicaid benefits u*nder all eligibility categories*…." Agreement § III.A [Emphasis Added]. This requirement is based on 42 C.F.R. § 435.916(a)(f)(1) (incorporated by Section III.E) stating that "prior to a determination of ineligibility, the agency must consider all bases of eligibility." This is confirmed in DSS instructions to DSSs incorporated into Section III.I. *See*, *e.g.*, Agreement Ex. D p. 71. That DSS considered all categories is required to be documented. Sea 2nd Decl. Ex. 25, slide 34; Sea Jan. 9, 2024 Decl. Ex. 22 ¶ k. Nonetheless, at least 244 out of 361 DSS files in the June sample contained no such documentation. Summary of Evid. #8. This violation came in a variety of circumstances.

First, 60,645 North Carolinians receiving N.C. Medicaid under a category for coverage of COVID-19 testing saw their Medicaid terminated by Defendant without any attempt to determine whether they remained eligible under a different Medicaid category. 2nd Sea Decl. Ex.

11 (DHB Admin ltr 6-23, p. 8). These beneficiaries were told that if they wanted Medicaid eligibility to be considered under other categories, they would need to reapply. Sea 2nd Decl. Ex. 12. This termination notice was not on the required form under the Agreement §III.D, Exhibit A.

Defendant justified this action on the basis that federal funding for the COVID-19 testing Medicaid category would end in May 2023. Sea 2nd Decl. Ex. 13. However, this fact in no way precluded the possibility that these Medicaid beneficiaries remained eligible under a different Medicaid category. For example, a beneficiary in the COVID category could have become pregnant, now have a child in their care, or have turned age 65. *See generally,* https://medicaid.ncdhhs.gov/eligibility. Defendant also claimed that someone at the federal Medicaid agency verbally told the state agency their plan was permissible. Sea 2nd Decl. Ex. 13. However, Defendant never responded to class counsel's request to produce a written communication to this effect. *Id*.[3] Regardless, a federal agency cannot give Defendant permission to violate a Settlement Agreement to which it is not a party.[4]

Second, evidence shows DSSs often terminate full Medicaid or reduce full Medicaid to coverage to only family planning services due to an increase in income without first requesting information to determine whether the beneficiary could meet a deductible to retain coverage for full Medicaid. Redetermination instructions incorporated into Section III.I of the Settlement Agreement specify that this must be done. *See*, *e.g.* Agreement Ex. D pp. 87-88. Nonetheless,

[3] CMS did produce a powerpoint on the subject but it supports Plaintiffs' position in two different places. Sea 2nd Decl. Ex. 13, Ex. 14 (CMS PowerPoint "Ending coverage in Optional Covid groups") slides 7, 10. While Slide 13 purports to provide an exception, it applies only where COVID-19 coverage was approved "outside of a state's eligibility system." *Id.* at slide 13. The fact that these beneficiaries were all automatically terminated by Defendant's eligibility system (NC FAST) proves this was not the case here. Sea Decl. Ex. 11 p. 8 ¶ G.1, 2.

[4] In March 2023, the parties reached an agreement to resolve this dispute. Sea 2nd Decl. Ex. 13. However, at a meeting in December 2023, Defendant informed class counsel that "there was no meeting of the minds," and that it would not abide by the Agreement. Sea 2nd Decl. Ex. 40 ¶ 12.

11,507 class members were terminated from full Medicaid due to increased income during the months of June through September, and 15,645 class members were reduced to Family Planning coverage only due to increased income in June through September. Summary of Evid. #9. Review of the cases in the June and July-September samples showed that of 150 beneficiaries terminated from full Medicaid for increased income, 88 did not first receive a request for medical bills to meet a deductible. Summary of Evid. #5. Of 277 beneficiaries reduced to family planning coverage due to increased income, 213 (77%) were not first sent a request for information asking if they could meet a deductible. Summary of Evid. #5. Many of those found to have been illegally terminated or reduced were either minor children or their parent. *Id.*

Third, DSSs are also often doing the converse: terminating for failure to provide information showing the beneficiary can meet a deductible or other information without considering whether the beneficiary is eligible for Medicaid coverage for family planning, which has a much higher income limit. Sea 2nd Decl. Ex. 54. For example, in case No. 949624424Q, both parents and their adult children were eligible for family planning coverage but were terminated for failure to provide bills to meet a deductible. Instructions to counties incorporated into Section III.I of the Agreement specify that DSS must consider family planning coverage where a Medicaid deductible has not been met or other information such as about assets is requested, even if the beneficiary does not respond to the request for information. Agreement, Ex. D pp. 15, 33-35, 88, 103, 104, 115. [DE 122-4].[5] Recent guidance from the federal Medicaid agency confirms this requirement. Sea 2nd Decl. Ex. 45. Yet in the June and July-September

[5] On November 17, 2023 DHHS removed much of the language in the manual sections cited here. Sea 2nd Decl. Exs. 50, 46. However, because this was done without court approval or Plaintiffs' consent, this was a violation of Section III.I of the Settlement Agreement. Sea 11/16/23 email. Class counsel immediately objected and requested that the language be reinstated but to date this has not occurred. Sea 2nd Decl. ¶ 52.

samples 270 out of 617 cases (44%), the beneficiary was terminated after receiving a request for information even though the beneficiary was under the income limit for Family Planning coverage. Summary of Evid. #5. This is particularly significant because, on December 1, 2023, almost 273,000 beneficiaries receiving Family Planning coverage were moved to Full Medicaid under the new Expansion category. https://www.northcarolinahealthnews.org/2023/12/28. Those terminated instead of being put into Medicaid coverage for Family Planning were excluded from this transition.

Fourth, Defendant for months failed to inform beneficiaries that they should report other changes that could make them eligible in a different Medicaid category. Such a change causing the beneficiary to remain Medicaid eligible could include a new pregnancy, a new grandchild in the home, or a new part-time job for a person with a disability. *See generally,* https://medicaid.ncdhhs.gov/eligibility. Last year, the parties reached agreement on a change to Defendant's Request for Information form to notify beneficiaries in bold print "In addition to the information requested above, **it is very important that you inform us of any changes in your situation since your last review.**" DHHS agreed to make this change in January 2023 but the parties agreed to a delay until April. Sea 2nd Decl. Exs. 28, 29. In fact, the change was not made for forms generated in NCFAST until June 23, 2023 and was not made for forms generated from the DHHS website until September 12, 2023. Sea Jan. 9, 2024 Decl. Ex. 22 ¶3. The June sample contained 71 out of 364 (20%) Request for Information forms without this information. Summary of Evid. #4.

Finally, Defendant frequently fails to consider all categories of eligibility before terminating or reducing coverage because its' computer is not programmed to do so. NC FAST, not the DSS worker, determines eligibility, based on information entered by the worker into the

system. Sea 2nd Decl. Ex. 24 pp. 5, 7. Nonetheless NCFAST is *not programmed to consider all categories* in making its eligibility determination. Sea 2nd Decl. Exs. 24, 27, Sea Jan. 11, 2024 Decl. Ex. 38 ¶ 19. Rather, for a beneficiary receiving Medicaid in a category primarily for the aged, blind and disabled, only those categories are considered by NC FAST. *Id.* Similarly, for a beneficiary receiving Medicaid in a category primarily for families and children, only those categories are considered by NCFAST. *Id.* For example, B.D. was terminated from coverage for family planning (a families and children program) because in addition to her Social Security disability benefits, she had started working part-time. NC FAST correctly determined her to be over the income limit for family planning coverage but missed that she was eligible for full Medicaid under the Health Care for Working Disabled category. Summary of Evid. #? (Case No. 949304269N). In another case, NC FAST did not account for a beneficiary receiving family planning coverage turning age 65 (Case No. 947101942R). Defendant has told class counsel that it relies on DSS workers to manually consider categories not considered by NCFAST. Sea 2nd Decl. Exs. 24, 27. However, DSS appears to have asked this beneficiary nothing about her Medicare or assets to determine if she was eligible for the Medicaid category that pays Medicare premiums. (Case No 947101942R). Despite repeated requests, Defendant has provided to class counsel no copy of any instruction to DSSs telling them which categories NCFAST does not consider and that it is the worker's responsibility to manually determine eligibility for those categories instead of relying on the NCFAST determination of ineligibility. Sea 2nd Decl. Exs. 24, 27, 33; Sea 2nd Decl. Ex. 40 ¶ 19.

C. Termination or Reduction of Medicaid Without Requesting Information from the Beneficiary

42 C.F.R. §§ 435.916(a)(3) and (b) (incorporated by Agreement, § III.E) prohibit termination or reduction of Medicaid without first requesting information in writing from the

beneficiary to determine eligibility. In addition, the instructions to DSSs (incorporated by Agreement § III.I) specify that Medicaid may never be terminated or reduced without first requesting information in writing from the beneficiary. *See, e.g.* Agreement, Ex, D p. 61. The reason for requiring such contact is to give the beneficiary the opportunity to challenge the current accuracy of evidence being relied upon in determining ineligibility and to allow the beneficiary to report changes that could support continuing eligibility (*e.g*. pregnancy, loss of job, new child in home). Sea 2nd Decl. Ex. 15 p.4, Ex. 16 (containing language in bold asking beneficiary to report any changes), 42 (asking beneficiary to verify accuracy of information obtained by agency *ex parte*).

Despite these requirements, DSSs frequently terminate or reduce benefits without first requesting information from the beneficiary. In the June and July-September samples provided by Defendant, over 20% (213 out of 1027) of the relevant cases had terminations or reductions without first sending the necessary written request for information to the beneficiary. Summary of Evid. #1. Examples include failure to send the required prepopulated form before terminating or reducing benefits *ex parte* due to an income increase; termination for failure to cooperate with child support or apply for other benefits without first sending a request with a deadline to do so; termination for failure to provide information before the deadline to do so has run; reducing coverage to parents *ex parte* because their youngest child is an adult without sending the prepopulated form to verify the mother is not pregnant and/or does not now have a grandchild in her care. *Id*. During a meeting with class counsel, DHHS initially defended *ex parte* terminations before reversing its position two weeks later. Sea 2nd Decl. Ex 17, 18.[6]

[6] Some counties who are failing to send the prepopulated renewal form (NCFAST-20020) to beneficiaries are instead trying to complete a very incomplete version of the form by telephone, apparently with Defenant's approval. Sea 2nd Decl. Ex. 64. This practice is plainly insufficient
Footnotes continued on the next page.

D. Requiring the Beneficiary to Provide Information that is Not Needed to Renew Medicaid Eligibility, Not Needed in that Particular Form, or Is Requested in an Overbroad or Confusing Manner.

42 C.F.R. § 435.916(e) (incorporated by Agreement, § III.E) states "the agency may request from beneficiaries only information needed to renew eligibility." Class counsel have discovered numerous instances where DSSs required the beneficiary to provide documents that were not needed to renew eligibility, were not needed in that particular form, or where the request was overbroad and/or confusing.

First, DSSs frequently request verification of information not needed to redetermine eligibility. Summary of Evid #4. This violates Section III.E of the Agreement. *See also* Agreement, Ex. D, p. 94 ¶¶ F, I; Sea 2nd Decl. Ex. 11, slide 45. In the June and July-Sept samples, 143 out of 714 (20%) requests for information (DHB-5097) required the return of information not needed to renew Medicaid. Summary of Evidence #4. One common improper request is for proof of income for everyone in the household regardless of whether everyone living in the home is receiving or applying for Medicaid or financially responsible for someone who is. *Id*.; Sea 2nd Decl. Ex. 60 pp. 10, 17, 23, 33, 45. Other examples include requests for proof of income from 12 past months even if the job that has ended, proof of how bills are being paid, proof of state residency, proof the beneficiary is not working, copies of utility bills, leases and driver's licenses, race and ethnic origin, a voter registration form, and a privacy practices form. Sea 2nd Dec. Ex. 60 pp. 20, 10, 30, 47, 17, 36. Sea Ex 60 p. 42, 45; Summary of Evidence #4.

Second, DSS often insists that the information be provided in a particular form. Perhaps the most egregious evidence of this violation is that DSS almost never informs beneficiaries that

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under 42 C.F.R. § 435.916(a), which requires that the full written pre-populated form be provided to the beneficiary but that the beneficiary may then choose to complete it by phone. This makes sense given the length and complexity of the information on the form and the time beneficiaries are likely to need to review it and properly complete it. Sea 2nd Decl. Ex. 42.

the prepopulated renewal form (NCFAST 20020) may be completed by telephone. Instructions incorporated into Section III.I of the Settlement Agreement specify that DSS must permit the renewal form (NCFAST-20020) to be completed with a telephonic signature. Agreement Ex. D p. 74. Defendant's own auditing instructions specify that "telephonic signature *must be offered* and allowed." Sea 2nd Decl Ex. 22 p. 5 (emphasis added). However, the renewal form itself requires that the physical form be signed and returned to DSS. Sea 2nd Decl. Ex. 42, pp. 1, 6. This means DSS must otherwise inform the beneficiary of the right to complete the form by phone. With very few exceptions, DSSs are not doing so. Summary of Evid. #4. Indeed, in a large majority of cases, DSSs are sending a second form (DHB-5097) which specifically requires that the beneficiary complete, sign and return the 20020 form, making no mention of the option to complete it by phone. Summary of Evid. #4; Sea 2nd Decl. Ex. 60 pp. 1, 4, 17, 20, 23,45. In the June and July-September samples, only *8 out of 541* (1.5%) DHB-5097 forms asking for completion of NCFAST-20020 provided the option to do so by phone. The impact of this violation has been devastating: 124,776 beneficiaries who were required to complete and sign the NCFAST-20020 were terminated in the months of June through September for failure to provide information. Summary of Evid. #9. In one case, a mother and two minor children were terminated for failure to physically sign the renewal form *after* the mother called and spoke to the DSS worker to provide the information by phone. Sea 2nd Decl. Ex. 60 p. 39.

DSSs also very often require the return of specific documents, ignoring the other ways to verify income, assets and other eligibility requirements (*e.g.*, provide paystubs OR employer statement OR permission for DSS to contact employer). In the June and July-Sept samples, 276 out of 713 (38%) requests for information (DHB-5097) required the return of specific documents. Summary of Evid. #4. Examples of required documents included all pay stubs, an

employer completed wage form, complete tax returns, pension award letter, completion of asset form, vehicle form, child support form, or one or more of several numbered forms. Summary of Evid. #4; Sea 2nd Decl. Ex. 60, pp. 4, 7, 10, 20, 23, 36.

One important alternative to these specific documents is the applicant's detailed statement. Defendant's March 7, 2023 DSS instructions state "Accept a complete self-attestation for all eligibility criteria, except citizenship and immigration status, when documentation and/or electronic sources are not available." Sea 2nd Decl. Ex. 11, p. 2. *See also*, Sea 2nd Decl. Ex. 5, slide 25. In the June and July-September samples, DSS included the option of giving a detailed statement if other proof is unavailable on *only 7 of 696* (1%) requests for information. Summary of Evid. #4. 395 of the 689 (57%) beneficiaries who were not given this option were terminated for failure to provide information. By insisting on particular documents without giving the option to prove eligibility in another way, Defendant is violating 42 C.F.R. § 435.916(e) (incorporated into Agreement § III.E). This practice also violates Exhibit D (p. 94 ¶ G) to the Agreement.

Third, DSS requests for information are often confusing or overbroad. Some requests fail to inform the beneficiary of what information is needed, including a request telling the beneficiary of the need to meet a deductible but nothing about how to meet it, a request for proof of income without saying whose income, and a request saying you have too many assets but nothing about what the assets are or the right to rebut the agency's information. Sea 2nd Decl. Ex. 60 p. 13, 27; Summary of Evid #4. Other requests are overbroad, asking for wages, self-employment records, *and* to apply for unemployment benefits all on the same form or a request for unpaid medical bills where there was no notice of a deductible. Summary of Evid #4.

E. <u>Failure to permit beneficiaries sufficient time to provide requested information.</u>

42 C.F.R. § 435.916(a)(3)(i) (incorporated by Agreement, § III.E) requires the agency to "provide the individual …with at least 30 days" to respond to the agency's first request for information. The instructions to DSSs (incorporated by § III.I) specify that DSS must "allow 30 calendar days" for the beneficiary to respond to the request. *See e.g.,* Agreement Ex. D p. 74.

Frequent violations of this requirement have been discovered by class counsel in two different forms. *First*, in 182 out of 358 cases (51%) in the June sample where there was an initial request for information, the form (DHB-5097) allowed only 12 days to respond. Summary of Evid. #3. 72 of these 182 cases were terminated for failure to provide information. *Id.* This violation appears to be based on an error in NC FAST programming which was supposed to have been corrected in April but was still occurring in at least some cases as late as October 2023. Sea 2nd Decl. Exs. 19, 20.

Second, in 496 out of 1339 cases (37%) where information was requested or an enrollment form was sent in the June and July-September samples, the deadline to respond to the request fell on a weekend or holiday. Summary of Evid. #3. In several cases in the samples, this violation was combined with the prior one, so that instead of being allowed the required 30 days to provide information, families were terminated for failure to provide information within 10 or 11 days. Summary of Evid. #3. When class counsel discovered this issue in late August, they learned that NC FAST calculates the due date printed on all agency requests for information and that NC FAST was not programmed to extend the deadline to the next working day. Sea 2nd Decl. Exs. 22, 18. DHHS did not fully correct this programming until November 20, 2023. Sea 2nd Decl. Ex. 23.

Allowing the deadline to expire on a weekend or holiday violated the Settlement Agreement because it denied thousands of beneficiaries the full thirty days to respond to a

request for information as required by Section III.E of the Agreement. Redetermination instructions specify the beneficiary can provide the requested information by phone or in person, which is impossible on weekends and holidays because all DSS offices are closed. Agreement Ex D. p. 61. Even if the information was provided by mail, it was not until November 16, 2023 that Defendant instructed counties not to treat information received over the weekend as late. Sea 2nd Decl. Ex. 26. Defendant's own monitoring instructions verify that this is a Franklin violation. Sea 2nd Decl. Ex. 21 p. 4 ("5097/20020 due dates cannot fall on a weekend or holiday and will be the first workday following the weekend/holiday.")

F. Failure to provide reasonable access to DSS by telephone.

Section III.G of the Settlement Agreement sets out detailed requirements to protect the rights of beneficiaries to contact their Medicaid worker by telephone during the redetermination process, including avoiding busy signals, providing the option to leave a message, limiting hold times, and returning messages within a reasonable time. These protections are vital for at least five reasons: (1) to allow beneficiaries to request DSS assistance in obtaining verification or in completing eligibility forms as required by 42 C.F.R. § 435.907(e) (also incorporated into Agreement § III.E); (2) to permit beneficiaries to exercise their right to provide requested information to prove eligibility by phone, including by giving a detailed statement; (3) to permit beneficiaries to complete the renewal form by phone; (4) to report changes of address so that beneficiaries actually receive the mail sent to them by the agency; and (5) to report changes affecting their eligibility such as a new pregnancy or birth, the loss of income, or change in immigration status. *See*, *supra* at §§ I.B, I.C, I.D, I.E.

On March 1, 2023 at the request of class counsel, Defendant issued a letter to DSSs informing them of the phone access requirements and giving them one month to come into

compliance. Sea 2nd Decl. Ex. 34. On March 28, 2023, Defendant issued a second letter providing more specific timeframes. Sea 2nd Decl. Exs. 34, 35, 36. On May 26, 2023, Defendant drafted a third administrative letter to address continuing significant delays by DSSs in complying with the requirements of Section III.G. Sea 2nd Decl. Ex. 37. Defendant agreed to share the letter with class counsel but did not do so until June 19. Sea 2nd Decl. Ex. 38. On June 20, Class counsel provided written comments on the May 26 draft letter. Sea 2nd Decl. Ex. 38. However, Defendant never responded to the June 20 email and never issued the May 26 draft administrative letter. Sea Decl. Ex. 40 ¶ 17.

Meanwhile, class counsel began its own phone access testing which repeatedly confirmed what class members have reported: significant phone access violations statewide, including the six counties with the largest Medicaid populations: Mecklenburg (308,115 beneficiaries): inability to leave message during work hours; Wake (201,268 beneficiaries): inability to leave message after hours and disconnected calls; Guilford (167,063): inability to leave message both during and after hours; Cumberland (128,060): long wait times with no ability to leave message during work hours; Forsyth (109540): inability to leave message after hours; Durham (74936): failure to return messages. See Summary of Evidence #10; Sea 2nd Decl. Ex. 51 (N.C. Medicaid Enrollment Dashboard). Other large counties with violations included Buncombe (56990): inability to leave message after hours; Pitt (55,505): inability to leave message after hours and failure to return messages; Rockingham (28910): failure to return calls; Moore (20,236): failure to return messages and lack of Spanish speaker. *Id.* Halifax County's automated message for the Medicaid Supervisor stated that they were busy but that callers should not leave messages because they would not be returned. *Id.* Thirteen counties failed to offer Spanish interpretation, with a Gates County representative simply hanging up when our caller began speaking in

Spanish. *Id.* One beneficiary tried to reach Mecklenburg DSS seven times on September 21 and was unable to get through or leave a message all seven times. Decl. of Ashley White. In October, a Spanish speaking beneficiary repeatedly was unable to speak to anyone at Wake DSS, could not leave a message, and had his calls disconnected with the message to call back later. Decl. of Victor Benitez. *See also* 1st, 2nd, 3rd, and 4th Decls. of Jamirah Williams-Johnson showing similar violations for Alamance, Guilford, Robeson, and Mecklenburg Counties. In some counties, where the beneficiary could leave a message, the call often was not returned. *See, e.g.* Decl. of Candace Wheeler (Lenoir).

Class counsel repeatedly reported to Defendant the evidence of substantial noncompliance with Section III.G and requested corrective action. Sea 2nd Decl. Exs. 47, 48, 49, 62, 63; Sea Jan. 9 Decl. Ex. 22 ¶ 8 [DE 138]. Defendant's response was sorely inadequate. On November 14, 2023, DHHS finally issued instructions requiring 20 still noncompliant counties to provide the ability to leave a voicemail after work hours and on weekends. Sea 2nd Decl. Ex. 65. This right was included in Section III.G because working parents trying to keep their children's Medicaid coverage often cannot call during work hours. However, the November 14 administrative letter permitted these counties until July 1, 2024, *fifteen months* after the Settlement Agreement took effect, to begin to comply with this requirement. In the meantime, the letter simply requires an outgoing message with an email address for beneficiaries to contact DSS. *Id*. As shown by research conducted by the Pew Research Center, many beneficiaries do not have ready access to email to communicate with DSS. Sea 2nd Decl. Ex. 61. This is why the Agreement specifically requires the ability to leave a voicemail and that the beneficiary's message be promptly responded to by DSS. Agreement § III.G.

G. <u>Failure to provide reasonable online access to DSS.</u>

Section III.J of the Settlement Agreement requires that all Medicaid beneficiaries be informed at least annually by their DSS worker of how to set up an online account "that allows them to receive notices, report changes, upload documents, request assistance, or contact their DSS worker electronically…." However, in only 13 out of 286 relevant DSS files from the June sample was the required documentation present. Summary of Evid. #8. Moreover, until October 14, 2023, even those beneficiaries who did manage to set up an account were not able upload documents unless they had elected to receive notices electronically. Sea 2nd Decl. Ex. 23. Given the great difficulty which beneficiaries have had in contacting DSS by phone, the effective removal of this alternative way of communicating with DSS undoubtedly contributed to the high number of procedural terminations.

H. Failure to communicate with beneficiaries with limited English proficiency in their preferred language.

Section III.E of the Settlement Agreement requires DHHS to take all reasonable steps to assure compliance with 42 C.F.R. § 435.916. Subsection 435.916(g) states, "Any renewal form or notice must be accessible to persons who are limited English proficient and persons with disabilities, consistent with § 435.905(b) of this subpart." Section 435.905(b) requires that information be provided to beneficiaries in a manner that is accessible and timely to individuals who are limited English proficient through written translations of important notices to Spanish speakers and, for other languages, at a minimum providing taglines in non-English languages on all important written communications that indicate in several languages where to call to obtain free language interpretation services.

Defendant is in substantial noncompliance with these requirements in at least six different ways. *First*, as discussed above, beneficiaries are often denied access to a Spanish speaker when they call the county DSS. *Second*, the beneficiary's personal and financial information

prepopulated on the Medicaid renewal form (NCFAST-20020) is almost always in English, even if the rest of the form is in Spanish, because NC FAST is not programmed to translate the specific information about the family which is prepopulated onto the form. Sea 2nd Decl. Ex. 67, Summary of Evid #6. In the June and July-September samples, 42 of 50 Spanish 20020s were partially in English. *Id.* Third, when a request for information form (DHB-5097) is sent to a Spanish speaker, the most important information—which information is needed—is in a free text field that must be composed and translated by the DSS worker. Sea 2nd Decl Ex. 67. This often does not occur in the beneficiaries' primary language. 11 out of 49 Spanish 5097s in the June and July-September samples were partially in English. Summary of Evid. #6. *Fourth*, it is common for some important communications to be entirely in English, even though the individual has notified DSS that Spanish is their preferred language. In 24 out of 59 cases with Spanish speakers in the samples, at least one of the three communications was entirely in English. *Id*. *Fifth*, until corrected on September, 16, 2023, the form required to be sent to beneficiaries by Section III.B of the Agreement (DHB-2187) was sent in English if the child spoke English even though the parent requested that all communications be in Spanish. Sea 2nd Decl. Exs. 66, 23.

Sixth, Defendant has not added taglines in other languages to any communications to beneficiaries regarding the redetermination process. In February 2023, class counsel notified Defendant of his responsibility under Section III.E of the Settlement Agreement to include taglines with all DSS written communications during the redetermination process. Sea 2nd Decl. Ex. 68. Class counsel inquired again in May. Sea 2nd Decl Ex. 69 (also raising problem of English lang on Spanish 20020). One year later nothing has changed. Sea 2nd Decl. Ex. 23.

The consequences of these violations are severe. In case No. 946792350P a child was terminated for failure to provide information although both the NCFAST-20020 and DHB-5097

were in English to a family requesting to communicate in Spanish. Summary of Evid. #6. In case No. 949624424Q, a family of six were terminated for failure to provide information although the most important information was in English on both the DHB-5097 and NCFAST-20020. *Id.* In case No. 955740387K, a child was terminated for failure to provide information although the DHB-5097 was in English and the NCFAST-20020 was partially in English. *Id.*

I. Failure to Copy the Authorized Representative of Persons with Disabilities on All Communications

Section III.E of the Settlement Agreement requires compliance with 42 CFR § 435.916. Subsection 435.916.(g) states "Any renewal form or notice must be accessible to …persons with disabilities." In addition, the redetermination sections of the Medicaid manual contained in Exhibit D and incorporated by reference into Section III.I of the Settlement Agreement require that if the beneficiary has a court-appointed guardian, attorney in fact, or other authorized representative, the authorized representative must be copied on all communications with the beneficiary concerning Medicaid redeterminations. Agreement Ex. D pp. 6-7, 28, 67, 97. These instructions refer the worker to the Notice and Hearing Sections of the manual (MA-3430 or MA-2420) and to an NCFAST Job Aid titled Adding an Authorized Representative. *Id.* It appears from those instructions that, to assure that the authorized representative is copied on the communication, the worker only needs to enter the name and address of the representative into NC FAST and need not manually copy that person on a communication to the beneficiary generated from NC FAST.[7]In fact, NC FAST does not copy the authorized representative on the

[7] Both of these manual sections state the following: "The authorized representative, power of attorney and guardian information must be keyed in NC FAST to ensure the individual receives Medicaid and Special Assistance notices." Sea 2nd Decl. Exs. 70, 71. These sections of the manual then again reference the worker to the same Job Aid. *Id.* The Job Aid gives detailed instructions for how to enter the name and address of the authorized representative into NC
Footnotes continued on the next page.

DSS-8110 (termination notice), NCFAST-20020 (renewal form) or the DHB-5097 (request for information), even though they are generated from NC FAST. Sea 2nd Decl. Ex. 67. Rather, Defendant relies on the DSS worker to do so and requires documentation in the file that this has occurred. Sea 2nd Decl. Ex 73. However, in 4 out of 7 cases in the June sample where an authorized representative was on file, the agency failed to document copying the authorized representative on these critical communications during redetermination. Summary of Evid. #8.

In addition, the authorized representative is *never* copied on the four other notices required by the Settlement Agreement to be sent to every beneficiary during the redetermination process. Agreement, §§ III.B.1 (DHB-2187), III.P (Exhibit F and DHB-5085) and III.I (5046). At a meeting in December, Defendant confirmed that the authorized representative is not copied on these notices when Defendant or its contractor mails these notices to the beneficiary. Sea 2nd Decl. Ex. 40 § 18. Defendant also confirmed that counties have not been instructed to print out and send a copy of these notices to the authorized representative. *Id.* These are important notices. The 5085 explains the beneficiary's rights and responsibilities during the redetermination process and includes a separate notice of rights under the Settlement Agreement. The DHB-2187 allows persons receiving Medicaid under a non-disability category to allege disability and retain their Medicaid until a disability determination is made. Failure to provide these communications to the person acting for the beneficiary violates Sections III.B, III.E, and III.P of the Settlement Agreement.

The potential for harm from these violations, including improper terminations, is great. For example, many Medicaid beneficiaries have severe developmental disabilities or behavorial

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FAST and says nothing about the need for the DSS worker to manually copy the authorized representative. Sea 2nd Decl Ex. 72.

health diagnoses requiring enhanced Medicaid services. These beneficiaries are classified as Tailored Plan eligibles. https://medicaid.ncdhhs.gov/behavioral-health-IDD%20Tailored-Plan. In June, 2075 terminations were of Tailored Plan eligibles. Summary of Evid. #9. 1480 of those terminations were for procedural reasons. *Id.* In October, 3001 Tailored Plan eligibles were terminated, 1621 for procedural reasons. *Id.* Given the high percentage of Tailored Plan eligibles likely to have and need authorized representatives, termination of Medicaid for these highly vulnerable beneficiaries is certain to have caused interruption of critically needed services.

J. Failure to provide sufficient advance notice prior to the effective date of termination or reduction of benefits

Section III.D of the Agreement requires "that before Medicaid is terminated or reduced, the beneficiary is mailed adequate timely written notice…" As this Court previously held in this case, timely advance written notice of termination or reduction of Medicaid is guaranteed by Due Process so that beneficiaries have sufficient time to obtain a pre-termination hearing. Order granting Prelim. Inj. at 34 (Aug. 9, 2018) [DE 55]. In addition, Section III.I of the Agreement requires compliance with manual instructions to DSSs that are incorporated in Exhibit D. Those instructions throughout require compliance with notice and hearing provisions in Sections MA-3430 and MA-2420 of the same instructions. *See e.g.* Agreement Ex. D pp. 5, 24, 28, 32, 38, 41, 49, 54, 61. [DE 122-4]. Sections MA-3430 and MA-2420 specify that, with narrow exceptions, advance notice of termination or reduction must be mailed at least 10 business days before the effective date of the action. Sea 2nd Decl. Exs. 52 p. 12, 53 p. 11-12.

Because Medicaid changes are always made effective the first moment of the first day of the month, the notice must be dated 10 workdays before the month the change takes effect. *Id.* (MA-2420 p. 14, MA-3430 p. 13). According to the manual, the state's computer system NCFAST assures compliance with this 10 workday requirement. *Id.* (MA-2420 p.12, MA-3430

p. 11-12). In fact, NC FAST programming does not do so. Sea 2nd Decl. Ex. 59 (redacted sample notices). During the months of June through September 2023, 3736 beneficiaries had their Medicaid reduced or terminated with less than 10 work days advance notice in cases where such notice was required. Summary of Evid. #9. In some cases, the amount of advance notice was only one day. *Id.* When class counsel discovered this substantial noncompliance, Defendant was immediately notified and asked to take corrective action. Sea 2nd Decl. Ex. 55. To date, Defendant has not responded. Sea 2nd Decl. ¶ 62.

K. Failure to allow the correct amount of time to appeal a notice of termination or reduction.

Section III.D of the Agreement requires that a notice of termination or reduction contain the content shown in Exhibit A to the Agreement, which states "You have sixty (60) calendar days, that is until [DATE], to ask for a hearing." Class counsel discovered in late 2023 that NCFAST programming does not extend the date inserted by the computer in the [DATE] field to the next business day if the 60th calendar day falls on a weekend or holiday. Sea 2nd Decl. Ex. 56. The samples for June and July-September include 516 out of 1143 (45%) notices of termination or reduction where the 60th day fell on a weekend or holiday. Summary of Evidence #7.

Defendant's failure to extend the appeal deadline to the next business day has real world consequences. All DSS offices are closed on weekends and holidays and Defendant's instructions to counties specify that no matter how the appeal is requested (by phone, mail, or electronically), if the request is received after business hours, the date of the appeal request is to be considered the next business day. Sea Decl. Exs. 52, 53. For example, if the 60th day falls on a Monday holiday, the appeal must be filed by the 57th day (Friday) in order to be timely. So far Defendant has not corrected this programming. Sea Decl. ¶ 62.

L. Failure to Assure that All County DSS Staff Conducting Medicaid Redeterminations First Received Training on the Requirements of the Settlement Agreement

Section III.M of the Agreement requires training of all DSS staff on the requirements of the Agreement before they conduct the Medicaid redeterminations subject to the Agreement. Defendant required verification of who received the training. Sea 2nd Decl. Ex. 44. Yet, the information produced to class counsel show that 162 of the 557 staff (29%) who conducted redeterminations contained in the July-September sample did not attend the training. Summary of Evid. # 11. The results of this lack of training are clear in the violations discussed above.

II. PLAINTIFFS HAVE MET THEIR BURDEN OF ESTABLISHING SUBSTANTIAL NONCOMPLIANCE.

Section II.M of the Agreement defines "Plaintiffs" to include both the named plaintiffs and members of the certified class. Thus, substantial noncompliance as to any class member may trigger the court's enforcement. The term "substantial noncompliance" is defined the Agreement as follows:

> The determination of "Substantial compliance" or "Substantial noncompliance" with the requirements contained in Section III of this Agreement shall be made based on a careful weighing of the following factors, with no single factor, alone, sufficient to support a finding of substantial noncompliance: a) has the party made a strong and sustained effort to fully comply with the requirement; b) has the requirement's purpose or objective been complied with even though its formal language is not met; c) does the identified deficiency cause more than minimal harm or risk of harm to members of the plaintiff class, d) is the degree of noncompliance with the requirement great enough to constitute a marked deviation from the terms of the requirement; e) is the noncompliance a temporary failure during a period of otherwise sustained compliance with the provision; f) is there full compliance with a substantial majority of the agreement's requirements taken as a whole; g) is the noncompliance by a small number of county DSSs that Defendant has taken steps to promptly and substantially correct?

Settlement Agreement, § II.L. Each of the above factors favors a finding of substantial noncompliance. They will be discussed in order.

Is there sustained effort to fully comply?: As established in detail above, Defendant's efforts to fully comply have been marked by slow, clumsy, and ineffective efforts both to come into compliance and to correct noncompliance, and by responding to class counsel's demands to correct noncompliance with either unreasonable delay, ineffective steps, and/or refusal to act altogether. Examples include:

- Permitting DSSs to wait until *15 months* after the Agreement took effect to comply with Section III.G. *See supra* at p.19.
- Taking almost no steps thus far to begin to fully comply with Section III.E as to persons with limited English proficiency. *See supra* at pp. 20-22.
- Failing to take any steps thus far to copy the authorized representative on important communications required by Sections III.B and III.P. *See supra* at 22-24.

Defendant's response to class counsel's repeated notifications of noncompliance in June was not only to refuse to reopen any June terminations or reductions, but also to fail to take swift actions to prevent the violations from continuing in subsequent months. "Defendant" includes "county Departments of Social Services," Agreement, Section II.A, which have largely ignored their noncompliance, including dozens of counties repeatedly failing to provide the documents needed to measure their noncompliance.) See generally, Plaintiffs' Motion to Compel [DE 138]

Are purposes of requirements met?: The requirements violated here are not technical violations but rather are integral to protecting the rights of beneficiaries. These violations have contributed to 238,864 class members losing Medicaid coverage in just five months—most without any determination that they were no longer eligible. Summary of Evid. # 9. Cognitively disabled and limited English proficient beneficiaries encounter a system where their authorized representatives are not copied on DSS communications and important communications to Spanish speakers are in English. Eligibility categories for which beneficiaries remain eligible are ignored by a computer system split in two where the two halves don't talk to each other.

What is the risk of harm?: It is well settled that the loss of Medicaid coverage creates not only a risk of harm, but of irreparable harm..*See*, *e.g.*, *Pashby v. Delia*, 709 F.3d 307 (4th Cir. 2013) (threat of losing needed medical care through Medicaid coverage constituted irreparable harm); *Crawley v. Ahmed*, No. 08-14040, 2009 WL 1384147, at *28 (E.D. Mich. May 14, 2009) (irreparable harm existed because "it is undeniable that the unpaid bills, loss of needed medical assistance, and ultimately poor health suffered by Plaintiffs, cannot be adequately addressed by the promise of future Medicaid coverage").

Is there marked deviation?: Plaintiffs have proven substantial noncompliance with Sections III.A, III.B, III.D, III.E, III.G, III.I, III.J, III.M, and III.P of the Agreement. As detailed above, this noncompliance comes in multiple nefarious variations. These violations occurred in substantial percentages of the cases where class counsel were given the data to monitor. The violations have affected hundreds of thousands of low-income children, parents, and aged, blind and disabled adults in North Carolina who were terminated from Medicaid. Moreover, tens of thousands of class members continue to have their coverage terminated or reduced every month while violations of the Settlement Agreement continue.

Is the failure temporary?: Far from a temporary failure, the evidence shows sustained noncompliance since the Settlement Agreement took effect took effect, most of which has not yet been corrected even prospectively.

Is there full compliance with most provisions?: Section III of the Agreement contains the 18 operational requirements of the Settlement Agreement. The evidence demonstrates substantial noncompliance with nine of these subsections (III.A, III.B, III.D, III.E, III.G, III.I, III.J, III.M, and III.P), and substantial noncompliance with a tenth subsection (III.Q) was established in Plaintiffs' January 9, 2024 Motion to Compel [DE 138].

Noncompliance by Few counties Promptly Corrected?: The evidence in Summaries 1 through 11 shows noncompliance across the state. Continuing violations by the state agency occur in every county. As discussed earlier, Defendant's response has been slow and mostly ineffective.

III. THE RELIEF REQUESTED IS REASONABLE AND APPROPRIATE.

Defendants are in substantial noncompliance with Sections III.A, B, D, E, G, I, J, M, and P of the Settlement Agreement. As discussed above, the Court has clear jurisdiction and power to enforce the Settlement Agreement. Plaintiffs ask the Court to enforce the Agreement by ordering the Defendant to (A) Order Defendant and his successors, agents, officers, servants, employees, attorneys and representatives, and all persons acting in concert or participating with him, to take all necessary steps to bring the state Medicaid agency and its agents, county DSSs, into substantial compliance with the Settlement Agreement; (B) Order Defendant to identify and then reinstate Medicaid for all class members whose benefits were reduced or terminated in noncompliance with the Settlement Agreement as specified in paragraph 4, above, and to maintain that coverage until a redetermination, as required by Section III of the Settlement Agreement, has occurred; and (C) Require Defendant to provide regular reports to class counsel and the Court on the actions taken in response to the Court's order, that (1) show the number of class members reinstated to Medicaid whose Medicaid was terminated or reduced, by month and county, and (2) provide random samples, from each county, of DSS/NCFAST files for beneficiaries whose Medicaid was terminated or reduced whom Defendant or its agents have determined need not be reinstated to Medicaid coverage. Mot. to Enforce Sett. Agreement at 2.

In cases such as this one, brought under 42 U.S.C. § 1983 to enforce provisions of the Medicaid Act and Constitution, district courts are invested with broad equitable powers to fashion appropriate remedial relief. *Doe v. Kidd*, 419 Fed. Appx. 411 (4th Cir. 2011). Ordering

Defendant to bring the state agency and its agents into substantial compliance is plainly envisioned by Section V.C of the Settlement Agreement; *Id*. (requiring Defendant to "correct the noncompliance"). Identification of class members whose Medicaid was terminated or reduced in violation of the Agreement and reinstatement of their benefits, until they receive a legal redetermination of eligibility, is fully within the scope of correcting the noncompliance. The Fourth Circuit has upheld a remedy of restoration of benefits in *Kimble v. Solomon,* 599 F.2d 599, 605 (4th Cir.1979). *Accord D.T.M. v. Cansler,* 382 F. App'x 334, 337 (4th Cir. 2010), *aff'g*, 608 F. Supp. 2d 694, 700 (E.D.N.C. 2009) (ordering reinstatement of Medicaid services to the class); *L.S. v. Delia*, No. 5:11-CV-354-FL, 2012 WL 12911052, at *11, n. 11 (E.D.N.C. Mar. 29, 2012). Finally, ordering Defendant to provide reports and random samples from the process of identifying and reinstating class members is essential to assuring compliance with the order to enforce and is based on the process agreed to by the parties in Sections III.Q and III.R of the Agreement which proved essential to uncovering Defendant's previous noncompliance.

CONCLUSION

For the reasons stated above, Plaintiffs respectfully request that this Court grant Plaintiffs Second Motion to Enforce and order the relief requested therein.

Dated: February 23, 2024

Respectfully submitted,

ATTORNEYS FOR PLAINTIFFS

/s/ Douglas S. Sea
Douglas Stuart Sea
State Bar No. 9455
Cassidy Estes Rogers
State Bar No. 46006
CHARLOTTE CENTER FOR LEGAL ADVOCACY
1431 Elizabeth Avenue
Charlotte, North Carolina 28204
Telephone: (704) 971-2593

Telefax: (704) 376-8627
dougs@charlottelegaladvocacy.org

/s/ Jane Perkins
Jane Perkins
State Bar No. 9993
NATIONAL HEALTH LAW PROGRAM
200 N. Greensboro Street,
Ste. D-13
Carrboro, NC 27510
Telephone: (919) 968-6308
perkins@healthlaw.org

CERTIFICATE OF SERVICE

I certify that on this day, I served a true copy of the Plaintiffs' Memorandum in Support of Plaintiffs' Second Motion to Enforce the Settlement Agreement upon the Defendant's attorneys via electronic means through the CM/ECF system to:

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

Rajeev K. Premakumar
Associate General Counsel
N.C. Department of Health and Human Services

Katherine McCraw
Special Deputy Attorney General
N.C. Department of Justice

This the 23rd day of February 2023.

/s/ Douglas Stuart Sea