**UNITED STATES DISTRICT COURT**
**MIDDLE DISTRICT OF FLORIDA**
**JACKSONVILLE DIVISION**

Chianne D., et al.,

Plaintiffs,

v. Case No. 3:23-cv-985

Jason Weida, et al.,

Defendants.
_____/

**Plaintiffs' Reply in Support of a Classwide Preliminary Injunction**

Due process guarantees an adequate notice that "fully inform[s]" the enrollee of the case against them so they can decide whether to request a pre-termination hearing. *Goldberg v. Kelly*, 397 U.S. 254, 266 (1970). The notices in this case border on incomprehensible. As a result, people incorrectly decide not to appeal, or lose the right to benefits pending appeal, and must then scramble to figure out next steps. Plaintiffs' motion seeks relief tailored to remedy that harm—an order for Defendants to pause just those terminations using the defective notices and reinstate coverage for those who have received them only until Defendants issue revised notices that comply with due process and the Medicaid Act.

## I. Plaintiffs' request a common prohibitory injunction.

Defendants characterize Plaintiffs' requested relief as "disfavored" because it would disrupt the "status quo." Defs.' Resp. to Pls.' Mot. for Prelim. Inj., Dkt. 39 at 4. But "there is no 'particular magic in the phrase 'status quo,'" as "the purpose of a

preliminary injunction is 'to preserve the court's ability to render a meaningful decision on the merits.'" *U.S. v. Stinson*, 661 F. App'x 945, 952 (11th Cir. 2016) (quoting *Canal Auth. of State of Fla. v. Callaway*, 489 F.2d 567, 576 (5th Cir. 1974)). Thus, "[i]f the . . . status quo itself is causing one of the parties irreparable injury, it is necessary to alter the situation so as to prevent the injury . . . by returning to the last uncontested status quo between the parties." *Canal Auth.*, 489 F.2d at 576.

Plaintiffs seek to do just that, by returning to the last uncontested time between the parties—March 31, 2023, before Defendants began terminating Medicaid using the challenged notices—and maintain that posture until final resolution of this case. *See Banks v. Trainor*, 525 F.2d 837, 841-42 (7th Cir. 1975) ("to maintain the status quo," preliminary injunction required reinstatement of "food stamp benefits of the members of plaintiff class" until notice with "breakdown of income and deductions was provided"); *M.A. ex rel. Avila v. Norwood*, No. 15 C 3116, 2016 WL 11818203, at *11 (N.D. Ill. May 4, 2016) (preliminary relief to "restore . . . services to the plaintiffs and class members" necessary because "potential harm to the plaintiffs of not maintaining the status quo during the progression of this case is high."); *L.S. ex rel. Ron S. v. Delia*, No. 5:11-CV-354, 2012 WL 12911052, at *9 (E.D.N.C. Mar. 29, 2012) (ordering prohibitory injunction in due process case "to restore" Medicaid services of the class).

Regardless of how the injunction is characterized, the seriousness of the situation warrants the requested relief. Courts have routinely entered similar classwide preliminary injunctions to remedy ongoing harms from inadequate notices. *See K.W. ex rel. D.W. v. Armstrong*, 789 F.3d 962, 974 (9th Cir. 2015) (classwide preliminary

injunction to "restore and continue" Medicaid services "until the defendants first provide adequate advance notice"); *Washington v. DeBeaugrine*, 658 F. Supp. 2d 1332, 1339 (N.D. Fla. 2009) (classwide preliminary injunction ordering that "defendant . . . must not terminate or reduce a plaintiff's benefits in respects at issue in this case prior to affording the plaintiff a hearing meeting the requirements of this order."); *Olson v. Wing*, 281 F. Supp. 2d 476, 486 (E.D.N.Y. 2003) (classwide preliminary injunction warranted, despite the fact that named plaintiffs' benefits had been restored, because likelihood of irreparable harm for unnamed class members was substantial).

## II. Defendants ignore substantial case law establishing that loss (or threatened loss) of Medicaid coverage is irreparable harm.

Plaintiffs A.V. and C.D. remain without Medicaid coverage. Since filing, Chianne D. has regained Medicaid postpartum coverage, *see* Ex. 1, Chianne D. 2nd Decl. ¶ 16, but both she and class member, Kimber Taylor, face another loss at the end of their coverage periods. Defendants call the problems "bare procedural injuries." *See* Dkt. 39 at 21-23. However, substantial case law establishes that loss of Medicaid coverage constitutes irreparable harm as a matter of course, *see* Dkt. 3 at 20 (collecting cases), as does threatened loss of benefits, *see*, *e.g.*, *Beltran v. Meyers,* 677 F.2d 1317, 1322 (9th Cir. 1982) (irreparable injury is established when enforcement of a Medicaid policy "may deny needed medical care"); *Whelan v. Colgan*, 602 F.2d 1060, 1062 (2d Cir. 1979) ("threatened termination of benefits such as medical coverage . . . raised the spectre of irreparable injury"); *Mitson v. Coler,* 670 F. Supp. 1568, 1577 (S.D. Fla. 1987) (potential denial of nursing home service irreparable injury). Of note, evidence from

DCF shows that even short periods without coverage for new mothers and babies (like Chianne, Ms. Taylor, her son, and other absent class members) can result in long-term harm to physical, mental, and financial well-being. *See* Dkt. 3 at 14-19. The record amply supports finding irreparable harm for Plaintiffs and the class.[1]

Nor does the timing of this motion undermine the finding of irreparable harm. In *Wreal, LLC v. Amazon.com, Inc.*, the plaintiffs' delay was entirely "unexplained." 840 F.3d 1244, 1248 (11th Cir. 2016). Here, upon learning they were losing coverage, Plaintiffs immediately tried to restore coverage and obtain needed care, thus demonstrating the "need for speedy and urgent action." *Id.* When those efforts did not restore coverage, Plaintiffs promptly filed this action.

## III. Plaintiffs are likely to succeed on the merits.

### A. Defendant's notices violate the bedrock principle of due process that the agency must provide specific, individualized notice.

*First*, Defendants do not address Plaintiffs' claim that DCF's notices fail to clearly articulate what action DCF is taking and whether particular household members are actually losing coverage. Dkt. 3 at 7-8. This unrefuted flaw in the notices is an independent reason to find Plaintiffs likely to succeed on their claims.

*Second*, Defendants do not contend that their notices provide the specific "legal and factual bases" for DCF's decision—because they do not. *See* Dkt. 3 at 8-11

[1] Unlike in *Soskin v. Reinertson*, 353 F.3d 1242, 1264 (10th Cir. 2004), there are no unanswered questions about who received the notice or who is losing coverage: the class is defined by receipt of the challenged notices of Medicaid termination. Further, although Plaintiffs need not establish standing for each class member, *see* Class Reply at 1, because each class member has already suffered or imminently faces loss or threatened loss of Medicaid, they satisfy the concrete injury requirement.

(quoting *Goldberg*, 397 U.S. at 267-68). Instead, Defendants attack the underlying law, asserting that such notice is not required. But Medicaid notices must state the "specific reasons supporting the intended action." 42 C.F.R. § 431.210. Defendants' approach would render *Goldberg* hollow. The *Goldberg* Court spoke in terms of the individual, requiring that the individual be "fully informed of the case against *him*." 397 U.S. at 266 (emphasis added). *See also K.W. ex rel. D.W. v. Armstrong,* 298 F.R.D. 479, 482-83 (D. Idaho 2014) ("*Goldberg* requires a notice tailored to the individual.").

Appellate courts have repeatedly emphasized that notice "must be sufficiently specific for it to enable an applicant to prepare rebuttal evidence to introduce at his hearing appearance." *Billington v. Underwood*, 613 F.2d 91, 94 (5th Cir. 1980). *Barry v. Lyon,* 834 F.3d 706, 720 (6th Cir. 2016) (notice must provide "specific, individualized reasons for the agency action"); *Ortiz v. Eichler,* 794 F.2d 889, 893, 894 n.4 (3d Cir. 1983 ("[T]he need for specific and detailed notice of the bases for adverse agency action in order to guard against the erroneous deprivation of these benefits" is "well recognized."); *Dilda v. Quern*, 612 F.2d 1055, 1057 (7th Cir. 1980) (notices stating only "the ultimate reason," without "a breakdown of income and allowable deductions," provides "little protection against errors committed by the Department.").

Defendants' cases are inapposite. Dkt. 39 at 10-11. Two of those cases concern across-the-board changes, where the courts applied "a lower standard for determining a notice to be adequate than where [as here] the reduction or termination of aid is on an individual basis." *LeBeau* 703 F.2d 639, 644–45 (1st Cir. 1983); *see Garrett v. Puett*,

707 F.2d 930, 931 (6th Cir. 1983).[2] The other cases concerned form notices used by the Social Security Administration to deny requests for reconsideration. *See Jordan v. Benefits Review Bd. of U.S. Dep't of Labor*, 876 F.2d 1455, 1459 (11th Cir. 1989)*; Adams v. Harris,* 643 F.2d 995, 996 (4th Cir. 1981).[3] The notices in those cases came *after* the initial denial notice (the sufficiency of which was not contested) and the claimants' subsequent reconsideration request—and in *Jordan*, following an evidentiary hearing. These cases do not address the initial denial notice, which must supply "sufficient information" for an individual to determine "*whether* a challenge to an agency's action is warranted," in the first instance. *Kapps v. Wing*, 404 F.3d 105, 124 (2d Cir. 2005).[4]

**B. Other communications, publicly available sources, and Plaintiffs' actual knowledge do not excuse the fatal flaws in the notices.**

Defendants' primary argument seems to be that the content of DCF's termination notice does not matter because the wild goose chase triggered by that notice (*e.g.*, repeated calls to the call center, sorting through previous notices from months before, and general statements of program information), could eventually amount to adequate notice if an enrollee gets accurate information from DCF staff and figures out how to put all the puzzle pieces together.

---

[2] *Cf. Barry*, 834 F.3d at 719-20 (notice that informed food stamp recipient that "you . . . [are] not eligible for assistance due to a criminal disqualification" was not constitutionally sufficient.); *Hamby v. Neel*, 368 F.3d 549, 560 (6th Cir. 2004).

[3] Defendants incorrectly cite *Adams* as an Eleventh Circuit case.

[4] Notably, the notices in *Jordan* identified the three necessary eligibility criteria and "an enclosed guide which discusses the type of evidence that could be used to meet" those criteria. *Jordan*, 876 F.2d at 1459. And the notices in *LeBeau* included "a calculation of each recipient's grant and listing figures for the recipient's gross earned income, gross unearned income, deductions allowed, total deductions, net income, other adjustments and the standard of assistance for the recipient's family." 703 F.2d at 641.

The Court should reject this version of due process because it ignores controlling law. Medicaid regulations demand that DCF provide all of the required information "in writing . . . at the time the agency denies an individual's claim for eligibility." 42 C.F.R. §§ 431.206(b), 431.210. There are no exceptions based on receipt of pre-termination communications or a recipient's actual knowledge or diligence. In fact, the regulations separately require the agency to "publicize its hearing procedures" and provide that information "at the time of application." *Id.* § 431.206(a), (c)(1). Thus, prior and public notice are independent requirements that do not excuse Defendants' failure to provide adequate notice at the time of denial. *Cf. Allen v. Dep't of Health & Soc. Servs.*, 203 P.3d 1155, 1169 (Alaska 2009) (rejecting similar self-help claims).

Likewise, the constitutional claim turns on an objective analysis of the notice communicating ineligibility, making an individual's subjective knowledge and level of diligence irrelevant to the claim. *See Mullane v. Cent. Hanover Bank & Trust Co.*, 339 U.S. 306, 314 (1950) (instructing that notices must be "*reasonably* calculated"). Defendants' leading case affirms this standard: "[t]he question is not whether a particular individual failed to understand the notice but whether the notice is reasonably calculated to apprise intended recipients, as a whole, of their rights." 876 F.2d at 1460. *Jordan* held the plaintiff had a special obligation to "take [the] next step and inquire" only because he claimed a "special problem of comprehension" not shared by others. *Id.* In reaching that conclusion, the court discounted Jordan's miscomprehension claim by noting his

past familiarity with the procedures. *Id.*[5]

Citing *Rosen v. Goetz*, 410 F.3d 919, 931 (6th Cir. 2005), Defendants note that they send Medicaid enrollees other written communications prior to the termination notice.[6] *See* Dkt. 39 at 14-15. Maybe so. But the analogy to *Rosen* only works if those prior communications purport to "supply the facts on which [DCF] relied," to make its ineligibility decision. *Mullane*, 339 U.S. at 314. None do. For instance, Defendants highlight that Chianne received notices alerting her to the start of the renewal process and a request for information.[7] Dkt. 39-4 at 17, 96-104. These communications cannot offer an enrollee the type of "specific" explanation for "why they are being disenrolled" that was deemed sufficient in *Rosen*, 410 F.3d at 931, because at the time these prior communications are sent, DCF has not yet made its eligibility decision. *See C.R. ex rel. Reed v. Noggle*, 559 F. Supp. 3d 1323, 1340 (N.D. Ga. 2021) (rejecting reliance on prior document with additional detail because it "was not a final decision" and distinguishing *Rosen* because none of the notices provided the required detail).

Defendants also point to the call center and information purportedly available through the fair hearing process. Dkt. 39 at 14-15. Even if additional clarity were available through these avenues—and Plaintiffs dispute that it is, *see infra*—it would

[5] Defendants' remaining cases do not concern public benefits, where the "brutal need" of recipients warrants greater process. *Goldberg*, 397 U.S. at 261. Further, in each instance, the court emphasized that the plaintiffs had received actual notice with substantial time to respond. *See Oneida Indian Nation of N.Y. v. Madison Cnty.*, 665 F.3d 408, 435 (2d. Cir. 2011); *Moreau v. F.E.R.C*, 982 F.2d 556, 569 (D.C. Cir. 1993); *E.E.O.C. v. PanAmerican World Airways, Inc.*, 897 F.2d 1499 (9th Cir. 1990).

[6] Defendants incorrectly cite *Rosen* as an Eleventh Circuit case.

[7] Defendants' reference to communications received prior to procedural terminations (terminations based on enrollees not returning a renewal packet or documentation) is beside the point. Plaintiffs' class is limited to individuals whom Defendants have determined are ineligible.

not cure the underlying flaws in the notice of termination. *See Schroeder v. Hegstrom*, 590 F. Supp. 121, 128 (D. Or. 1984) (opportunity to "ask for assistance from welfare caseworkers in understanding why the reduction or termination occurred does not remedy the shortcomings of an inadequate notice."). The problem with these avenues is that it "improperly places on the recipient the burden of acquiring notice whereas due process directs [Defendant] to supply it." *Murphy by Murphy v. Harpstead*, 421 F. Supp. 3d 695, 708 (D. Minn. 2019). As a result, "only the aggressive receive their due process right to be advised of the reasons for the proposed action." *Vargas*, *v. Trainor*, 508 F.2d 485, 490 (7th Cir. 1974); *see also Goldberg*, 397 U.S. at 269, n. 16. ("[T]he prosecution of an appeal demands a degree of security, awareness, tenacity, and ability which few dependent people have."). And of course, information available only *after* filing an appeal is insufficient to allow the individual to "choose for himself whether to appear or default, acquiesce or contest." *Mullane.*, 339 U.S. at 314.

For similar reasons, publicly available information cannot remedy DCF's defective notices. "The law does not entertain the legal fiction that every individual has achieved a state of legal omniscience; in other words, there is no presumption that all of the citizens actually know all of the law all of the time." *Grayden v. Rhodes*, 345 F.3d 1225, 1243 (11th Cir. 2003). And because generalized public information will never provide specific information about the agency action in a particular case, it cannot satisfy the obligation to provide individualized notice. *See id.* at 1248-49.[8]

[8] Defendants' reliance on *Arrington v. Helms*, 438 F.3d 1336 (11th Cir. 2006), is misplaced. That ruling does not stand for the proposition that publicly available information is always sufficient to satisfy due

**C. Plaintiffs exercised diligence and still lacked actual knowledge.**

Even if these other sources of information were relevant, they do not give clear reasons for DCF's actions. Reaching Florida's call center is challenging and time consuming: wait times are among the worst in the country and nearly half of all calls are abandoned. Compl., Dkt. 1, ¶ 85; Dkt. 38-1 at 29 ("you were probably on hold for . . . two hours"). Defendants reference the online ACCESS accounts but do not provide any examples of what additional information is purportedly available there. In a recent report from the U.S. Office of the Inspector General, Florida officials admitted that DCF's "system was not designed to capture reasons for termination."[9] So it is, at best, unclear what additional information might be available through DCF's online systems. In Plaintiffs' experience, that information is limited to the applications and renewals Plaintiffs submit to DCF and limited history of notices and eligibility status (*i.e.*, enrolled or closed). *See* Ex 1, Chianne 2nd Decl. ¶¶ 13-15.

Turning to the Plaintiffs: Jennifer V. could not understand from the notice that A.V. was even losing coverage—so how could she be expected to inquire about the reasons DCF was terminating A.V.'s coverage? Defendants have produced no other communications with Jennifer V. that explain their reasons for finding A.V. ineligible.

Defendants do not address Ms. Taylor at all. She called DCF seeking clarity

---

process; rather it reaffirmed that courts must apply the "reasonably calculated" test in each context. *Id.* at 1352-53. Because the need for individualized notice, including hearing rights, is well-established in the Medicaid context, *Arrington*'s holding is inapplicable here.

[9] U.S. Dep't of Health & Human Servs., Office of Inspector General, *Four States Reviewed Received Increased Medicaid COVID-19 Funding Even Though They Terminated Some Enrollees' Coverage for Unallowable or Potentially Unallowable Reasons* 6 (Sept. 2023), https://oig.hhs.gov/oas/reports/region6/62109002.asp.

about why she and her son were losing coverage, but the DCF agent simply reiterated the statement in the notice that she was over income and advised her to apply for other coverage for her and her son. Dkt. 3-12 ¶¶ 15-19. Ms. Taylor did not pursue an appeal because without more information, she assumed DCF was right. *Id.*; *cf. Vargas*, 508 F.2d at 490 (detailed notice especially important because of "human tendency . . . to assume that an action taken by a government agency in a pecuniary transaction is correct"). At no point was she informed about the availability of continuous postpartum or newborn coverage. Following the DCF agent's advice, she applied for other coverage, but both she and her son were denied. *Id.* ¶ 19. Eventually, Ms. Taylor and her son's Medicaid coverage was reinstated, but the gap was extremely stressful for her at a critical moment when she was caring for her weeks-old baby. *Id.* ¶ 20.

Finally, as Defendants acknowledge, Chianne D. made several calls to try to understand the notice and the basis for DCF's decision. Dkt. 39-4 at 32 ("I'm trying my hardest here"). In her initial calls—in the critical days before she and C.D. lost coverage—she did not receive the specific information that would have allowed her to contest DCF's decision on appeal. Although she had reviewed her ACCESS account, it was not helpful. *See* Dkt. 39-4 at 23. DCF's call center agents gave her conflicting information about C.D.'s eligibility. *Id.* at 30. Those who told her she was not eligible merely parroted the generic language from the notices that her income was "too high." *Id.* at 24, 34, 38. When Chianne asked what the income standard is, the agent responded that they were "not qualified to answer that question." *Id.* at 38. Neither agent mentioned an appeal or fair hearing. One agent advised Chianne to "reapply."

No one referenced the possibility that Chianne might still be eligible for postpartum coverage. It took multiple calls and several days before someone offered any information about what income DCF was using—and even then, the agents could not clearly or accurately explain how C.D.'s share of cost was calculated. Dkt. 39-4 at 78-81.[10] Even if these calls could be said to provide actual knowledge, they came too late to enable Chianne to meaningfully exercise her pre-termination hearing rights. *Cf. Mallette v. Arlington Cnty. Emps. Supplemental Ret. Sys. II,* 91 F.3d 630, 641 (4th Cir. 1996) (recognizing due process claim due to delay in disclosing factual information until the day of the hearing).

Further, at no point did anyone or anything ever inform Chianne that individuals who have given birth are entitled to 12 months continued eligibility regardless of income changes or explain why DCF had not found her eligible for this coverage.[11] Like Ms. Taylor, Chianne had no way to know that DCF had erroneously terminated her coverage. True, DCF filed an appeal on Chianne's behalf, but only after she and C.D. lost coverage. The resulting gap left Chianne to "concentrate upon finding the means for daily subsistence" including for C.D.'s substantial medical needs, and "in turn, adversely affect[ed] h[er] ability to seek redress from the welfare

[10] The DCF agent's statement that share of cost is calculated by disregarding $20 of income was grossly incorrect. Dkt. 38-1 at 79. For a family of four the disregard is $585. *See* DCF ESS Program Policy Manual, Ch. 2600, Section 2630.0500 (share of cost is calculated by subtracting "Medically Needy Income Limit (MNIL)" from family's income); Appx. A-7 (listing MNIL amounts).

[11] Defendants' posted information on Medicaid eligibility does not reference continuous postpartum coverage. Dkt. 39-3 at 5-7. A fact sheet on DCF's website incorrectly states postpartum coverage is only available for two months. *See* DCF, Family-Related Medicaid Program Fact Sheet, 2 https://www.myflfamilies.com/sites/default/files/2023-02/family-relatedmedicaidfactsheet.pdf (last visited Oct. 16, 2023).

bureaucracy." *Id.* at 264. That is precisely the harm adequate notice should prevent.

**D. Plaintiffs' notice claims are enforceable through the Medicaid Act.**

Defendants concede that when a regulation fleshes out the content of a statutory right, it may be considered in the § 1983 claim to enforce that statutory provision. Dkt. 39 at 20. True, in *Yarborough v. Decatur Hous. Auth.*, 931 F.3d 1322, 1325–27 (11th Cir. 2019) (en banc), the court refused to allow enforcement of a regulation requiring a particular standard of evidentiary proof at the hearing. It emphasized that the statute at issue created a right to a written decision and was not modified by terms like "reasoned" or "properly" that the regulations might define. *Id.* at 1326-27.

Here, on the other hand, as with the constitutional right to a hearing, for § 1396a(a)(3)'s "fair" hearing right to be meaningful, it must include adequate notice. *Cf.* 42 C.F.R. § 431.205(d), (f) (Medicaid hearing system must comply with *Goldberg* and U.S. Constitution); *Mullane*, 339 U.S. at 314 (finding the "right to be heard has little reality or worth" absent adequate notice); *Cramer v. Chiles*, 33 F. Supp. 2d 1342, 1347 (S.D. Fla. 1999) ("The purpose of the advance notice is to afford the recipient of the service an opportunity for a pre-termination hearing. 42 C.F.R. § 431.231(c)."). Thus, many courts have concluded that the notice regulations are part and parcel of § 1396a(a)(3)'s hearing right. *See K.B. ex rel. T.B. v. Mich. Dep't of Health & Hum. Servs.*, 367 F. Supp. 3d 647, 661–62 (E.D. Mich. 2019) (§ 1396a(a)(3) requires notice of the opportunity for a hearing under 42 C.F.R. § 431.210); *Crawley v. Ahmed*, 2009 WL 1384147, at *26 & n.7 (E.D. Mich. May 14, 2009) (§ 1396a(a)(3) requires timely and adequate notice of decisions under 42 C.F.R. §§ 431.206–.211); *Guadagna v. Zucker*,

CV 17-3397, 2021 WL 11645538, at *13 (E.D.N.Y. Mar. 19, 2021) (§ 1396a(a)(3) encompasses "a number of provisions fleshing out the right to pre-termination notice"); *see also Doe, 1-13 ex rel. Doe Sr. 1-13 v. Bush*, 261 F.3d 1037, 1056 (11th Cir. 2001) (Medicaid Act grants "individuals denied services . . . a right to notice and an opportunity to be heard"); *C.R.,* 559 F. Supp. 3d at 1341 (using notice regulations to inform scope of § 1396a(a)(3)); *Hernandez v. Medows*, 209 F.R.D. 665, 670 (S.D. Fla. 2002) (notice regulations "implement the federal statutory requirement").

**IV. The public interest weighs in Plaintiffs' favor.**

Defendants' arguments on public interest ignore the case law establishing that compliance with federal requirements is in Defendants' and the public's interest. Dkt. 3 at 21. Accordingly, courts have rejected similar appeals to financial costs when evaluating the propriety of a preliminary injunction. For example, in *Smith v. Benson*, the court squarely acknowledged that "Florida has limited resources, particularly in an economic downturn, and must make tough choices about where to invest those limited resources . . . While I doubt neither the gravity nor the difficulty of funding Medicaid obligations, such concerns do not excuse a violation of federal law." 703 F. Supp. 2d 1262, 1277–78 (S.D. Fla. 2010).

Moreover, there are reasons to doubt Defendants' cost estimates. They offer no explanation for how they arrived at the number of hours it would take to update the computer system. They also do not acknowledge the availability of substantial federal funding—75% of the costs—for developing and maintaining an accurate eligibility and notice system. *See* Compl. ¶ 34 (citing 42 U.S.C. § 1396b(a)(3)(B)).

Nor would an order requiring the State to comply with the law in this case cause the State to violate unwinding laws in other respects. Federal regulations require Medicaid agencies to continue services if the requisite advance notice is not sent to a Medicaid recipient. 42 C.F.R. § 431.231(c)(1). And federal matching funds are available "[f]or services provided . . . under a court order" including to "individuals in the same situation as those directly affected by the decision or order." *Id.* §§ 42 C.F.R. § 431.250(b)(2), (d). The Consolidated Appropriations Act does not affect those laws. In fact, the Centers for Medicare & Medicaid Services expects states to employ the reinstatement remedy when erroneous terminations occur during the unwinding period. *See* Dear State Medicaid Director Ltr. 3-5 (Aug. 30, 2023), https://www.medicaid.gov/sites/default/files/2023-08/state-ltr-ensuring-renewal-compliance.pdf. And at least one state recently did just that in response to concerns. *See* Ex. 2, Oregon Transmittal (restoring coverage and pausing terminations "until notices are updated to provide more individualized information."). The relief sought here is not only permitted, but feasible, expected, and in the public interest.

Dated: October 16, 2023.

*By: /s/Sarah Grusin*

**NATIONAL HEALTH LAW PROGRAM**
Sarah Grusin (admitted *pro hac vice*)
Jane Perkins (admitted *pro hac vice*)
Miriam Heard (admitted *pro hac vice*)
Amanda Avery (admitted *pro hac vice*)
1512 E. Franklin Street, Suite 110
Chapel Hill, NC 27541
(919) 968-6308
grusin@healthlaw.org

**FLORIDA HEALTH JUSTICE PROJECT**
Katy DeBriere (Fl. Bar No. 58506)
Miriam Harmatz (Fl. Bar No. 562017)
Lynn Hearn (Fl. Bar No. 123633)

debriere@floridahealthjustice.org
harmatz@floridahealthjustice.org
hearn@floridahealthjustice.org

**UNITED STATES DISTRICT COURT**
**MIDDLE DISTRICT OF FLORIDA**
**JACKSONVILLE DIVISION**

Chianne D., et al.,

Plaintiffs,

v. Case No. 3:23-cv-985

Jason Weida, et al.,

Defendants.
_____/

**Index of Exhibits to**
**Plaintiffs' Reply in Support of a Preliminary Injunction**

| Exhibit Number | Title of Exhibit |
|---|---|
| 1 | Second Declaration of Chianne D. |
| 2 | Oregon Policy Transmittal, Oct. 11, 2023 |

# SECOND DECLARATION OF CHIANNE D.

I, Chianne D., hereby declare under the pains and penalties of perjury that the following is true and correct and based on personal knowledge.

1. I am a Plaintiff in the case of *Chianne D., et al. v. Weida, et al.*, Case No. 3:23-cv-00985-MMH-LLL (M.D. Fla., Aug. 22, 2023). I submitted a declaration in this case dated August 19, 2023.

2. We still cannot afford to pay the medical bills from June 2023 when C.D. didn't have any health coverage. I believe the bills have gone into collections which is an overwhelming thought.

3. I have reviewed the declaration of William Roberts, and the attachments, including transcripts of some of my calls with the Department of Children and Families (DCF).

4. I don't specifically remember seeing the February 27, 2023 notice attached to Mr. Roberts declaration at Doc. 38-1, Ex. A. Looking at it now, it is confusing. And it doesn't say anything about the eligibility status of my daughter, C.D. She is not listed on the notice at all.

5. I don't believe that the attachments to Mr. Roberts' declaration include all of the phone calls I made during this time period. Before the first call Mr. Roberts included, I had already spoken with another lady who said a "tier three" representative would be able to edit something in the system if there is an

error. The first transcript Mr. Roberts attached is when I called back because I didn't hear back from the tier three representative. (Doc. 38-31, pp. 22, 3:12-14, 24, 5:2-5).

6. I remember that during my calls with DCF, representatives gave me conflicting information. I believe there are other earlier calls between me and DCF where a DCF representative told me my daughter was enrolled through 2024. I referenced that statement on later calls with DCF, when I said "So my account is reflecting something different than what other agents have been telling me;" "...when I talk to other agents, they're like, 'No. In our system it shows you're still active until 2024.' " (Doc. 38-41, Ex. D-2, 3:2-3:10). I also tried to explain on one call that "...your agents have been telling me for weeks to disregard any message because we were fine and still covered." (Doc. 38-1, D-3, 21:8-21:10).

7. I see now from the transcripts that the call described in my August 19th declaration—where the DCF agent was unable to answer my questions—took place on June 1st, not May 30th. Before reading the transcripts, I had conflated several of my calls to DCF. I was transferred or told I would be called back several times during these calls which makes the calls run together in my mind.

8. I do remember that when I read the April 24th notice, I did not understand that I had the right to request a hearing to appeal the termination. And I definitely did not understand that Medicaid for me and my daughter could continue

at least through the outcome of the hearing if I filed an appeal before our Medicaid was terminated. If I had known to request this before our coverage ended, I would have.

9. I didn't submit any paperwork to request an appeal. I think the call center representative submitted a request for me after the June 1st call.

10. I did get an acknowledgement of the appeal and the date for a hearing. I knew that the date wouldn't work for me, though, because I was scheduled to start a new job. I also wanted to resolve any mistakes as quickly as possible. That is why I asked for an earlier hearing date.

11. I withdrew the appeal after my daughter was enrolled in KidCare. At the time I dismissed the appeal, I couldn't identify any mistakes. I had no idea I may still be eligible for postpartum Medicaid. Even after all of my struggles with DCF, they never said anything about my potential Medicaid eligibility as a postpartum mother.

12. Mr. Roberts' declaration includes a second call transcript dated June 1, 2023. (Doc. 38-1, Ex. D-5). Mr. Roberts suggests that this was a call between me and DCF. (Doc. 38-1, ¶10). That is not correct. Joni Hughes, at C.D.'s medical daycare, referred me to a man named Jarvis at the Player's Center for Child Health who she said has been known to help people get back on Medicaid.

13. My understanding is that Jarvis's entire job is to assist families like me with Medicaid applications. I first spoke with Jarvis on June 1, 2023. I signed a document allowing him to call DCF on my behalf to figure out what was going on. He also had my ACCESS login information, but he told me he could not determine whether there was a mistake about C.D.'s eligibility by looking at the information in ACCESS, including our notices. The fifth transcript reflects the call between him and a DCF agent. I was not on that call.

14. When I found out C.D. and I were losing coverage, I also tried checking my ACCESS account to figure out what was happening. What I remember is that the information in ACCESS did not align with my initial phone calls with the DCF call center about C.D.'s eligibility. A redacted screenshot of a portion of my ACCESS account is attached to my declaration as Exhibit A.

15. As far as I know, my ACCESS account does not provide any information about the income DCF used to determine we were ineligible (other than looking at the applications and renewals I submitted) or what the income limit is for a family our size. And I don't think there's any way to see in my ACCESS account any information about what other potential categories of Medicaid eligibility exist and the eligibility criteria for those categories. I didn't see anything in my ACCESS account about postpartum coverage. What I can see from my ACCESS account is notices that date back to 2020, some of the applications and

renewals I sent to DCF for Medicaid and food assistance, and a history of the family's eligibility.

16. After this lawsuit was filed, DCF reinstated my Medicaid.

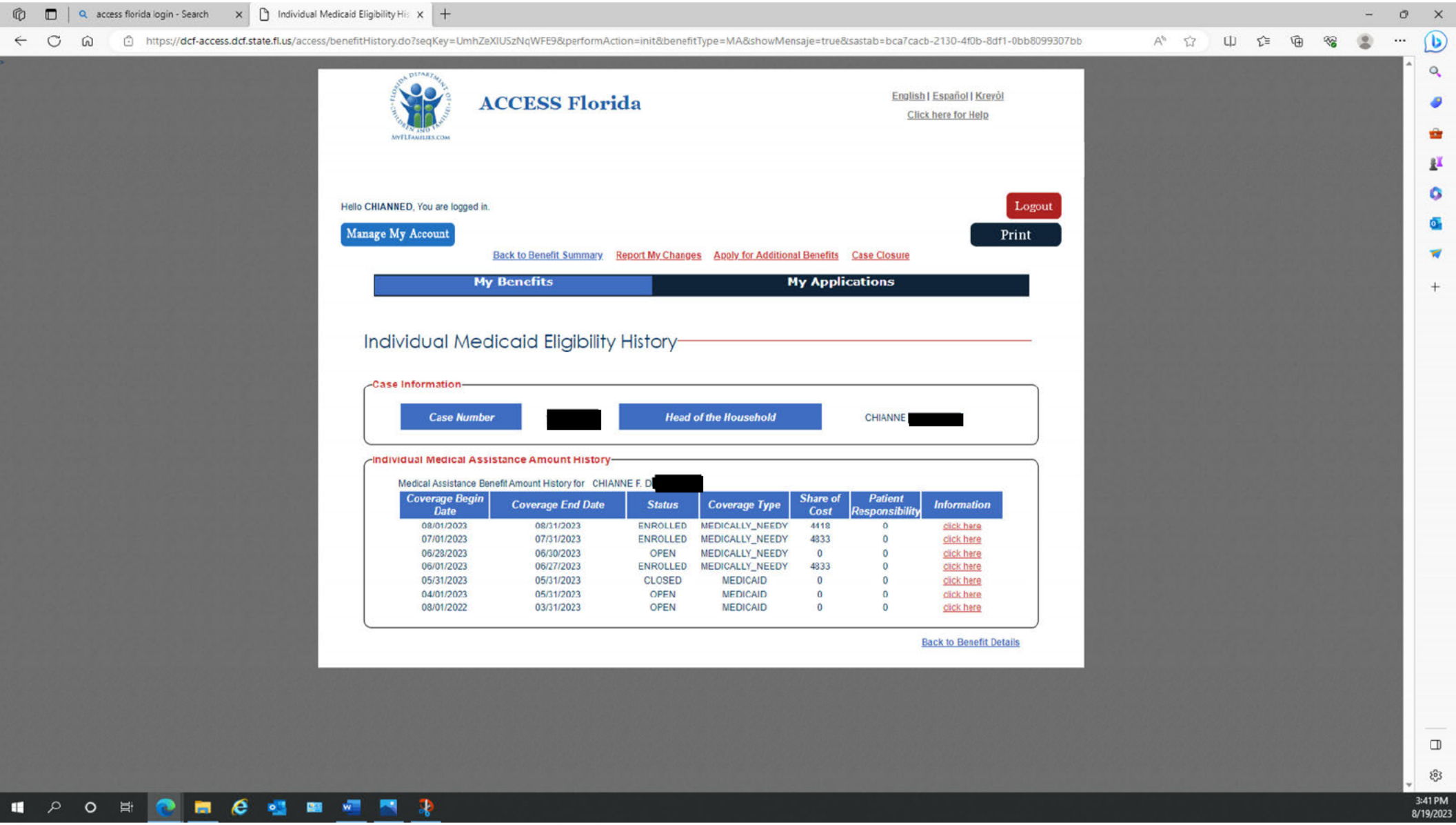
17. S.D. was born in February 2023. Now that I know about continuous coverage for postpartum moms and babies, S.D. and I think we should be eligible for full Medicaid until February 2024. It is my understanding we will have our eligibility redetermined at that time.

Date: Oct 16, 2023

Chianne D[redacted] (Oct 16, 2023 10:05 EDT)

Chianne D., Declarant

# Exhibit A



access florida login - Search | Individual Medicaid Eligibility His

https://dcf-access.dcf.state.fl.us/access/benefitHistory.do?seqKey=UmhZeXlUSzNqWFE9&performAction=init&benefitType=MA&showMensaje=true&sastab=bca7cacb-2130-4f0b-8df1-0bb8099307bb

ACCESS Florida

English | Español | Kreyòl

Click here for Help

Hello CHIANNED, You are logged in.

Logout

Manage My Account

Print

Back to Benefit Summary | Report My Changes | Apply for Additional Benefits | Case Closure

My Benefits | My Applications

## Individual Medicaid Eligibility History

**Case Information**

| Case Number | [redacted] | Head of the Household | CHIANNE [redacted] |
|---|---|---|---|

**Individual Medical Assistance Amount History**

Medical Assistance Benefit Amount History for CHIANNE F. D[redacted]

| Coverage Begin Date | Coverage End Date | Status | Coverage Type | Share of Cost | Patient Responsibility | Information |
|---|---|---|---|---|---|---|
| 08/01/2023 | 08/31/2023 | ENROLLED | MEDICALLY_NEEDY | 4418 | 0 | click here |
| 07/01/2023 | 07/31/2023 | ENROLLED | MEDICALLY_NEEDY | 4833 | 0 | click here |
| 06/28/2023 | 06/30/2023 | OPEN | MEDICALLY_NEEDY | 0 | 0 | click here |
| 06/01/2023 | 06/27/2023 | ENROLLED | MEDICALLY_NEEDY | 4833 | 0 | click here |
| 05/31/2023 | 05/31/2023 | CLOSED | MEDICAID | 0 | 0 | click here |
| 04/01/2023 | 05/31/2023 | OPEN | MEDICAID | 0 | 0 | click here |
| 08/01/2022 | 03/31/2023 | OPEN | MEDICAID | 0 | 0 | click here |

Back to Benefit Details

3:41 PM
8/19/2023

# ACCESS Florida

English | Español | Kreyòl

Click here for Help

Hello **CHIANNED**, You are logged in.

Logout

Manage My Account

Print

Back to Benefit Summary | Report My Changes | Apply for Additional Benefits | Case Closure

**My Benefits** | **My Applications**

## My Information

### Case Information

| | | | |
|---|---|---|---|
| *Case Number* | [redacted] | *Head of the Household* | CHIANNE [redacted] |

### Current Contact Information

The following information is for CHIANNE F. D[redacted]

| | |
|---|---|
| *Living Address* | [redacted] JACKSONVILLE FL [redacted] |
| Telephone | [redacted] |
| *Cell Phone* | [redacted] |

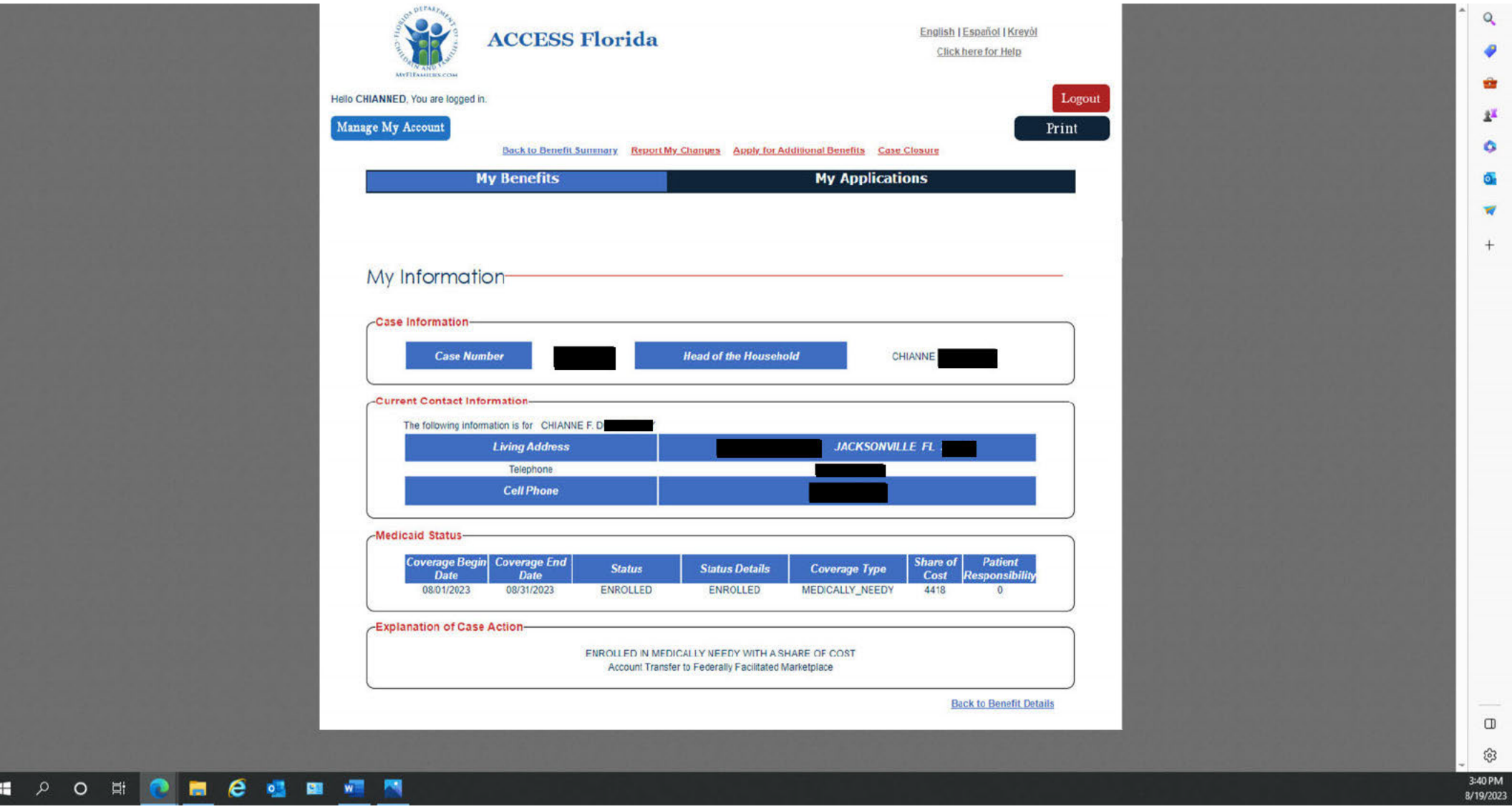
### Medicaid Status

| *Coverage Begin Date* | *Coverage End Date* | *Status* | *Status Details* | *Coverage Type* | *Share of Cost* | *Patient Responsibility* |
|---|---|---|---|---|---|---|
| 05/31/2023 | 05/31/2023 | CLOSED | CLOSED | MEDICAID | 0 | 0 |

### Explanation of Case Action

YOU ARE RECEIVING THE SAME TYPE OF ASSISTANCE FROM ANOTHER PROGRAM

Back to Benefit Details



ACCESS Florida

English | Español | Kreyòl
Click here for Help

Hello CHIANNED, You are logged in.

Logout

Manage My Account

Print

Back to Benefit Summary | Report My Changes | Apply for Additional Benefits | Case Closure

My Benefits | My Applications

## My Information

### Case Information

| Case Number | [redacted] | Head of the Household | CHIANNE [redacted] |
|---|---|---|---|

### Current Contact Information

The following information is for CHIANNE F. D[redacted]

| Living Address | [redacted] JACKSONVILLE FL [redacted] |
|---|---|
| Telephone | [redacted] |
| Cell Phone | [redacted] |

### Medicaid Status

| Coverage Begin Date | Coverage End Date | Status | Status Details | Coverage Type | Share of Cost | Patient Responsibility |
|---|---|---|---|---|---|---|
| 08/01/2023 | 08/31/2023 | ENROLLED | ENROLLED | MEDICALLY_NEEDY | 4418 | 0 |

### Explanation of Case Action

ENROLLED IN MEDICALLY NEEDY WITH A SHARE OF COST
Account Transfer to Federally Facilitated Marketplace

Back to Benefit Details

3:40 PM
8/19/2023

# Transmittal

# Oregon Eligibility Partnership

Oregon Department of Human Services

**Date Issued:**

**Transmittal #:**

**Subject/Topic:**

**Primary Audience:** ☒ ☒

☐ ☒

☐ ☐

**Effective Date:**

**Transmittal Type:**

**Impacted Area(s):** ☒ ☐

☐ ☐

☐

**Reference Material(s):**

**Summary:**

**Background**

**ODHS and OHA Response**

**For specific office actions, see below.**

- 
- 
- 

**Note:**

**Long Term Services and Supports**

**Central Office Actions**

- **March 2024**
- 
- 

## Local Office Actions

- 
  - 
  - 
- 
  - 
- 
- 

---

## Authorizing Signature:

## Questions?

| |
|---|
| |

# OEP Eligibility Instructions for OSIPM OVI/OVR Notice Issue

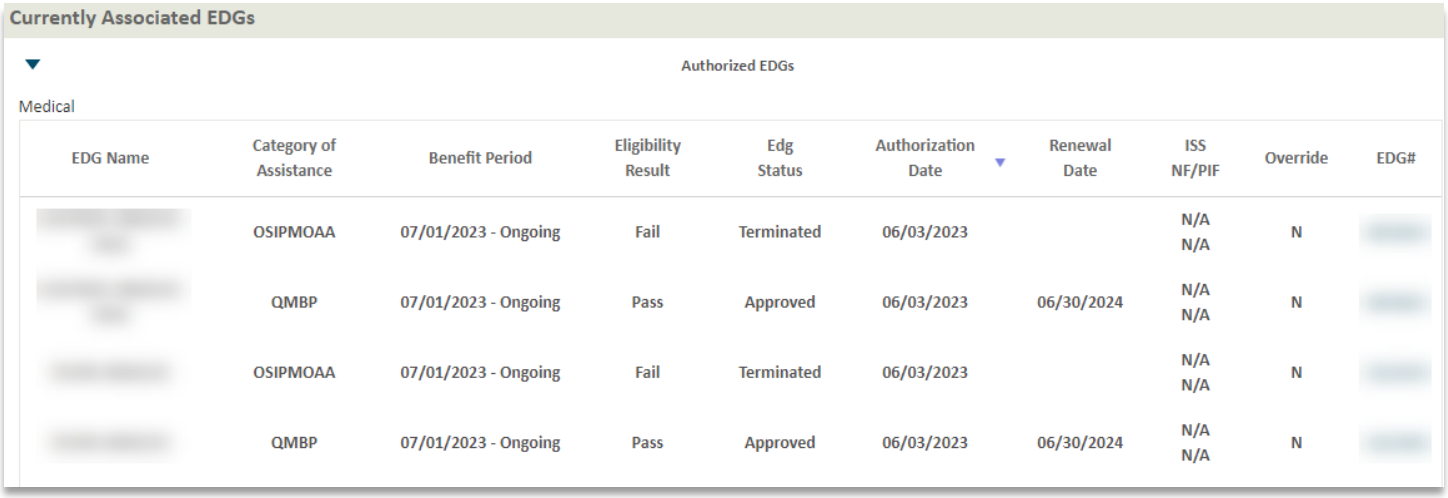
**Background**:
Oregon Supplemental Income Program – Medical (OSIPM) cases that had income or resources over allowable limits were closed during renewal, whether through passive or active renewal. People were sent closure notices based on the information they provided. However, we've gotten feedback that people want more detailed information in our notices to help them decide if they should request a hearing.

To allow time to add clarity to our notices and address these concerns, the Department has decided to reopen these specific OSIPM cases that were closed **since March 31, 2023**, because they did not meet income and resource limits at renewal.

Most cases that meet criteria will be automatically reopened through a system update. If someone contacts you because their OSIPM was closed at renewal for being over income or resources please review their case, update any relevant information, and run eligibility. If necessary, override OSIPM with a **March 31, 2024** end date.

**Step 1**
Confirm the only termination reason was over income (OVI) or over resources (OVR) **and** the person was getting OSIPM before the termination. Remember, if other people on the case are getting medical benefits, the case mode will still display as active.

It's also possible the person's OSIPM ended but they are still approved for a Medicare Savings Program (MSP). Follow this process to reopen OSIPM, even if the person is still eligible for an MSP.

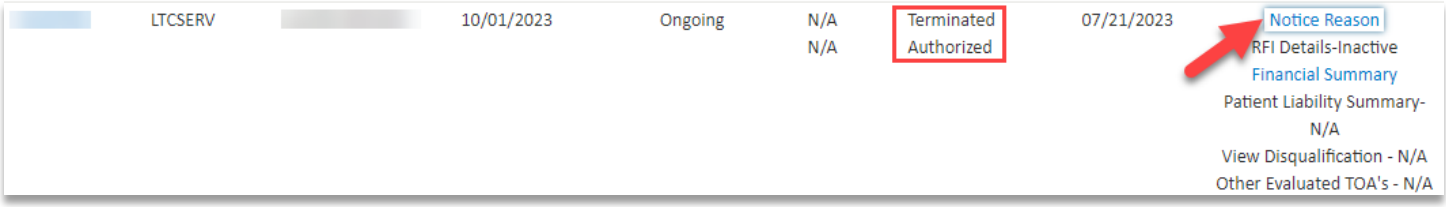


Currently Associated EDGs

Authorized EDGs

Medical

| EDG Name | Category of Assistance | Benefit Period | Eligibility Result | Edg Status | Authorization Date | Renewal Date | ISS NF/PIF | Override | EDG# |
|---|---|---|---|---|---|---|---|---|---|
| [redacted] | OSIPMOAA | 07/01/2023 - Ongoing | Fail | Terminated | 06/03/2023 | | N/A N/A | N | [redacted] |
| [redacted] | QMBP | 07/01/2023 - Ongoing | Pass | Approved | 06/03/2023 | 06/30/2024 | N/A N/A | N | [redacted] |
| [redacted] | OSIPMOAA | 07/01/2023 - Ongoing | Fail | Terminated | 06/03/2023 | | N/A N/A | N | [redacted] |
| [redacted] | QMBP | 07/01/2023 - Ongoing | Pass | Approved | 06/03/2023 | 06/30/2024 | N/A N/A | N | [redacted] |




Follow these instructions if any of the medical TOAs below have ended **since 03/31/2023**.

- SSIR; 1619B
- OSIPMAD/AB/OAA
- PTCC; PTDC; OMSW
- OSIPMEPD
- OSIPMACS
- OSIPMBHI
- LTCSERV
- All Healthier Oregon TOAs

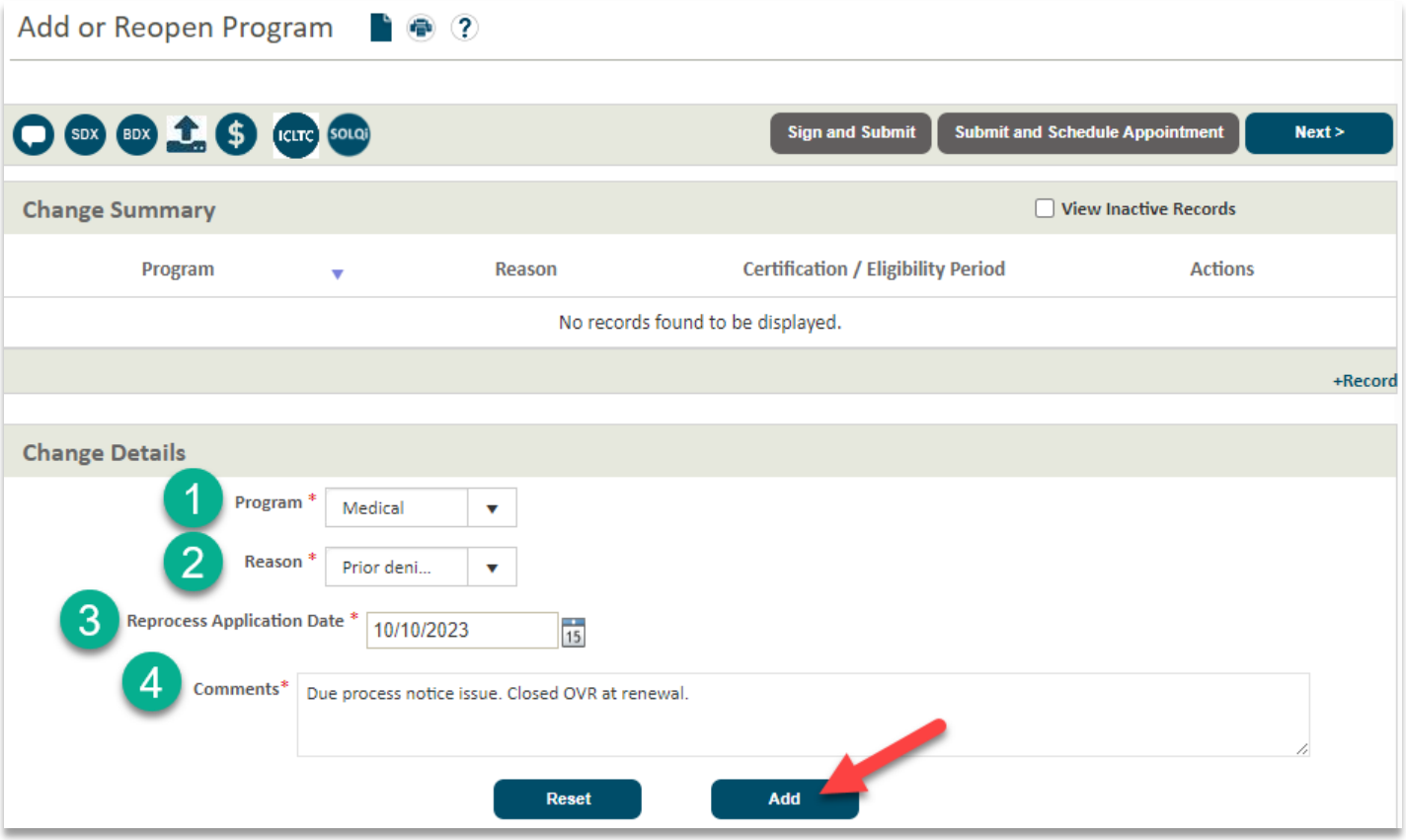
If OSIPM was closed for reason(s) other than being OVI or OVR, explain the reason(s) medical was closed and confirm the information used in the decision was correct. Ask the person if they would like to reapply or request a hearing.

If OSIPM was closed for being OVI or OVR, continue to **Step 2**.

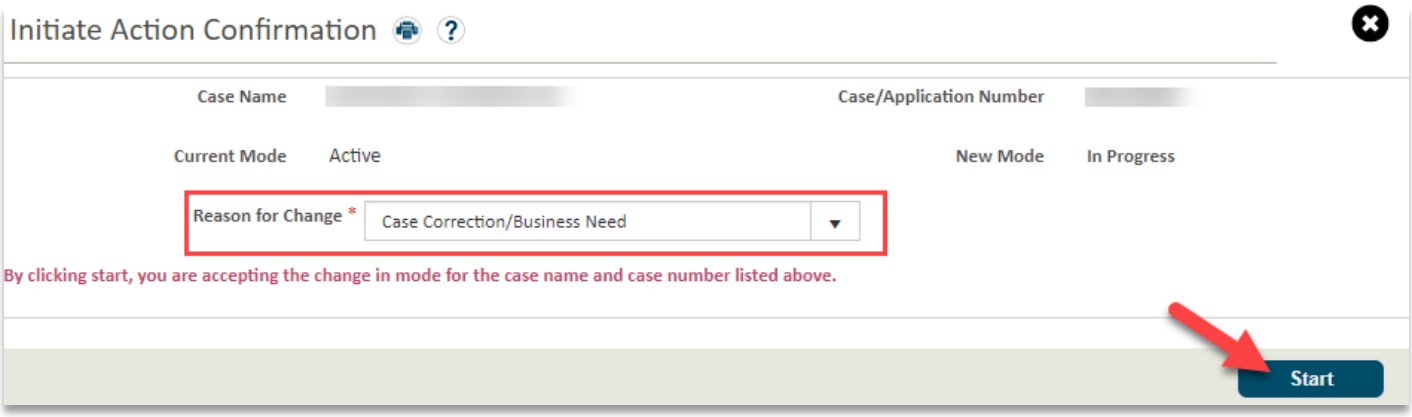
**Step 2**

If the case is discontinued/inactive, select **Add or Reopen Program** from the **Case Summary**. If medical is approved **Report a Change** or **Continue Next Action** as appropriate.

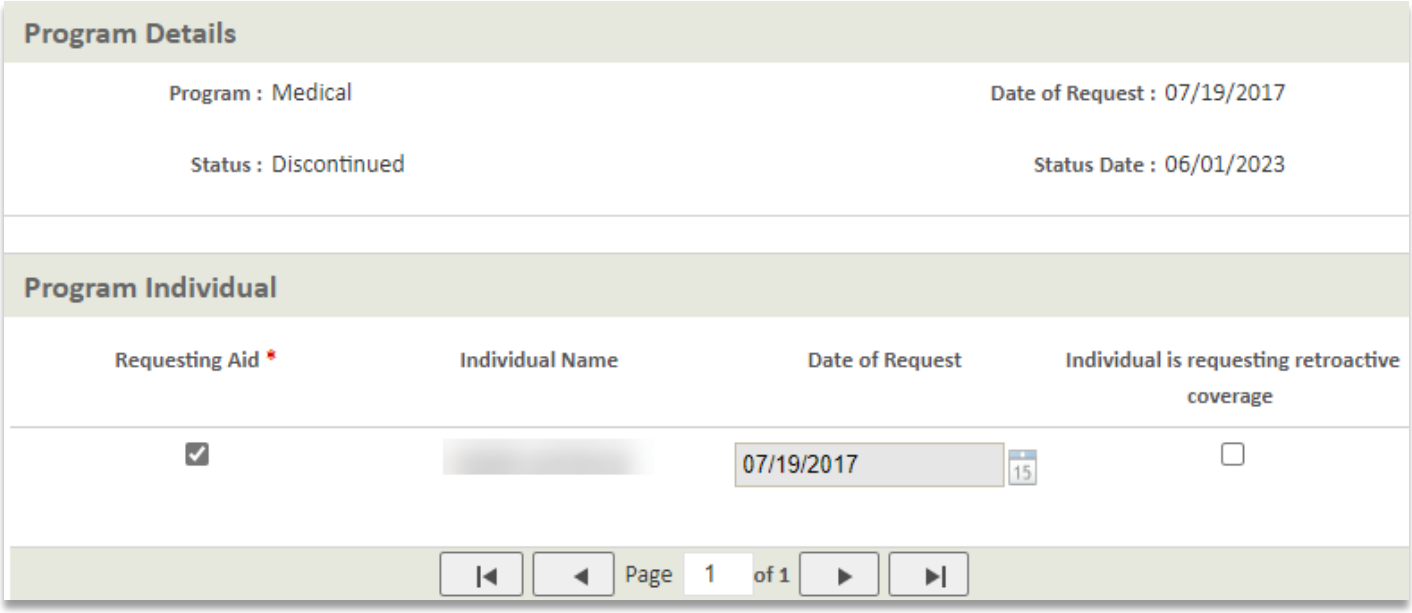
- When using **Add or Reopen Program** use **Prior Denial/Closure Correct – Reapplying for Program** as the **Reason.**
- Use today's date as the **Reprocess Application Date**.
- Enter "Due Process Notice Issue. Closed OVI/OVR at renewal" in the Comments field.




- When using **Report a Change**, use **Case Correction/Business Need** as the **Reason for Change**.



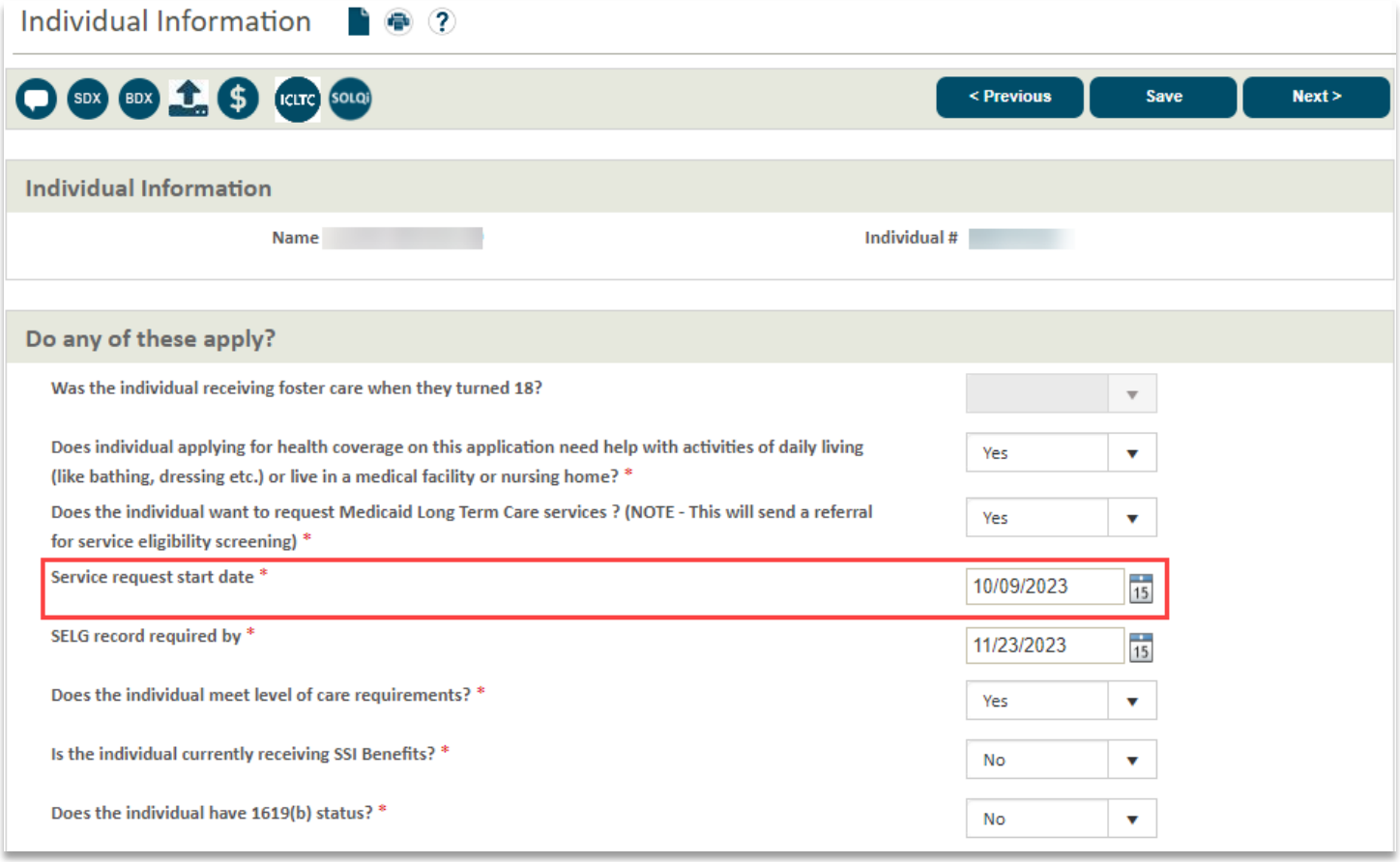

Add the medical program request for the person if needed.



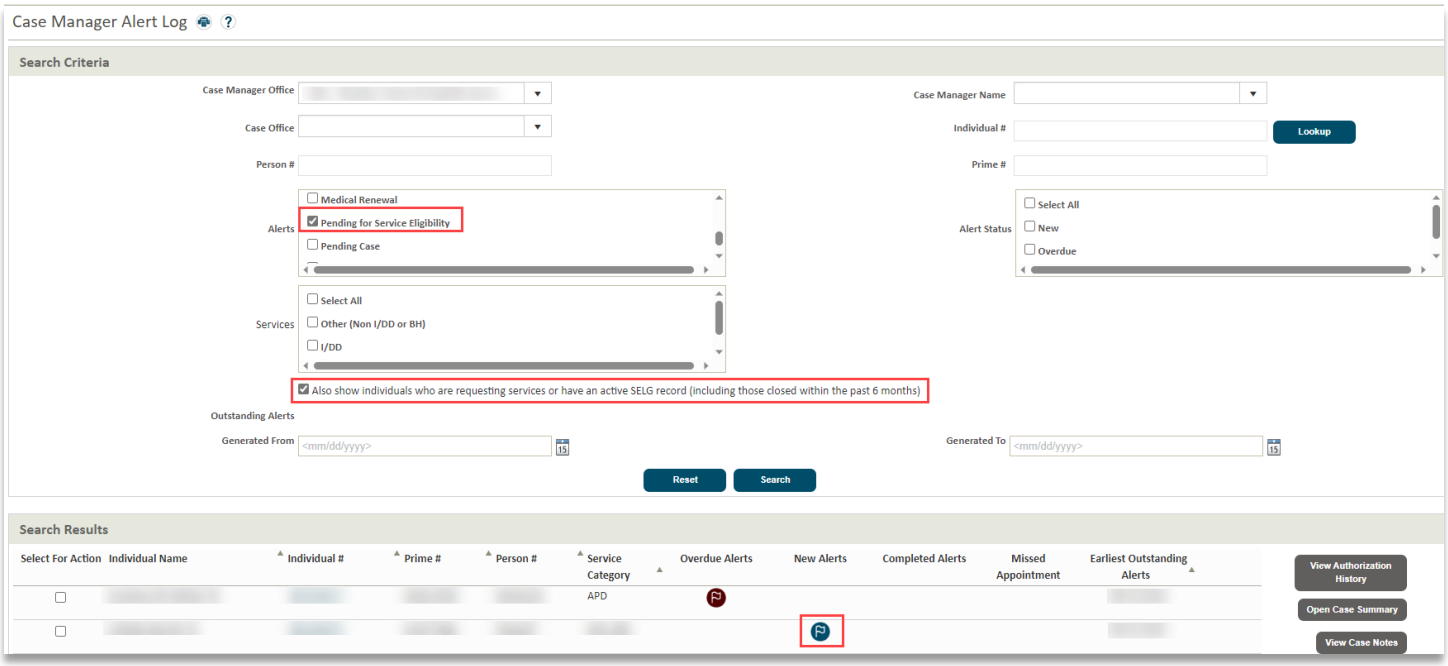

**Step 3**
If the person was receiving long-term services and supports (NMAGISERV or LTCSERV) before their medical ended, update the **Individual Information** screen with a new service request using today's date.

Change the question, "Does the individual applying for health coverage on this application need help with activities of daily living (like bathing, dressing, etc.) or live in a medical facility or nursing home?" to **no** and then back to **yes** to enable the following question.

Answer **yes** to the question, "Does the individual want to request Medicaid Long-Term Care services?" The LTC Service Request task will be created on click of **next**.

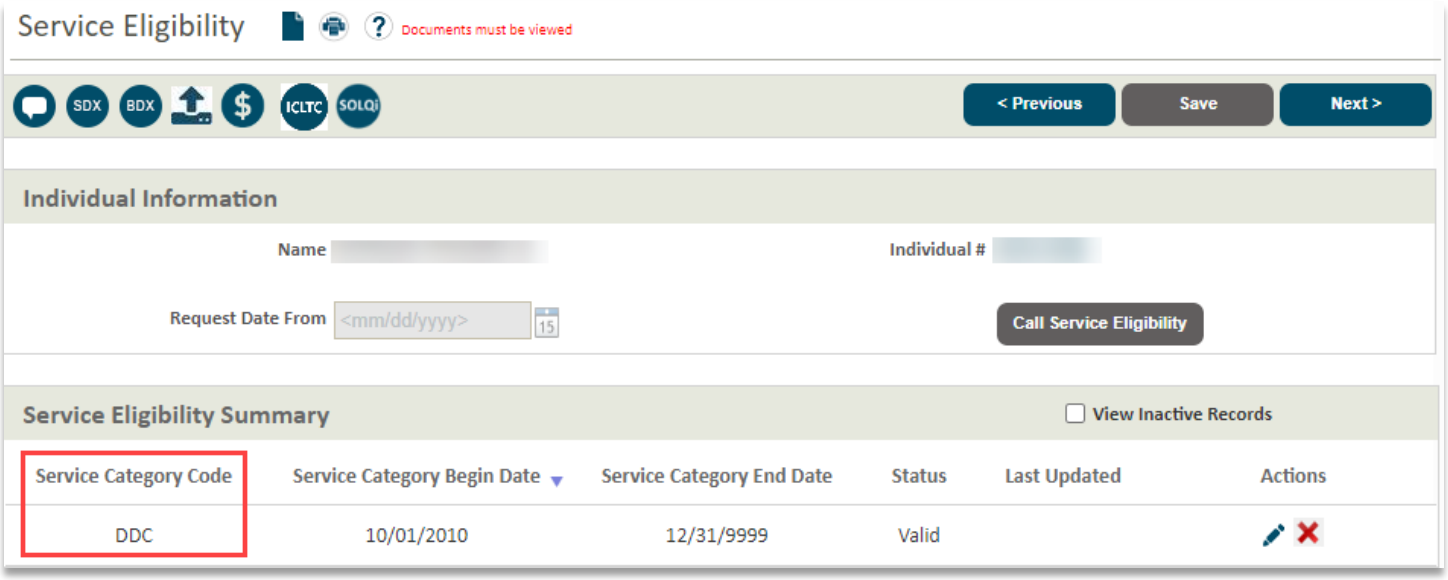



APD/AAA Case Managers are notified of pending service requests on the CM Alert Log.




View the **Service Eligibility** screen.

- If the person was getting Intellectual or Developmental Disability (I/DD) services, refer them to their county's I/DD office.
- If the person was getting behavioral health services, refer them to their county's Community Mental Health Program (CMHP).




**Step 4**
Review the case to make sure income and resources were properly excluded if appropriate. Common non-MAGI exclusion reasons include:

1. Primary residence of the applicant and/or their spouse.
2. Vehicle used for transportation.
3. Current month's income.

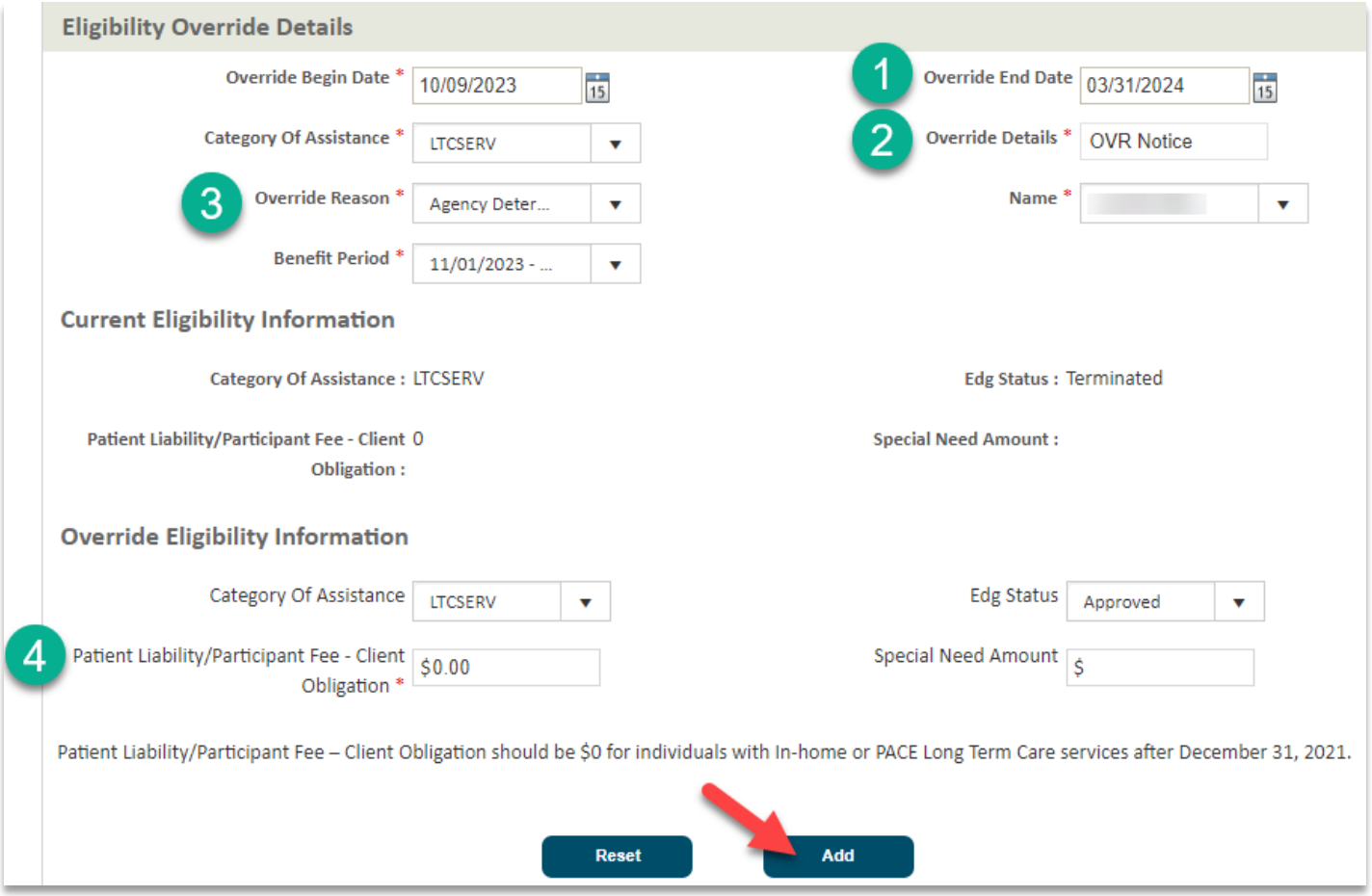
Ask the person or their Authorized Representative if any income or resource information has changed, update the case accordingly, and run eligibility. More information is in the Resources, Income and Income Types QRGs, and in OPEN by searching **Treatment of Specific Assets**.

**Step 5**
**If they are eligible after running eligibility, do not override and stop here.** If they have income over 300% of the SSI standard and are receiving long-term services and supports, they may need to establish an Income Cap Trust to stay eligible.

If the person is still OVI/OVR after running eligibility, override the terminated/denied non-MAGI TOAs to approved.

- Enter **03/31/2024** as the override end date.
- Enter "OVI/OVR Notice Issue" in the **Override Details** field using the correct Notice Reason.

- Use **Agency Determination** as the **Override Reason**.
- If there was a client obligated patient liability or participant fee for the terminated TOA, enter that amount.




If using override to approve non-MAGI, inform the person of program income and resource standards and let them know they are still OVI/OVR for the program but have been temporarily approved.

- If the person was getting a Medical Related Payment (MRP), add the payment record back.
- View the **Financial Summary** and review how their countable income and resources were determined.
- If the person has resources over allowable limits, use the Excess Resources for OSIPM Talking Points QRG to talk about resource limits and how they can avoid a potentially disqualifying transfer of assets.
- Refer them to the ADRC and/or 211 for financial and/or legal resources.
- Let the person know they will go through another medical renewal before **March 31, 2024**.
- Confirm we have the correct contact information, including phone number and mailing address.

**Step 6**
Add a detailed case note to explain the reason for the action(s):

[Person/Authorized Representative's Name] contacted Department because OSIPM closed on [insert date]. Reviewed notice reasons and confirmed individual's [TOA(s)] closed due to OVI/OVR. Reviewed case information and updated [detail any updates made to the case]. Ran eligibility and individual is/not eligible. Overrode [denied TOA] to approve with 03/31/2024 end date using OVI/OVR Notice reason. Let individual know they will go through another renewal before 03/31/2024 and referred to ADRC/211 for financial/legal resources.