No. 14-6191

IN THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

MELISSA WILSON, *et al.*,

Plaintiffs-Appellees,

v.

DARIN GORDON, in his official capacity as Deputy Commissioner of the Tennessee Department of Finance & Administration and Director of the Bureau of TennCare, *et al*.,

Defendants-Appellants.

On Appeal from the United States District Court
For the Middle District of Tennessee, No. 3-14-1492

APPELLANTS' OPENING BRIEF

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November 26, 2014

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

Disclosure of Corporate Affiliations and Financial Interest

Sixth Circuit
Case Number: 14-6191 Case Name: Wilson, et al. v. Gordon, et al.

Name of counsel: Michael W. Kirk

Pursuant to 6th Cir. R. 26.1, Darin Gordon, et al.
Name of Party

makes the following disclosure:

1. Is said party a subsidiary or affiliate of a publicly owned corporation? If Yes, list below the identity of the parent corporation or affiliate and the relationship between it and the named party:

No.

2. Is there a publicly owned corporation, not a party to the appeal, that has a financial interest in the outcome? If yes, list the identity of such corporation and the nature of the financial interest:

CERTIFICATE OF SERVICE

I certify that on November 26, 2014 the foregoing document was served on all parties or their counsel of record through the CM/ECF system if they are registered users or, if they are not, by placing a true and correct copy in the United States mail, postage prepaid, to their address of record.

s/ Michael W. Kirk
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This statement is filed twice: when the appeal is initially opened and later, in the principal briefs, immediately preceding the table of contents. See 6th Cir. R. 26.1 on page 2 of this form.

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STATEMENT IN SUPPORT OF ORAL ARGUMENT

Defendants-Appellants (the "State") respectfully request oral argument. This appeal raises important questions concerning (i) the federal courts' subject matter jurisdiction to hear class actions after the named plaintiffs' individual claims have become moot, and (ii) the assignment of state and federal responsibilities for Medicaid eligibility determinations after the Affordable Care Act ("ACA").

JURISDICTIONAL STATEMENT

The district court issued the preliminary injunction at issue in this appeal on September 2, 2014, and the State filed a timely notice of appeal on September 26, 2014. Before Plaintiffs' claims became moot, the district court had subject matter jurisdiction over this case under 28 U.S.C. § 1331 and 28 U.S.C. § 1343(a)(3) and (4). This Court has jurisdiction to review the district court's issuance of the preliminary injunction under 28 U.S.C. § 1292(a)(1). *See Williamson v. Recovery Ltd. P'ship*, 731 F.3d 608, 620 (6th Cir. 2013).

STATEMENT OF THE ISSUES

1. Do the federal courts retain subject matter jurisdiction over a putative class action where all of the named plaintiffs bargain for and obtain complete relief on their individual claims, such that their claims are moot, before a class is certified?

2. Did Plaintiffs demonstrate a likelihood of success on the merits of their claim that the State is legally liable for the Federal Exchange's alleged failure to promptly adjudicate certain Medicaid applications?

3. Did the district court abuse its discretion by issuing a preliminary injunction that overturns the State's considered judgment about how to most effectively implement the ACA's changes to Medicaid?

4. Did the district court abuse its discretion by ordering the State to conduct hearings on delayed applications submitted to the Federal Exchange without joining the federal government as a required party or accounting for the fact that the State does not have access to information it needs to hold hearings in a manner that comports with federal law?

STATEMENT OF THE CASE

The federal Medicaid program, originally "created in 1965 under Title XIX of the Social Security Act, . . . pays for medical and health-related assistance for certain low-income individuals and families." *Caremark, Inc. v. Goetz*, 480 F.3d 779, 783 (6th Cir. 2007). Prior to January 1, 2014, Medicaid was "administered [solely] by the states but financed with both state and federal funds." *Id.* In the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified in scattered sections of 26 & 42 U.S.C.) [hereinafter "Affordable Care Act" or "ACA"], Congress for the first time instructed the Secretary of Health

and Human Services, acting through the Centers for Medicare and Medicaid Services ("CMS"), to participate directly in the administration of the Medicaid program. Specifically, the ACA required the Secretary to establish and operate a Federal Exchange that, among other responsibilities, must accept and adjudicate applications for enrollment into Medicaid. *See* 42 U.S.C. §§ 18041(c), 18083(a).

Tennessee's Medicaid program, known as TennCare, is administered by the Bureau of TennCare, which is housed within the Division of Health Care Finance and Administration, which itself is part of the State's Department of Finance and Administration. *See* Declaration of Darin Gordon ("Gordon Decl."), R.E. 52 at 660, ¶ 1.[1] Currently TennCare serves approximately 1.2 million enrollees. *Id.* at 661, ¶ 2.

A. Federal Law Mandates the Creation of a Federal Exchange and Authorizes States To Rely on the Exchange To Make Certain Medicaid Eligibility Determinations.

The ACA provided for the establishment of "Exchanges" through which individuals can apply for healthcare coverage under a number of different programs, including Medicaid. *See* 42 U.S.C. §§ 18031, 18041, 18083(a). The statute authorizes states to operate their own Exchanges, and instructs the Secretary to establish a federally operated Exchange in all states that choose not to establish

[1] In accordance with 6th Cir. R. 28(a)(1), all record materials are cited to the relevant ECF PageID #, rather than the page number of the underlying document.

their own. *See id.* § 18041(c); *see also National Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2665 (2012). In 2014, only 14 states and the District of Columbia established state Exchanges. *See* Richard Cauchi, *State Actions To Address Health Insurance Exchanges*, Nat'l Conference of State Legislatures (May 9, 2014), http://goo.gl/wtCmFm. Accordingly, CMS established and operates a Federal Exchange—sometimes called the "federally-facilitated marketplace," "FFM," or "HealthCare.gov"—in the 36 remaining states, including Tennessee. *Id*.

Under the ACA, every Exchange—including the Federal Exchange—must accept applications for Medicaid benefits. 42 U.S.C. § 18083(a). In states like Tennessee that use the Federal Exchange, CMS regulations give state officials a choice as to how Medicaid applications submitted to the Exchange are processed. States can opt for a "determination model," under which the Federal Exchange makes final eligibility determinations for most Medicaid applicants and forwards to the state the names of those found eligible for enrollment. *See* 42 C.F.R. §§ 431.10(c)(1)(i), 435.1200(c). Alternatively, states can choose to adopt an "assessment model," under which final eligibility determinations are left to the state. *See* 45 C.F.R. § 155.302(b); 42 C.F.R. § 435.1200(d).

Consistent with federal regulations and CMS guidance, Tennessee and eleven other states initially chose a determination model. *See* CMS, *Medicaid and CHIP Marketplace Interactions*, http://goo.gl/cc0xa2. Some states, including

Tennessee as well as New Jersey, Pennsylvania, and Wisconsin, adopted the determination model on an interim basis while they worked to implement the ACA's many changes to state Medicaid programs. *Id.* Other states, including Alabama, Arkansas, and Montana, plan to rely on the Federal Exchange to make Medicaid eligibility determinations for the foreseeable future. *Id.*

B. The ACA Changes How Medicaid Eligibility Determinations Are Made.

In addition to changing who makes Medicaid eligibility determinations, the ACA also changed how those determinations are made. Prior to the ACA, states used a variety of methodologies for determining whether someone's income was low enough to qualify for Medicaid. The ACA largely replaced this patchwork of state rules for calculating deductions, income disregards, and the like with a single nationwide approach that depends on the applicant's Modified Adjusted Gross Income ("MAGI"). *See* ACA, Pub. L. No. 11-148, § 2002 (codified at 42 U.S.C. § 1396a(e)(14)); 42 U.S.C. § 1397bb(b)(1)(B)(v). The federally-mandated MAGI calculation is today the most common basis on which people qualify for Medicaid, but other Medicaid eligibility categories are still subject to the pre-ACA approach that varied from state to state. *See* 42 U.S.C. § 1396a(e)(14)(D). People who seek benefits under those categories are said to be "non-MAGI" applicants.

The ACA also mandated the creation of a streamlined Medicaid application, *see* 42 U.S.C. § 18083(b), which those charged with making eligibility

determinations must use in conjunction with data queried electronically from agencies such as the Internal Revenue Service ("IRS") and the Social Security Administration ("SSA"), *see id.* § 18083(c); *see also* 42 C.F.R. § 435.949. To facilitate that process, CMS created the Data Services Hub, which CMS describes as "provid[ing] one connection to the common federal data sources needed to verify consumer application information for income, citizenship, immigration status, access to minimum essential coverage, etc." Kathleen Sebelius, *What's Working in the Marketplace: The Data Services Hub*, HHS (Oct. 26, 2013), http://goo.gl/IsPQTb (last visited Nov. 26, 2014). The ACA prohibits a state from asking for information beyond what is on the streamlined application unless the applicant seeks a determination of eligibility in a non-MAGI category. *See* 42 U.S.C. § 18083(b)(1)(C).

C. The Federal Exchange Assumes Responsibility for Certain TennCare Eligibility Determinations.

Implementing the ACA's changes to the Medicaid application process posed a special challenge for Tennessee because its pre-ACA computer system for making eligibility determinations could not be readily updated to perform MAGI calculations. *See* Declaration of Tracy Purcell ("Purcell Decl."), R.E. 55 at 712-13, ¶¶ 11-12. The State contracted with Northrop Grumman to build a new eligibility system capable of making the required calculations, but to the State's frustration that new system is not yet working. *Id.* at 715, ¶ 15.

When it became apparent that the new system would not be operational in time for implementation of the ACA, Tennessee sought and obtained permission from CMS to direct applications requiring MAGI eligibility determinations to the Federal Exchange. *See* Tennessee's Strategy for October 1, 2013 Mitigation Plan, R.E. 4-1 at 274. As previously noted, the State elected to use a "determination model" for these applications, whereby the Federal Exchange makes final determinations of Medicaid MAGI-eligibility and transmits those decisions to the State. *See id*. Under this arrangement, the State continues to use existing verification methodologies for any individual who applied for TennCare benefits under one of the categories not subject to the new MAGI rules. *See id.* This approach, including the State's strategy of sending all MAGI-applicants to the Federal Exchange, was approved by CMS. *See* CMS Approval Letter R.E. 4-1 at 263; *see also* CMS Letter to TennCare (June 27, 2014), R.E. 4-1 at 298, Ex. 14 (CMS approved use of the Federal Exchange "to receive and process [all MAGI] applications on the state's behalf . . . as a short-term measure, not a long-term solution").

The process currently in place for TennCare enrollment is working for the vast majority of applicants. Purcell Decl., R.E. 55 at 718, ¶ 19. Between January 1, 2014 and the end of June, the Federal Exchange approved approximately 89,000 applicants from Tennessee in MAGI categories and the State took the needed

action to assure these individuals were enrolled in TennCare. *Id*. In addition, TennCare enrolled approximately 27,000 non-MAGI enrollees and 19,000 deemed newborns pursuant to 42 C.F.R. § 435.117(a). *Id*. Indeed, the number of new TennCare enrollees in the first quarter of 2014 was the third highest such figure in the program's 20-year history. *Id*. Enrollment in TennCare has risen at a greater percentage rate than even the rate in some states that expanded their Medicaid programs. *See* CMS Enrollment Percentage Change Chart for April, R.E. 55-2 at 729. CMS reports that as of April, Tennessee had an enrollment increase rate of 6 percent over pre-ACA enrollment numbers, while the average rate change for non-expansion states like Tennessee is 2.4 percent—less than half the rate of increase that Tennessee has achieved. *See id.* at 731.

D. The Federal Exchange Fails To Make Timely Eligibility Determinations for Some TennCare Applicants.

The initial rollout of the Federal Exchange did not go smoothly, and its role processing TennCare applications was no exception. At first, the Federal Exchange was unable to even tell the State who it had adjudged eligible for TennCare in the manner required by federal law, but federal and state officials worked together to quickly develop and implement a solution to that problem. *See* Declaration of Wendy Long ("Long Decl."), R.E. 54 at 678-79, ¶ 3(a); Letter from Cindy Mann, Director, CMS, to State Health Officials and State Medicaid Directors, (Nov. 29, 2013), http://goo.gl/gSpZV0. The Federal Exchange also

struggled to process the TennCare applications of certain pregnant women and Medicare enrollees—two discrete groups the State was able to help by developing processes through which those affected could receive TennCare benefits without applying to the Federal Exchange. *See* Long Decl., R.E. 54 at 679-80, ¶¶ 3(b), 3(c).

Many of the problems the Federal Exchange had with processing Medicaid applications had been addressed by the State through Tennessee-specific work-arounds by the time this suit was filed in July 2014, but three significant problems persisted. First, and most importantly, the Federal Exchange has been unable to timely process Medicaid applications flagged by its computer system for data inconsistencies. As explained above, the ACA requires the Federal Exchange to electronically query agencies such as the IRS and the SSA, using the Data Services Hub, to obtain relevant data concerning individual Medicaid applications. *See* 42 U.S.C. § 18083(c); 42 C.F.R. § 435.949. When a discrepancy arises between the data obtained from the Hub and the individual's application (for example, a discrepancy concerning the applicant's income as reported on the application versus income as reported in the IRS's database), the Federal Exchange will request that the applicant submit verification documentation (for example, copies of pay stubs). Although the State has no involvement in this process, its understanding is that the Federal Exchange has not developed a process for

reviewing the supplemental verification documentation submitted by applicants and, as a result, adjudication of those applications has been delayed. *See* Supplemental Declaration of Wendy Long ("Long Supp. Decl."), R.E. 80-3 at 1195-96, ¶ 12. This problem is not unique to Tennessee; Medicaid applicants in every state that relies on the Federal Exchange to make eligibility determinations face the same difficulty.

The State's ability to redress delays caused by the first problem has been greatly hampered by a second: the Federal Exchange has not provided the State with the basic information it needs to process those individuals' applications itself. When this suit was filed, the Federal Exchange's practice was not to share *any* information about individuals whose TennCare applications it had received but not yet adjudicated. *See* Long Decl., R.E. 54 at 684-85, ¶ 3(h). As a result, the State had no idea who or how many people had suffered delays due to the Federal Exchange's failure to timely review supplemental verification materials. In the intervening months, the situation has only marginally improved, with the Federal Exchange intermittently sending the State so-called "special flat files"—essentially giant Excel spreadsheets—listing the names of people whose unadjudicated applications were flagged for some type of data inconsistency. *See* Long Supp. Decl., R.E. 80-3 at 1191, 1194-95, ¶¶ 4, 11. These flat files do not contain reliable application dates or information from any subsequent correspondence between the

applicant and the Federal Exchange. *Id.* at 1192, ¶ 6. This makes it impossible for the State to tell from the flat files how long an applicant has been waiting or whether he has satisfactorily responded to a Federal Exchange request for supplemental verification.

Despite their substantial limitations, the flat files have enabled the State to implement a new process to assist Tennesseans whose Medicaid applications have been delayed by the Federal Exchange. In some instances, the State can resolve a data inconsistency using information in its own files. Where an applicant's reported income is at odds with IRS data, for example, the State can sometimes use information relating to the applicant's participation in the state food stamp program to resolve the inconsistency and issue a decision on the pending TennCare application. *See* TennCare, *Do You Need To Know How To File an Eligibility Appeal?*, http://goo.gl/qdkOD9. In other cases, the State may be able to obtain additional needed information from the applicant. In this manner, the State has begun adjudicating the delayed Medicaid applications of the individuals listed on the flat files.

When this suit was filed, there was also a third problem with the Federal Exchange's handling of TennCare applications: the Federal Exchange did a bad job processing the TennCare applications of babies born to mothers not eligible for TennCare (mostly mothers whose immigration status disqualifies them from

enrolling in Medicaid). *See* Long Decl., R.E. 54 at 681-82, ¶ 3(d). To address that problem, the State sought CMS approval in May 2014 to create a presumptive eligibility process for these newborns that would enable them to be enrolled in TennCare beginning at birth without requiring submission of a Medicaid application to the Federal Exchange. *See id*. CMS eventually signaled that it would approve this plan, and the State informed Plaintiffs' counsel of this development the night before they filed this lawsuit. *Id*.

E. Plaintiffs Sue the State over the Federal Exchange's Failure To Timely Adjudicate Their TennCare Applications.

On July 23, 2014, despite the fact that the State has no control over the Federal Exchange's processing of Medicaid applications, eleven named plaintiffs sued the State over the Federal Exchange's failure to promptly act on their applications. Each Plaintiff alleged that he or she had submitted an application to the Federal Exchange. *See* Complaint, R.E. 1 at 23-32, ¶¶ 99, 103, 109, 115, 120, 127, 133-34, 141. Each alleged that he or she has not received a timely adjudication of that application. *See id*. at 23-32, ¶¶ 99, 104, 111, 115, 122, 131, 135, 141. Plaintiffs claimed that the State was obliged to somehow ensure that their applications be processed within 45 days, *see* 42 U.S.C. § 1396a(a)(8); 42 C.F.R. § 435.912(c)(3), and that the Medicaid Act and the Due Process Clause required the State to hold hearings on applications not adjudicated within that timeframe, *see* 42 U.S.C. § 1396a(a)(3). All of Plaintiffs' alleged injuries flowed

from the Exchange's failure to adjudicate their TennCare applications, and Plaintiffs sought only prospective declaratory and injunctive relief to redress those injuries. *See* Complaint, R.E. 1 at 37-38.

When they filed suit, the TennCare applications of ten of the named plaintiffs were still pending with the Federal Exchange. The only other named plaintiff—the infant S.P.—had been enrolled in TennCare on July 18, 2014. Declaration of Kim Hagan ("Hagan Decl."), R.E. 53 at 672, ¶ 13.

Plaintiffs initially requested an expedited hearing on their motions for a preliminary injunction and class certification, but they agreed to withdraw that request as part of a broader agreement with the State. Under the terms of the deal, Plaintiffs agreed to litigate their motions on an ordinary schedule and provide the State with the information it needed to adjudicate the TennCare applications of each of the named plaintiffs and up to 100 total delayed applications. In exchange, the State agreed that it would seek information from CMS that would enable it to adjudicate the TennCare applications, and if CMS provided the necessary information, the State would itself determine whether the named plaintiffs and other individuals identified by Plaintiffs' counsel were eligible for TennCare and enroll those who qualified. *See id.* ¶ 12.

As contemplated by the parties' agreement, Plaintiffs sent the State information about the named plaintiffs "to obtain eligibility determinations."

Declaration of Sara Zampierin ("Zampierin Decl."), R.E. 70-1 at 1018, ¶ 3; *see also* Hagan Decl., R.E. 53 at 672, ¶ 12 (explaining that "the State . . . agree[d] to provide individualized help for the named Plaintiffs"). The State used that information in conjunction with other information CMS provided from the Federal Exchange to adjudicate each of the named plaintiffs' TennCare applications, and each was determined to be eligible for TennCare. *See* Hagan Decl., R.E. 53 at 672, ¶ 13; Long Supp. Decl., R.E. 80-3 at 1193, ¶ 8. Through this process, all of the named plaintiffs were enrolled in TennCare on or before August 19, 2014. Long Supp. Decl., R.E. 80-3 at 1193, ¶ 8.

F. The District Court Certifies a Class and Issues an Injunction Even Though the Named Plaintiffs Are Already Enrolled in TennCare.

On September 2, 2014—two weeks after the last named plaintiff was enrolled in TennCare—the district court certified a class consisting of:

> All individuals who have applied for Medicaid (TennCare) on or after October 1, 2013, who have not received a final eligibility determination in 45 days (or in the case of disability applicants, 90 days), and who have not been given the opportunity for a "fair hearing" by the State Defendants after these time periods have run.

R.E. 90 at 1278. On the same day, the district court also issued a preliminary injunction directing the State "to provide the Plaintiff Class with an opportunity for a fair hearing on any delayed adjudication." PI Order, R.E. 91 at 1287. Under the terms of the injunction, the State must provide a hearing within 45 days to any class member who requests one and provides proof that he or she submitted a

TennCare application (or 90 days in the case of an application based on disability). *Id.* at 1287-88. In its certification order, the district court explained that these hearings are "for the purpose of determining the cause of the delay, not to appeal a denial of a claim." R.E. 90 at 1274.

The district court rejected the State's argument that the case should be dismissed as moot, reasoning that the State should not be allowed to "pick[ ] off" the named plaintiffs by enrolling them in TennCare and that the claims at issue here are both "inherently transitory" and "capable of repetition, yet evading review." *See* R.E. 90 at 1275-77; R.E. 91 at 1286-87.

The district court issued the preliminary injunction after concluding that Plaintiffs were likely to succeed on the merits because the State bears ultimate responsibility for delays caused by the Federal Exchange. R.E. 91 at 1284-85. In balancing the remaining factors and issuing the preliminary injunction, the district court refused to defer to the State's considered judgment that the relief requested by Plaintiffs would be an inefficient and counterproductive use of the State's limited resources. *Id*. at 1286. The court ordered the State to conduct hearings but did not explain how the State could do so without access to class members' complete case files, stating only that "there is no legal or factual barrier preventing the State from obtaining information about particular individuals from the Federal Exchange." *Id*.

SUMMARY OF ARGUMENT

The preliminary injunction should be vacated both because this case was moot when the district court issued it and because it was an abuse of discretion to hold the State legally responsible for delays caused by the Federal Exchange.

1. This Court has said that "it is doubtful that there is a live controversy" when the named plaintiffs in a class action "voluntarily relinquish[ ]" their claims. *Pettrey v. Enterprise Title Agency, Inc.*, 584 F.3d 701, 705 (6th Cir. 2009). That is what happened in this case when the named plaintiffs submitted information about themselves to the State and agreed to have the State use it to specially adjudicate their Medicaid applications in exchange for withdrawing their motion to expedite proceedings in the district court. By agreeing to and assisting in the mooting of their own claims, Plaintiffs deliberately gave up the ability to represent the class. The courts of appeals are divided on the question, but the better view under Sixth Circuit precedent is that where, as here, the named plaintiffs *willingly participate* in the mooting of their individual claims prior to class certification, "there is no longer a self-interested party advocating for class treatment in the manner necessary to satisfy Article III." *Ruppert v. Principal Life Ins. Co.*, 705 F.3d 839, 844 (8th Cir. 2013) (quoting *Rhodes v. E.I. du Pont de Nemours & Co.*, 636 F.3d 88, 100 (4th Cir. 2011)); *see Pettrey*, 584 F.3d at 705.

2. Plaintiffs' suit is also moot for a second, independent reason: the named plaintiffs were all enrolled in TennCare by the time the district court certified the class, thus bringing this case within the rule that "[w]here . . . the named plaintiff's claim becomes moot *before* certification, dismissal of the action is required." *Brunet v. City of Columbus*, 1 F.3d 390, 399 (6th Cir. 1993) (emphasis in original). Although the courts have recognized exceptions to that rule, none apply here because there is no evidence that the mooting of Plaintiffs' claims was part of a broader effort by the State to thwart class action proceedings, because an absent class member with a live claim could obtain a ruling on certification before his case becomes moot, and because there is no reason to believe that the named plaintiffs will have similar claims in the future. *See generally Cruz v. Farquharson*, 252 F.3d 530, 535 (1st Cir. 2001).

3. If the Court proceeds to the merits, it should reverse the preliminary injunction as an abuse of discretion. The district court's conclusion that Plaintiffs were likely to succeed on the merits was fundamentally flawed because the State is not legally liable for delays caused by the Federal Exchange. Rather, federal officials are responsible for the efficient processing of the Medicaid applications that they receive; to the extent that federal officials, rather than the State, make eligibility determinations, they stand in the State's shoes with respect to the federal requirement that Medicaid applications be adjudicated with reasonable promptness.

See 42 U.S.C. § 18041(c). Any other result would be unworkable, for the State is powerless to supervise the federal officials who operate the federal exchange.

4. Neither does a balancing of the other preliminary injunction factors support the district court's decision. The preliminary injunction undermines the State's ability to exercise its judgment about how best to effectively implement ACA-mandated changes to TennCare and assist those who are facing delays as a result of problems caused by the Federal Exchange.

5. The district court also abused its discretion by issuing the preliminary injunction without joining CMS as a required party or considering the extent to which injunctive relief should run against the federal officials who delayed processing of Plaintiffs' applications in the first place. Indeed, because CMS was not joined as a party and ordered to assist the State, the preliminary injunction exposes the State to inconsistent legal obligations. The district court ordered the State to hold hearings on delayed applications, but it cannot do so in a manner that comports with federal law because it does not have access to applicant case files, which remain in the sole possession of the federal government. *See* 42 C.F.R. § 431.242.

STANDARD OF REVIEW

"The issue of mootness implicates the court's subject matter jurisdiction," *Mosley v. Hairston*, 920 F.2d 409, 414 (6th Cir. 1990), and "[t]he standard of

review on the issue of subject matter jurisdiction is de novo." *American Landfill, Inc. v. Stark/Tuscarawas/Wayne Joint Solid Waste Mgmt. Dist.*, 166 F.3d 835, 837 (6th Cir. 1999).

This Court reviews a district court's issuance of a preliminary injunction for abuse of discretion. *Jolivette v. Husted*, 694 F.3d 760, 765 (6th Cir. 2012). Under that standard, the Court must review "the district court's legal conclusions de novo and its factual findings for clear error." *Taubman Co. v. Webfeats*, 319 F.3d 770, 774 (6th Cir. 2003). "[T]he determination of whether the movant is likely to succeed on the merits is a question of law and is accordingly reviewed de novo." *Ohio State Conference of NAACP v. Husted*, – F.3d –, 2014 WL 4724703, at *5 (6th Cir. Sept. 24, 2014) (citations and internal quotation marks omitted).

ARGUMENT

I. THE DISTRICT COURT LACKED SUBJECT MATTER JURISDICTION BECAUSE THE CASE IS MOOT.

The parties struck a bargain shortly after this suit was filed. Plaintiffs agreed to withdraw their motion to expedite proceedings in the district court, and in exchange the State agreed to specially process the TennCare applications of the named plaintiffs and up to 100 total applications identified by Plaintiffs' counsel as having been delayed. Pursuant to that agreement, Plaintiffs sent the State information about the named plaintiffs "to obtain eligibility determinations." Zampierin Decl., R.E. 70-1 at 1018, ¶ 3; *see also* Hagan Decl., R.E. 53 at 672, ¶ 12

(explaining that "the State . . . agree[d] to provide individualized help for the named Plaintiffs"). The State then used the information Plaintiffs provided in conjunction with other information it was able to obtain from the Federal Exchange, as supplemented, in some cases, by information in the State's own files, to adjudicate the named plaintiffs' TennCare applications. Hagan Decl., R.E. 53 at 672, ¶ 13; Long Supp. Decl., R.E. 80-3 at 1193, ¶ 8.[2] Through this process—a process for which Plaintiffs bargained—the last of the named plaintiffs was enrolled in TennCare on August 19, 2014. *See* Long Supp. Decl., R.E. 80-3 at 1193, ¶ 8.

The named plaintiffs agreed to have their TennCare applications handled by the State through the special process just described and are now enrolled in TennCare. That moots their individual claims. Consequently, for two independent reasons, they are no longer entitled to pursue this litigation on behalf of absent class members. First, the named plaintiffs may not represent the class after *voluntarily relinquishing* their individual claims as part of an agreement with the State. Second, this case is moot because the named plaintiffs' individual claims became moot *before* the district court certified the class.

[2] The State did not have occasion to use this process to adjudicate one of the eleven named plaintiffs' applications because she was already enrolled in TennCare when this suit was filed. *See* Hagan Decl., R.E. 53 at 672, ¶ 13.

A. Plaintiffs Cannot Continue To Press Claims on Behalf of the Class After Voluntarily Relinquishing Their Individual Claims.

Relaxed mootness rules apply when a class representative's claims become moot through no fault of his own, but the Supreme Court has left open the question whether those rules also apply to a named plaintiff who *voluntarily relinquishes* his individual claims. Thus, in *U.S. Parole Commission v. Geraghty*, the Court held that a plaintiff whose claim had expired upon his release from prison could appeal the denial of certification on behalf of the putative class but expressly reserved the question "whether a named plaintiff who *settles* [his] individual claim" could appeal under similar circumstances. 445 U.S. 388, 404 n.10 (1980) (emphasis added). Like *Geraghty*, every other Supreme Court case to touch on mootness in the class action context has involved events beyond the named plaintiff's control that arguably mooted his individual claims.[3] The courts of appeals are divided over whether named plaintiffs who take affirmative steps that moot their individual claims may continue to litigate on behalf of an uncertified class. But the better view under this Court's cases is that once "the named plaintiffs' claims [are]

[3] *E.g.*, *Deposit Guar. Nat'l Bank v. Roper*, 445 U.S. 326, 332 (1980) (wherein the defendant offered to settle named plaintiffs' claims for full amount sought but "[a]t no time did the named plaintiffs accept the tender in settlement of the case"); *Gerstein v. Pugh*, 420 U.S. 103, 110 n.11 (1975) (individual class members' claims automatically expired upon release from pretrial detention); *Sosna v. Iowa*, 419 U.S. 393, 395 (1975) (individual class members' claims automatically expired after no more than one year).

voluntarily relinquished," there is no longer sufficient adversity between the parties to satisfy Article III. *Pettrey*, 584 F.3d at 705. Accordingly, because Plaintiffs voluntarily relinquished their individual claims by agreeing to have the State enroll them in TennCare through a process not available to other class members, this case is moot.

In *Pettrey v. Enterprise Title Agency, Inc.*, the district court refused to certify a class, and the named plaintiffs then settled their individual claims and sought to appeal the certification ruling. This Court dismissed the case as moot, explaining that "it is doubtful that there is a live controversy here because the named plaintiffs' claims were voluntarily relinquished," and that in any event the case was moot because the plaintiffs had settled not only their individual claims but also their right to recover attorneys' fees and costs from the class. *Id.* To be sure, unlike the plaintiffs in *Pettrey*, Plaintiffs here have not relinquished any rights to attorneys' fees and costs. But *Pettrey* says it is "doubtful that there is a live controversy" once the named plaintiffs voluntarily relinquish their individual claims *regardless* of whether they "retain[ ] personal stakes in [the] litigation by virtue of the fact that they could . . . shift[ ] the litigation costs to their fellow class members if they succeed[ ] in obtaining class certification." *Id.* The *Pettrey* Court's doubts were well-founded, for an "interest in attorney's fees is, of course, insufficient to create an Article III case or controversy where none exists on the

merits of the underlying claim." *Lewis v. Continental Bank Corp.*, 494 U.S. 472, 480 (1990). Accordingly, this case is moot.

The Eighth Circuit approvingly cited this Court's decision in *Pettrey* when it held that an interest in shifting fees and costs to other class members is not enough to prevent a case from becoming moot following the named plaintiffs' voluntary settlement of their individual claims. *Ruppert v. Principal Life Ins. Co.*, 705 F.3d 839, 844 (8th Cir. 2013). In so ruling, the Eighth Circuit endorsed the Fourth Circuit's view that "when a putative class plaintiff voluntarily dismisses the individual claims underlying a request for class certification, . . . there is no longer a self-interested party advocating for class treatment in the manner necessary to satisfy Article III standing requirements." *Id.* (quoting *Rhodes v. E.I. du Pont de Nemours & Co.*, 636 F.3d 88, 100 (4th Cir. 2011)). Put another way, once the named plaintiffs *willingly* relinquish the attributes that made them class members in the first place, they no longer have the kind of "personal stake in the controversy" necessary to guarantee the concrete, adversarial presentation that Article III requires. *Brunet v. City of Columbus*, 1 F.3d 390, 400 (6th Cir. 1993) (dismissing uncertified class action suit as moot after named plaintiffs settled their individual claims); *see also Camesi v. University of Pittsburgh Med. Ctr.*, 729 F.3d 239, 248 (3d Cir. 2013) (citing *Pettrey* and observing in the Fair Labor Standards Act collective action context that "it would be anomalous to conclude that

[plaintiffs who settle their individual claims] are 'similarly situated' " to absent class members who "have actually retained their individual claims"). *Cf. U.S. Bancorp Mortg. Co. v. Bonner Mall P'ship*, 513 U.S. 18, 25 (1994) (distinguishing, for purposes of the *Munsingwear* mootness doctrine, between a party whose claim becomes moot due to "the vagaries of circumstance" and a party who "has voluntarily forfeited his legal remedy").

Three court of appeals opinions take a contrary approach. In *Pastor v. State Farm Mutual Automobile Insurance Co.*, the Seventh Circuit said without explanation that a named plaintiff could continue to pursue claims on behalf of the class because the settlement of her individual claims "did not resolve the dispute between the unnamed class members and the defendant and so did not render the case moot." 487 F.3d 1042, 1043-44 (7th Cir. 2007). Similarly, in *Richards v. Delta Air Lines, Inc.*, the D.C. Circuit said that it "see[s] no difference between those who voluntarily settle individual claims and those who have their individual claims involuntarily extinguished." 453 F.3d 525, 529 (D.C. Cir. 2006); *accord Love v. Turlington*, 733 F.2d 1562, 1564 (11th Cir. 1984). Those opinions contain almost no analysis and are at odds with this Court's observation in *Pettrey* that the Supreme Court has "recognized the distinction between a voluntary relinquishment of claims and an involuntary termination of claims." 584 F.3d at 705. Furthermore, when they decided this issue, the Seventh, D.C., and Eleventh

Circuits did not have the benefit of the more recent and more thoroughly reasoned court of appeals decisions discussed above. This Court should follow its own decision in *Pettrey* and the clear trend among the courts of appeals and hold that this case is moot because Plaintiffs voluntarily relinquished their individual claims.

B. Plaintiffs Cannot Press Claims on Behalf of the Class Because Their Individual Claims Became Moot Prior to Certification.

Quite apart from the fact that the named plaintiffs assented to the mooting of their individual claims, this case is moot because their claims became moot prior to certification. The general rule in class action cases is clear: "[w]here . . . the named plaintiff's claim becomes moot *before* certification, dismissal of the action is required." *Brunet*, 1 F.3d at 399 (citing *Sosna*, 419 U.S. at 399)). Under that rule, the complaint must be dismissed because the district court did not certify a class until after all of the named plaintiffs were enrolled in TennCare.

The district court did not agree because it concluded that this case is subject to three exceptions to the usual practice of dismissing the class action complaint where all named plaintiffs' claims become moot prior to certification. But for the reasons that follow, the district court was wrong on all three counts.

1. The State did not "pick off" the named plaintiffs to evade class-wide proceedings.

In holding that Plaintiffs could continue to pursue this case even though their individual claims are moot, the district court expressed concern that a contrary

ruling would allow the State to " 'pick[ ] off' the named Plaintiffs" and thereby " 'opt out' of a class action lawsuit by simply providing relief to the named Plaintiffs." R.E. 90 at 1276 (citing *Carroll v. United Compucred Collections, Inc.*, 399 F.3d 620, 625 (6th Cir. 2005)). But that concern is not implicated where, as here, the named plaintiffs *voluntarily accede* to the mooting of their individual claims. "[L]ike any plaintiff," the named plaintiff in a class action case "can assent to a settlement ending her suit." *Genesis Healthcare Corp. v. Symczyk*, 133 S. Ct. 1523, 1535 (2013) (Kagan, J., dissenting); *see, e.g.*, *Potter v. Northwest Mortg., Inc.*, 329 F.3d 608, 611 (8th Cir. 2003); *Toms v. Allied Bond & Collection Agency, Inc.*, 179 F.3d 103, 106 (4th Cir. 1999); *Walsh v. Ford Motor Co.*, 945 F.2d 1188, 1189 (D.C. Cir. 1991) (R. Ginsburg, J.). At bottom, that is what happened here, and thus a ruling for the State would not empower defendants to avoid class actions by "involuntarily terminat[ing]" a named plaintiff's claim. *Pettrey*, 584 F.3d at 705.

But even if the State had unilaterally acted on Plaintiffs' individual Medicaid applications, that would not be enough, standing alone, to support the inference that the State was impermissibly attempting to "pick off" the named plaintiffs and that the named plaintiffs should therefore be allowed to continue pressing claims on behalf of the class. To the contrary, the federal courts are reluctant to conclude that governmental officials are engaged in "a scurrilous pattern and practice of

thwarting judicial review" of class actions, and the mere mooting of named plaintiffs' claims on a single occasion is "too frail a foundation" to support such a finding. *Cruz v. Farquharson*, 252 F.3d 530, 535 (1st Cir. 2001).

The record here not only fails to support such an inference, it positively refutes it. As the parties jointly explained to the Court, the State agreed "to take certain actions to alleviate the immediate concerns of the Plaintiffs" (i.e., the actions that led to Plaintiffs' enrollment in TennCare and the mooting of their claims) not for the purpose of "picking them off," but rather in exchange for Plaintiffs' agreement to "withdraw their motion for an expedited hearing, [R.E.] 6, and along with the State, respectfully request that the Court grant the State until August 14, 2014 to file its responses to the motion for class certification and a preliminary injunction." R.E. 24 at 370-71.

In *Cruz*, the First Circuit held that named plaintiffs who sued over the delayed processing of green card applications could not continue to pursue claims on behalf of an uncertified class after their applications were adjudicated. The Ninth Circuit reached a similar result in *Sze v. INS*, 153 F.3d 1005, 1008 (9th Cir. 1998), declining to infer from the defendant's resolution of the named plaintiffs' naturalization applications that the defendant was deliberately attempting to thwart class action proceedings. *See id.* ("Plaintiffs have demonstrated no more than correlation; they have not shown causation."); *see also Rocky v. King*, 900 F.2d

864, 870-71 (5th Cir. 1990). This case is easier than *Cruz* and *Sze*. There is no evidence to support the supposition that the State deliberately sought to thwart class action proceedings, the record affirmatively provides an alternative explanation for the State's actions, the State took those actions with the express agreement of Plaintiffs, and there is no evidence supporting the conclusion that the class claims in this case will evade judicial review unless these Plaintiffs are allowed to press them.

It bears emphasis that recent pronouncements by both the Supreme Court and this Court raise doubts about the continuing vitality of cases suggesting that a suit does not become moot when a defendant attempts to avoid class litigation by "picking off" the named plaintiffs. The Supreme Court recently characterized its discussion of that issue in *Roper* as "dicta" and approved an effort by a defendant to avoid an FLSA collective action by deliberately mooting the named plaintiff's claim. *Genesis Healthcare*, 133 S. Ct. at 1532 (majority op.). Anticipating *Genesis Healthcare*, this Court said in *Pettrey* that even where "picking off the named plaintiff [is] a concern, we are not at liberty to create a controversy where one no longer exists." 584 F.3d at 707. Whatever those statements portend for the *Roper* dictum and its progeny, the more recent cases are a compelling reason not to further extend the "picking off" precedents. At least where the named plaintiffs *agree* to the complete satisfaction of their individual claims and there is no pattern

suggesting that a governmental defendant is actually attempting to evade class action procedures, plaintiffs whose claims become moot prior to certification should not be permitted to continue to pursue a class action.

2. The class's claims are not "inherently transitory."

The district court was also wrong to conclude, *see* R.E. 90 at 1276-77, that Plaintiffs' suit fits within an exception to the mootness doctrine for claims "so inherently transitory that the trial court will not have even enough time to rule on a motion for class certification before the proposed representative's individual interest expires." *Geraghty*, 445 U.S. at 399. The Supreme Court recently reiterated that this exception applies only where "*no plaintiff* possesse[s] a personal stake in the suit long enough for litigation to run its course," and the challenged conduct would therefore be "effectively unreviewable" if former class members were not allowed to proceed. *Genesis Healthcare*, 133 S. Ct. at 1531 (emphasis added). In other words, the exception is limited to class claims that are "likely to evade review, no matter who prosecute[s] them." *Swan v. Stoneman*, 635 F.2d 97, 102 n.6 (2d Cir. 1980); *see* NEWBERG ON CLASS ACTIONS § 2:13 (5th ed. 2014) (noting that exception applies where "individual plaintiffs cannot even expect to maintain [live claims] long enough to obtain a decision on . . . class certification").

It follows that the idiosyncratic agreement that mooted Plaintiffs' individual claims—a side agreement with the State pursuant to which their TennCare

applications received special handling in exchange for a litigation scheduling compromise—does not render the entire class's claims "inherently transitory." Far from becoming moot prior to certification due to "a factor closely related to the essence of the claim," *Swan*, 635 F.2d at 102 n.6, Plaintiffs' claims became moot because they chose to avail themselves of an alternative path to TennCare enrollment not available to ordinary class members.

Neither are Plaintiffs' claims inherently transitory because it is uncertain when the delays class members are experiencing will end. To be sure, in some cases allegedly unlawful delays are so brief as to fit within the exception. *See, e.g.*, *County of Riverside v. McLaughlin*, 500 U.S. 44, 51-52 (1991) (finding claim inherently transitory where allegedly unlawful delays were no more than seven days long); *Robidoux v. Celani*, 987 F.2d 931, 938-39 (2d Cir. 1993) (claims inherently transitory where unlawful delays so short that government "will almost always be able to process a delayed application before a plaintiff can obtain relief through litigation"). But not every allegedly unlawful delay is so brief that the trial court will lack "enough time to rule on a motion for class certification before the proposed representative's individual interest expires." *Geraghty*, 445 U.S. at 399. Thus, where class members suffered delays of months rather than days in the handling of their green card applications, the First Circuit held that the class's claims were not inherently transitory. *Cruz*, 252 F.3d at 535.

This case is much closer to *Cruz* than *McLaughlin* or *Robidoux*. Members of the plaintiff class applied for TennCare benefits as long ago as October 2013, and the named plaintiffs each alleged delays on average of many months. *See, e.g.*, Complaint, R.E. 1 at 23, ¶ 99 (over five months); *id*. at 24, ¶ 103 (same); *id*. at 30, ¶ 133 (seven months). Unlike in many other class action suits, the certification issues in this case are not particularly fact-intensive or difficult; the district court was able to rule on the certification motion just 41 days after it was made. The district court could no doubt resolve with similar dispatch a motion for class certification brought by a class member who retains a live claim. With class members allegedly experiencing delays two to three times longer than the amount of time it took the district court to certify the class, there is no basis for concluding that "the challenged conduct [will be] effectively unreviewable" if Plaintiffs or other former members of the class are not allowed to proceed. *Genesis Healthcare*, 133 S. Ct. at 1531.

3. Plaintiffs' claims are neither capable of repetition nor evading review.

The district court also erred by concluding that this case fits within the exception to ordinary mootness principles for conduct capable of repetition but evading review. *See* R.E. 90 at 1276. That exception only applies in those "exceptional situations," *Los Angeles v. Lyons*, 461 U.S. 95, 109 (1983), in which "(1) the challenged action necessarily evades review, and (2) there is 'a reasonable

expectation' that the same plaintiff will have the same complaint again." *Platt v. Board of Comm'rs on Grievances and Discipline*, – F.3d –, 2014 WL 5002078, at *3 (6th Cir. Oct. 8, 2013). The first of those requirements is not satisfied here for the same reason that the class's claims are not inherently transitory: class members with live claims could file suit and obtain a ruling on certification before their claims become moot.

But the district court was also mistaken when it concluded that there is a " 'reasonable expectation' that the *same plaintiff* will have the *same complaint* again." *Platt*, 2014 WL 5002078, at *3 (emphases added). To satisfy that requirement, "a mere physical or theoretical possibility" is not enough. *Murphy v. Hunt*, 455 U.S. 478, 482 (1982); *accord Alvarez v. Smith*, 558 U.S. 87, 93 (2009). Instead, "there must be a 'reasonable expectation' or a 'demonstrated probability' that the same controversy will recur involving the same complaining party." *Murphy*, 455 U.S. at 482. For two reasons, there is no such "reasonable expectation" here.

First, although the district court seemed to assume that Plaintiffs and other TennCare enrollees must reapply to the Federal Exchange every 12 months to remain enrolled in the program, *see* R.E. 90 at 1276, that is not so. Rather, the relevant federal regulations mandate a redetermination process that is distinct from the initial enrollment process and that does not involve the Federal Exchange but

rather is conducted by the State. *See* 42 C.F.R. § 435.916. Most importantly, any delay in the redetermination process visits no injury whatsoever upon the enrollee because he or she remains enrolled in Medicaid during the pendency of any such delay. *Id.* § 435.930 ("The agency must . . . [c]ontinue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible . . . ."); *id.* § 435.916(f)(1) ("Prior to making a determination of ineligibility, the agency must consider all bases of eligibility."); *see also Crippen v. Kheder*, 741 F.2d 102, 107 (6th Cir. 1984) (interpreting prior version of these regulations and observing that even where there is reason to suspect that certain Medicaid enrollees are no longer eligible, "the state must continue to furnish benefits to such individuals" until final determinations of ineligibility are made). Second, the State has not yet established a post-ACA redetermination process. As a result, there is no prospect that Plaintiffs will again suffer the injury that gave rise to their claims in this lawsuit.

II. THE DISTRICT COURT ABUSED ITS DISCRETION IN ISSUING THE PRELIMINARY INJUNCTION.

"A plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Winter v. NRDC*, 555 U.S. 7, 20 (2008). The preliminary injunction in this case must be reversed because Plaintiffs failed to make the required showing.

A. Plaintiffs Are Unlikely To Succeed on the Merits.

"[A] finding that there is simply no likelihood of success on the merits is usually fatal" to a request for a preliminary injunction, *Gonzales v. National Bd. of Med. Exam'rs*, 225 F.3d 620, 625 (6th Cir. 2000), and there is no likelihood of success on the merits here because the State is not legally responsible for federal officials' failure to promptly adjudicate TennCare applications submitted to the Federal Exchange.

Before federal officials took responsibility for administering aspects of state Medicaid programs through the Federal Exchange, the chain of command in Medicaid cases was clear. By statute, every state that participates in Medicaid must designate "a single State agency to administer or to supervise the administration of the plan." 42 U.S.C. § 1396a(a)(5). Federal regulations have long permitted the single State agency to delegate responsibility for day-to-day operations to other State agencies or to private entities, but the single state agency may not delegate its "authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters." 42 C.F.R. § 431.10(e). Consistent with those provisions of federal law, several courts have held the designated single state agency legally responsible for problems with a state's Medicaid program notwithstanding delegations of authority to other state agencies or private parties. *E.g.*, *Catanzano v. Dowling*, 60 F.3d 113, 118 (2d Cir. 1995); *McCartney ex rel.*

McCartney v. Cansler, 608 F. Supp. 2d 694, 701 (E.D.N.C. 2009), *aff'd sub nom. D.T.M. ex rel. McCartney v. Cansler*, 382 F. App'x 334 (4th Cir. 2010); *Carr v. Wilson-Coker*, 203 F.R.D. 66, 75 (D. Conn. 2001). Those rulings make sense, for "it is patently unreasonable to presume that Congress would permit a state to disclaim federal responsibilities by contracting away its obligations to a private entity." *Catanzano*, 60 F.3d at 118 (internal quotation marks omitted).

The novel question presented in this case is whether the single state agency's duty to "supervise the administration of the plan" also applies to aspects of a state Medicaid plan administered by the federal government. 42 U.S.C. § 1396a(a)(5). It does not. The State can neither "ensure that [federal officials] . . . [c]ompl[y] with all relevant Federal and State law," 42 C.F.R. § 431.10(c)(3)(i)(A), nor exercise "oversight over" their "eligibility determinations," *id.* § 431.10(c)(3)(ii). Any such state oversight of federal officials would run afoul of the longstanding rule that the states may not supervise or regulate the activities of the federal government. *See, e.g.*, *Johnson v. Maryland*, 254 U.S. 51, 57 (1920) (Holmes, J.) (noting "the immunity of the instruments of the United States from state control"). Congress would need to speak much more clearly than it has to authorize a departure from that fundamental principle of federalism. *Gregory v. Ashcroft*, 501 U.S. 452, 460-61 (1991).

The district court nevertheless held that "the State can[not] delegate its responsibilities under the Medicaid program to some other entity—whether that entity is a private party or the Federal Government." R.E. 91 at 1284. That was error. The Medicaid Act and the ACA do not make the State responsible for federal officials it cannot control. To the contrary, where a state declines to set up its own exchange, the ACA directs the Secretary of HHS, acting through CMS, to "establish and operate such Exchange within the State," and to "take such actions as are necessary to implement" the many statutes and regulations that govern exchange operations. 42 U.S.C. § 18041(c). It follows that *federal* officials are responsible for ensuring that the *Federal Exchange* complies with all applicable laws—including the requirement that exchanges charged with making Medicaid eligibility determinations do so "with reasonable promptness." *Id.* § 1396a(a)(8); *see* 45 C.F.R. § 155.310(e)(1) (similar). The federal government stands in the State's shoes when it operates an exchange in place of the State, and Plaintiffs' only remedy for delays at the hands of the Federal Exchange is against the federal officials who oversee it.

Nothing in the ACA grants State officials the authority to supervise Federal officials in carrying out the Medicaid duties assigned to the Exchange by the ACA. The district court pointed to 42 U.S.C. § 18118(d), *see* R.E. 91 at 1284, but it merely provides in general that the relevant sections of the ACA should not be

"construed to modify any existing Federal requirement concerning the State agency responsible for determining eligibility" for Medicaid. It most certainly does not state or even implicitly hint that State officials will be liable whenever the Federal Exchange fails to carry out the duties that Congress has assigned to federal officials. The State is not aware of *any* case—before the enactment of the ACA or since—that holds a state Medicaid agency legally liable for the failures of the Federal Government or any other entity the State agency had no authority to oversee.

Confirmation that the ACA contemplates no role whatever for the State Medicaid agency while an application for Medicaid enrollment is pending with the Federal Exchange may be found in the regulations setting forth when the Federal Exchange must provide application file data to the State Medicaid agency. The Federal Exchange must provide the State with all information that it has gathered with respect to an application whenever it has (i) determined the applicant to be MAGI eligible; (ii) assessed the applicant as eligible, leaving the final eligibility determination to the State; or (iii) assessed the applicant as non-eligible and the applicant has requested that her application be considered for a non-MAGI category. *See* 45 C.F.R. §§ 155.302(b)(3) & (b)(4)(ii), 155.310(d)(3), 155.345(d)(1), 155.510(c). But there is no regulation that requires the Federal Exchange to provide *pending* application files to the State Medicaid agency,

confirming that the ACA does not contemplate any State actions while an unresolved application is pending with the Federal Exchange.

The district court was also wrong to defer to the United States' litigation-driven position that "the state Medicaid agency . . . at all times retains the ultimate responsibility to ensure that a reasonably prompt decision is made on applications . . . that have been submitted in the first instance to the [Federal] Exchange." R.E. 91 at 1284 (quoting R.E. 85 at 1244). Courts must "deny deference to agency litigating positions that are wholly unsupported by regulations, rulings, or administrative practice," *Smiley v. Citibank, NA*, 517 U.S. 735, 741 (1996) (internal quotation marks omitted), for "[d]eference to what appears to be nothing more than an agency's convenient litigating position would be entirely inappropriate," *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 213 (1988). Thus, in *Bowen* the Supreme Court declined to defer to a novel statutory construction proposed for the first time by the agency's lawyers during litigation. *Id.* at 212-13. Because nothing in the federal government's regulations or administrative practice supports the self-interested position it took in the district court, that position is likewise not entitled to judicial deference.

The Medicaid Act and the ACA assign legal responsibility for the Federal Exchange's timely processing of Medicaid applications to the Federal Secretary, acting through CMS. It was the Federal Exchange that failed to process Plaintiffs'

Medicaid applications on a timely basis. State officials cannot be held liable when Federal officials fail to carry out functions Congress has assigned to the federal entity. Accordingly, Plaintiffs cannot succeed on the merits, and the preliminary injunction should be vacated.

B. The District Court Abused Its Discretion by Concluding that the Preliminary Injunction Would Help Class Members and Was in the Public Interest.

In addition to demonstrating a likelihood of success on the merits, a plaintiff who seeks a preliminary injunction must also show irreparable injury, that the balance of equities tips in his favor, and that an injunction is in the public interest. *Winter*, 555 U.S. at 23-24. The district court abused its discretion in concluding that Plaintiffs made the necessary showing.

The district court was of course correct that class members who have "foregone or are foregoing vital medical treatments, services, and prescriptions" due to difficulty enrolling in TennCare have suffered an irreparable injury. R.E. 91 at 1286. Although the State does not believe that it has a *legal duty* to redress such injuries when they are caused by the Federal Exchange, it has worked diligently and cooperatively with CMS since the beginning of the ACA's fraught rollout to develop practical solutions to problems arising from the new regime and to help as many eligible Tennesseans enroll as possible. As part of those voluntary efforts,

the State has taken numerous steps that have enabled many TennCare applicants to enroll despite problems with the Federal Exchange:

- When the State learned that CMS initially would be unable to provide Account Transfer files that would permit the automated enrollment of applicants found MAGI eligible by the Federal Exchange, the State immediately obtained CMS approval to implement a waiver permitting TennCare to enroll individuals using the information CMS could provide, and designed a special program to facilitate that process. *See* Long Decl., R.E. 54 at 678-79, ¶ 3(a).

- When the State learned there were problems with pregnant women remaining enrolled in TennCare due to the Federal Exchange's inability to provide required information to the State, the State created a workaround that enabled these women to stay on the program. *See id.* at 680-81, ¶ 3(c).

- When the State learned that the Federal Exchange was having difficulties processing TennCare applications from certain Medicare enrollees, it amended its long-term care application form so that those individuals could apply directly to the State. *See id.* at 679, ¶ 3(b).

- When the State learned that newborn infants born to non-TennCare eligible mothers were encountering difficulties applying through the Federal Exchange, the State designed and implemented a special presumptive eligibility program for those newborns. The State has conducted affirmative outreach to over 3,000 families whose children might qualify under this new program. *See id.* at 682-83, ¶ 3(f).

- When the Federal Exchange provided the State with a list of individuals whose TennCare applications were delayed due to the Federal Exchange's inability to process supplemental verification materials, the State began using information in its own files to enroll applicants it was able to determine to be eligible. *See* TennCare, *Do You Need To Know How To File an Eligibility Appeal?*, http://goo.gl/qdkOD9 [hereinafter "*Do You Need To Know*"].

As the above examples illustrate, this litigation will not determine *whether* the State assists TennCare applicants facing delays at the hands of the Federal Exchange but *which* steps the State will take to that end.

"[A] federal judge sitting as chancellor is not mechanically obligated to grant an injunction for every violation of law," *Weinberger v. Romero-Barcelo*, 456 U.S. 305, 313 (1982), and the above examples illustrate that even without an injunction the State is committed to doing what it can to mitigate problems caused by the Federal Exchange. In the State's judgment, its limited human and financial capital would be better spent working with CMS to develop practical solutions to the problems that have caused delays at the Federal Exchange rather than on the resource-intensive appeals process that the district court ordered. In short, both class members and the public interest would be better served by allowing the State to continue to devote all of its energy to working with Federal officials to find solutions to the particular issues that have caused delays at the Federal Exchange.

An extra measure of judicial deference is due to those "charged with the responsibility of setting [a new law's] machinery in motion; of making the parts work efficiently and smoothly while they are yet untried and new." *Power Reactor Dev. Co. v. International Union of Elec. Workers*, 367 U.S. 396, 408 (1961); *see also Community Health Ctr. v. Wilson-Coker*, 311 F.3d 132, 138 (2d Cir. 2002) ("We take care not lightly to disrupt the informed judgments of those who must

labor daily in the minefield of often arcane policy, especially given the substantive complexities of the Medicaid statute."). The district court should have deferred to the State's judgment about how best to remediate problems caused by the Federal Exchange, and its failure to do so was an abuse of discretion.

III. THE DISTRICT COURT ABUSED ITS DISCRETION BY DECLINING TO JOIN THE FEDERAL GOVERNMENT AS A REQUIRED PARTY AND SUBJECTING THE STATE TO INCONSISTENT LEGAL OBLIGATIONS.

A. The District Court Erred by Crafting an Injunction in the Federal Government's Absence.

The district court abused its discretion in fashioning a preliminary injunction in the absence of the federal officials who caused the delays that are the subject of this litigation. Even if one accepts the district court's counterintuitive conclusion that the State is somehow legally liable for the failures of the Federal Exchange, that does not absolve federal officials of responsibility for their own actions. In determination states like Tennessee, the law requires the Federal Exchange to both "determine eligibility promptly and without undue delay," 45 C.F.R. § 155.310(e)(1), and hear applicant appeals in cases of undue delay, *see id.* § 155.510(b); 42 C.F.R. §§ 431.10(c)(1)(ii), 431.220(a)(1). Thus, as the agency responsible for overseeing the Federal Exchange, CMS at a minimum bears more responsibility than the State for the delays Plaintiffs experienced.

Yet despite that incontrovertible reality, Plaintiffs declined to name CMS as a defendant and have steadfastly resisted the State's arguments that CMS should be joined as a required party under Federal Rule of Civil Procedure 19(a). This position is puzzling because CMS is in every respect better situated than the State to accord Plaintiffs relief. CMS is no less able than the State to hold hearings on delayed TennCare applications, and unlike the State it already possesses information about members of the plaintiff class that is necessary to adjudicate their applications. *See* Long Supp. Decl., R.E. 80-3 at 1192, ¶ 6. In contrast, the State's ability to redress Plaintiffs' injuries is contingent on federal officials' cooperation. Without CMS's help, the State would not even know who had applied to the Federal Exchange, much less be able to conduct hearings or act on the applications of those who have suffered undue delays at the hands of the Federal Exchange. Under these circumstances, the district court should have concluded that it could not "accord complete relief among [the] existing parties" in CMS's absence. FED. R. CIV. P. 19(a)(1)(A); *see Focus on the Family v. Pinellas Suncoast Transit Auth.*, 344 F.3d 1263, 1279-80 (11th Cir. 2003); *Dombrovskis v. Esperdy*, 321 F.2d 463, 465 (2d Cir. 1963). And regardless of the proper application of Rule 19 to this case, the district court abused its discretion by blinding itself to remedial alternatives that would have placed greater

responsibility on the shoulders of the federal officials who caused the delays at issue in this case.

B. The Preliminary Injunction Exposes the State to Inconsistent Legal Obligations.

Further underscoring that it was error for the district court to issue a preliminary injunction in CMS's absence is the fact that the injunction exposes the State to contradictory legal obligations. On the one hand, the preliminary injunction requires the State to hold hearings on "delayed adjudications." R.E. 91 at 1287. On the other, federal regulations specify that before the State holds any such hearing "[t]he applicant . . . must be given an opportunity to . . . [e]xamine . . . [t]he content of the applicant's . . . case file." 42 C.F.R. § 431.242. The State does not have access to applicant case files; they are in the exclusive possession of the Federal Exchange, and federal officials have so far declined to share them with the State. As a result, the preliminary injunction places the State in the impossible position of being required to hold hearings without the ability to conduct them in a manner that comports with federal law.

When an individual applies for Medicaid through an exchange, federal regulations require the Exchange to create and maintain a "case file"—sometimes called a "[c]ase record"—that "contains information on a beneficiary regarding program eligibility." *Id.* § 431.958; *see id.* §§ 431.242, 431.980(e). The undisputed record in this case establishes that the State neither possesses nor has

any means of acquiring Plaintiffs' case files from the Federal Exchange. *See* Long Supplemental Decl., R.E. 80-3 at 1191, 1194-95, ¶¶ 4, 11. Rather than complete case files, the Federal Exchange has instead furnished the State with "special flat files"—Excel spreadsheets that contain some rudimentary information about applicants. But unlike complete case files, the special flat files include neither reliable application dates nor any of the correspondence between the Federal Exchange and the listed applicants. *Id.* at 1192, ¶ 6.

The preliminary injunction's mandate that the State hold hearings without any means of accessing applicant case files compels the State to violate two provisions of federal law. First, access to the complete case file both prior to and during any hearing is among the key "[p]rocedural rights of the applicant" listed in 42 C.F.R. § 431.242. This is more than a procedural technicality. Applicants need complete case files to marshal the best evidence that they have suffered undue delays, and hearing officers need them to make fully informed decisions about whether the Federal Exchange or the applicant is at fault for the delays in a particular case. Second, without complete case files, if the State wishes to actually adjudicate the Medicaid application submitted to the Federal Exchange, which is ultimately what Plaintiffs want and have sought in this litigation, the State has no choice but to ask applicants about their income and when they first applied for TennCare—information the Federal Exchange already has but refuses to share with

the State. Requesting information an applicant has already submitted to the Federal Exchange violates the ACA's mandate that those who apply for Medicaid through an exchange "receive notice of eligibility . . . without any need to provide additional information or paperwork" unless the information already submitted is "insufficient to determine eligibility." 42 U.S.C. § 18083(b)(2). Without the Federal Exchange's cooperation, the State cannot comply with the ACA's prohibition on duplicative requests for information.

The district court did not credit these arguments because the State was able to use an alternative process through which the named plaintiffs and a small number of other eligible class members successfully enrolled in TennCare. *See* R.E. 91 at 1286 ("[T]here is no legal or factual barrier preventing the State from obtaining information about particular individuals from the Federal Exchange."). But those individuals did not receive hearings as contemplated by the preliminary injunction, much less did they have access to their case files prior to any hearings. Rather, the State simply adjudicated those individuals' TennCare applications on the basis of information they voluntarily provided directly to the State, despite the fact that much of this information was already in the hands of the Federal Exchange. Thus, whatever else can be said of the ad hoc process by which the State enrolled the named plaintiffs and some class members, it is not the

"[s]treamlin[ed] . . . procedure[ ] for enrollment through an Exchange" that the ACA and federal regulations require. 42 U.S.C. § 18083; *see* 42 C.F.R. § 431.242.

The district court could have easily saved the State from its inconsistent legal obligations by ordering that the responsible federal officials be joined as required parties in this litigation and directing them to do their part in seeing that Plaintiffs' applications are adjudicated in accordance with federal law. *See* FED. R. CIV. P. 19(a)(B)(ii) (stating that an entity is a required party if in its absence the court's ruling would "leave an existing party subject to a substantial risk of incurring . . . inconsistent obligations"). But in the federal government's absence, the district court should have at most ordered that the State hold hearings if the Federal Exchange supplied the required case files. Any relief beyond that must run against the federal officials who have exclusive custody of Plaintiffs' case files and were responsible for the delays Plaintiffs experienced in the first place.

When sitting in equity, a federal court must "mould each decree to the necessities of the particular case." *Weinberger v. Romero-Barcelo*, 456 U.S. 305, 312 (1982) (quoting *Hecht Co. v. Bowles*, 321 U.S. 321, 329 (1944)). One such necessity in this case is that any injunctive relief issued against the State take into account both the State's other legal obligations and the fact that it has no authority to tell federal officials what to do. The district court abused its discretion by failing to craft an order that reflects those realities.

CONCLUSION

For the foregoing reasons, the preliminary injunction should be vacated and the case should be remanded with instructions to dismiss it as moot. In the alternative, the preliminary injunction should be reversed on the merits.

November 26, 2014

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing brief complies with the type-volume limitations provided in Fed. R. App. 32(a)(7)(B). The foregoing brief contains 11,452 words of Times New Roman (14 point) proportional type. The word processing program used to prepare this brief was Microsoft Word 2013.

s/Michael W. Kirk

ADDENDUM

DESIGNATED ELECTRONIC DISTRICT COURT DOCUMENTS

Record Entry No.	Description	Pages
1	Complaint	23-32, 37-38
4-1	Declaration of Samuel Brooke	263, 274, 298
24	Joint Motion to Expedite Entry of Scheduling Order	370-71
52	Declaration of Darin Gordon	660-61
53	Declaration of Kim Hagen	672
54	Declaration of Wendy Long	678-82, 684-85
55	Declaration of Tracy Purcell	712-13, 715, 718
55-2	Medicaid and CHIP March and April 2014 Monthly Enrollment	729
70-1	Declaration of Sara Zampierin	1018
80-3	Supplemental Declaration of Wendy Long	1191-96
85	Statement of Interest of the United States	1244
90	Order Granting Class Certification	1274-78
91	Preliminary Injunction Order	1284-88
97	Notice of Appeal	

ADDENDUM

RELEVANT STATUTES, REGULATIONS, AND RULES

42 U.S.C. § 1396a

(a) Contents
A State plan for medical assistance must –
. . .

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;
. . .

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under subchapter I or XVI of this chapter (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under subchapter XVI of this chapter, or by the agency or agencies administering the supplemental security income program established under subchapter XVI or the State plan approved under part A of subchapter IV of this chapter if the State is not eligible to participate in the State plan program established under subchapter XVI of this chapter;
. . .
(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;
. . . .

42 U.S.C. § 18041

(c) Failure to establish Exchange or implement requirements
(1) In general
If--

(A) a State is not an electing State under subsection (b); or
(B) the Secretary determines, on or before January 1, 2013, that an electing State--
(i) will not have any required Exchange operational by January 1, 2014; or
(ii) has not taken the actions the Secretary determines necessary to implement--
(I) the other requirements set forth in the standards under subsection (a); or
(II) the requirements set forth in subtitles A and C and the amendments made by such subtitles;
the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements.
(2) Enforcement authority
The provisions of section 2736(b) of the Public Health Services Act [42 U.S.C. 300gg-22(b)] shall apply to the enforcement under paragraph (1) of requirements of subsection (a)(1) (without regard to any limitation on the application of those provisions to group health plans).

. . . .

42 U.S.C. § 18118

(d) No effect on existing requirements
Nothing in this title (or an amendment made by this title, unless specified by direct statutory reference) shall be construed to modify any existing Federal requirement concerning the State agency responsible for determining eligibility for programs identified in section 18083 of this title.

42 C.F.R. § 431.10

(c) Delegations.
(1) Subject to the requirement in paragraph (c)(2) of this section, the Medicaid agency--
(i)(A) May, in the approved state plan, delegate authority to determine eligibility for all or a defined subset of individuals to--

(1) The single State agency for the financial assistance program under title IV–A (in the 50 States or the District of Columbia), or under title I or XVI (AABD), in Guam, Puerto Rico, or the Virgin Islands;

(2) The Federal agency administering the supplemental security income program under title XVI of the Act; or

(3) The Exchange.

(B) Must in the approved state plan specify to which agency, and the individuals for which, authority to determine eligibility is delegated.

(ii) Delegate authority to conduct fair hearings under subpart E of this part for denials of eligibility for individuals whose income eligibility is determined based on the applicable modified adjusted gross income standard described in § 435.911(c) of this chapter, to an Exchange or Exchange appeals entity, provided that individuals who have requested a fair hearing of such a denial are given a choice to have their fair hearing instead conducted by the Medicaid agency.

(2) The Medicaid agency may delegate authority to make eligibility determinations or to conduct fair hearings under this section only to a government agency which maintains personnel standards on a merit basis.

(3) The Medicaid agency--

(i) Must ensure that any agency to which eligibility determinations or appeals decisions are delegated--

(A) Complies with all relevant Federal and State law, regulations and policies, including, but not limited to, those related to the eligibility criteria applied by the agency under part 435 of this chapter; prohibitions against conflicts of interest and improper incentives; and safeguarding confidentiality, including regulations set forth at subpart F of this part.

(B) Informs applicants and beneficiaries how they can directly contact and obtain information from the agency; and

(ii) Must exercise appropriate oversight over the eligibility determinations and appeals decisions made by such agencies to ensure compliance with paragraphs (c)(2) and (c)(3)(i) of this section and institute corrective action as needed, including, but not limited to, rescission of the authority delegated under this section.

(iii) If authority to conduct fair hearings is delegated to the Exchange or Exchange appeals entity under paragraph (c)(1)(ii) of this section, the agency may establish a review process whereby the agency may review fair hearing decisions made under that delegation,

but that review will be limited to the proper application of federal and state Medicaid law and regulations, including sub-regulatory guidance and written interpretive policies, and must be conducted by an impartial official not directly involved in the initial determination.

. . .

(e) Authority of the single State agency. The Medicaid agency may not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.

42 C.F.R. § 431.242

The applicant or beneficiary, or his representative, must be given an opportunity to--
(a) Examine at a reasonable time before the date of the hearing and during the hearing:
(1) The content of the applicant's or beneficiary's case file; and
(2) All documents and records to be used by the State or local agency or the skilled nursing facility or nursing facility at the hearing;
(b) Bring witnesses;
(c) Establish all pertinent facts and circumstances;
(d) Present an argument without undue interference; and
(e) Question or refute any testimony or evidence, including opportunity to confront and cross-examine adverse witnesses.

45 C.F.R. § 435.912(c)

(3) Except as provided in paragraph (e) of this section, the determination of eligibility for any applicant may not exceed--
(i) Ninety days for applicants who apply for Medicaid on the basis of disability; and
(ii) Forty-five days for all other applicants.

. . . .

45 C.F.R. § 155.310

(d) Determination of eligibility.
(1) The Exchange must determine an applicant's eligibility, in accordance with the standards specified in § 155.305.

. . .

(3) Special rule relating to Medicaid and CHIP. To the extent that the Exchange determines an applicant eligible for Medicaid or CHIP, the Exchange must notify the State Medicaid or CHIP agency and transmit all information from the records of the Exchange to the State Medicaid or CHIP agency, promptly and without undue delay, that is necessary for such agency to provide the applicant with coverage.

(e) Timeliness standards.

(1) The Exchange must determine eligibility promptly and without undue delay.

(2) The Exchange must assess the timeliness of eligibility determinations based on the period from the date of application or transfer from an agency administering an insurance affordability program to the date the Exchange notifies the applicant of its decision or the date the Exchange transfers the application to another agency administering an insurance affordability program, when applicable.

. . . .

Federal Rule of Civil Procedure 19

(a) Persons Required to Be Joined if Feasible.

(1) *Required Party.* A person who is subject to service of process and whose joinder will not deprive the court of subject-matter jurisdiction must be joined as a party if:

(A) in that person's absence, the court cannot accord complete relief among existing parties; or

(B) that person claims an interest relating to the subject of the action and is so situated that disposing of the action in the person's absence may:

(i) as a practical matter impair or impede the person's ability to protect the interest; or

(ii) leave an existing party subject to a substantial risk of incurring double, multiple, or otherwise inconsistent obligations because of the interest.

(2) *Joinder by Court Order.* If a person has not been joined as required, the court must order that the person be made a party. A person who refuses to join as a plaintiff may be made either a defendant or, in a proper case, an involuntary plaintiff.

(3) *Venue.* If a joined party objects to venue and the joinder would make venue improper, the court must dismiss that party.

. . . .

CERTIFICATE OF SERVICE

I hereby certify that a true and accurate copy of the foregoing was served upon all counsel of record on this 26th day of November, 2014, via the Court's Electronic Case Filing system.

s/Michael W. Kirk