No. 14-6191

IN THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

MELISSA WILSON, et al., individually and on behalf of all others similarly situated,

Plaintiffs-Appellees,

v.

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

Defendants-Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF TENNESSEE (No. 3:14-cv-1492 (Hon. Todd J. Campbell))

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE IN SUPPORT OF APPELLEES

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STATEMENT OF INTEREST

This appeal presents the question whether a State that participates in the Medicaid program bears the ultimate responsibility to ensure that eligibility determinations are made reasonably promptly, *see* 42 U.S.C. § 1396a(a)(8), and to provide an opportunity for a hearing before the State Medicaid agency if an application for benefits is not acted upon with reasonable promptness, *see id.* § 1396a(a)(3), regardless of any delegation that the State may make to a federal agency or other entity. The Medicaid program is administered by the Secretary of Health & Human Services (HHS) through the Centers for Medicare & Medicaid Services (CMS). The federal government has a strong interest in the proper resolution of the question presented.

STATEMENT OF THE CASE

1. The Medicaid statute, enacted in 1965 as Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, provides federal financial assistance to States to pay for medical care for needy individuals. *National Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2581 (2012) (*NFIB*). "States are not required to participate in Medicaid, but all of them do." *Arkansas Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 275 (2006).

"In order to receive [Medicaid] funding, States must comply with federal criteria governing matters such as who receives care and what services are

provided at what cost." *NFIB*, 132 S. Ct. at 2581. To that end, a State must submit to CMS a state Medicaid plan that details the nature and scope of the State's Medicaid program as well as any amendments to the plan. *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204, 1208 (2012). CMS reviews the State plans and proposed amendments "to determine whether they comply with the statutory and regulatory requirements governing the Medicaid program." *Ibid.*

A State plan must designate "a single State agency to administer or to supervise the administration of the plan." 42 U.S.C. § 1396a(a)(5). A State plan 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." *Id.* § 1396a(a)(8). In addition, a State plan must "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." *Id.* § 1396a(a)(3). HHS regulations have long provided that eligibility determinations must be made within 45 days, or 90 days if the application is based on a disability. *See* 42 C.F.R. § 435.912(c)(3). Determinations must be made promptly and without undue delay. *See id.* § 435.912(b). Longstanding HHS regulations also provide that the single State agency may authorize other entities to perform certain functions under its plan, *see*

id. § 431.10(c), but may not delegate authority to supervise the administration of the plan, *see id*. § 431.10(e).

2. In 2010, Congress enacted the Patient Protection and Affordable Care Act (Affordable Care Act), Pub. L. No. 111-148, 124 Stat. 119.[1] Several of the Act's provisions are pertinent to this appeal.

First, to establish consistency in eligibility determinations under the Medicaid program, the Affordable Care Act provided, effective January 1, 2014, for household income for most individuals to be determined using modified adjusted gross income (MAGI). 42 U.S.C. § 1396a(e)(14). The new methodology, which is an adaptation of longstanding Internal Revenue Service rules, replaced the use of other methodologies in calculating household income.[2]

Second, the Affordable Care Act provided for the creation of Exchanges, which are state-specific marketplaces where consumers can compare and purchase health plans offered in their State by private insurers. 42 U.S.C. § 18031 *et seq*. The Act provides that if a State does not elect to create the required Exchange for itself, or fails to have its Exchange operational by January 1, 2014, HHS shall

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[1] Amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

[2] Although most categories of eligibility are now determined pursuant to MAGI rules, the MAGI methodology does not apply for persons eligible on the basis of disability; elderly and blind individuals; cost sharing for Medicare enrollees; and foster children. 42 U.S.C. § 1396a(e)(14)(D)(i)(I-V).

establish and operate such Exchange for the State. 42 U.S.C. § 18041(c)(1). An Exchange operated by HHS is known as a federally facilitated Exchange. 45 C.F.R. § 155.20. Though run by HHS, each federally facilitated Exchange is a State-specific marketplace offering State-specific health insurance plans.[3]

Third, the Affordable Care Act streamlined the process by which an individual may obtain health coverage through any "applicable State health subsidy program," a term defined to include Medicaid, the Children's Health Insurance Program (CHIP), and insurance affordability programs offered through an Exchange (which include advance premium tax credits and cost-sharing reductions for coverage purchased through an Exchange). The Act directed the Secretary to develop a single, streamlined system and application form that State residents may use to enroll in any applicable State health subsidy program. 42 U.S.C. § 18083(a), (b), (e). The Act required each State, as a condition of Medicaid participation, to develop a secure electronic interface for data exchange that allows a determination of eligibility for all applicable State health subsidy programs, and, to the maximum extent practicable, to use this system to determine eligibility. 42 U.S.C. § 18083(c); *id.* § 1396w-3(b)(3). The Act also created a "no

[3] This case does not implicate the issue presented in *King v. Burwell*, No. 14-114 (S. Ct.), where the petitioners contend that the premium tax credits and cost-sharing subsidies that Congress authorized for low- and moderate-income federal taxpayers are not available for insurance plans purchased through federally facilitated Exchanges.

wrong door" policy, which means that individuals can apply for health coverage through the State Medicaid agency, the State CHIP agency, or the Exchange for their State. An application "may be filed with an Exchange or with State officials operating one of the other applicable State health subsidy programs," such as the State Medicaid agency. 42 U.S.C. § 18083(b)(1)(A)(iii). Applications "may be filed online, in person, by mail, or by telephone." *Id*. § 18083(b)(1)(A)(ii).

Regardless of which "door" they choose, individuals can get eligibility determinations for all types of applicable State health subsidy programs and have their accounts routed to the program for which they are eligible. A State must ensure that individuals found ineligible for Medicaid or CHIP are screened for eligibility to enroll in a plan offered through an Exchange, and enroll the individual in such a plan if the individual is found eligible. *Id*. § 1396w-3(a), (b)(1)(C). Likewise, if an individual applying to an Exchange is found eligible for Medicaid or CHIP, the individual must be enrolled in the applicable program. *Id*. § 18083(a).

3. As discussed above, the Affordable Care Act requires State Medicaid agencies and Exchanges to use new income standards for determining eligibility and to have operating systems that can accept applications and make determinations based upon these standards. The Secretary developed a single, streamlined application for all applicable insurance affordability programs,

including Medicaid and CHIP. In addition, the Secretary provided enhanced federal financial assistance to States to enable them to upgrade or purchase systems that can accept and process applications using the new standards and uniform application. *See* 75 Fed. Reg. 21,950 (Apr. 19, 2011). Tennessee received such federal funds and was expected to have a new system capable of making MAGI-based eligibility determinations by October 1, 2013.

In mid-2013, Tennessee advised CMS that it would not be compliant with the new requirements by October 1, but that it expected the new system to be fully operational by January 1, 2014. *See* R.4-1 at Page ID #265. As a mitigation strategy, CMS permitted Tennessee to refer Medicaid applications based on MAGI to the federally facilitated Exchange for Tennessee for the period October 1, 2013 until January 1, 2014. *See ibid*. Under this mitigation plan, the Exchange would make MAGI eligibility determinations and forward the results to Tennessee, which would enroll eligible applicants in Tennessee's Medicaid program (known as TennCare). *See ibid*. Tennessee was to continue to "use its existing application online, in paper and in person until [January 1, 2014]." *Ibid*.

Tennessee did not meet the January 1, 2014 deadline. Tennessee still does not have a system to make MAGI-based eligibility determinations, nor a definite date by which it will have such a system. *See* R.91 at Page ID #1283. Although

CMS did not formally extend the mitigation plan, Tennessee continues to refer all MAGI applicants to the Exchange. *See* R.4-1 at Page ID #274.

The Exchange is able to make most eligibility determinations promptly. However, the Exchange is currently unable to make eligibility determinations for applicants when information received from the applicant differs from other information received through its verification processes concerning income or state residency. CMS has worked with Tennessee, and with other States that have had this issue, to implement strategies to more efficiently process these applications. But because Tennessee has refused to provide either an alternative pathway or a system capable of conducting verifications of income and residency, CMS has not been able to implement in Tennessee the workarounds that have facilitated enrollment for applicants in other States.

4. Plaintiffs are a certified class of individuals who applied for Medicaid in Tennessee 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" before the State Medicaid agency after these time periods have run. *See* R.90 at Page ID ##1278-79. Plaintiffs contend that Tennessee is violating its obligation under the Medicaid statute to make eligibility determinations with reasonable promptness, as required by 42 U.S.C. § 1396a(a)(8), and refusing to provide fair hearings on delayed

applications, as required by 42 U.S.C. § 1396a(a)(3). Plaintiffs also allege these failures violate their due process rights.

After briefing and a hearing, the district court (Campbell, J.) entered a preliminary injunction that requires Tennessee to provide a "fair hearing . . . within 45 days after [a] Class Member requests a hearing and provides the [State] with proof that an application for medical assistance was filed." R.91 at Page ID ##1287-88. The district court rejected Tennessee's effort to absolve itself of responsibility by attributing the delayed adjudications to the federally facilitated Exchange. The court reasoned that a State cannot "delegate its responsibilities under the Medicaid program to some other entity—whether that entity is a private party or the Federal Government." *Id*. at Page ID #1284. "If a state decides to participate in the Medicaid program, it is required to ensure that applications are adjudicated reasonably promptly and that hearings on delayed adjudications are held reasonably promptly." *Ibid*. (citing, *e.g.*, *McCartney ex rel. McCartney v. Cansler*, 608 F. Supp. 2d 694, 701 (E.D.N.C. 2009) (a State "may not disclaim its responsibilities under federal law by simply contracting away its duties"), *aff'd*, 382 F. App'x 334 (4th Cir. 2010)).

The court explained that "this principle is longstanding and was not altered by the Affordable Care Act." R.91 at Page ID #1284. The court cited with approval the Statement of Interest filed by the United States, which explained that,

"[u]nder the Medicaid statute, 42 U.S.C. § 1396a *et seq*., it is the state Medicaid agency, in this case TennCare, that at all times retains the ultimate responsibility to ensure that a reasonably prompt decision is made on applications, including ones that have been submitted in the first instance to the federally facilitated Exchange in the State." *Ibid*. (quoting R.85 at Page ID #1244).

ARGUMENT

A State that chooses to participate in Medicaid must designate "a single State agency to administer or to supervise the administration of the plan." 42 U.S.C. § 1396a(a)(5). That single State agency must ensure that all applications are adjudicated promptly, *id*. § 1396a(a)(8), and must provide "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." *Id*. § 1396a(a)(3). Accordingly, the district court correctly ordered Tennessee to provide an opportunity for a fair hearing within 45 days after a class member requests a hearing and provides the State with proof that an application for Medicaid was filed. *See* R.91 at Page ID ##1287-88.

1. The district court correctly rejected Tennessee's contention that it could absolve itself of responsibility for making timely determinations of Medicaid eligibility by referring applicants to the federally facilitated Exchange. The Medicaid statute requires "a single State agency to administer or to supervise the

administration of the plan." 42 U.S.C. § 1396a(a)(5). Longstanding regulations provide that a State may authorize other entities to perform certain functions under its plan, *see* 42 C.F.R. § 431.10(c), but may not delegate authority to supervise the administration of its plan, *see id.* § 431.10(e). Accordingly, as Tennessee acknowledges, a State Medicaid agency remains "legally responsible for problems with a state's Medicaid program notwithstanding delegations of authority to other state agencies or private parties." State's Br. 34; *see also Catanzano ex rel. Catanzano v. Dowling*, 60 F.3d 113, 118 (2d Cir. 1995) ("it is patently unreasonable to presume that Congress would permit a state to disclaim federal responsibilities by contracting away its obligations to a private entity") (internal quotation marks omitted); *Carr v. Wilson-Coker*, 203 F.R.D. 66, 75 (D. Conn. 2001) (a State Medicaid agency's "duties relative to ensuring that the plaintiffs receive medical services with reasonable promptness are non-delegable"); *McCartney ex rel. McCartney v. Cansler*, 608 F. Supp. 2d 694, 701 (E.D.N.C. 2009) (State Medicaid agency "may not disclaim its responsibilities under federal law by simply contracting away its duties"), *aff'd*, 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 law demands that the designated single state Medicaid agency must oversee and remain accountable for uniform statewide utilization review procedures conforming to bona fide standards of medical necessity.").

As the district court explained, "this principle is longstanding and was not altered by the Affordable Care Act." R.91 at Page ID #1284 (citing 42 U.S.C. § 18118). The cited Affordable Care Act provision specifies that "[n]othing 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" Medicaid or another applicable State health subsidy programs. 42 U.S.C. § 18118(d) (emphasis added).

Tennessee does not contend that there is any "direct statutory reference" in the Affordable Care Act that modifies the State Medicaid agency's preexisting obligations to administer or supervise the administration of the plan, to make timely eligibility determinations, and to provide an opportunity for a hearing if eligibility determinations are delayed. Instead, Tennessee argues that the Act implicitly modified the State Medicaid agency's responsibilities by allowing the federally facilitated Exchanges to play a role in determining Medicaid eligibility. Tennessee contends its statutory duty to "'supervise the administration of the plan,'" State's Br. 35 (quoting 42 U.S.C. § 1396a(a)(5)), cannot apply to "aspects of a state Medicaid plan administered by the federal government" because "states may not supervise or regulate the activities of the federal government." *Ibid.*

This argument misses the point, which is not that the State should supervise a federal agency directly, but that the State Medicaid agency retains ultimate responsibility to ensure that the State Medicaid program is administered in accordance with the requirements of the Medicaid statute. For example, although State Medicaid agencies have long had agreements with the federal Social Security Administration (SSA) "to determine Medicaid eligibility for individuals who are recipients of" Supplemental Security Income (SSI) benefits, "the State Medicaid agency is required to make an independent determination of disability" when "SSA has not made an SSI disability determination within the Medicaid time limit for making a prompt determination on an individual's applications for Medicaid" and the individual has applied both to SSA and the State Medicaid agency. 54 Fed. Reg. 50,755 (Dec. 11, 1989). Similarly, if a federally facilitated Exchange is unable to make a timely determination of Medicaid eligibility, the State Medicaid agency is required to make an independent determination of Medicaid eligibility and to provide an opportunity for a fair hearing if such a determination is delayed.

These obligations follow directly from the Medicaid statute, which assigns them to the "single State agency" responsible for the administration of the State's plan. 42 U.S.C. § 1396a(a)(3), (5) and (8). Neither the Affordable Care Act nor its implementing regulations altered the requirement that the State Medicaid agency ensure that eligibility determinations are made with reasonable promptness and to

provide the opportunity for a fair hearing if such a determination is delayed. And requiring the State agency to make an independent determination when a federally facilitated Exchange is unable to make a determination in a timely manner is entirely consistent with the structural constitutional principles Tennessee invokes, because it does not require the State agency to control the actions of federal officials or otherwise to "supervise or regulate the activities of the federal government." State's Br. 35. The district court therefore correctly ordered Tennessee to provide "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).

2. The preliminary injunction requires Tennessee to provide a "fair hearing . . . within 45 days after [a] Class Member requests a hearing and provides the [State] with proof that an application for medical assistance was filed." R.91 at Page ID ##1287-88. The State incorrectly contends that the district court could not properly issue that order without joining the United States as a required party under Federal Rule of Civil Procedure 19(a). The Rule 19 argument rests largely on the same premise as the merits argument and fails for the reasons discussed above.

The State also contends that joinder of the United States is necessary to ensure that the State is not subject to inconsistent obligations under federal law. The premise of this argument is that the preliminary injunction requires the State to

violate other provisions of federal law that protect the rights of class members themselves. That premise is incorrect.

Contrary to the State's suggestion (Br. 44-45), the injunction does not require the State Medicaid agency to ask applicants for their income information; the "flat files" that the Exchange transfers to the State include the income attested to by the applicant.[4] Moreover, the Affordable Care Act provision on which the State relies permits a State to seek additional information from an applicant when, as here, the information originally submitted by the applicant is "insufficient to determine eligibility." 42 U.S.C. § 18083(b)(2).

Nor does the injunction prevent the State from complying with 42 C.F.R. § 431.242, which requires that applicants be permitted to examine the contents of their case files before eligibility hearings. The regulation defines a "[c]ase record" as "a hardcopy or electronic file that contains information on a beneficiary regarding program eligibility." 42 C.F.R. § 431.958. The purpose of the requirement is to ensure that an applicant has access to the material the State Medicaid agency will consider in conducting a hearing, and the agency complies with the regulation by making available the relevant information it has.

[4] "Flat files" are spreadsheets used to transfer applicant information to the State.

Notably, although the State purports to invoke the interests of the class members, plaintiffs themselves rejected these contentions when they were urged in district court. Plaintiffs explained that, "[i]f credited, Defendants' argument 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." R.99 at Page ID #1495. "The regulations . . . clearly contemplate that the applicant can introduce any relevant evidence at the hearing." *Ibid*. (citing 42 C.F.R. § 431.242). "Though Defendants correctly note that the ACA protects individual applicants from being required to submit additional documentation if the application is complete, it does not prevent individuals from voluntarily submitting more information in requesting a fair hearing or attempting to obtain an adjudication more quickly." *Ibid*.

CONCLUSION

The judgment of the district court should be affirmed.

Respectfully submitted,

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FEBRUARY 2015

CERTIFICATE OF COMPLIANCE WITH
FEDERAL RULE OF APPELLATE PROCEDURE 32(A)

I hereby certify that this brief complies with the requirements of Fed. R. App. P. 32(a)(5) and (6) because it has been prepared in 14-point Times New Roman, a proportionally spaced font. I further certify that this brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because it contains 3,419 words, excluding the parts of the brief exempted under Rule 32(a)(7)(B)(iii), according to the count of Microsoft Word.

/s/ Alisa B. Klein
Alisa B. Klein

CERTIFICATE OF SERVICE

I hereby certify that on February 4, 2015, I electronically filed the foregoing brief with the Clerk of this Court by using the appellate CM/ECF system. The participants in the case are registered CM/ECF users and service will be accomplished by the appellate CM/ECF system.

/s/ Alisa B. Klein
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