**No. 14-6191**

# IN THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

MELISSA WILSON, ET AL.,
*Plaintiffs-Appellees*,

v.

DARIN GORDON, ET AL.,
*Defendants-Appellants*.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE, NO. 3:14-CV-1492

# BRIEF OF PLAINTIFFS-APPELLEES

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January 28, 2015

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## CORPORATE DISCLOSURE STATEMENT

Pursuant to 6th Cir. R. 26.1, all Plaintiffs-Appellees make the following disclosures:

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. All Plaintiffs-Appellees are individuals.

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:

No.

/s/ Samuel Brooke

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## STATEMENT OF THE CASE

This appeal involves a preliminary injunction requiring Tennessee's Medicaid program, "TennCare," to permit fair hearings to individuals who have applied for the program but have not received a decision in the timeframe required by federal law, starting in October 2013 and continuing to present. Order (RE 91, PageID# 1280–88). Plaintiffs-Appellees' (hereinafter "Plaintiffs'") allegations relate primarily to how Tennessee has implemented modifications to the Medicaid Act following enactment of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, (hereinafter "Affordable Care Act" or "ACA").

### A. Background on Medicaid Prior to Passage of the Affordable Care Act

The federal Medicaid program was "designed to provide medical assistance to persons whose income and resources are insufficient to meet the costs of necessary care and services." *Atkins v. Rivera*, 477 U.S. 154, 156 (1986). It was created in 1965 as Title XIX of the Social Security Act. Pub. L. No. 89-97 (codified as amended at 42 U.S.C. §§ 1396–1396w-5).

States administer their Medicaid programs subject to federal requirements imposed by the Medicaid Act and regulations and policy directives of the federal Centers for Medicare and Medicaid Services (hereinafter "CMS"). The state and federal governments share responsibility for funding Medicaid, and though participation is voluntary, states that elect to accept federal Medicaid funds

must comply with requirements imposed by federal law. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2581 (2012); *Atkins*, 477 U.S. at 157. If a state opts to participate, the state must create a "State plan for medical assistance," approved by the federal Department of Health and Human Services, which identifies the scope of the state's program and assures that it will be administered in conformity with federal law. 42 U.S.C. § 1396a; 42 C.F.R. § 430.10. Tennessee has participated in Medicaid since 1968. *See* 1968 Tenn. Pub. Acts, ch. 551.

### 1. The Medicaid Act Ensures the Right to Apply and the Right to a Prompt Determination of Eligibility.

State Medicaid plans "must . . . 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. § 1396a(a)(8). The state "must afford an individual wishing to do so the opportunity to apply for Medicaid without delay." 42 C.F.R. § 435.906. Determinations of eligibility must be made within 45 days, or within 90 days if eligibility is based on a disability, *id.* § 435.912(c)(3), and state plans must "[f]urnish Medicaid promptly to beneficiaries without any delay caused by the agency's administrative procedures." *Id.* § 435.930(a).

### 2. The Medicaid Act and Due Process Clause Ensure the Right to a Fair Hearing on Delayed Application Determinations.

The Medicaid statute requires that a state plan "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 . . . not acted upon with reasonable promptness." 42 U.S.C. § 1396a(a)(3) (emphasis added); 42 C.F.R. § 431.220(a); *see also* § 435.912(c)(3) (45 days, or 90 days if based on a disability). The Due Process Clause also requires appropriate notice and a hearing. *See Hamby v. Neel*, 368 F.3d 549, 559–60 (6th Cir. 2004).

### 3. The Medicaid Act Requires the Single State Agency to Be Responsible for Administration of its Medicaid Program.

The Medicaid statute requires that once a state elects to participate in Medicaid, it must designate "a single State agency to administer or to supervise the administration of the plan . . . ." 42 U.S.C. § 1396a(a)(5). That state agency, here the Department of Finance and Administration, acting through the Bureau of TennCare, "may not delegate, to other than its own officials, the authority to supervise the plan." 42 C.F.R. § 431.10(e) (as amended by 77 Fed. Reg. 17,202 (Mar. 23, 2012)).

### B. Changes to Medicaid under the Affordable Care Act

In March 2010, Congress enacted the Affordable Care Act, and also amended that Act through passage of the Health Care and Education Reconciliation Act, Pub. L. No. 111-152. The ACA implemented many changes to Medicaid programs, including changes to the method of calculating income when determining eligibility, and to the application process.

#### 1. The Affordable Care Act Modified and Simplified the Determination of Financial Eligibility for Medicaid.

The ACA introduced a new standard methodology to calculate income and financial eligibility for most categories of Medicaid, called Modified Adjusted Gross Income (MAGI). *See* 42 U.S.C. § 1396a(e)(14). Previously, states used diverse income-counting methodologies, including deductions and income disregards that varied across states. The new MAGI methodology adapts longstanding Internal Revenue Service rules applicable to the reporting and calculation of income on personal income tax returns. *See* 26 U.S.C. § 62. "The adoption of MAGI-based methodologies to determine income represents a significant simplification for the Medicaid program," Eligibility Changes Under the ACA, 76 Fed. Reg. 51148-01, 51155 (Aug. 17, 2011), and it creates a uniform method for both counting income and determining household composition. *See* 26 U.S.C. § 36B(d); 42 U.S.C. § 1396a(e)(14); 42 C.F.R. § 435.603.

Some categories of eligibility for Medicaid are unaffected by this change, and are referred to as "non-MAGI" categories. Two relevant non-MAGI categories for Tennessee include its CHOICES program and its Medicare Savings Program (hereinafter "MSP"). CHOICES is TennCare's program for long-term care services for the elderly (65 years of age and older) or disabled (21 years of age and older). *See* Tenn. Code §§ 71-5-1401 to -1424. MSP is designed to help with Medicare payments and is administered through TennCare. *See* Purcell Decl. (RE 55, PageID# 705). Neither requires a MAGI determination.

**2. The Affordable Care Act Modified and Streamlined the Application Process.**

The ACA and its implementing regulations introduced a number of changes to the application process, most of which came into effect on January 1, 2014.

First, the ACA requires creation of a health insurance marketplace or "exchange" in each state, which can be used by individuals to purchase health insurance plans. 42 U.S.C. § 18031. States are given the option to create their own exchange, but, if they decline to do so, CMS will operate the Exchange. *Id.* §§ 18041, 18083(a).

Second, the ACA requires use of a single, streamlined application for state health insurance and subsidy programs, including Medicaid, Children's

Health Insurance Program (CHIP), and insurance plans offered through exchanges. 42 U.S.C. §§ 18083(b)(1)(A); 1396w-3(b)(3).

Third, it establishes multiple pathways to enrollment, and states are required to "accept an application from the applicant . . . (1) [v]ia the internet Web site . . . ; (2) by telephone; (3) via mail; (4) in person; and (5) through other commonly available electronic means." 42 C.F.R. § 435.907(a).

Fourth, states "must provide assistance to any individual seeking help with the application or renewal process in person, over the telephone, and online." 42 C.F.R. § 435.908(a).

Fifth, the application process is supposed to maximize an applicant's ability to complete the form properly and minimize the burden on individuals. 42 U.S.C. § 18083(b)(1); 42 C.F.R. § 435.1200(b)(3)(i). Every state is required to accept and process all Medicaid applications, utilizing the new ACA eligibility requirements described in Section B.1, *supra*, by October 1, 2013. 42 U.S.C. § 18083(b), (c); 42 C.F.R.§ 435.907(a); Letter from Mann to Gordon (June 27, 2014) (RE 4-1, PageID# 297) (noting Tennessee's having failed to do so); Letter from Kahn to Gordon (Aug. 16, 2013) (RE 4-1, PageID# 263). This is true whether the state operates its own exchange or declines to do so.

Sixth, if the federal Exchange is used in a state, that state must decide how to handle determinations of eligibility for Medicaid made by the Exchange.

The state can elect to be a "determination" state, whereby the state will accept the Exchange's final determination of eligibility for MAGI-based categories, or it can elect to be an "assessment" state, whereby the Exchange's determination is treated as a preliminary determination that the state ultimately confirms or denies. *See* 42 C.F.R. § 435.1200(c), (d), 45 C.F.R. § 155.302(b). This "determination" or "assessment" election does not modify the states' independent requirement to accept and process applications themselves; it simply addresses who is authorized to make final decisions on Medicaid applications processed with the federal Exchange.[1]

Together, these requirements are intended to simplify and streamline the process for applicants and expand access to health coverage. *See* Eligibility Changes Under the ACA, 77 Fed. Reg. 17144-01, 17145 (Mar. 23, 2012).

### C. Tennessee Fails to Timely Modify its Application Processes to Implement the Affordable Care Act.

For over 40 years and until January 1, 2014, the TennCare Bureau contracted with the Tennessee Department of Human Services (hereinafter "DHS")

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[1] However, even in a determination state, the federal Exchange must adhere to eligibility determinations or appeals decisions made by the state Medicaid agency. *See* 45 C.F.R. §§ 155.302(b)(5); 155.345(h); Fair Hearings and Appeal Processes, 78 Fed. Reg. 42160-01, 42167–68 (July 15, 2013). Thus, determination states always retain the legal authority to adjudicate *all* Medicaid applications.

to administer the TennCare eligibility process. Most individuals who were eligible for TennCare coverage applied in person at local DHS offices, which are located in all 95 counties of Tennessee. Applicants were interviewed by DHS caseworkers, who keyed application information into a computer system known by the acronym "ACCENT." *See* Mitigation Planning Memo (RE 4-1, PageID# 228 at n.3). Eligibility determinations were made and communicated to the applicant promptly, and the caseworker was required to assist the applicant in obtaining verification documents if the applicant encountered difficulties. Tenn. Medicaid Manual (RE 4-1, PageID# 239–55).

ACCENT is a computer mainframe system that is over 20 years old, which struggled even under TennCare's pre-ACA application processes. *See* Purcell Decl. ¶¶ 11–12 (RE 55, PageID# 712–13). Given ACCENT's limitations, the State executed a contract in December 2012 to develop a new computer system to meet ACA requirements, known as the TennCare Eligibility Determination System, or TEDS. Contract (RE 4-1, PageID# 257–61); *see also* 42 U.S.C. § 18083(c).

State systems must comply with seven standards under the ACA, including acceptance of applications at the state level, and the ability to make MAGI-based determinations, by October 1, 2013. Letter from Mann to Gordon (June 27, 2014) (RE 4-1, PageID# 296–97); Letter from Kahn to Gordon (Aug. 16,

2013) (RE 4-1, PageID# 263). Tennessee notified CMS in 2013 that it would not meet the ACA compliance deadlines, and CMS required Tennessee to submit a mitigation plan to minimize the adverse impact on applicants and enrollees. Letter from Kahn (RE 4-1, PageID# 263); Tenn. Mitigation Plan (RE 4-1, PageID# 274–75). Tennessee represented that TEDS would be operational and that the State would accept its own applications by January 1, 2014. Tenn. Mitigation Plan (RE 4-1, PageID# 274–75).

Due to these and related technology delays, the State became a "determination" state. It also separately proposed to temporarily refer all MAGI-based applicants to the federal Exchange rather than processing them itself. This process was to last from October through December 2013 only. *Id.* CMS approved this temporary workaround on August 16, 2013. Letter from Kahn to Gordon (Aug. 16, 2013) (RE 4-1, PageID# 263).

Notwithstanding the provisions of the ACA designed to simplify the application process and limit the burden on applicants, TennCare began closing application portals and limited assistance offered to applicants. In September 2013, Defendants notified all county DHS offices that DHS would no longer accept or process any TennCare applications beginning in January 2014. Garner Memo (RE 4-1, PageID# 277–81). TennCare did install a computer in DHS offices, by which a person could go online to apply at the federal Exchange, but the

direct assistance that was previously provided by caseworkers was withdrawn, and DHS staff were generally unaware of and unable to provide assistance with the new application process. Clifton Decl. (RE 64, PageID# 949–55).[2] TennCare posted notices on its website regarding the new application processes, directing MSP and CHOICES applicants to a state application and requiring all other applicants to apply through the federal Exchange. TennCare Website (RE 4-1, PageID# 283, 285). Defendants created a call center, called the Tennessee Health Connection ("TNHC"), which is the sole point of contact for TennCare applicants to seek information from the State of Tennessee, *id.*, though, as illustrated below through the experience of the eleven Named Plaintiffs, the call center had little ability to directly assist applicants. *See infra* at16.

TennCare failed to start processing applications by January 1, 2014. CMS wrote to Defendant Gordon in June, noting that TennCare lacked nearly all

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[2] Tennessee claims that it replaced the DHS caseworkers with "Certified Application Counselors," referred to as CACs, to help applicants, though it admits the CACs were not available from January 1 (when the caseworkers were terminated) to April 2014. *See* Letter from Gordon to Mann (July 14, 2014) (RE 4-1, PageID# 225). Whatever can be said of this assertion—*see* Clifton Decl. (RE 64, PageID# 949–55) (noting unavailability of CACs)—the role of CACs in this process pales in comparison to the direct assistance and follow-through previously provided by DHS caseworkers. *Contrast* Tenn. Medicaid Manual (RE 4-1, PageID# 239–55) (detailing role of caseworkers) *with* 45 C.F.R. § 155.225(c).

of the identified "critical success factors" of ACA implementation, including the ability to process applications based on MAGI rules and to accept single, streamlined applications. Letter from Mann to Gordon (June 27, 2014) (RE 4-1, PageID# 296–98). CMS reiterated that it had "express[ed] concerns" over the past nine months about the continued delays in implementing a permanent solution, as well as the inability of individuals to apply directly to the Tennessee Medicaid agency for coverage based on MAGI rules, and noted that the State "has repeatedly expressed reluctance to deploy resources toward adopting mitigation solutions for in-state applications." *Id.* (PageID# 297). CMS emphasized that its "approval to leverage the [federal Exchange] to receive and process applications on the state's behalf was approved as a short-term measure, not a long-term solution." *Id.* (PageID# 298). CMS outlined possible solutions, noting that it had already offered Tennessee options such as "manual MAGI processing (with tools that can facilitate this processing that can be readily adapted for Tennessee) and hiring additional staff to assist with application processing (for which enhanced Medicaid matching funds may be available)." *Id.* (PageID# 297).

The State declined CMS's overtures, noting that it would not implement further mitigation strategies to address delayed applications and would instead wait for the implementation of the TEDS program, and in the interim it would continue to refer all MAGI-based applicants to the federal Exchange. *Letter*

*from Gordon to Mann* (July 14, 2014) (RE 4-1, PageID# 222–26). More recently the State announced that the process to implement TEDS will continue much longer than expected; on January 12, 2015, the State announced that it had cancelled its TEDS contract and that it was seeking a new vendor to start from scratch.[3]

Tennessee remains the only state in the country to not permit applicants the ability to apply directly to the state for Medicaid coverage, and every state but Tennessee now permits online Medicaid applications at the state level.[4] This is true for both "assessment" and "determination" states. *See* Gaskill Decl., Ex. 2 (RE 65, PageID# 973–74) (showing all determination states except Tennessee directly accept all Medicaid applications).

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[3] *See* TennCare, *Tennessee to Go in New Direction for Medicaid Eligibility Determination System* (Jan. 12, 2015), http://news.tn.gov/node/13420. Plaintiffs ask the Court to take judicial notice of this admission under Rule 201(b)(2) of the Federal Rules of Evidence.

[4] "Under the ACA, states must provide individuals the option to apply online for Medicaid at the state level, which currently is available in all states except Tennessee, where individuals can only apply online through the Federally-facilitated Marketplace." Kaiser Fam. Found., *Modern Era Medicaid: Findings From A State Survey of Eligibility, Enrollment, Renewal, and Cost Sharing Policies in Medicaid and CHIP as of January 2014*, 2–3 (2015), *available at* http://files.kff.org/attachment/report-modern-era-medicaid-findings-from-a-50-state-survey-of-eligibility-enrollment-renewal-and-cost-sharing-policies-in-medicaid-and-chip-as-of-january-2015. Plaintiffs ask the Court to take judicial notice of this fact pursuant to Fed. R. Evid. 201(b)(2).

Finally, and as noted above, Defendants have continued the in-state processing of the non-MAGI categories of CHOICES and MSP. Applicants to these programs may apply directly to TennCare. Purcell Decl. (RE 55, PageID# 711–12). Nevertheless, as noted below, applicants for CHOICES and MSP have also suffered extensive delays and lack of access to a fair hearing, in violation of the federal law. *See infra* at 16–18.

### D. Named Plaintiffs and Class Members Are Injured by Delays of Their TennCare Applications.

The Named Plaintiffs are eleven individuals from across Tennessee, ranging in age from infants to young parents to grandmothers. They share these fundamental facts in common: they applied for TennCare; TennCare did not process their applications in a timely manner or permit them an opportunity for a fair hearing on the delay; and they suffered harm as a result.

The delayed adjudications caused severe harm to several infant Plaintiffs. For example, Plaintiff and infant C.A.[5] was taken to an initial pediatrician appointment shortly after his birth in February, but while the family waited more than 146 days for their TennCare application to be processed, C.A.

[5] Several Plaintiffs were permitted to proceed under their initials only to protect the identity of minors and the parents of minors. Order (RE 27, PageID# 375).

could not return to the same pediatrician without insurance, and thus missed critical well-child assessments. D.P. Decl. (RE 1-1, PageID# 41–43). Plaintiff and infant S.G. was born prematurely in February 2014, resulting in his needing a monthly regimen of shots to prevent respiratory and airway virus, or "RSV," and to ensure his healthy physical development. Each installment costs around $3,000. While S.G. waited over 147 days for his TennCare application to be approved, he went without this critical treatment. L.G. Decl. (RE 1-3, PageID# 48–52). *See also* Declarations of J.P. (RE 1-2, PageID# 44–47) (infant S.P. contracted e-coli infection and incurred substantial debt while waiting more than 168 days for decision); M.M. (RE 1-4, PageID# 53–60) (infant S.V. has fallen ill repeatedly; family cannot afford bills and fears S.V. may not continue to receive ongoing treatment as they wait over 79 days for decision on TennCare); T.V. (RE 1-7, PageID# 67–69) (infant K.P. went without medical care while family waited over 180 days for decision on TennCare).

The delayed adjudications also caused severe harm to several adult Plaintiffs who qualify for Medicaid because they are the parents or caretakers for dependent children. For example, Plaintiff Melissa Wilson, a caretaker for her grandchildren, suffers from debilitating renal kidney failure, lupus, high blood pressure and osteoporosis, and needs to see four specialists and take many prescriptions; while she waited more than 163 days for a decision on her TennCare

application she relied on a limited community health clinic and filled only three of her 17 drugs prescribed. Wilson Decl. (RE 1-8, PageID# 70–71). The delay has caused her severe harm; once she received TennCare coverage and was able to see her doctors, she learned that that she would have to be placed on dialysis and can no longer work because her condition worsened without adequate treatment. 2d Wilson Decl. (RE 83-1, PageID# 1212–13). *See also* Declarations of April Reynolds (RE 1-6, PageID# 64–66) (mother of three who nearly suffered a heart attack could not afford to visit doctor while waiting more than 154 days for decision on TennCare application); Mohammed Mossa (RE 1-5, PageID# 61–63) (Mohammed Mossa and Mayan Said, parents of five young children and battling leukemia, high blood pressure, diabetes, anemia, and kidney stones, waited more than 155 days for decision on TennCare application and forewent treatment and survived off of donated drugs).

The delay in Medicaid determinations also caused Plaintiffs and class members to delay essential medical care, with potentially deadly consequences. For example, Plaintiff D.A. was worried about potential bills and thus delayed seeking medical attention after contracting an infection; when he finally went into the emergency room he was diagnosed as infected with MRSA and was told that if he had waited another four hours he would likely be dead. D.P. Decl. (RE 1-1, PageID# 41–43).

The desperation of Plaintiffs and class members was exacerbated by TennCare's failure to acknowledge any responsibility or provide solutions for the delays, and its failure to provide a fair hearing to review these delays. Each named Plaintiff's application had been pending at least 3-4 times the length of time permitted by federal law as of the day they filed this case;[6] yet, when Plaintiffs called TNHC to ask for an update and to ask if they could have a hearing regarding the delay, they were consistently told that TNHC had no update on their applications and that Tennessee was not offering a hearing on the delays. Declarations (RE 1-1 to 1-8, PageID# 41–71).

Nor are the substantial delays limited to those who were forced by TennCare to apply through the federal Exchange. Class members include those who have applied for TennCare CHOICES long-term care services for the elderly, and TennCare MSP for help with Medicare payments. For example, M.A.B. is the mother of a 39-year-old class member who has serious mental and intellectual disabilities, and who applied for MSP several times. After counsel brought this case to TennCare's attention, the application was finally resolved over seven

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[6] *See* Declarations (RE 1-1 to 1-8, PageID# 41-71) (D.A. and C.A., 146 days; S.P., 168 days; S.G., 147 days; S.V., 194 days; Mohammed Mossa and Mayan Said, 155 days; April Reynolds, 154 days; T.V. and K.P., 180 days; Melissa Wilson, 163 days).

months after he applied and more than five months after TennCare should have issued a decision. M.A.B. Decl. (RE 70-2, PageID# 1049–55). Class member Mathew LeCompte lives with cerebral palsy, hydrocephalus, and severely impaired vision; through his mother he applied for CHOICES. Because CHOICES eligibility is based on a disability, the State has ninety days to adjudicate CHOICES claims. After counsel brought this case to TennCare's attention, the application was finally resolved five months after he applied and two months after TennCare should have issued a decision. LeCompte Decl. (RE 66, PageID# 975–79). Class member Raymond Simpson applied for CHOICES after being partially paralyzed by a series of strokes. Simpson Decl. (RE 67, PageID# 980–981). TennCare immediately found that his urgent medical needs met the State's stringent clinical criteria to receive in-home services, but nonetheless failed to act on his application despite his son's increasingly desperate pleas for help. *Id.* (PageID# 982–86). Mr. Simpson was finally approved nearly six months after he applied and nearly three months beyond the 90 day limit established by law. *Id*. Finally, class member Tracey Barnes applied for MSP. After counsel brought her case to TennCare's attention, she finally received a decision nearly four months after she had applied, and over two months after TennCare was legally required to give her a decision; the decision came on August 28, 2014, the eve of the hearing

on the motions for class certification and preliminary injunction. Barnes Decl. (RE 83-2, PageID# 1215–17); Transcript (RE 93, PageID# 1396–97).

### E. Procedural History of the Case

Plaintiffs filed this class action on July 23, 2014, naming as defendants Darin Gordon, the Director of the Bureau of TennCare; Larry Martin, the Commissioner of the Department of Finance and Administration, and Dr. Raquel Hatter, Commissioner of Human Services (referred to collectively as "Defendants" "TennCare," "Tennessee," or "the State"). Complaint (RE 1, PageID# 4–5). Plaintiffs allege that they and thousands of Tennesseans who have applied for coverage under TennCare are suffering excruciating delays in receiving a decision on their applications, in contradiction of 42 U.S.C. § 1396a(a)(8). They also allege denial of a fair hearing on the failure by the State to render timely decisions, in contradiction of 42 U.S.C. § 1396a(a)(3) and the Due Process Clause. *Id.* (PageID# 35–37).

Plaintiffs simultaneously filed a motion for class certification and a motion for a preliminary injunction to compel Defendants to render decisions on the delayed TennCare applications in a timely manner. Motions (RE 2, PageID# 76–77; RE 4, PageID# 172–73). Plaintiffs requested a hearing on these motions by Friday, August 1, 2014, nine days after initiating the lawsuit. Motion (RE 6,

PageID# 330–37). Their request for a hearing on August 1 was not addressed by the District Court until August 5. Order (RE 28, PageID# 376).

The day the lawsuit commenced, Defendants' counsel contacted Plaintiffs' counsel and requested identifying information related to the eleven Named Plaintiffs to permit the State to investigate their applications, which information was promptly given. Zampierin Decl. ¶ 2 (RE 70-1, PageID# 1018).[7]

Later that week Defendants' counsel requested that Plaintiffs agree to permit them more time to respond to the motions. After receiving no immediate response from the District Court to its request for an expedited hearing, Plaintiffs agreed to jointly propose to the District Court that the State's oppositions would be due on August 14, with a hearing to be held as expeditiously thereafter as possible. Jt. Mot. (RE 24, PageID# 370–72).

Defendants also began implementing a work-around for people Plaintiffs' counsel brought to their attention as allegedly being unreasonably delayed. Hagan Decl. (RE 53, PageID# 671–72). The State agreed to try to help, but made no assurances that it could do so, and also warned that it would assist no more than 100 total applicants. *Id.*

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[7] The State requested complete names, addresses, dates of birth, social security numbers, and application numbers.

The District Court conducted a hearing on the motions for class certification and preliminary injunction on August 29, 2014. Docket (Aug. 29, 2014 Minute Entry). By then, the State had resolved applications for all the Named Plaintiffs and all but one of the putative class members who submitted declarations in this case, with one being resolved on the eve of the hearing. Transcript (RE 93, PageID# 1396–97, 1425–27).

The District Court granted both motions on September 2, 2014. Orders (RE 90, PageID# 1271–79; RE 91, PageID# 1280–88). Specifically the District Court certified a class defined as:

> 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.

Order (RE 90, PageID# 1278). The Court related certification back to the filing of the complaint. *Id.* (PageID# 1277). Defendants have not appealed this ruling.

The District Court also entered a preliminary injunction as follows:

> The Defendants are enjoined from continuing to refuse to provide "fair hearings" on delayed adjudications, as required by 42 U.S.C. §§ 1396a(a)(3), (8) and 42 C.F.R. § 435.912(c)(3). More specifically, based on these provisions, and the Fourteenth Amendment Due Process Clause, the Defendants are ordered to provide the Plaintiff Class with an opportunity for a fair hearing on any delayed adjudication. Any fair hearing shall be held within 45 days after the Class Member requests a hearing and provides the Defendants with proof that an application for medical assistance was filed (or the

> hearing shall be held within 90 days after that date, if the application was based on disability).
>
> "Delayed adjudication," for purposes of this injunction, means an adjudication that has not occurred within 90 days after the filing of an application for Medicaid on the basis of disability, and within 45 days after the filing of all other Medicaid applications.

Order (RE 91, PageID# 1287–88 (footnote omitted)).

Defendants filed a notice of appeal on September 26, 2014, as to the preliminary injunction only. Notice of Appeal (RE 97, PageID# 1481). Defendants have not sought to stay the Preliminary Injunction Order.

## STANDARD OF REVIEW

Review of a grant of a preliminary injunction "is deferential." *City of Pontiac Retired Employees Ass'n v. Schimmel*, 751 F.3d 427, 430 (6th Cir. 2014) (en banc). The question of "[w]hether the movant is likely to succeed on the merits is a question of law . . . review[ed] de novo," but the "'ultimate determination as to whether the four preliminary injunction factors weigh in favor of granting . . . preliminary injunctive relief'" is reviewed for abuse of discretion. *Id.* (citations omitted). Related findings of fact are reviewed for clear error. *Six Clinics Holding Corp., II v. Cafcomp Sys., Inc.*, 119 F.3d 393, 399 (6th Cir. 1997).

Thus, the District Court's grant of a preliminary injunction should be disturbed only if the District Court relied upon clearly erroneous findings of fact,

improperly applied the governing law, or used an erroneous legal standard. *City of Pontiac Retired Emps. Ass'n*, 751 F.3d at 430.

## SUMMARY OF THE ARGUMENT

**1.** The Preliminary Injunction Order compels the State to provide a fair hearing to those who have not received a determination on their delayed applications, significantly ameliorating much of the harm suffered by thousands of low-income Tennesseans who have been trapped in a black hole for months. In challenging that Order, Tennessee attempts to shift its blame onto others, particularly the federal government. But while other states experienced *initial* difficulties with the rollout of the ACA, Tennessee is the outlier. TennCare stood alone by deciding to abruptly end direct help it previously offered TennCare applicants, which help is often critical to ensure low-income families can navigate the application process. *See supra* at 7–13. TennCare refused repeated efforts by CMS to address the delay problems so as to alleviate the burdens on its residents. *See supra* at 11. TennCare became, and remains, the only state in the nation to refuse to process MAGI-based Medicaid applications directly, in violation of federal law. *See supra* at 12. This distinction will not end soon—TennCare just announced that after two years of futility, it is starting over in trying to create a permanent computer solution. *See supra* at note 3 and accompanying text.

While that process drags on, the preliminary injunction provides a vital safety net for tens of thousands who are falling through the TennCare cracks. It does so by closely mirroring Tennessee's existing obligations under the Due Process Clause and 42 U.S.C. § 1396a(a)(3). The Order should remain in effect to ensure that the goal of Medicaid, "to provide medical assistance to persons whose income and resources are insufficient to meet the costs of necessary care and services," *Atkins*, 477 U.S. at 156, is not sacrificed during TennCare's continued struggle to modernize its Medicaid eligibility systems and implement the ACA.

**2.** Plaintiffs are likely to succeed on the merits of their claims, and particularly their claims under § 1396a(a)(3) and the Due Process Clause, which are the source of the Preliminary Injunction Order's mandate. Section 1396a(a)(3) compels TennCare to permit "a fair hearing before the State agency" to any delayed applicant, which is precisely what the Order compels as well. *Id.*; Order (RE 91, PageID# 1287). The text of the statute is unequivocal, and as with any statutory interpretation, its plain text begins and ends the inquiry. Nor does Tennessee's assertion of "federalism" provide any refuge; the Medicaid Act has always been a hybrid state-federal system, and the "head chef in the Medicaid kitchen" has always been the state Medicaid agency, even when it is a federal agency that is the source of delay. The ACA does nothing to change this.

**3.** The federal government is not a necessary party. The question of whether CMS is *also* responsible is a red herring, for courts need not join every joint tortfeasor in order to provide relief. Nor is there any serious risk that Defendants can be subjected to conflicting legal obligations by providing fair hearings, especially since the Medicaid Act and the U.S. Constitution compel provision of these hearings.

**4.** The other requirements for a preliminary injunction are satisfied. Plaintiffs suffered irreparable harm. The balance of equities tips in Plaintiffs favor, and the injunction is in the public interest, because Defendants were violating the very laws they are supposed to implement and uphold.

**5.** Though the Named Plaintiffs received relief prior to the entry of the District Court's class certification order, the District Court properly concluded that a limited exception to the mootness doctrine exists. Courts disfavor permitting defendants to unilaterally "pick off" identified and prospective plaintiffs as this would defeat the class action mechanism, and the ability of the State to quickly resolve any application before a motion for class certification could be granted, as happened here, makes Plaintiffs' claims inherently transitory. Nor did Plaintiffs voluntarily relinquish their claims pursuant to a settlement agreement; Plaintiffs merely negotiated a briefing schedule, and never wavered in requesting that the motions be expedited.

## ARGUMENT

### I. THE DISTRICT COURT CORRECTLY CONCLUDED THAT PLAINTIFFS ARE LIKELY TO SUCCEED ON THE MERITS OF THEIR CLAIMS.

The District Court properly concluded that Plaintiffs are likely to prevail. First, the obligations of TennCare to make a prompt determination, pursuant to 42 U.S.C. § 1396a(a)(8), and to provide fair hearings when delays occurred, pursuant to § 1396a(a)(3) and the Due Process Clause, was unaltered by the passage of the ACA, even for MAGI applicants who the State has referred to the federal Exchange. Second, to the extent there is any ambiguity in the meanings of the Medicaid Act and its regulations, the District Court properly relied upon the Statement of Interest from the United States. Finally, the injuries of Plaintiffs and the class emanated from the actions and inactions of TennCare.

#### A. TennCare's Relevant Obligations Under the Medicaid Act Are Unchanged by the Affordable Care Act.

The Medicaid Act provides that "all eligible individuals should have the opportunity to apply for medical assistance," and that this assistance "shall be provided to the individual with reasonable promptness." *Westside Mothers v. Olszewski*, 454 F.3d 532, 540 (6th Cir. 2006); 42 U.S.C. § 1396a(a)(8). It also requires every state plan to "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." 42 U.S.C.

§ 1396a(a)(3) (emphasis added). g This right to a fair hearing is also guaranteed by the Due Process Clause, which requires notice and opportunity for a hearing. *See Hamby*, 368 F.3d at 560. Nothing in the ACA relieved state Medicaid agencies of these obligations.

The Medicaid Act additionally provides that once a state elects to participate in Medicaid, it must designate "a single State agency to administer or to supervise the administration of the plan . . . ." 42 U.S.C. § 1396a(a)(5). That State agency, TennCare, "may not delegate, to other than its own officials, the authority to supervise the plan." 42 C.F.R. § 431.10(e). This requirement has long been a part of the federal Medicaid law, and prevents the single State agency from escaping liability for its duties under the Medicaid Act by delegating tasks to other entities. *See Linton v. Commissioner*, 779 F. Supp. 925, 936 (M.D. Tenn. 1990), *aff'd on other grounds*, 65 F.3d 508 (6th Cir. 1995) (duty to certify nursing home participation in Medicaid non-delegable); *Tenn. Ass'n of Health Maintenance Orgs. v. Grier*, 262 F.3d 559, 565 (6th Cir. 2001); *Carr v. Wilson-Coker*, 203 F.R.D. 66, 75 (D. Conn. 2001) (§ 1396a(a)(8) non-delegable); *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) (fair hearing non-delegable), *aff'd sub nom. D.T.M. ex rel. McCartney v. Cansler*, 382 F. App'x 334 (4th Cir. 2010); *J.K. ex. rel. R.K. v. Dillenberg*, 836 F. Supp. 694, 699 (D. Ariz. 1993).

The District Court followed the above case law to conclude that Plaintiffs are likely to prevail, and it based its interim relief on the Due Process Clause and 42 U.S.C. § 1396a(a)(3) by requiring the State to provide "a fair hearing on any delayed application." Order (RE 91, PageID# 1287). The Preliminary Injunction Order does nothing more than require the State to comply with these statutory and constitutional obligations.

TennCare agrees that under long-established Medicaid law it is the single State agency which is "legally responsible for problems with a state's Medicaid program . . . ." State Br. 34–35. Yet, it argues that Congress somehow implicitly abrogated these statutory obligations by passing the ACA, such that the Preliminary Injunction Order is improper. State Br. 34–39. The statutory and the regulatory framework of the Medicaid Act and the ACA do not support the State's argument.

As with any question of statutory construction, it is a bedrock principle that "the starting point is the language employed by Congress . . . [and w]here the statute's language is plain, the sole function of the courts is to enforce it according to its terms." *Vergos v. Gregg's Enters., Inc.*, 159 F.3d 989, 990 (6th Cir. 1998) (citations and quotations omitted). The text of 42 U.S.C. § 1396a(a)(3) is plain: an applicant has a right to "*a fair hearing before the State agency*" when a claim is not acted upon with reasonable promptness. *Id.* (emphasis added); *see*

*Carr*, 203 F.R.D. at 75 (Single State Agency responsible for providing a fair hearing under § 1396a(a)(3)). The same is true for § 1396a(a)(5), which compels the State to designate "a single State agency to *administer or to supervise the administration of the plan* . . . ." *Id.* (emphasis added). The plain text of these provisions, and especially § 1396a(a)(3) which parallels the mandate in the Preliminary Injunction Order, resolves this appeal, for "the sole function of the courts is to enforce [the statute] according to its terms." *Vergos*, 159 F.3d at 990.

If the above were not enough, Congress did one better: It made its intent in passing the ACA clear by stating explicitly that the obligations of the single State agencies remain the same now as before: "Nothing in this title . . . shall be construed to modify any existing Federal requirement concerning the State agency responsible for determining eligibility for [programs including Medicaid]." 42 U.S.C. § 18118(d).

The State attempts to brush these inconvenient truths aside by citing 42 U.S.C. § 18041(c)(1), a provision relating to the creation of a federal Exchange. State Br. 36. This provision does not bear the weight the State asks it to carry. Section 18041(c)(1) establishes that the federal Exchange will be created, but it does not relieve TennCare of its obligation to oversee its program under § 1396a(a)(5) or to provide fair hearings under § 1396a(a)(3), and it certainly does not ordain CMS as the chief czar of all eligibility determinations for all state

programs. *Cf. K.C. ex rel. Africa H. v. Shipman*, 716 F.3d 107, 119 (4th Cir. 2013) (noting "[o]ne head chef in the Medicaid kitchen is enough").

Lacking any statutory support for its theory, the State instead focuses on regulations implementing the ACA and insists that since it elected to be a "determination" state for MAGI determinations, it should be absolutely immunized when applicants fail to receive timely determinations. The regulations cited say the opposite.

As an initial matter, Tennessee overstates the significance of its choice to become a determination state; this election merely delineates whether the federal Exchange is authorized to make a final eligibility determination on Medicaid applications submitted to it. *See supra* at 7 and note 1. That election does not absolve Tennessee of its separate mandate to accept and process Medicaid applications itself, and does not upset TennCare's obligation to provide timely determinations and delay hearings under § 1396a(a)(3) and (a)(8). 42 U.S.C. § 18083(b), (c); 42 C.F.R. § 435.907(a).

The actual text of 42 C.F.R. § 431.10 also makes clear that Tennessee retains these longstanding Medicaid obligations. Section 431.10(c)(1) authorizes the state to permit the federal Exchange to make final Medicaid eligibility determinations, but the same regulation also requires the "single State agency" to ensure that all federal laws are followed notwithstanding that authorization. *Id.*

§ 431.10(c)(3); *see also id.* § 435.1200(b)(3)(iii), (c)(3). The regulation further admonishes that it is "[t]he single State agency [that] is responsible for determining eligibility for all individuals applying for or receiving benefits . . . and for fair hearings filed . . .," 42 C.F.R. § 431.10(b)(3), and it instructs the single State agency to take appropriate measures if federal laws are not being followed, ensuring that it remains in charge. *Id.* § 431.10(c)(3). Far from supporting the State's position, these regulations reinforce what is provided already by statute—the single State agencies remain ultimately responsible for their Medicaid program under the ACA, just as they were before. 42 U.S.C. §§ 18118(d), 1396a(a)(5). Finally, if there were truly any doubt as to the regulations' meaning, they must be construed in a manner consistent with Tennessee's obligations under 42 U.S.C. § 1396a(a)(3). *See, e.g.*, *Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 844 (1984) ("regulations are given controlling weight unless they are . . . manifestly contrary to the statute").

Tennessee correctly notes that individuals who have been forced to apply for TennCare through the federal Exchange may have an *alternative* remedy available to them, since fair hearings are *also* available through the federal Exchange. 42 U.S.C. § 18081(f). However, this parallel method does not eliminate the freestanding and mandatory requirement of § 1396a(a)(3) for TennCare to also make available a fair hearing, which the federal government has

consistently reaffirmed. *See* 42 U.S.C. § 18118(d); Exchanges: Eligibility and Enrollment, 78 Fed. Reg. 42160-01, 42165 (July 15, 2013) ("[B]oth state Medicaid agencies and the Exchange have distinct responsibilities to provide for such hearings, and we do not have authority to eliminate individuals' statutory rights, or a Medicaid agency's or Exchange's statutory responsibility."); *id.* at 42164 ("[T]he statute requires that the option [to have a hearing before the State] be provided.").

TennCare further argues that because no regulation *requires* the federal Exchange to provide pending application files to the State, "the ACA does not contemplate any State actions while an unresolved application is pending with the [federal Exchange]." State Br. 38. This conclusion does not follow from its premise. The absence of a regulatory mechanism compelling the transfer of pending applications from the federal Exchange to the State does not inhibit the State's ability to comply with the fair hearing requirement of the Due Process Clause and § 1396a(a)(3) or the narrow Preliminary Injunction Order entered by the District Court. *See* Section II.B, *infra* (discussing hearing and regulatory requirements). Nor does this omission implicitly override Medicaid's statutory and regulatory requirements that the single State agency at all times retains the ultimate legal obligation to ensure that individuals' federal rights are protected—something all other "determination" states have recognized by continuing to accept and process Medicaid applications.

Lacking any statutory or regulatory authority, the State finally falls back on abstract concepts of federalism, arguing that it cannot be expected to dictate how the federal Exchange conducts its affairs. State Br. 35. This is not something Plaintiffs have requested, and the Preliminary Injunction Order does not compel TennCare to dictate the day-to-day operations of the federal Exchange. Rather TennCare must be held accountable for what is within its control: ensuring that when an applicant's eligibility is not made reasonably promptly, the State must make available a fair hearing.

The State goes on to suggest that a state Medicaid agency has never been held "legally liable for failures of the Federal Government . . . ." State Br. 37. The Medicaid Act and its regulations speak to the contrary. A long-standing feature of the Medicaid program has been the requirement by the single State agency to ensure determinations are provided promptly and to provide fair hearings, even if the cause of the delay originates within a federal agency. For example, when making a determination of disabilities, state Medicaid agencies are generally required to defer to the federal Social Security Administration's (hereinafter SSA's) determination. 42 C.F.R. § 435.541(a). However, if the SSA does not make a determination in 90 days (as it is legally required to do), the ultimate burden lies with the *state* to make that determination in a timely manner. *Id.* § 435.541(c)(2) & (3). Of course, the state Medicaid agency may not

commandeer the SSA, but it is required to ensure its own compliance with its federal obligations.

Thus, the State's contention that the ACA has created a new division of power between state Medicaid agencies and the federal Government is dramatically overstated. The Medicaid Act and its regulations have long held the single State agencies ultimately responsible for their programs and obligations under federal statues, even when it is an alleged "failure[] of the Federal Government" which gives rise to the delay.

### B. The Statement of Interest of the United States Confirms TennCare's Legal Obligations, and Is Owed Deference.

In addition to the statutory and regulatory text and the relevant historical case law, the District Court was also guided by a statement of interest by the United States, which is charged with implementing the ACA. As the United States explained, "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." Order (RE 91, PageID# 1284); *see also* Stmt. of Interest of United States of America (RE 85, PageID# 1244).

TennCare tries to sidestep the import of the United States' statement of interest by arguing that it is an agency "litigating position that [is] wholly unsupported by regulations, rulings, or administrative practice." *See* State Br. 38

(quoting *Smiley v. Citibank, NA*, 517 U.S. 735, 741 (1996)). The *Smiley* factors doom this argument. The United States is not a party in this action. The position of the United States flows directly from the language of the Medicaid Act (42 U.S.C. § 1396a(a)(3), (a)(5), (a)(8)), the ACA (42 U.S.C. § 18118(d)), and implementing regulations (42 C.F.R. §§ 431.10; 435.1200). Finally, the United States articulated this position far before the travails experienced in Tennessee could be anticipated and before this litigation commenced, both through generally applicable regulations and through specific communications to TennCare. *See* 42 C.F.R. §§ 431.10; 435.1200; Letter from Mann to Gordon (June 27, 2014) (RE 4-1, PageID# 296–97) (noting Tennessee is not meeting critical success factors and offering assistance and examples of mitigation approaches used by other states); Exchanges: Eligibility and Enrollment, 78 Fed. Reg. 42160-01, 42164–65 (July 15, 2013); Eligibility Changes Under the ACA, 77 Fed. Reg. 17144-01, 17188 (Mar. 23, 2012) ("As is true whenever a single State agency delegates authority to another entity to make eligibility determinations, we continue to require that the single State agency must supervise the administration of the plan, is responsible for making the rules and regulations for administering the plan, and is accountable for the proper administration of the program.").

As noted in the previous section, there is not any ambiguity to the meaning and construction of 42 U.S.C. § 1396a(a)(3), (a)(5), and (a)(8). Yet if any

ambiguity did exist, the federal government's position is owed deference and was appropriately relied upon by the District Court. *See Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944); *Chao v. Occupational Safety & Health Review Comm'n*, 540 F.3d 519, 523 (6th Cir. 2008). Moreover, the federal agency's position is owed deference under *Auer v. Robbins*, 519 U.S. 452 (1997), as the agency's interpretation of its own regulations. *See, e.g.*, *Chase Bank USA Nat'l Ass'n v. McCoy*, 131 S. Ct. 871 (2011) (granting near conclusive weight to agency interpretation of its regulations as set forth in an amicus brief); *Talk Am. Inc. v. Mich. Bell Tel. Co.*, 131 S. Ct. 2254 (2011) (same); *Rosen v. Goetz*, 410 F.3d 919, 927 (6th Cir. 2005) (CMS's interpretation of its own regulations are entitled to controlling weight unless plainly erroneous or in conflict with the statute, and CMS's review of TennCare's challenged procedures inform the courts' review of those same procedures.).

### C. Plaintiffs' Injuries Are the Result of TennCare's Actions and Inactions.

Finally, the State insists that all of the problems experienced by the Plaintiff class can be traced directly to the federal Exchange. This is untrue. First, the federal Exchange has no role in the State's failures related to the non-MAGI class members. The certified class includes class members who have applied for the TennCare CHOICES long term care program and for the TennCare MSP for help with Medicare payments. Plaintiffs' counsel identified four such class

members to the District Court. *See supra* at 16–18. The CHOICES and MSP programs do not require a MAGI determination, and these applications continue to be accepted and processed directly by TennCare; delays in these categories are entirely the fault of the TennCare administration.

Moreover, the federal government cannot be faulted for Tennessee's decisions that led to the long delays experienced by the Plaintiff class. It was TennCare's decision to become the only state in the country to refuse to process Medicaid applications directly, in contravention of federal law. It was TennCare's decision to terminate its staff trained in helping applicants navigate the TennCare application process. It was TennCare's decision to refuse to implement any of the mitigation approaches proposed by CMS which could have alleviated some, if not all, of the harm that has befallen the Plaintiff class. *See supra* at 7–13. And critical to this appeal, it was TennCare's decision to refuse to conduct any fair hearings, as required under 42 U.S.C. § 1396a(a)(3) and the Due Process Clause, which is remedied by the Preliminary Injunction Order.

## II. THE DISTRICT COURT DID NOT ABUSE ITS DISCRETION BY ENTERING THE PRELIMINARY INJUNCTION ORDER IN THE ABSENCE OF THE FEDERAL GOVERNMENT.

The federal government is not a necessary party to the Preliminary Injunction Order, and the District Court did not abuse its discretion in issuing its order without the federal government's presence. TennCare can provide all the

relief demanded by the Order on its own, and the Order carefully tracks TennCare's compliance with its existing obligations under federal law, ensuring that it does not subject TennCare to any inconsistent legal obligations.

### A. The Federal Government Is Not A Necessary Party.

The State's focus on the federal government is a red herring. Assuming *arguendo* that both TennCare *and* the CMS each have some responsibility for the delays experienced by Plaintiffs and Class Members, the legal analysis does not change. A joint tortfeasor is not a necessary party under Rule 19. *See Temple v. Synthes Corp., Ltd.*, 498 U.S. 5, 7 (1990) (per curiam). Thus, once this Court "accepts the [D]istrict [C]ourt's counterintuitive conclusion that the State is somehow legally liable for the failures of the Federal Exchange," State Br. 42, it need not determine whether Tennessee or the federal Exchange is "more" responsible. Since TennCare bears the legal responsibility to ensure that a fair hearing is provided under 42 U.S.C. § 1396a(a)(3) and the Due Process Clause, the Preliminary Injunction Order is appropriate.

The State nevertheless suggests that the District Court abused its discretion by failing to take into consideration that the federal Exchange is the primary repository for information on Plaintiffs' applications. State Br. 43. As noted above, this is factually false for non-MAGI category class members. *See* Section I.C, *supra*. Furthermore, whether the State can obtain sufficient

information from the federal Exchange is a factual issue reviewed for clear error. *Six Clinics Holding Corp.*, 119 F.3d at 399. The District Court's conclusion "that there is no legal or factual barrier preventing the State from obtaining information about particular individuals from the Federal Exchange," Order (RE 91, PageID# 1286), was supported by declarations provided by the State itself. *See* Hagan Decl. (RE 53, PageID# 671–73). It is further validated by the State' proven ability since the injunction was entered to continue obtaining from CMS information necessary to determine if an application has been pending with the federal Exchange for more than 45 or 90 days. *See* State Br. 40 (noting that CMS has provided TennCare with a list of delayed applicants). Far from a "definite and firm conviction that a mistake has been made," a review of the evidence proffered by TennCare establishes that the District Court's factual determinations were reasonable. *Alioto v. C.I.R.*, 699 F.3d 948, 952 (6th Cir. 2012) (citing clear error standard) (citations omitted).

### B. The District Court's Preliminary Injunction Order Does Not Subject Defendants to Inconsistent Legal Obligations.

There is no "substantial risk" that Defendants will be subject to inconsistent legal obligations, Fed. R. Civ. P. 19(a), such that the Preliminary Injunction Order was an abuse of discretion. Defendants suggest for the first time on appeal that they cannot simultaneously comply with the Order and federal law protecting the procedural rights of applicants, citing a federal regulation, 42 C.F.R.

§ 431.242. *See* State Br. 44–47. This is a new argument.[8] "[I]n general, '[i]ssues not presented to the district court but raised for the first time on appeal are not properly before the court.'" *McFarland v. Henderson*, 307 F.3d 402, 407 (6th Cir. 2002) (citation omitted, alterations in original).

Even if considered, this argument is premised on a factual dispute regarding whether the State can adequately acquire relevant information from federal officials; the District Court's determination that it could do so was not clearly erroneous. *See supra* at 37–39 (articulating standard).

It is also premised on a faulty construction of § 431.242. The regulation concerns the requirements for a fair hearing and provides that the applicant must be able to review his or her "case file," as well as any "documents and records" to be used by the single State agency at the hearing. 42 C.F.R. § 431.242(a)(1)–(2). Related regulations also require that "[t]he State agency must grant an opportunity for a hearing to . . . [a]ny applicant who requests it because his claim for services . . . is not acted upon with reasonable promptness," *id.* § 431.220(a); and that "[t]he hearing must cover . . . [a]gency action or failure to

[8] Defendants raised this issue for the first time in the District Court 20 days after the preliminary injunction order was entered, in their Reply in Support of their Motion to Dismiss. (RE 94, PageID# 1458). That motion is still pending.

act with reasonable promptness . . . .," *id.* § 431.241(a). These regulatory requirements for applicants' fair hearings are long-standing; as discussed previously, TennCare has long been required to offer fair hearings for delayed applications, including those delayed by other federal agencies such as the SSA. *See supra* at 32–33. In those hearings and in the hearings required by the Order, the State must simply provide all the evidence related to the applicant that it possesses, so that the applicant may have an opportunity to refute it at the hearing.[9] This straightforward construction is consistent with the State's statutory obligation to conduct such hearings. *See* 42 U.S.C. § 1396a(a)(3); *Chevron*, 467 U.S. at 844 ("regulations are given controlling weight unless they are . . . manifestly contrary to the statute").

This construction is further reinforced by the choice Congress granted all applicants who apply at the federal Exchange (whether from a determination or an assessment state): applicants may request a fair hearing from *either* the single

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[9] This is especially true for the delay hearings at issue here. The Preliminary Injunction Order requires proof of the application date before the fair hearing can be set. Order (RE 91, PageID# 1287–88). Since the purpose of the hearing is to determine if there was a delay, *see* Order (RE 90, Page ID# 1274) ("This hearing is for the purpose of determining the cause of the delay, not to appeal a denial of a claim."), the applicant has met her burden, and her procedural rights will be protected if she is given access to whatever the State has in its possession before the fair hearing.

State agency *or* the federal Exchange. 42 U.S.C. §§ 1396a(a)(3); 18081(f); *see also* Exchanges: Eligibility and Enrollment, 78 Fed. Reg. 42160-01, 42164–65 (July 15, 2013). Additionally, the fair hearing process is *de novo*, 42 C.F.R. §§ 431.242(a), .244(a)–(b); *see also Curtis v. Roob*, 891 N.E.2d 577, 580–81 (Ind. Ct. App. 2008), and permits the introduction of evidence by the applicant, 42 C.F.R. § 431.242(b)–(e), further mitigating any risk to the procedural rights of the applicants.

Defendants also suggest in passing that the "hearing officer" needs the full file to render a "fully informed decision" on the reason for the delay. State Br. 45. Yet they cite no statute or regulation that requires that the record before the Administrative Law Judge document every correspondence or contain every piece of evidence. Instead, the regulations acknowledge that "[h]earing recommendations or decisions must be based exclusively on evidence introduced at the hearing." 42 C.F.R. § 431.244(a).

If credited, Defendants' arguments would turn the existing regulations and procedures on their head by allowing any State to evade its responsibility for providing an adjudication or a fair hearing by failing to maintain an adequate case file. To the contrary, the federal fair hearing regulations—included those cited by Defendants—are designed to ensure that all applicants are able to review and

confront the evidence relevant to the hearing and to the ultimate decision. See 42 C.F.R. §§ 431.242(a); 431.244(a).

Defendants also suggest that the Preliminary Injunction Order may force them to violate 42 U.S.C. § 18083(b)(2) since, they contend, to ultimately adjudicate the applications the State may need to ask applicants for information already submitted to the federal Exchange. *See* State Br. 45–46. This argument appears to miss the entire point of this litigation. Section 18083 seeks to streamline the application process for Medicaid applicants, specifically by ensuring that information available to the state Medicaid agency not be unnecessarily demanded from the applicant. The purpose of Section 18083 has already been denied the Plaintiffs and Class Members, who have suffered protracted delays far beyond the outer time limits permitted by federal law. It is disingenuous to suggest that the Preliminary Injunction Order, which attempts to partially redress this problem, is invalid because an applicant who seeks a fair hearing from the State may need to submit additional information.

Finally, the State fundamentally mischaracterizes the Preliminary Injunction Order. True, Plaintiffs ultimately wish to receive a decision on their applications. However, the Preliminary Injunction Order requires a fair hearing to decide only whether the application has been unreasonably delayed. The Order does not compel an actual adjudication of the application, and it requires no

additional information from the applicant, except possibly proof of the application date if that is not already within the possession of the State, which the applicant is permitted to submit. *See* 42 C.F.R. § 431.242. Section 18083(b)(2) is therefore unaffected by the Preliminary Injunction Order.

## III. THE DISTRICT COURT DID NOT ABUSE ITS DISCRETION BY ENTERING THE PRELIMINARY INJUNCTION ORDER BECAUSE (1) PLAINTIFFS ESTABLISHED IRREPARABLE HARM, (2) THE BALANCE OF EQUITIES TIPS IN THEIR FAVOR, AND (3) THE INJUNCTION IS IN THE PUBLIC INTEREST.

As the State concedes, class members who have "foregone or are foregoing vital medical treatments, services, and prescriptions" have suffered irreparable harm. State Br. at 39. *See also supra* at 13–18 (detailing serious and long-lasting health problems caused by delays).

Despite irreparable harm, the State argues that the preliminary injunction was inappropriate because, in its own "judgment," its limited resources would be better spent in other ways. But additional expenses imposed upon the State by ordering compliance with existing law cannot tip the balance where the life and health of class members is at stake. *See Blum v. Caldwell*, 446 U.S. 1311, 1316 (1980); *Parents League for Effective Autism Servs. v. Jones-Kelley*, 565 F. Supp. 2d 905, 917–18 (S.D. Ohio 2008), *aff'd*, 339 F. App'x 542 (6th Cir. 2009). The State has significant discretion to implement its laws, but its discretion ends where, as here, its choices are resulting in the denial of statutory and constitutional

rights of applicants. *See G & V. Lounge, Inc. v. Mich. Liquor Control Comm'n*, 23 F.3d 1071, 1079 (6th Cir. 1994 ("[I]t is always in the public interest to prevent the violation of a party's constitutional rights."); *Glenwood Bridge, Inc. v. City of Minneapolis*, 940 F.2d 367, 372 (8th Cir. 1991) (the public interest is served when federal law is enforced).[10]

The preliminary injunction also does nothing to prevent TennCare from working with CMS to develop better solutions to the extreme delays faced by applicants, so long as those class members who request a hearing are given one, or a determination on their application, before the deadline set forth in the Preliminary Injunction Order. The Court should reject the State's late attempt to offer this as a reason weighing against the preliminary injunction, especially in light of CMS's judgment that, before the lawsuit was filed, the State "ha[d] repeatedly expressed reluctance to deploy resources toward adopting mitigation solutions." Letter from Mann to Gordon (June 27, 2014) (RE 4-1, PageID# 297).

Moreover, the State dramatically overstates its burden. The Preliminary Injunction Order merely requires the State to provide fair hearings to

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[10] A contrary rule absolutely deferring to the State's judgment would also mean a preliminary injunction could almost never issue against a public entity, since it would be a rare defendant who would admit its actions were contrary to the public interest.

those whose applications are delayed—a duty already mandated by 42 U.S.C. § 1396a(a)(3) and the Due Process Clause. The State already had processes in place to provide hearings for eligibility denials, but it refused delayed applicants the ability to request such hearings. Any alleged harms caused by a sudden influx of hearing applicants upon issuance of the preliminary injunction are the direct result of the State's own refusal to conduct these hearings earlier.

Nor does the State earn a free pass because it has taken some steps to mitigate other problems experienced by other categories of applicants, including pregnant women and newborns; these examples do nothing to remedy delays for the Plaintiff class. The State refused to address the problem of overly delayed applications before the District Court acted, notwithstanding months of meetings between it and Plaintiffs' counsel where this issue was raised and actions on behalf of the State were requested. *See* Hagan Decl. ¶ 5 (RE 53, PageID# 669) (noting meetings with counsel).[11] The District Court did not abuse its discretion by

[11] The State also indicates that, as part of its "voluntary efforts" to help applicants enroll, it has established a process to obtain delayed information from the federal Exchange and enroll applicants determined to be eligible using information in its own files. State Br. at 39–40. This process was put into place only after the District Court entered its Preliminary Injunction Order, compelling the State to act on these applications through providing fair hearings to class members.

granting narrowly drawn injunctive relief as a partial remedy for these violations of federal law and the Constitution.

## IV. THE CASE IS NOT MOOT UNDER WELL-ESTABLISHED EXCEPTIONS TO THE MOOTNESS DOCTRINE.

Contrary to the State's contentions, *see* State Br. 19–33, TennCare's provision of relief to the Named Plaintiffs did not moot this class action under well-established exceptions to the mootness doctrine, and the District Court correctly found that the class certification related back to the filing of the complaint.[12]

[12] If the Court believes that the case is moot, it should remand with instructions to allow for substitution of additional named plaintiffs. *See Phillips v. Ford Motor Co.*, 435 F.3d 785, 787 (7th Cir. 2006) ("Unless jurisdiction never attached, . . . or the attempt to substitute comes long after the claims of the named plaintiffs were dismissed, . . . substitution for the named plaintiffs is allowed.") (citations omitted). There were, and continue to be, class members willing to serve as class representatives if necessary, as evidenced by declarations expressing their desire to help others through their participation in the lawsuit. *See* Declarations of Barnes ¶ 11 (RE 83-2, PageID# 1216); Murphy ¶ 11 (RE 68, PageID# 1005); Corbin ¶ 9 (RE 69, PageID# 1009); J.M. ¶ 10 (RE 70-4, PageID# 1072); J.F. ¶ 20 (RE 70-3, PageID# 1059–60); LeCompte ¶ 12 (RE 66, PageID# 978). Though these particular individuals have now been picked off by the State's actions, thousands of other class members would be eligible to stand in as plaintiffs.

### A. The State's Decision to Provide Relief to Individuals Identified by Plaintiffs' Counsel Only, but Not to All Class Members, Does Not Moot the Case.

The Supreme Court has clearly stated that "[r]equiring multiple plaintiffs to bring separate actions, which effectively could be 'picked off' by a defendant's tender of judgment before an affirmative ruling on class certification could be obtained, obviously would frustrate the objectives of class actions; moreover it would invite waste of judicial resources by stimulating successive suits brought by others claiming aggrievement." *Deposit Guar. Nat'l Bank v. Roper*, 445 U.S. 326, 339 (1980). Once a class certification motion has been ruled upon and there is an ongoing controversy between the class itself and defendants, the mooting of a named plaintiff's claim does not moot the case. *U.S. Parole Comm'n v. Geraghty*, 445 U.S. 388, 403–04 (1980) (discussing and expanding *Sosna v. Iowa*, 419 U.S. 393 (1975)).

In light of this, various courts of appeal, including this Court, have created remedies to ensure that a defendant who is facing a class action may not "opt out" by trying to moot the named plaintiffs' claims through voluntary cessation of its illegal conduct with respect to individual plaintiffs only. For example, in *Blankenship v. Secretary of Health, Education and Welfare,* 587 F.2d 329 (6th Cir. 1978), this Court found that although all named plaintiffs had received their requested relief (disability hearings) before the class was certified,

the action was not moot. *Id.* at 332–33. It held that their claims "epitomize[d] the type of claim which continually evades review if it is declared moot merely because the defendants have voluntarily ceased the illegal practice complained of in the particular instance." *Id.* at 333. Because defendants had the ability to "expedite processing for any plaintiffs named in a suit while continuing to allow long delays with respect to all other applicants," the "refusal to consider a class-wide remedy merely because individual class members no longer need relief would mean that no remedy could ever be provided for continuing abuses." *Id.* *See also White v. Mathews*, 559 F.2d 852, 857 (2d Cir. 1977).

This Court reaffirmed the logic of *Blankenship* in more recent cases. In *Brunet v. City of Columbus*, 1 F.3d 390 (6th Cir. 1993), the Court emphasized that a case is not moot "where a motion for class certification has been pursued with reasonable diligence and is then pending before the district court"; otherwise, the entire class action mechanism would be "at the mercy of a defendant, even in cases where a class action would be most clearly appropriate." *Id.* at 400 (internal quotations and citations omitted). In *Carroll v. United Compucred Collections, Inc.*, 399 F.3d 620 (6th Cir. 2005), this Court rejected defendants' arguments of mootness, explaining that "the [*Brunet*] court suggested that it would be inappropriate to hold that a case was mooted by a settlement offer made to a named plaintiff when a motion for class certification was pending," and holding the same.

*Carroll*, 399 F.3d at 625. These cases are in line with the other courts of appeal. *See Stein v. Buccaneers Ltd. P'ship*, 772 F.3d 698, 707–08 (11th Cir. 2014); *Pitts v. Terrible Herbst, Inc.*, 653 F.3d 1081, 1090–91 (9th Cir. 2011); *Lucero v. Bureau of Collection Recovery, Inc.*, 639 F.3d 1239, 1250 (10th Cir. 2011); *Weiss v. Regal Collections*, 385 F.3d 337, 347–49 (3d Cir. 2004); *Primax Recoveries, Inc. v. Sevilla*, 324 F.3d 544, 546–47 (7th Cir. 2003); *Zeidman v. J. Ray McDermott & Co.*, 651 F.2d 1030, 1050 (5th Cir. Unit A July 1981).

This precedent directly controls the instant case. Plaintiffs diligently sought class certification, filing the motion with the complaint and seeking an expedited resolution. *See supra* at 18–21. Prior to filing, Plaintiffs' TennCare applications had been pending for many months, far in excess of the authorized periods under federal law; Plaintiffs contacted TennCare repeatedly to ask for the status of their pending applications but never received an answer about their eligibility, and were told that hearings were unavailable to them. *See supra* at 16. Plaintiffs' counsel even brought some of these cases directly to the attention of TennCare before filing, and even then TennCare did not adjudicate the claims. Hagan Decl. ¶ 11 (RE 53, PageID# 671). It was only after Plaintiffs filed suit that the State suddenly adjudicated Plaintiffs' TennCare applications.

The State employed this strategy against not just the Named Plaintiffs but also other putative class members brought to its attention by Plaintiffs' counsel

before the class was certified. Plaintiffs' counsel identified over 100 individual applicants who were experiencing delays to the State. Zampierin Decl. ¶ 2 (RE 86, PageID# 1247). Some of these individuals also filed declarations in this case and expressed their desire to help others through their participation in this lawsuit.[13] As the State openly acknowledged in oral arguments before the District Court, it moved quickly to provide relief to these individuals before the hearing on the preliminary injunction and class certification motions, including approving one in the overnight hours prior to the hearing. Transcript (RE 93, PageID# 1425–26).

To be clear, the State's decision to adjudicate these applications was welcome, if long overdue and compelled by federal law. 42 U.S.C. § 1396a(a)(8). The State insists there is no evidence to suggest TennCare's actions were taken in an effort to evade judicial review. State Br. 26–27. Plaintiffs disagree given its clear willingness to adjudicate the applicants presented to it but its steadfast refusal to cease its illegal conduct for the thousands of *unidentified* putative class members. *See* Long Decl. (RE 80-3, PageID# 1189) (emphasizing State would not voluntarily assist more than 100 individuals). But the "picking off" doctrine is properly focused on the *ability* and *action* of TennCare in resolving Plaintiffs'

[13] *See supra* note 12.

claims, not its motivation. *See Genesis Healthcare Corp. v. Symczyk*, 133 S. Ct. 1523, 1531 (2013) ("But this doctrine has invariably focused on the fleeting nature of the challenged conduct giving rise to the claim, not on the defendant's litigation strategy."). TennCare's proven ability to pick off identified Plaintiffs by promptly adjudicating their claims conclusively establishes why, under *Blankenship*, *Brunet*, and *Carroll*, the District Court found an exception to mootness existed.

The State's only response is to argue that *Genesis* casts doubt on this line of cases, but *Genesis* actually reaffirms these holdings. The Supreme Court made clear that claims of injunctive relief challenging ongoing conduct are the most appropriate claims in which to apply this exception to mootness. *Id.* at 1531 ("Unlike claims for injunctive relief challenging ongoing conduct, a claim for damages cannot evade review."). Accordingly, the holdings in *Carroll* and *Blankenship* remain unchanged, especially as applied to this action requesting injunctive relief.

### B. Plaintiffs' Claims Are Inherently Transitory.

Plaintiffs' claims for eligibility determinations and fair hearings are also inherently transitory. An inherently transitory claim is one where "a constant existence of a class of persons suffering the deprivation is certain," *Gerstein v. Pugh*, 420 U.S. 103, 110 n.11 (1975), and where "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 District Court did not have enough time to rule on a motion for class certification before the Named Plaintiffs and other possible class representatives were approved for TennCare. The fair hearings at issue in the preliminary injunction must be made available to anyone seeking a hearing on whether or not their application has been unduly delayed—which, by law, occurs 45 days after the application has been submitted, or 90 days if the application is made on the basis of a disability. 42 U.S.C. § 1396a(a)(3), (a)(8); 42 C.F.R. § 435.912(c)(3). Critically, when an adjudication is delayed beyond these statutory timeframes, it is unclear how much longer it will be pending and how much longer the applicant will be denied a fair hearing, for as a matter of law both should already have occurred. *See Gawry v. Countrywide Home Loans, Inc.*, 395 F. App'x 152, 158–59 (6th Cir. 2010) ("[T]he crux of the 'inherently transitory' exception is the uncertainty about the length of time a claim will remain alive.") (citation and internal quotation omitted); *see also Gerstein*, 420 U.S. at 110 n.11 (finding claims inherently transitory because "[t]he length of pretrial custody cannot be ascertained at the outset, and it may be ended at any time"). Thus the relevant inquiry is not, as Defendants suggest, how long it has been since the applicants originally applied, but rather how long they will remain pending after

they file a lawsuit against TennCare to challenge the excessive delay. *Contra* State Br. 31.

In the instant case, TennCare has at all times possessed the means (and legal obligation) to provide both coverage and opportunity for a hearing. And it has done so: TennCare enrolled almost all the named Plaintiffs before it even filed its response to the motion for class certification, and all were enrolled before the motion was heard. *See* Hagan Decl. ¶ 13 (RE 53, PageID# 672); Long Decl. ¶ 8 (RE 80-3, PageID# 1193). TennCare also quickly enrolled or was in the process of enrolling all individuals who were identified to it by Plaintiffs' counsel. *See* Transcript (RE 93, PageID# 1396–97, 1425–27). Plaintiffs' claims are therefore "inherently transitory since the [Defendants] will almost always be able to process a delayed application before a plaintiff can obtain relief through litigation." *See Robidoux v. Celani*, 987 F.2d 931, 938–39 (2d Cir. 1993);[14] *see also Swisher v.*

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[14] The State concedes *Robidoux* presented inherently transitory claims, but suggests the instant case is closer to *Cruz v. Farquharson*, 252 F.3d 530 (1st Cir. 2001). State Br. 30. *Cruz* is distinguishable, for it took defendants at least ten weeks to adjudicate their immigration applications, and during that time the plaintiffs did not act diligently by moving for class certification. *Id.* at 532–34 & n.3. The court also found no evidence that the defendants had "devised a scurrilous pattern and practice of thwarting judicial review." *Id.* at 535. By contrast, here TennCare openly admits that while it was willing to provide relief to up to 100 individuals, it would not provide relief to any of the other thousands of class members. Long Decl. ¶ 1 (RE 80-3, PageID# 1189).

*Brady*, 438 U.S. 204, 213 n.11 (1978) (the rapidity with which plaintiffs' claims could be mooted "create[d] mootness questions with respect to named plaintiffs, and even perhaps with respect to a series of intervening plaintiffs appearing thereafter."); *Haro v. Sebelius*, 747 F.3d 1099 (9th Cir. 2014) (district court could not have been expected to rule on motion for class certification one month after case was filed); *Olsen v. Brown*, 594 F.3d 577, 579, 583 (7th Cir. 2010) (noting claim of inmates lasted 139 days on average, but emphasizing that the essence of the inherently transitory exception is uncertainty about the length of time a claim will remain alive).

It is also clear that other class members would have continued to suffer, in violation of 42 U.S.C. § 1396a(a)(3) and (a)(8) and the Due Process Clause, if the Preliminary Injunction Order had not issued, given TennCare's insistence that it would not voluntarily assist more than the first 100 delayed applications Plaintiffs' counsel presented to it. Long Decl. (RE 80-3, PageID# 1189). Thus, "a constant existence of a class of persons suffering the deprivation [was] certain." *Gerstein*, 420 U.S. at 110 n.11.

Finally, because the claims are inherently transitory, Plaintiffs need not show that they will be again subject to the conduct at issue. *See Geraghty*, 445 U.S. at 399. However, the District Court correctly noted that the claims are also likely capable of repetition but evading review. Plaintiffs are subject to renewal

and reverification of eligibility every 12 months. Defendants have made no progress in developing a system for this process, *see* Transcript (RE 93, PageID# 1379), thus causing their legal arguments regarding federal requirements for continuous enrollment to have no state counterpart against which to be measured. State Br 32–33. Considering the utter failure of Tennessee to create an automated Medicaid process to date,[15] and the evidence of their inability to process even the non-MAGI applications, *see supra* at 16–18, the District Court's factual determination that problems would likely recur was not clear error. *Alioto*, 699 F.3d at 952.

### C. Named Plaintiffs Did Not "Settle" Their Injunctive Claims Prior to Certification.

The State also suggests that the Named Plaintiffs' claims were resolved pursuant to an "agreement" bargained for between the parties. State Br. 21–25.[16] This creative argument, presented for the first time on appeal, is belied

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[15] *See supra* note 3 and accompanying text.

[16] Defendants suggest that Plaintiffs withdrew their request to have their motions heard on an expedited schedule. *See*, *e.g.*, State Br. 13. That is incorrect. Plaintiffs withdrew their request to have the motions heard on August 1, but they never withdrew their request for an expedited hearing. *See* Jt. Mot. (RE 24, PageID# 371) (reiterating request to expedite hearing). The District Court granted that request by scheduling a hearing on August 29, 2014. Order (RE 30, PageID# 378).

by the record. The only arrangement reached by the parties was one related to the briefing schedule on the motions for preliminary injunction and class certification. *See* Jt. Mot. (RE 24, PageID# 370–72). It had nothing to do with settling the Named Plaintiffs' claims, and for several independent reasons is immaterial to this appeal.

First, TennCare points to no "settlement agreement" that shows that named Plaintiffs voluntarily acceded to a full settlement of their claims. This is fatal to their argument, as the cases they cite found mootness for individual plaintiffs who entered into a full agreement to settle and dismiss their claims in the lawsuit. *See Pettrey v. Enter. Title Agency, Inc.*, 584 F.3d 701, 703 (6th Cir. 2009) ("[T]he plaintiffs entered into a settlement agreement and released all of their individual claims for damages, attorneys' fees, and costs against the defendants . . . [and] the district court dismissed the action with prejudice."); *Ruppert v. Principal Life Ins. Co.*, 705 F.3d 839, 841 (8th Cir. 2013) (Plaintiff and defendant "entered into a confidential settlement agreement," and "the district court entered a consent judgment [that] . . . incorporated the terms of the Confidential Agreement."); *Rhodes v. E.I. du Pont de Nemours & Co.*, 636 F.3d 88, 100 (4th Cir. 2011) ("This Court has held that a putative class representative who voluntarily settles his case and releases all his individual claims, under language providing for the release of 'any and all' monetary claims 'including any claims for . . . compensation [that he

or she] may have as a member/representative of the putative class,' may not thereafter appeal from an adverse class certification ruling.") (citations omitted).

Furthermore, the State candidly admits that there was no agreement to settle claims to attorneys' fees and costs. Again, that distinguishes the cases it relies upon. *See Pettrey*, 584 F.3d at 705 (distinguishing *Roper* and *Geraghty* because plaintiffs had been compensated for attorneys' fees and costs and had released those individual claims).[17] Because no settlement agreement, much less a complete agreement, is present in this case that evinces Plaintiffs' intent to relinquish their claims and dismiss their individual suits, the State's novel argument fails.

Second, the purported "agreement" described by the State was not an agreement to waive the Named Plaintiffs' claims at all, because the State gave no assurances that it would in fact adjudicate their delayed applications. The State contends that it promised that "only if CMS provided the case file would the State be obligated to review the file and attempt to resolve any discrepancies (such as

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[17] Nor did the *Pettrey* court express any "doubt[]" that these facts related to fees and costs were significant. *See* State Br. at 22. In fact, the Court found it significant that the plaintiffs had received full compensation for their attorneys' fees and costs incurred in the case through the negotiated settlement, and used these facts to distinguish *Roper* and *Geraghty*. *Pettrey*, 584 F.3d at 705.

income discrepancies) that might be holding up a final adjudication of eligibility at the [federal Exchange]." Long Decl. ¶ 4 (RE 80-3, PageID# 1191). This mere "attempt to resolve any discrepancies" represents nothing more than TennCare's promises to engage resources in an effort to determine eligibility—something which the State was already obliged to do under federal law.

Third, the record is clear that the ability of the State to adjudicate the Named Plaintiffs' claims, and their legal obligation to do so, was independent of any purported negotiation. The same day this lawsuit was filed, the State asked for and received from Plaintiffs' counsel identifying information of the Named Plaintiffs. *See* Zampierin Decl. ¶ 2 (RE 70-1, PageID# 1018).[18] At that point, before any alleged agreement, TennCare had the unilateral ability to resolve Plaintiffs' applications, and of course it did so before the District Court could rule on the motion for class certification. *See* Section IV.B, *supra* (discussing inherently transitory nature of Plaintiffs' claims).

Fourth, the only "agreement" reached was one as to the appropriate briefing schedule. The case was filed on July 23, 2014, and Plaintiffs requested a hearing on their motions for preliminary injunction and class certification by

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[18] *See supra* note 7 and accompanying text.

August 1, 2014. The District Court did not respond to Plaintiffs' motion to expedite the hearings, and the first judge to whom this case was assigned recused himself on the date originally requested for the hearing. *See* Order (RE 25, PageID# 373). It was reasonable for Plaintiffs' counsel to reach a scheduling agreement with the State since it appeared unlikely that a hearing could be conducted on August 1. Furthermore, at no time did Plaintiffs withdraw their request to have the ultimate disposition of the motions expedited. *See* Jt. Mot. (RE 24, PageID# 371) (reiterating request to expedite hearing).

Plaintiffs therefore respectfully submit that Defendants' novel theory is legally erroneous and factually unsupported by the record.

## CONCLUSION

For the foregoing reasons, the District Court's judgment should be affirmed.

DATED: January 28, 2015

Respectfully submitted,

/s/ Samuel Brooke

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## CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitations of Federal Rule of Appellate Procedure 32(a)(7)(B) and Sixth Circuit Rule 32 because it contains 13,808 words, excluding the parts of the brief exempted by Rule 32(a)(7)(B)(iii) and Sixth Circuit Rule 32(b)(1).

This brief complies with the typeface requirements of Rule 32(a)(5) and the type style requirements of Rule 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word in Times New Roman and 14 point font.

Date: January 28, 2015 /s/ Samuel Brooke

# ADDENDUM

## DESIGNATION OF RELEVANT DISTRICT COURT DOCUMENTS

### Pursuant to 6 Cir. R. 28(b)(1)(A)(i) & 6 Cir. R. 30(g)(1)

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| 4-1 | Mitigation Planning for January 1, 2014 (updated July 14, 2014) (attached to Brooke Declaration) | 227–30 |
| 4-1 | TennCare Medicaid and TennCare Standard Policy Manual (attached to Brooke Declaration) | 239–55 |
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| 4-1 | TennCare Website (attached to Brooke Declaration) | 283 |
| 4-1 | TennCare Website (attached to Brooke Declaration) | 285 |
| 4-1 | Letter from Mann to Gordon (June 27, 2014) (attached to Brooke Declaration) | 296–98 |
| 6 | Plaintiffs' Request for Expedited Hearing on Motions for Preliminary Injunction and Class Certification | 330–37 |

| Record Entry No. | Description | PageID# |
|---|---|---|
| 24 | Joint Motion To Enter a Scheduling Order on Plaintiffs' Motions for a Preliminary Injunction and for Class Certification | 370–72 |
| 25 | Order of Reassignment | 373 |
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| 66 | Declaration of Carlene LeCompte | 975–79 |
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| 70-1 | Declaration of Sara Zampierin | 1018–19 |
| 70-2 | Declaration of M.A.B. | 1049–55 |
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| 85 | Statement of Interest of the United States of America | 1244–46 |
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| 90 | Class Certification Order | 1271–79 |
| 91 | Preliminary Injunction Order | 1280–88 |
| 93 | Transcript of Motion Hearing (Aug. 29, 2014) | 1379, 1396–97, 1425–27 |
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# ADDENDUM

## RELEVANT STATUTES, REGULATIONS, & RULES

## Pursuant to Fed. R. App. P. 28(f)

## Statutes

**42 U.S.C. § 1396a. State plans for medical assistance**

(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. State flexibility in operation and enforcement of Exchanges and related requirements**

. . . .

(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.

. . . .

**42 U.S.C. § 18083. Streamlining of procedures for enrollment through an Exchange and State Medicaid, CHIP, and health subsidy programs**

. . . .
(b) Requirements relating to forms and notice
(1) Requirements relating to forms
(A) In general
The Secretary shall develop and provide to each State a single, streamlined form that--
(i) may be used to apply for all applicable State health subsidy programs within the State;
(ii) may be filed online, in person, by mail, or by telephone;
(iii) may be filed with an Exchange or with State officials operating one of the other applicable State health subsidy programs; and
(iv) is structured to maximize an applicant's ability to complete the form satisfactorily, taking into account the characteristics of individuals who qualify for applicable State health subsidy programs.
(B) State authority to establish form
A State may develop and use its own single, streamlined form as an alternative to the form developed under subparagraph (A) if the

alternative form is consistent with standards promulgated by the Secretary under this section.

(C) Supplemental eligibility forms

The Secretary may allow a State to use a supplemental or alternative form in the case of individuals who apply for eligibility that is not determined on the basis of the household income (as defined in section 36B of Title 26).

(2) Notice

The Secretary shall provide that an applicant filing a form under paragraph (1) shall receive notice of eligibility for an applicable State health subsidy program without any need to provide additional information or paperwork unless such information or paperwork is specifically required by law when information provided on the form is inconsistent with data used for the electronic verification under paragraph (3) or is otherwise insufficient to determine eligibility.

(c) Requirements relating to eligibility based on data exchanges

(1) Development of secure interfaces

Each State shall develop for all applicable State health subsidy programs a secure, electronic interface allowing an exchange of data (including information contained in the application forms described in subsection (b)) that allows a determination of eligibility for all such programs based on a single application. Such interface shall be compatible with the method established for data verification under section 18081(c)(4) of this title.

(2) Data matching program

Each applicable State health subsidy program shall participate in a data matching arrangement for determining eligibility for participation in the program under paragraph (3) that--

(A) provides access to data described in paragraph (3);

(B) applies only to individuals who--

(i) receive assistance from an applicable State health subsidy program; or

(ii) apply for such assistance--

(I) by filing a form described in subsection (b); or

(II) by requesting a determination of eligibility and authorizing disclosure of the information described in paragraph (3) to applicable State health coverage subsidy programs for purposes of determining and establishing eligibility; and

(C) consistent with standards promulgated by the Secretary, including the privacy and data security safeguards described in section 1942 of

the Social Security Act [42 U.S.C. 1396w-2] or that are otherwise applicable to such programs.

(3) Determination of eligibility

(A) In general

Each applicable State health subsidy program shall, to the maximum extent practicable--

(i) establish, verify, and update eligibility for participation in the program using the data matching arrangement under paragraph (2); and

(ii) determine such eligibility on the basis of reliable, third party data, including information described in sections 1137, 453(i), and 1942(a) of the Social Security Act [42 U.S.C. 1320b-7, 653(i), 1396w-2(a)], obtained through such arrangement.

(B) Exception

This paragraph shall not apply in circumstances with respect to which the Secretary determines that the administrative and other costs of use of the data matching arrangement under paragraph (2) outweigh its expected gains in accuracy, efficiency, and program participation.

(4) Secretarial standards

The Secretary shall, after consultation with persons in possession of the data to be matched and representatives of applicable State health subsidy programs, promulgate standards governing the timing, contents, and procedures for data matching described in this subsection. Such standards shall take into account administrative and other costs and the value of data matching to the establishment, verification, and updating of eligibility for applicable State health subsidy programs.

. . . .

**42 U.S.C. § 18118**. Rules of construction

. . . .

(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.

## Regulations

**42 C.F.R. § 431.10. Single State agency.**

(a) Basis, purpose, and definitions.

(1) This section implements section 1902(a)(4) and (5) of the Act.

(2) For purposes of this part--

Appeals decision means a decision made by a hearing officer adjudicating a fair hearing under subpart E of this part.

Exchange has the meaning given to the term in 45 CFR 155.20.

Exchange appeals entity has the meaning given to the term "appeals entity," as defined in 45 CFR 155.500.

Medicaid agency is the single State agency for the Medicaid program.

(b) Designation and certification. A State plan must--

(1) Specify a single State agency established or designated to administer or supervise the administration of the plan; and

(2) Include a certification by the State Attorney General, citing the legal authority for the single State agency to--

(i) Administer or supervise the administration of the plan; and

(ii) Make rules and regulations that it follows in administering the plan or that are binding upon local agencies that administer the plan.

(3) The single State agency is responsible for determining eligibility for all individuals applying for or receiving benefits in accordance with regulations in part 435 of this chapter and for fair hearings filed in accordance with subpart E of this part.

(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.

(d) Agreement with Federal, State or local entities making eligibility determinations or appeals decisions. The plan must provide for written agreements between the Medicaid agency and the Exchange or any other State or local agency that has been delegated authority under paragraph (c)(1)(i) of this section to determine Medicaid eligibility and for written agreements between the agency and the Exchange or Exchange appeals entity that has been delegated authority to conduct Medicaid fair hearings under paragraph (c)(1)(ii) of this section. Such agreements must be available to the Secretary upon request and must include provisions for:

(1) The relationships and respective responsibilities of the parties, including but not limited to the respective responsibilities to effectuate the fair hearing rules in subpart E of this part;
(2) Quality control and oversight by the Medicaid agency, including any reporting requirements needed to facilitate such control and oversight;
(3) Assurances that the entity to which authority to determine eligibility or conduct fair hearings will comply with the provisions set forth in paragraph (c)(3) of this section.
(4) For appeals, procedures to ensure that individuals have notice and a full opportunity to have their fair hearing conducted by either the Exchange or Exchange appeals entity or the Medicaid agency.

(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. Procedural rights of the applicant or beneficiary.**

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.

**42 C.F.R. § 435.541. Determinations of disability.**

(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.
(1) If the agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act, the agency may not make a determination of disability when the only application is filed with SSA.
(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made

by SSA automatically confers Medicaid eligibility, as provided for under § 435.909.

(b) Effect of SSA determinations.

(1) Except in the circumstances specified in paragraph (c)(3) of this section--

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.

(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:

(1) The individual applies for Medicaid as a non-cash beneficiary and has not applied to SSA for SSI cash benefits, whether or not a State has a section 1634 agreement with SSA; or an individual applies for Medicaid and has applied to SSA for SSI benefits and is found ineligible for SSI for a reason other than disability.

(2) The individual applies both to SSA for SSI and to the State Medicaid agency for Medicaid, the State agency has a section 1634 agreement with SSA, and SSA has not made an SSI disability determination within 90 days from the date of the individual's application for Medicaid.

(3) The individual applies to SSA for SSI and to the State Medicaid agency for Medicaid, the State does not have a section 1634 agreement with SSA, and either the State uses more restrictive criteria than SSI for determining Medicaid eligibility under its section 1902(f) option or, in the case of a State that uses SSI criteria, SSA has not made an SSI disability determination in time for the State to comply with the Medicaid time limit for making a prompt determination on an individual's application for Medicaid.

(4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and--

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and

has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and--

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

. . . .

**42 C.F.R. § 435.907. Application.**

(a) Basis and implementation. In accordance with section 1413(b)(1)(A) of the Affordable Care Act, the agency must accept an application from the applicant, an adult who is in the applicant's household, as defined in § 435.603(f), or family, as defined in section 36B(d)(1) of the Code, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant, and any documentation required to establish eligibility--

(1) Via the internet Web site described in § 435.1200(f) of this part;

(2) By telephone;

(3) Via mail;

(4) In person; and

(5) Through other commonly available electronic means.

. . . .

**42 C.F.R. § 435.908. Assistance with application and renewal.**

(a) The agency must provide assistance to any individual seeking help with the application or renewal process in person, over the telephone, and online, and in a manner that is accessible to individuals with disabilities and those who are limited English proficient, consistent with § 435.905(b) of this subpart.

. . . .

**42 C.F.R. § 435.912. Timely determination of eligibility.**

. . . .

(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.

. . . .

**42 C.F.R. § 435.1200. Medicaid agency responsibilities.**

. . . .

(b) General requirements. The State Medicaid agency must--

(1) Fulfill the responsibilities set forth in paragraphs (d) and (e) and, if applicable, paragraph (c) of this section in partnership with other insurance affordability programs.
(2) Certify for the Exchange and other insurance affordability programs the criteria applied in determining Medicaid eligibility.
(3) Enter into and, upon request, provide to the Secretary one or more agreements with the Exchange and the agencies administering other insurance affordability programs as are necessary to fulfill the requirements of this section, including a clear delineation of the responsibilities of each program to--
(i) Minimize burden on individuals;
(ii) Ensure compliance with paragraphs (d) through (f) of this section and, if applicable, paragraph (c) of this section;
(iii) Ensure prompt determinations of eligibility and enrollment in the appropriate program without undue delay, consistent with timeliness standards established under § 435.912, based on the date the application is submitted to any insurance affordability program.

(c) Provision of Medicaid for individuals found eligible for Medicaid by another insurance affordability program. If the agency has entered into an agreement in accordance with § 431.10(d) of this subchapter under which the Exchange or other insurance affordability program makes final determinations of Medicaid eligibility, for each individual determined so eligible by the Exchange or other program, the agency must--

(1) Establish procedures to receive, via secure electronic interface, the electronic account containing the determination of Medicaid eligibility;
(2) Comply with the provisions of § 435.911 of this part to the same extent as if the application had been submitted to the Medicaid agency; and
(3) Comply with the provisions of § 431.10 of this subchapter to ensure it maintains oversight for the Medicaid program.

. . . .

## Rules

**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 on this day I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for Sixth Circuit by using the appellate CM/ECF system.

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

Date: January 28, 2015 /s/ Samuel Brooke