IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
AT NASHVILLE

MELISSA WILSON, *et al.*, ***Plaintiffs,*** **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.***	)	**No. 3-14-1492** **Judge Campbell** **Magistrate Judge Bryant**

DEFENDANTS' MEMORANDUM IN OPPOSITION
TO PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

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DEFENDANTS' MEMORANDUM IN OPPOSITION
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Defendants (the "State") respectfully submit that Plaintiffs' extraordinary request for an injunction requiring the State to adjudicate, within 48 or 72 hours, applications for enrollment into Medicaid that were submitted to the federal government for adjudication should be denied.

INTRODUCTION

Each of the Plaintiffs alleges that he or she (or his or her parent) filed an application for enrollment into Medicaid with the federal marketplace established under the Affordable Care Act ("ACA") and operated by the federal government. Despite the passage of several months, Plaintiffs allege, the federal agency that operates the federal marketplace has not adjudicated these applications. Instead of seeking relief from that agency, however, Plaintiffs have sued the State. They ask the Court to enter a preliminary injunction that would require the State to develop and implement, immediately, a brand new, manual system for assessing Medicaid

eligibility that would be capable of adjudicating applications within 72 hours of receiving evidence suggesting that an individual had applied for Medicaid more than 45 days earlier. Under this system, the State would be obliged to complete these adjudications even though in most instances it would not have the application, nor would it have any information gathered by the federal Exchange from the Internal Revenue Service ("IRS"), the Social Security Administration ("SSA"), or any other source, nor would it have any supplemental information submitted by the applicant.

Plaintiffs cannot carry their burden of demonstrating a likelihood of success on the merits for multiple independent reasons:

- Because Plaintiffs' alleged injuries were caused by the federal government's alleged failure to timely adjudicate their Medicaid applications and those injuries may only be redressed by the agency that has their applications, they lack standing to bring their claims against the State.

- There is no private right of action under 42 U.S.C. § 1983 to enforce the "reasonable promptness" requirements in 42 U.S.C. § 1396a(a)(3) and (8). *See Cook v. Hairston*, 948 F.2d 1288, 1991 WL 253302, at *5 (6th Cir. 1991) (unpublished table decision).

- The federal government's alleged delays in the adjudication of Plaintiffs' Medicaid applications do not violate federal law because the governing regulation provides for an exception to normal time limits in "unusual circumstances," and the responsible federal agency has determined that the operational problems experienced by the federal Exchange qualify for the exception.

- There is no provision of the Medicaid statute, the Affordable Care Act, or the implementing federal regulations requiring the State to develop and implement a backup system for adjudicating Medicaid applications submitted to the federal government when the federal government fails to do so on a timely basis.

- Plaintiffs' due process claim fails because there is no constitutional right to a hearing before an application is denied or when an application is not adjudicated with "reasonable promptness," and in any event, Plaintiffs have a right to appeal the decisions or failures to act by the federal Exchange to the appeal systems established by the exchange.

- Plaintiffs have failed to join a party—the federal agency that has allegedly failed to timely adjudicate their applications—necessary to provide complete relief.

Plaintiffs have also failed to demonstrate that they (or any member of the purported class) will suffer irreparable harm absent entry of the preliminary injunction they seek.

- The Medicaid applications of nine of the eleven named Plaintiffs have been adjudicated and they have been enrolled into TennCare. Accordingly, their claims are moot.

- The remaining two Plaintiffs have not alleged that they will suffer any irreparable harm absent the entry of injunctive relief.

- In addition, the State has asked the federal government to provide copies of any Medicaid applications and supporting documentation filed by the remaining Plaintiffs and agreed to promptly adjudicate those applications if the federal government provides them.

- The State has asked the federal government to approve a new hospital presumptive eligibility program that will enable hospitals to grant presumptive eligibility to any qualifying individual for a 45-day period of time while that individual applies for Medicaid.

Both the State's and the public's interest would be seriously harmed by entry of the relief sought by Plaintiffs. The implementation of the myriad, highly complex changes required by the ACA has led to backlogs in the processing of Medicaid applications in other States numbering in the tens, and even hundreds of thousands. *See, e.g.*, Phil Galewitz, *More than 1.7 Million Consumers Still Wait for Medicaid Decisions*, KAISER HEALTH NEWS (June 9, 2014), *available at* www.kaiserhealthnews.org/Stories/2014/June/09/More-Than-17-Million-Consumers-Still-Wait-For-Medicaid-Decisions.aspx (reporting backlogs of 900,000 in California, 283,000 in Illinois, 170,000 in North Carolina, 100,000 in Georgia, 65,000 in Ohio, 62,000 in South Carolina, 60,000 in Pennsylvania, 48,000 in Virginia, 44,000 in Arizona, and 42,000 in Nevada).

In contrast, while Tennessee has faced challenges in adapting to the new world under the ACA, it has managed to avoid substantial application backlogs. Indeed, the federal government,

through the federally facilitated marketplace, has approved approximately 89,000 applicants from Tennessee between January 1, 2014 and the end of June, all of whom have been enrolled in TennCare. In addition, approximately 46,000 individuals have been enrolled in TennCare during that period based on either the State's direct determination of their eligibility for Medicaid or the determination of the SSA that the individual qualified for Social Security Income ("SSI"). The number of new enrollees added to the TennCare rolls in the first quarter of 2014 was the third highest in the 20-year history of the program and the growth in Medicaid enrollment in Tennessee is more than double the average rate of increase experienced by other states that, like Tennessee, have not expanded Medicaid.

The injunction that Plaintiffs have asked the Court to enter threatens to severely disrupt a system that is working well for the vast majority of applicants and to create backlogs like those experienced in other states. The State does not have the Medicaid applications allegedly filed with the federal government, it does not have the data gathered by the federal government from other federal databases (e.g., the IRS and the SSA), and it does not have the verification documentation that Plaintiffs allegedly submitted in response to requests from the federal government. In these circumstances, it is impossible for the State to adjudicate eligibility—much less to do so in 48 or 72 hours as Plaintiffs have demanded. And even if the State had the application files, it does not have an operational computer system capable of adjudicating the applications under the new standards adopted in the Affordable Care Act. As a result, before the State could review any significant volume of Medicaid applications, it would be necessary to hire and train an enormous number of workers to conduct the necessary manual review. This manual review, undertaken by newly trained workers, promises to produce fewer accurate results and to raise new concerns about the ability to issue appropriate notices, the ability to track these

cases, and the ability to offer fair hearings that comport with due process. Most importantly, an injunction promising such short turnaround will undoubtedly divert many of the tens of thousands of applicants who would otherwise have successfully applied through the federal Exchange, resulting in huge backlogs like those experienced in other states.

Finally, even if the Court was inclined to enter injunctive relief for the named Plaintiffs, there has been no showing that would support the entry of classwide injunctive relief. It is noteworthy that Plaintiffs seek *different* relief for the named Plaintiffs than they do for the class. *Compare* Pls.' Draft Prelim. Inj. Order, D.E. 4-2, at ¶ A (individual relief sought for named Plaintiffs), *with id*. at ¶¶ B-D (systemic relief sought for class). The Court should not consider, must less impose, such sweeping injunctive relief—relief that threatens to throw a largely working Medicaid application system into chaos—on such a thin record.

STATEMENT

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

responsibilities, must accept and adjudicate applications for enrollment into Medicaid. *See* 42 U.S.C. §§ 18041(c), 18083(a).

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

A. Changes to Medicaid Eligibility Rules Mandated by the ACA.

The ACA made several significant changes to the Medicaid program that became effective January 1, 2014. As noted above, the ACA provided for the establishment of "Exchanges" through which individuals could apply for health care coverage in a number of different programs, including Medicaid. *See* 42 U.S.C. §§ 18031, 18041, 18083(a). The statute authorizes states to operate their own Exchange, and instructs the Secretary to establish a federally operated Exchange in all states that choose not to establish their own Exchange. *See id.* §18041(c); *see also National Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2665 (2012). As of mid-2014, only 14 states and the District of Columbia have established state Exchanges. *See* Richard Cauchi, *State Actions To Address Health Insurance Exchanges*, Nat'l Conference of State Legislatures (May 9, 2014), www.ncsl.org/research/health/state-actions-to-implement-the-health-benefit.aspx. Accordingly, CMS established and operates a federal Exchange known as the federally-facilitated marketplace ("FFM") or HealthCare.gov in the 36 remaining states, including Tennessee. *Id.*

The ACA also revised the process for applying for Medicaid by (i) mandating the creation of a streamlined application that could be used to apply for a number of health care

assistance programs including Medicaid, *see* 42 U.S.C. § 18083(b); and (ii) requiring both states and the federal government to determine eligibility using data that could be queried electronically from agencies such as the IRS and the SSA, *see id.* § 18083(c); *see also* 42 C.F.R. § 435.949. To facilitate this process, CMS created the Data Services Hub, which CMS describes as "provid[ing] one connection to the common federal data sources needed to verify consumer application information for income, citizenship, immigration status, access to minimum essential coverage, etc." Kathleen Sebelius, *What's Working in the Marketplace: The Data Services Hub* (Oct. 26, 2013), www.hhs.gov/digitalstrategy/blog/2013/10/marketplace-data-services-hub.html. The ACA prohibits a state from asking for information beyond what is on the streamlined application (or an alternative State application approved by CMS) unless the applicant seeks a determination of eligibility in a non-MAGI category. *See* 42 U.S.C. § 18083(b)(1)(C).

Finally, the ACA requires the use of a new methodology, known as Modified Adjusted Gross Income ("MAGI"), for calculating income and financial eligibility for most categories of Medicaid. *See id.* § 1396a(e)(14).[1]

B. <u>TennCare Application Process Under the ACA.</u>

In order to implement the new requirements imposed by the ACA and its implementing regulations, the State has made some changes to the TennCare application process. Because the State's existing eligibility computer system (known as ACCENT) is not capable of performing eligibility determinations under the new ACA-required MAGI rules and because the State's new eligibility computer system (known as Tennessee Eligibility Determination System ("TEDS")) is

[1] Certain Medicaid eligibility categories for "individuals eligible because of other aid or assistance, elderly individuals, medically needy individuals, and individuals eligible for medicare cost-sharing" are not subject to the new MAGI rules. 42 U.S.C. § 1396a(e)(14)(D). These are considered to be "non-MAGI categories."

not yet operational, *see* Declaration of Tracy Purcell (hereinafter "Purcell Decl.") at ¶¶ 12-13, 15, all TennCare applications requiring MAGI eligibility determinations must be submitted for adjudication to the FFM. CMS approved the use of "the FFM to receive and process [all MAGI] applications on the state's behalf as a short-term measure, not a long-term solution." Letter from Cindy Mann of CMS to Darin Gordon of TennCare at 3 (June 27, 2014) (hereinafter "Mann Letter") (attached as Exhibit 14 to the Declaration of Samuel Brooke, D.E. 4-1). When TEDS becomes operational, the State will begin adjudicating MAGI eligibility on all TennCare applications—both those submitted directly to TennCare and those submitted to the FFM and referred by the FFM to the State. *See* Purcell Decl. at ¶¶ 15, 17.

1. The State's Eligibility Computer Systems.

Before ACA implementation on January 1, 2014, Medicaid applications were processed by the State's Department of Human Services ("DHS") utilizing ACCENT. This largely automated system tracked all applications and performed eligibility determinations with minimal case worker involvement regarding whether an applicant grouped into one of the Medicaid categories that Tennessee covers (e.g., low income children, pregnant women, parents or caretaker relatives, institutionalized individuals). *Id.* at ¶¶ 3, 11. If the applicant did not group into one of these categories, ACCENT would automatically generate a denial notice. If the applicant was found to be categorically eligible, ACCENT would then, again with minimal caseworker involvement, apply and calculate the then-applicable income and asset requirements specific to that eligibility category and automatically generate a Medicaid approval or denial notice as appropriate. *Id*. at ¶ 11.

While there was some DHS worker involvement in this process, for example inputting the data, eligibility determinations and the issuance of required notices were largely automated.

Id. Given the large number of applicants who apply for TennCare each year, having an automated, as opposed to manual eligibility determination system, is essential. *Id.* at ¶ 21. The manpower it would take to manually process and issue appropriate notices in the tens of thousands of Medicaid applications TennCare receives each year would be enormous. *Id.* at ¶ 21(b) & (e). More importantly, a manual process would exponentially delay application processing times, would be far more prone to worker-error, and would greatly increase the likelihood that an application would get lost or missed or that important notices would not be issued. *Id.* at ¶ 21(b) & (d).

ACCENT is an archaic (over 20 years old), outdated mainframe system that could not readily be updated or reprogrammed in response to the ACA changes in eligibility rules. In particular, there are extreme limitations to the State's ability to reprogram the financial eligibility calculations or to update or change ACCENT denial notices. *Id.* at ¶¶ 11-12. Further, DHS still uses ACCENT to determine eligibility for other social welfare programs (e.g., the Supplemental Nutrition Assistance Program and the Temporary Assistance for Needy Families program), and there was a significant risk that any attempt to reprogram ACCENT to comport with the ACA would disrupt those critical functions. *Id.* at ¶ 12. In short, the systems limitations of ACCENT left the State with no choice but to design an entirely new eligibility system. Modification of ACCENT was simply not a viable option. *Id.*

Accordingly, the State contracted with Northrop Grumman to build a new eligibility system—TEDS—that would be utilized by TennCare to make eligibility determinations on an automated basis.[2] Although the overall contract is for $35.7 million, the State has paid Northrop

[2] With the implementation of the ACA, the State has transferred responsibility for TennCare eligibility determinations from DHS to TennCare. In light of this change, the State has

only for the work it has thus far successfully completed—less than $4.7 million to date. *Id.* at ¶ 15. While the State is frustrated that TEDS is not yet operational, the State is committed to ensuring that TEDS operates properly and has been fully tested and proven capable of performing its intended functions before it is brought online. Gordon Decl. at ¶ 6. Tennessee is very mindful of the lessons learned from the federal government's experience with HealthCare.gov and other states that rolled their systems out too early, before they were fully tested and ready, resulting in large backlogs of eligibility applications and/or drastic redesigns of their new systems. *See* Purcell Decl. at ¶ 21(b) & (f); Long Decl. at ¶ 14; *c.f.* Gordon Decl. at ¶ 6.

2. <u>The State's CMS-Approved Mitigation Plan.</u>

When it became apparent that TEDS would not be operational by October 1, 2013, Tennessee submitted a Mitigation Plan to CMS. *See* Brooke Decl., D.E. 4-1, Ex. 8 (Tennessee's Strategy for October 1, 2013 Mitigation Plan) at 1. As explained above, under this Mitigation Plan, all TennCare applications requiring MAGI eligibility determinations must be submitted for adjudication to the FFM. *See id.* In the Mitigation Plan, the State elected to use a "determination model" whereby the Federal Exchange would make final determinations of Medicaid MAGI-eligibility and transmit those decisions to the State. *See id.*[3] The Mitigation Plan also noted that until TEDS becomes operational, the State would not itself connect to the

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shifted many of its personnel resources from DHS to TennCare. Specifically, DHS has eliminated 256 vacant positions (not all of which were related to Medicaid eligibility determination) and TennCare was authorized to establish 256 new positions. TennCare has filled new eligibility worker positions and has only a handful of open appeals-related positions remaining to be filled. Declaration of Wendy Long ("Long Decl.") at ¶ 9(e).

[3] The ACA's implementing regulations provide that a state may either elect to have an Exchange make final Medicaid eligibility determinations (Determination States) or elect to have an Exchange assess likely eligibility for Medicaid, leaving the final determination to the state (Assessment States). *See* 42 C.F.R. § 435.1200(c).

federal data hub for application verifications, but would leverage the FFM's ability to connect to the hub and gather the necessary verifications for MAGI determinations. *See id.* at 2. The Plan provided that the State would continue to use existing verification methodologies for any individual who applied to the State to be reviewed for Medicaid categories that are not subject to the new MAGI rules (i.e., non-MAGI categories). *See id.* This Mitigation Plan, including the State's strategy of sending all MAGI-applicants to the FFM, was approved by CMS. *See* Brooke Decl., D.E. 4-1, Ex. 7 (CMS Approval Letter), at 1.

Subsequently, when it was clear that the State would be unable to meet the January 1, 2014 target date for having TEDS operational, the State submitted a further Contingency Plan to CMS explaining that the State would "continue to operate in a 'Determination' model with CMS determining MAGI eligibility for all Tennessee applicants." *See* Purcell Decl., Ex. A (Contingency Plan), at 1. CMS did not object to this plan. *Id.* at ¶ 18; *see also* Mann Letter at 3 (CMS approved use of "the FFM to receive and process [all MAGI] applications on the state's behalf as a short-term measure, not a long-term solution"). Most recently, in response to a request from CMS, the State submitted for CMS review and approval an updated Mitigation Plan on July 14, 2014. *See* Brooke Decl., D.E. 4-1, Ex. 4 (Mitigation Planning for January 1, 2014, updated July 14, 2014). This updated Mitigation Plan provides that Tennessee will continue to operate in a "Determination" model with CMS, through the FFM, determining MAGI eligibility for all Tennessee applicants until TEDS becomes operational. *See id.* at 1.

3. <u>Impact of Changes on the Experience of TennCare Applicants.</u>

The changes described above have had only a modest impact on the experience of the vast majority of TennCare applicants. Prior to the implementation of the ACA, the primary way in which individuals applied for Medicaid in Tennessee was by submitting an application to

DHS.[4] Applicants could do so by mail, by fax, or in person at any of the 95 county DHS offices located throughout the State. *See* Purcell Decl. at ¶ 7. For persons with limited literacy skills or limited English proficiency, in-person assistance submitting an application was provided at all of the DHS County offices. Likewise, persons with disabilities were provided assistance with submitting applications either through DHS or one of the State's Area Agencies on Aging and Disability ("AAAD"). *Id.* at ¶ 9.

The application process is similar post-ACA implementation, except that applicants may now also apply for TennCare online twenty-four hours a day through the federal government's HealthCare.gov website and they can apply by telephone through the FFM Call Center. Just as they could previously, applicants may still go to any of the 95 county DHS offices during normal business hours and receive in-person assistance; that assistance is now provided by specially trained counselors who help applicants use dedicated computer kiosks and/or telephones to apply for TennCare through the FFM. *Id*. In addition, the State now provides in-person, in-home application assistance for persons with disabilities in cooperation with the State's nine AAADs, a service that was unavailable prior to January 1. *Id*. Post ACA, applicants may also still mail in their applications to the FFM. If TennCare does receive a mailed application, it is forwarded to the FFM. *Id.* at ¶ 8. All other forms of assistance (for example the assistance for applicants with limited literacy or English proficiency skills) is still available after January 1, 2014. *Id.* at ¶ 9.

[4] Individuals receiving SSI are automatically enrolled in TennCare upon receipt of electronic eligibility data from the SSA and children in foster care have their eligibility for TennCare processed by the State's Department of Children's Services. This has not changed under the new law or the new application processes the State has put in place starting January 1, 2014. Purcell Decl. at ¶ 4(a) n.4.

The process for non-MAGI applicants is also largely the same before and after January 1, 2014.[5] SSI recipients and children in foster care are enrolled in TennCare in the same manner as before. *Id.* at ¶ 10. The State still provides presumptive eligibility ("PE") for pregnant women and women with breast and cervical cancer. These women, just as they could before January 1, 2014, can still apply for PE at any of the health departments located in every county throughout the State. *Id*. Newborns born to TennCare-eligible mothers can still be "deemed" eligible for TennCare and enrolled in the program pursuant to 42 C.F.R. § 435.117(a). The slight change to the pre-ACA process for deeming such newborns is that now the birth must be reported to TNHC rather than to a DHS caseworker or the DHS Call Center as was done previously. *Id.*

In sum, while all individuals applying in a MAGI-category must apply through the FFM during the interim period before TEDS becomes operational, there are in fact more ways than ever before to submit a TennCare application. Applications may be submitted online through an interactive web portal at HealthCare.gov (an option not available before the ACA), by telephone (an option not available before the ACA), or by mail, and in-person assistance is available at any of the 95 county DHS offices for any applicant who desires it. *Id.* at ¶ 8.

The process currently in place for TennCare enrollment is working for the vast majority of applicants. *Id.* at ¶ 19. Between January 1, 2014 and the end of June, the FFM approved approximately 89,000 applicants from Tennessee in MAGI categories and the State took the

[5] Plaintiffs complain that the FFM refers to the State only applicants who have indicated they want to be considered in a non-MAGI category by checking one of several boxes on the FFM application. *See* Pls.' PI Mem. at 8. But that is how CMS designed the program, and it only makes sense for the FFM to refer and for the State to consider the non-MAGI eligibility of individuals who actually want it and who might actually qualify for it. If Plaintiffs' real contention is that *all* Medicaid applicants should be considered for non-MAGI eligibility regardless of what information they submit on the required streamlined application, that is not the law and is entirely impractical. In any event, issues concerning non-MAGI eligibility are not before the Court.

needed action to assure these individuals were enrolled in TennCare. In addition, TennCare enrolled approximately 27,000 non-MAGI enrollees and 19,000 deemed newborns pursuant to 42 C.F.R. § 435.117(a). Indeed, the number of new enrollees added to TennCare's rolls in the first quarter of 2014 is the third highest in TennCare's 20-year history. *See id.* at ¶ 19. Enrollment in TennCare has risen at a greater percentage rate than even the rate in some states that expanded their Medicaid programs. CMS reports that as of April Tennessee had an enrollment increase rate of 6% over pre-ACA enrollment numbers, while the average rate change for non-expansion states like Tennessee is 2.4%—less than half the rate of increase that Tennessee has achieved. *See id.*, Ex. B (CMS Enrollment Percentage Change Chart for April), at 3.

C. Problems Experienced by the Federally-Facilitated Marketplace.

While the current application processes are thus working very well in Tennessee for the vast majority of applicants, a small percentage of applicants have experienced obstacles due to lack of functionality at the FFM. From the beginning, the State has done everything in its power to find reasonable ways to ameliorate the impact of the FFM's flaws on TennCare applicants, and the State has successfully implemented workarounds that addressed the most significant roadblocks.

1. FFM's Initial Inability To Transfer Account Data.

Between October 1, 2013 and early January 2014, the FFM was unable to transfer account data reflecting its MAGI eligibility determinations as required by the ACA. Instead, CMS began sending states "flat files," essentially large Excel spreadsheets that do not contain full electronic records for individuals. TennCare obtained the waiver necessary to enroll individuals based on the information provided on the Flat Files, and designed a program to

automate the process to some degree. *See* Long Decl. at ¶ 3(a); *see also* CMS SMD Letter (Nov. 29, 2013), *available at* www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-008.pdf. As a result of these efforts, Tennessee was able to enroll numerous individuals who would otherwise have had to wait for CMS to develop the capacity to provide the more detailed Account Transfers. In sharp contrast, many other states have reported problems processing and enrolling individuals from both the Flat Files and the Account Transfers, resulting in large backlogs of applicants who have been found to be eligible or potentially eligible for Medicaid by the FFM but cannot get enrolled. *See* Long Decl. at ¶ 3(a).

2. FFM's Inability To Make Final Eligibility Determinations for Pregnant Women Granted Provisional Presumptive Eligibility

The State has established a presumptive eligibility program for pregnant women pursuant to 42 C.F.R. § 435.1103(a) in order to facilitate early entry into prenatal care. Under the program, a pregnant woman may go to any of 120 county health department clinic sites to submit a simplified application, and if eligible, she will be provisionally enrolled in TennCare the next day. The presumptive eligibility lasts only for a short period, during which time the pregnant woman must complete the standard enrollment process in order to maintain eligibility for the entire pregnancy and postpartum period. If she does not submit a timely complete application, the pregnant woman loses eligibility pursuant to 42 C.F.R. § 435.1102(b)(2)(iv).

After implementation of the ACA began on January 1, 2014, the State learned that many presumptively eligible women were either in danger of losing, or had lost, eligibility because the FFM was not providing the State with a final eligibility determination or even information on whether these women had applied for Medicaid. To alleviate this problem, the State notified CMS that TennCare would continue, or reinstate as the case may be, eligibility for these women until the FFM developed a mechanism to notify the State of pending applications and final

dispositions of these applications. While these efforts have ensured pregnant women with PE do not inappropriately lose their eligibility, the FFM has yet to correct this problem, and as a result, it is likely that an unknown number of potentially ineligible women remain enrolled in TennCare. *See* Long Decl. at ¶ 3(c).

3. FFM's Difficulties Making Eligibility Determinations for Newborn Babies Born to Non-TennCare Eligible Mothers.

The State has learned that the FFM is having difficulty processing applications for babies born to non-TennCare eligible mothers, likely due to identity-proofing issues related to the mother's immigration status. *See id.* at ¶ 3(d). To alleviate this problem, the State sought CMS approval in May 2014 to create a presumptive eligibility process for these newborns that would enable these children to be enrolled in TennCare beginning at birth without requiring submission of a Medicaid application to the FFM. *See id*. Initially, CMS indicated it would not approve this plan, but on July 14, 2014, CMS advised the State that it had revised its view and approval was now possible. The State immediately informed CMS it would submit an amendment to the Tennessee State Plan to make this possible, which the State has done. The State also informed Plaintiffs' counsel of the State's intent to proceed with this presumptive eligibility program the night before they filed this lawsuit. *Id*. This presumptive eligibility program has enabled each of the infant named-Plaintiffs, who had not otherwise been found eligible for TennCare, to apply for Medicaid directly to the State and to be enrolled immediately in TennCare with coverage dating back to their births.

4. FFM's Difficulty Making Final Eligibility Determinations for Applicants Who Are Required To Submit Additional Documentation.

As explained above, the ACA requires the FFM to electronically query agencies such as the IRS and the SSA, using the Data Services Hub, to obtain relevant data concerning individual

Medicaid applications. *See* 42 U.S.C. § 18083(c); 42 C.F.R. § 435.949. When a discrepancy arises between the data obtained from the Hub and the individual's application (for example, a discrepancy concerning the applicant's income), the FFM will request that the applicant submit verification documentation (for example, copies of pay stubs). The State believes that the FFM may be experiencing delays in reviewing supplemental verification documentation submitted by some applicants, and as a result, adjudication of such applications may be delayed. Purcell Decl. at ¶ 17.

This problem (and any others the FFM may be experiencing) may be alleviated upon CMS approval of the State's proposed hospital presumptive eligibility ("HPE") program. The HPE program will enable hospitals to grant presumptive eligibility to qualifying individuals for a 45-day period of time while that individual applies for Medicaid. *See* Long Decl. at ¶ 3(g). The State submitted its HPE State Plan Amendment to CMS on July 14, 2014 and has begun discussions with CMS.

5. FFM's Inability To Transfer TennCare Application Files to the State.

The regulations implementing the ACA require the FFM to promptly transmit to the State Medicaid agency all information concerning a Medicaid application (i.e., the application, any information the Exchange has received from the IRS and the SSA through the Data Hub, and supplementary documentation submitted by the applicant) whenever the FFM has (i) determined the applicant to be MAGI eligible, (ii) assessed the applicant as eligible, leaving the final eligibility determination to the State, (iii) assessed the applicant as non-eligible and the applicant has requested that her application be considered for a non-MAGI category, or (iv) denied a Medicaid application and the applicant wishes to appeal the FFM's decision to the State Medicaid agency. *See* 45 C.F.R. §§ 155.302(b)(3), 155.310(d)(3), 155.345(d)(1),

155.505(b)(1)(ii). Notably, there is no regulation that requires the FFM to provide *pending* application files to the State Medicaid agency. Moreover, the FFM does not regularly provide states spending application information and does not provide states the application files associated with FFM denials (regardless of whether the applicant wishes to appeal to the State). Long Decl. at ¶ 3(h).

The FFM's failure in this regard presents significant problems because without access to the application file, TennCare has no ability to review or understand why the FFM has made or failed to make an eligibility determination. *Id*. This makes it impossible for the State to provide fair hearings to applicants who have applied at the FFM—without the application file, there is no way for the State to determine whether the decision of the FFM was correct or not. CMS, in recognition of these problems, recently indicated it would start providing the State with case files for applicants who wish to have their eligibility appeal processed by the State, but to date CMS has yet to provide the promised case file information. *See id.* In the meantime, the State has referred all appeals challenging FFM decisions to the appeal system maintained by the FFM. *Id*.

The FFM also currently lacks the capability to reliably and consistently provide the State with several other important categories of data: (i) information on whether or when an individual has applied at the FFM; (ii) information on FFM denials of Medicaid applications; and (iii) information on what verifications or other information is missing from an applicant's file or the reason why a file has not been adjudicated. *See* Long Decl. at ¶ 3(c) & (h). The State has brought these concerns to CMS's attention numerous times, and is continuing to work with CMS to find solutions, but as of now CMS has not been able to provide the State with any assurance as to when these problems will be rectified. *See id.*

ARGUMENT

"A preliminary injunction is an extraordinary remedy never awarded as of right." *Winter v. NRDC*, 555 U.S. 7, 24 (2008).

> In considering whether preliminary injunctive relief should be granted, a court considers four factors: (1) whether the movant has a strong likelihood of success on the merits; (2) whether the movant would suffer irreparable injury without the injunction; (3) whether issuance of the injunction would cause substantial harm to others; and (4) whether the public interest would be served by issuance of the injunction.

Jolivette v. Husted, 694 F.3d 760, 765 (6th Cir. 2012) (internal quotation marks and citation omitted). "Although no one factor is controlling, a finding that there is simply no likelihood of success on the merits is usually fatal." *Gonzales v. National Bd. of Med. Exam'rs*, 225 F.3d 620, 625 (6th Cir. 2000).

I. PLAINTIFFS HAVE FAILED TO DEMONSTRATE ANY LIKELIHOOD OF SUCCESS ON THE MERITS.

A. Plaintiffs Lack Standing.

As explained in more detail in the Memorandum in support of the State's Motion To Dismiss, the Plaintiffs are unlikely to succeed on the merits because they have not established two prerequisites for Article III standing: causation and redressability. *See* Defs.' Mem. in Supp. of Their Mot. To Dismiss ("State MTD Mem.") at 9-15. It is apparent on the face of the complaint that all of Plaintiffs' injuries were caused by technical problems with the federal Exchange. Because neither the State nor its agents control the federal Exchange, there is no "fairly traceable connection between the [Plaintiffs'] injur[ies] and the complained-of conduct of the [State]." *Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 103 (1998). For similar reasons, there is no relief against the State that would "remedy the injury suffered" by Plaintiffs. *Id.* at 107. The only remedy for the injuries Plaintiffs have suffered is for the federal Exchange

to complete its evaluation of Plaintiffs' applications, and the State does not control the federal Exchange. In short, the State did not cause Plaintiffs' injuries, and it cannot redress them.

B. Violations of Federal Law by the Federal Exchange Are Not Attributable to the State.

The delays Plaintiffs have allegedly experienced are the direct result of problems with the federal Exchange. But despite the fact that federal officials established and maintain the federal Exchange, Plaintiffs contend that its flaws are legally attributable to the State. That is not the law. The ACA assigns legal responsibility for the exchange's expeditious processing of Medicaid applications to the governmental entity that supervises its operation, and Plaintiffs' only remedy is against the federal agency responsible for the delays they have experienced.

Where a state declines to set up its own exchange, the ACA directs the Secretary of HHS, acting through CMS, to "establish and operate such Exchange within the State" and to "take such actions as are necessary to implement" the many statutes and regulations that govern exchange operations. 42 U.S.C. § 18041(c). It follows that *federal* officials are responsible for ensuring that the *federal Exchange* complies with all applicable laws -- including the requirement that exchanges charged with making Medicaid eligibility determinations do so "promptly and without undue delay." 45 C.F.R. § 155.310(e)(1). Were it otherwise, states that decline to establish their own exchanges would be placed in the untenable position of bearing legal responsibility for the actions of federal officials they cannot control.

Plaintiffs resist this commonsense understanding of the assignment of legal duties, arguing that the State "remains responsible for ensuring that all eligibility determinations, including those delegated to the [federal Exchange], comply with applicable laws and regulations." Complaint, D.E. 1, at ¶ 62; *see also* Pls.' Mem. in Supp. of Mot. for Prelim. Inj., D.E. 5 ("Pls.' PI Br."), at 19. But when a state declines to establish its own exchange, federal

officials succeed by operation of law to all state legal duties associated with exchange operations. The ACA unambiguously commands the Secretary, not the State, to "take such actions as are necessary to implement" all of the requirements the ACA imposes on the Exchange in states, like Tennessee, that have elected not to establish an Exchange. 42 U.S.C. § 18041(c)(1). Among those requirements is the obligation to make Medicaid eligibility determinations. *See id.* § 18083(a) & (b)(1)(A)(iii).

Federal regulations do not say otherwise when they forbid the states to "delegate . . . the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters." 42 C.F.R. § 431.10(e). The State could not delegate the power to "supervise" the federal Exchange because neither Tennessee nor any other state has the power to "supervise" or to "develop or issue policies, rules, and regulations" for the federal Exchange. *See* 42 U.S.C. § 18041(c) (vesting authority to establish and operate federal Exchanges, "directly or through agreement with a not-for-profit entity," in the Secretary of HHS). To be sure, Tennessee has delegated to the federal Exchange responsibility for Medicaid eligibility determinations and appeals. *See* 42 C.F.R. § 431.10(c) (authorizing such delegations). But Plaintiffs concede that this delegation is lawful, Pls.' PI Br. at 19, and *supervision* of how the federal Exchange carries out its functions is not the State's to delegate. The federal government is responsible for the federal Exchange.

Further confirmation that the ACA contemplates no role whatever for the State Medicaid agency while an application for Medicaid enrollment is pending with the FFM may be found in the regulations setting forth when the FFM must provide application file data to the State Medicaid agency. As explained above, the FFM must provide the State with all information that it has gathered with respect to an application whenever it has (i) determined the applicant to be

MAGI eligible, (ii) assessed the applicant as eligible, leaving the final eligibility determination to the State, or (iii) assessed the applicant as non-eligible and the applicant has requested that her application be considered for a non-MAGI category. *See* 45 C.F.R. §§ 155.302(b)(3) &(b)(4)(ii), 155.310(d)(3), 155.345(d)(1), 155.510(c). But there is no regulation that requires the FFM to provide *pending* application files to the State Medicaid agency, confirming that the ACA does not contemplate any State actions while an unresolved application is pending with the FFM.

The cases Plaintiffs cite for the proposition that the State has non-delegable duties under the Medicaid Act are not to the contrary. *See* Pls.' PI Br. at 20 (citing *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); *Carr v. Wilson-Coker*, 203 F.R.D. 66, 75 (D. Conn. 2001); *J.K. ex rel. R.K. v. Dillenberg*, 836 F. Supp. 694, 699 (D. Ariz. 1993)). All of those cases pre-date the ACA, and all involved delegations of authority to private entities or other state agencies—not a federal agency that the states are powerless to control. Plaintiffs' cases rest on the proposition that "it is patently unreasonable to presume that Congress would permit a state to disclaim federal responsibilities by contracting away its obligations *to a private entity*," *Catanzano*, 60 F.3d at 118 (emphasis added) (internal quotation marks omitted), but the same reasoning does not apply to state transfers of federal responsibilities back to the federal government that Congress has authorized.[6]

The State's authority to exercise "oversight over" a private entity's "eligibility determinations and appeals decisions," 42 C.F.R. § 431.10(c)(3)(ii), does not permit the State to exercise analogous authority over federal officials. Quite the opposite, CMS oversees the State's

[6] *K.C. ex rel. Africa H. v. Shipman*, 716 F.3d 107 (4th Cir. 2013), is even further afield. In that case, the state Medicaid agency had not even attempted to delegate to a local subdivision responsibility for appealing a preliminary injunction, and the Fourth Circuit held that the local subdivision could not bring an appeal where the state Medicaid agency chose not to do so.

Medicaid program. *See* 42 U.S.C. § 1396a(b) (State Medicaid plan must be approved by CMS). It has long been settled that states lack the authority to supervise or regulate the activities of the federal government. *See, e.g.*, *Johnson v. Maryland*, 254 U.S. 51, 57 (1920) (Holmes, J.) (noting "the immunity of the instruments of the United States from state control"). The Court should not find such an extraordinary reversal of traditional federal-state relations absent an exceedingly clear statement from Congress, *see Gregory v. Ashcroft*, 501 U.S. 452, 460-61 (1991). Notably, Plaintiffs are unable to cite *any* authority that suggests that state officials are somehow responsible for supervising the federal Exchange.

Perhaps recognizing that direct state supervision of the federal Exchange is a statutory and constitutional nonstarter, Plaintiffs step back in their prayer for relief and ask that the Court order the State to create and implement a back-up system for processing Medicaid applications and appeals whenever the federal Exchange takes too long to adjudicate the applications submitted to it. *See* Pls.' Draft Prelim. Inj. Order, D.E. 4-2, at 2. Nothing in the Medicaid statute, the ACA, or the implementing regulations requires the State, in 48 or 72 hours no less, to adjudicate a Medicaid application submitted to the federal Exchange that has not been adjudicated by the FFM on a timely basis. Rather than ordering the State to create and implement such an unauthorized back-up system to address the federal Exchange's problems, the far simpler solution—albeit a solution unavailable to the Court because Plaintiffs have not joined the Secretary and CMS as parties—would be to order the FFM to adjudicate any applications that have not been timely resolved.

Plaintiffs are mistaken when they suggest that the State's current reliance on the federal Exchange to make eligibility determinations violates provisions of the ACA regarding how a state should accept and process Medicaid applications. *See* Pls.' PI Br. at 21. The State is in

compliance with the provision they cite because Medicaid applications "may be filed . . . with State officials." 42 U.S.C. § 18083(b)(1)(A)(iii). As explained above, when applications are filed with TennCare, the State forwards them to the FFM for eligibility determinations. And 42 U.S.C. § 18083(c)(3)(A) makes clear that states are only required to make their own Medicaid eligibility determinations using data matching "to the maximum extent practicable." As explained above, challenges associated with the need to replace ACCENT have so far prevented the State from bringing its own data-matching system online, but the State and its contractor are working diligently to that end. In the meantime, CMS has approved the State's decision "to leverage the FFM to receive and process applications on the state's behalf," Mann Letter at 3—a stopgap solution that has worked well for the vast majority of Medicaid applicants in Tennessee. The State's CMS-approved reliance on the federal Exchange while it works to complete implementation of TEDS fully complies with the requirement that it implement its own data-matching system "to the maximum extent practicable." 42 U.S.C. § 18083(c)(3)(A).

C. Any Delay in Processing Plaintiffs' TennCare Applications and Appeals Does Not Violate Federal Law.

Even if the State were somehow responsible for the FFM's alleged delay in processing Plaintiffs' applications, Plaintiffs would still be unlikely to succeed on the merits because they have failed to demonstrate a violation of their rights under federal law. At most, Plaintiffs have a right to have their applications processed with "reasonable promptness," 42 U.S.C. § 1396a(a)(8), and in the unusual circumstances presented here, the delay is not unreasonable. Rather, it is the relief requested by Plaintiffs—an injunction that could divert tens of thousands of additional applicants away from the largely functional federal Exchange to a cumbersome and untested manual system—that is unreasonable.

1. Plaintiffs' Statutory Claims Are Not Actionable Under Section 1983.

Plaintiffs' Section 1396a(a)(8) claim fails because this provision of the Medicaid Act is not enforceable under 42 U.S.C. § 1983. The Sixth Circuit so held in an unpublished decision, explaining that the provision was not "sufficiently specific" to create a right enforceable under Section 1983, but rather merely "expresses general policy goals." *Cook v. Hairston*, 948 F.2d 1288, 1991 WL 253302, at *5 (6th Cir. 1991) (unpublished table decision). One district court in this circuit has followed *Cook*, *see Wood v. Wallace*, 825 F. Supp. 177, 184 (S.D. Ohio 1993), *rev'd on other grounds*, *Wood v. Tompkins*, 33 F.3d 600 (6th Cir. 1994), and other federal district courts have reached the same result in more recent years, *see Sanders ex rel. Rayl v. Kansas Dep't of Soc. & Rehab. Servs.*, 317 F. Supp. 2d 1233, 1250 (D. Kan. 2004); *MAC v. Betit*, 284 F. Supp. 2d 1298, 1307 (D. Utah 2003).[7] To be sure, the federal courts have divided over whether Section 1396a(a)(8) confers judicially enforceable rights. *See, e.g.*, *Doe ex rel. Doe v. Chiles*, 136 F.3d 709, 713-19 (11th Cir. 1998) (holding that Section 1396a(a)(8) gives rise to a federal right enforceable under 42 U.S.C. § 1983). But the better view, especially after the Supreme Court's decision in *Gonzaga University v. Doe*, 536 U.S. 273-83, 282 (2002), which held that the right to bring an individual cause of action under Section 1983 must be unambiguously conferred, is that Section 1396a(a)(8) merely "expresses general policy goals" and is not individually enforceable. *Cook*, 1991 WL 253302, at *5. As Section 1396a(a)(3) uses the same

[7] *Westside Mothers v. Olszewski*, 454 F.3d 532, 539-41 (6th Cir. 2006), is not to the contrary. In that case, the Sixth Circuit held that the Plaintiffs' claim failed because any individual right to "medical assistance" conferred by Section 1396a(a)(8) does not include a right to the provision of actual medical services. The Court thus had no occasion to decide whether Section 1396a(a)(8) ever gives rise to rights enforceable under 42 U.S.C. § 1983, and it certainly did not address the question whether Section 1396a(a)(8) confers a right, enforceable under Section 1983, to have a Medicaid enrollment application adjudicated "with reasonable promptness." *See Burks v. Lasker*, 441 U.S. 471, 476 n.5 (1979) ("The question whether a cause of action exists is not a question of jurisdiction, and therefore may be assumed without being decided.").

general, non-specific term ("reasonable promptness"), Plaintiffs likewise may not bring a Section 1983 action to enforce that provision.[8]

Plaintiffs err at the outset to the extent that they assert a *regulatory* right under 42 C.F.R. § 435.912(c)(3) to have their applications processed within 45 days rather than a *statutory* right to have them processed "with reasonable promptness." 42 U.S.C. § 1396a(a)(8); *see also id.* § 1396a(a)(3) (opportunity for hearing required only if application denied or "not acted upon with reasonable promptness"). "Language in a regulation . . . may not create a right that Congress has not," *Alexander v. Sandoval*, 532 U.S. 275, 291 (2001), and there is no statutory right in Section 1396a or anywhere else in the United States Code to have Medicaid applications processed within a specified number of days. To be sure, in a Section 1983 suit, a court may look to an "authoritative regulation [that] merely supplements the right identified in a specific statutory provision." *Harris v. Olszewski*, 442 F.3d 456, 464 (6th Cir. 2006). But Plaintiffs rely on federal regulations to do far more than that here. Rather than the flexible, context-specific "reasonable promptness" standard that appears in the statute, Plaintiffs would have the Court apply a rigid, one-size-fits-all time limitation that they read into 42 C.F.R. § 435.912(c)(3). Under binding Supreme Court and Sixth Circuit precedent, there is no private right of action where conduct permissible under a statute is prohibited by a federal regulation. *See Sandoval*, 532 U.S. at 286; *Ability Ctr. of Greater Toledo v. City of Sandusky*, 385 F.3d 901, 906 (6th Cir. 2004) ("[A] private plaintiff cannot enforce a regulation through a private cause of action

[8] In *Gean v. Hattaway*, 330 F.3d 758, 773 (6th Cir. 2003), the Sixth Circuit held that because "a right to a fair hearing," granted by Section 1395a(a)(3), "is not so vague and amorphous that its enforcement is beyond the abilities of a competent judiciary," it is enforceable under Section 1983. That holding in no way undermines the unpublished ruling in *Cook* because the ruling in that case turned on the amorphous nature of the term "reasonable promptness," which appears in both Sections 1395a(a)(3) and (8).

generally available under the controlling statute if the regulation imposes an obligation or prohibition that is not imposed generally by the controlling statute."). Thus, to the extent that federal regulations require anything more than "reasonable promptness," they are not enforceable under Section 1983.

2. "Reasonable Promptness" Is a Flexible Standard that Permits Delays in Unusual Circumstances.

The plain meaning of the statutory phrase "reasonable promptness" directs the Court to ask what is "[f]air, proper, or moderate *under the circumstances*." BLACK'S LAW DICTIONARY (9th ed. 2009) (emphasis added) (defining "reasonable"); *see also* WEBSTER'S NEW INTERNATIONAL DICTIONARY 2074 (2d ed. 1944) (reasonable: "Not more or less than reason dictates within due or just limits; proper"); *cf. Rosie D. v. Romney*, 410 F. Supp. 2d 18, 27 (D. Mass. 2006) (observing that "the statute does not specifically define 'reasonable promptness' " and that "[a] reasonable promptness violation may . . . turn on the nature of the services provided"). Thus, the Court must take into account the full context under which the processing of Plaintiffs' Medicaid applications has been delayed—including the sweeping changes to the Medicaid program mandated by the ACA, the myriad problems experienced by the FFM, the tens of thousands of additional Medicaid enrollments the State has been required to process in recent months, the fact that the State has not even received Plaintiffs' applications due to problems with a federal Exchange that the State does not control, and the threat Plaintiffs' requested relief would pose to the State's largely successful use of the federal Exchange to process Medicaid applications. In light of all of those circumstances, any delay Plaintiffs have experienced that is attributable to the State is not so lengthy as to run afoul of Section 1396a.

Section 1396a's legislative history confirms this analysis. The phrase "reasonable promptness" was borrowed from a provision of the 1950 Amendments to the Social Security

Act, Pub. L. No. 81-734, 64 Stat. 548 (codified as amended at 42 U.S.C. § 302(a)(4) (2012)); *see generally Sobky v. Smoley*, 855 F. Supp. 1123, 1148 (E.D. Cal. 1994) (tracing legislative history of "reasonable promptness" provision). As originally passed by the House of Representatives, the bill would have required states to make certain eligibility determinations "promptly," but the Senate version of the bill that ultimately became law required that states act only "with reasonable promptness." The Senate Report explains that this change was made "in order to assure the States reasonable time to make investigations and complete any other action necessary to determine eligibility." S. Rep. No. 81-1669 (May 17, 1950), *reprinted at* 1950 U.S.C.C.A.N. 3287, 3471. Thus, far from meaningless surplusage, the word "reasonable" was deliberately selected by Congress to make clear that states must do no more than what is practicable under the circumstances. By that metric, the State has not unreasonably delayed the processing of Plaintiffs' applications.

In deciding what constitutes "reasonable promptness" under the present circumstances, the Court should give substantial weight to State officials' judgment that allowing Plaintiffs to circumvent processing by the federal Exchange would likely divert many thousands of additional applicants who would otherwise apply through the federal Exchange to a far more cumbersome and untested manual system. *See infra* at pp. 42-43. The Court always owes deference to the judgment of those responsible for implementing an Act of Congress, but an extra measure of judicial deference is due to those " 'charged with the responsibility of setting [a new law's] machinery in motion; of making the parts work efficiently and smoothly while they are yet untried and new.' " *Power Reactor Dev. Co. v. International Union of Elec., Radio & Mach. Workers*, 367 U.S. 396, 408 (1961) (quoting *Norwegian Nitrogen Prods. Co. v. United States*,

288 U.S. 294, 315 (1933)); *see also United States Air Force v. FLRA*, 681 F.2d 466, 467 (6th Cir. 1982).

Any doubt as to the "reasonableness" of the efforts to implement the ACA in Tennessee is removed when one compares the bottom line results the State has achieved with the status of Medicaid enrollment in other states. Again, enrollment in TennCare has increased substantially since January 1—approximately 89,000 have been approved by the FFM in the first six months of 2014, and the State has directly determined the eligibility of an additional approximately 46,000 individuals during that period. The rate of enrollment in 2014 is the third highest in the history of the TennCare program, and the growth in TennCare enrollment is more than double the average rate of increase experienced by other States that, like Tennessee, have not expanded their Medicaid programs. *See* Purcell Decl. at ¶ 19 & Ex. B. And the State has avoided the substantial backlogs that have plagued many other state Medicaid programs. *See* Phil Galewitz, *More than 1.7 Million Consumers Still Wait for Medicaid Decisions*, KAISER HEALTH NEWS (June 9, 2014), *available at* www.kaiserhealthnews.org/Stories/2014/June/09/More-Than-17-Million-Consumers-Still-Wait-For-Medicaid-Decisions.aspx.

3. The Regulation Plaintiffs Rely upon Confirms that They Have Not Been Denied the Reasonably Prompt Processing of Their Applications.

Plaintiffs repeatedly assert that "the maximum period of time in which every applicant is entitled to a determination of eligibility . . . may not exceed 45 days for most categories of eligibility." Pls.' PI Br. at 20-21. But the regulation they cite, 42 C.F.R. § 435.912(c)(3), does not impose a rigid, unyielding 45-day deadline, but rather adopts a flexible understanding of "reasonable promptness" that permits exceptions in "unusual circumstances" such as those

created by the implementation of the ACA. And CMS has confirmed that the problems experienced by the FFM constitute "unusual circumstances" justifying such an exception.

The regulation Plaintiffs rely upon states that "*[e]xcept as provided in paragraph (e) of this section*, the determination of eligibility for any applicant may not exceed . . . [f]orty-five days" for applicants who do not apply for Medicaid on the basis of disability. 42 C.F.R. § 435.912(c)(3) (emphasis added). Paragraph (e), in turn, relieves the agency making eligibility determinations of any obligation to process Medicaid applications during the specified time periods under "unusual circumstances" like those presented here:

> The agency must determine eligibility within the standards except in unusual circumstances, for example—(1) When the agency cannot reach a decision because the applicant or an examining physician delays or fails to take a required action, or (2) When there is an administrative or other emergency beyond the agency's control.

Id. § 435.912(e).

Both examples of "unusual circumstances" closely parallel the situation alleged by Plaintiffs here. It is the federally-controlled exchange, rather than the applicant or an examining physician, that has "fail[ed] to take a required action," but from the standpoint of the State the problem is exactly the same. And it is difficult to imagine an "administrative . . . emergency beyond the agency's control" that more readily justifies delay than the combined impact of the major changes to the State's Medicaid program mandated by the ACA, the recent surge in Medicaid applications, and the fraught rollout of the federal Exchange. *See also id.* § 435.930(a) (State Medicaid agency must "[f]urnish Medicaid promptly to beneficiaries without any delay *caused by the agency's administrative procedures*" (emphasis added)).

Significantly, the federal agency responsible for administering these regulations has expressed the view that problems with the federal Exchange constitute "unusual circumstances"

that excuse compliance with the 45-day standard. Not long ago, Pennsylvania officials wrote to CMS to request a waiver of that standard because, among other things, problems with the federal Exchange had resulted in "a large number of applications in the queue to be processed." Letter from Leesa M. Allen, Pa. Exec. Medicaid Dir., to Jessica P. Kahn, Acting Dir., Div. of State Sys., Dep't of Health & Human Servs. (Nov. 25, 2013), attached in Long Decl., Ex. A. CMS responded that "a waiver is not necessary as our regulations provide for circumstances in which timelines are affected for reasons outside the state's control," citing the regulation now codified at 42 C.F.R. § 435.912(e). Letter from Jessica P. Kahn, Dir., Div. of State Sys., Dep't of Health & Human Servs. to Leesa M. Allen, Pa. Exec. Medicaid Dir. (Jan. 30, 2014), attached in Long Decl., Ex B.

In many respects, the difficulty the State faces in processing Plaintiffs' applications is even more serious than the difficulties identified by CMS as "unusual circumstances;" in contrast to Pennsylvania's lengthy queue, Tennessee has not even *received* Plaintiffs' applications from the federal Exchange. This Court owes substantial deference to CMS's interpretation of the Medicaid regulations, *see Rosen v. Goetz*, 410 F.3d 919, 927 (6th Cir. 2005), and CMS has concluded that the 45-day deadline does not apply in circumstances that were less "unusual" than those facing Tennessee.

D. Plaintiffs' Statutory and Constitutional Appeal Claims Fail Because Any Right To Appeal Has Not Yet Been Triggered.

The foregoing discussion focuses on the requirements of Section 1396a(a)(8), but Plaintiffs' Section 1396a(a)(3) and due process claims necessarily fail for the same reasons. Plaintiffs' hearing rights under 42 U.S.C. § 1396a(a)(3) are only triggered if their applications are "denied or . . . not acted upon with reasonable promptness," and neither of those events has yet occurred. Similarly, due process requires no more than "such procedural protections as the

particular situation demands," *Mathews v. Eldridge*, 424 U.S. 319, 334 (1976) (quoting *Morrissey v. Brewer*, 408 U.S. 471, 481 (1972)), and Plaintiffs are unable to cite any authority for the proposition that a hearing is required before an application is denied or not adjudicated with "reasonable promptness." In the end, Plaintiffs' three claims reduce to the single contention that the State should have already acted upon Medicaid applications that are in the sole possession of federal officials the State does not control. That contention fails for the reasons explained above.

Even if a right to a hearing had been triggered, Plaintiffs' statutory and due process claims fail because they are free to seek a fair hearing from the FFM. *See* 45 C.F.R. § 155.505 (right to appeal Exchange determinations to the HHS appeals entity). To be sure, the regulations require the State to adjudicate appeals of FFM eligibility determinations when an applicant chooses to appeal to the State Medicaid agency, *see* 42 C.F.R. § 431.205(b)(1)(ii), but that obligation is implicitly contingent upon CMS fulfilling its obligation to provide the State with the application files. As a practical matter, the State cannot adjudicate appeals when it does not have the application, it does not have the additional data provided by other federal agencies through the Data Services Hub, it does not have any supplemental verification documentation submitted by the applicant, and it does not have the FFM's decision on the application. *See* Long Decl. at ¶ 3(h) (FFM does not presently have the capability to provide pending application files or denials to the States). The federal Exchange is required to share Plaintiffs' application files with the State whenever an applicant wishes to appeal to the State, 45 C.F.R. § 155.510(b)(1)(ii), and its doing so is a necessary predicate to any duty on the State's part to hear appeals. Indeed, any adjudication of Plaintiffs' appeals without that information would itself risk depriving Plaintiffs of due process. *See Living Care Alts. of Utica, Inc. v. United*

States, 411 F.3d 621, 625 (6th Cir. 2005) (observing that "normal review of administrative decisions requires the existence of a record"). Again, whatever relief Plaintiffs are owed must run against the federal agency responsible for the delays they have experienced.

Finally, Plaintiffs' due process claim fails for the additional reason that they cannot demonstrate state action. There can be no violation of due process absent state action, and there is no state action without "an alleged constitutional deprivation 'caused by the exercise of some right or privilege created by the State or by a rule of conduct imposed by the State or by a person for whom the State is responsible.' " *American Mfrs. Mut. Ins. Co. v. Sullivan*, 526 U.S. 40, 50 (1999) (quoting *Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 937 (1982)). Because neither the State nor its agents caused the delays Plaintiffs have allegedly experienced, there is no state action that can be attributed to the State. *See N.B. v. District of Columbia*, -- F. Supp. 2d --, 2014 WL 1285132, at *10 (D.D.C. Mar. 31, 2014) (rejecting claim that denials of Medicaid benefits violated due process because there was no state action where denials were attributable to doctors and pharmacists rather than the District of Columbia government).

E. Plaintiffs Failed To Join a Required Party.

Plaintiffs are also unlikely to succeed on the merits because they have not joined the Secretary and CMS, required parties under FED. R. CIV. P. 19(a). *See* State MTD Mem. at 28-33. The State has no way of adjudicating applications in the sole possession of the federal Exchange operated by the Secretary through CMS. Thus, because neither the Secretary nor CMS have been joined, "the court cannot accord complete relief among existing parties." *See* FED. R. CIV. P. 19(a)(1)(A).

II. PLAINTIFFS HAVE FAILED TO DEMONSTRATE THAT THEY WILL BE IRREPARABLY HARMED ABSENT ENTRY OF A PRELIMINARY INJUNCTION AGAINST THE STATE.

A. None of the Named Plaintiffs Can Demonstrate Irreparable Harm.

Plaintiffs base their request for preliminary injunctive relief on the premise that the FFM's alleged delay in processing their Medicaid applications is depriving some of the Plaintiffs of needed healthcare coverage. Pls.' PI Br. at 15-19. In fact, each of the 11 named Plaintiffs has either already had his or her Medicaid application adjudicated or will have it adjudicated promptly upon receipt of their case file information from CMS, thus eliminating any need for the entry of a preliminary injunction.

1. Nine of the Eleven Named Plaintiffs Have Been Enrolled in TennCare.

Nine of the eleven named Plaintiffs (Melissa Wilson, April Reynolds, Mohammed Mossa, Mayan Said, S.P., K.P., S.V., C.A., and S.G.), were enrolled in TennCare shortly before or shortly after the compliant in this case was filed. *See* Declaration of Kim Hagan (hereinafter "Hagan Decl.") at ¶ 13. C.A., S.G., and K.P. were enrolled in TennCare pursuant to the new presumptive eligibility ("PE") program for newborn children of non-TennCare mothers. *See id.* CMS recently informed the State that it will favorably consider the program for approval, and the State has decided to implement the program in anticipation of this approval. Accordingly, the State provided Plaintiffs' counsel with PE applications for these newborns and upon return of those applications, the State determined that those children were eligible, and accordingly enrolled them in TennCare. *Id.*

Accordingly, these nine plaintiffs cannot demonstrate they will suffer irreparable harm absent entry of a preliminary injunction, and their claims are moot. *See Mosley v. Hairston*, 920 F.2d 409, 414 (6th Cir. 1990) ("The issue of mootness implicates the court's subject matter

jurisdiction inasmuch as federal courts are limited by Art. III of the Constitution to deciding cases and controversies. This requirement refers to 'live' controversies, those that persist in 'definite and concrete' form even after intervening events have made some changes in the parties' circumstances.").

2. The Two Remaining Named Plaintiffs Have Not Alleged Irreparable Harm.

The two remaining named Plaintiffs (T.V. and D.A.) have not alleged that they will suffer any irreparable harm absent injunctive relief. Neither has any immediate medical needs. *See* Declaration of T.V., D.E. 1-7, at ¶¶ 13-16 (alleging that her son, K.P., had medical needs, but identifying no medical needs for herself); Declaration of D.P., D.E. 1-1, at ¶ 5 (D.A., her husband, "is now okay"). Neither has alleged any other irreparable harm. Accordingly, these two plaintiffs have not "demonstrate[d] that irreparable injury is *likely* in the absence of an injunction." *Winter v. NRDC*, 555 U.S. 7, 22 (2008) (emphasis in original).

Moreover, T.V. and D.A. are both adults who allege that they submitted applications for TennCare to the FFM. *See* Complaint, D.E. 1, at ¶¶ 120, 127. It appears from the allegations in the Complaint and Plaintiffs' Declarations that the FFM's adjudication of these individuals' applications may be delayed by problems that the federal Exchange is reportedly experiencing with respect to the verification of income. *See id*. at ¶ 103; Declaration of T.V., D.E. 1-7, at ¶ 3 (alleging that FFM asked her to provide proof of income); Declaration of D.P., D.E. 1-1, at ¶ 3 (alleging that D.A. submitted income verification documents to the FFM). To alleviate this problem, the State has asked CMS to provide the State with these individuals' case files. Upon receipt of those files, the State has agreed to promptly adjudicate those applications. Hagan Decl. at ¶¶ 12-13.

In addition, the State recently sought permission from CMS to implement a hospital presumptive eligibility ("HPE") program that will enable hospitals to grant presumptive eligibility to qualifying individuals for a 45-day period of time while that individual applies for Medicaid. Long Decl. at ¶ 3(g). Upon approval of the HPE program by CMS and implementation by TennCare, D.A. and T.V. will be able to apply and obtain immediate enrollment in TennCare if they qualify (assuming CMS has not already provided the State with their application files).

Also weighing in the balance of whether a preliminary injunction is necessary to prevent irreparable harm is the fact that each Plaintiff alleges to have had completed applications pending with the FFM since January or February. This raises the question as to why they have waited until now to file this request for injunctive relief and why in most instances Plaintiffs' counsel has not brought these individuals to the State's attention for attempted resolution of their issues before now. *See* Hagan Decl. at ¶ 11 (Plaintiffs' counsel or other advocacy groups sought assistance with only 4 of the 11 Plaintiffs' cases). Soon after the implementation of the ACA, state officials began meeting with Plaintiffs' counsel and set up an informal process whereby Plaintiffs' counsel could bring problem cases to the attention of TennCare's Office of General Counsel. *Id*. at ¶ 5. When possible, TennCare assisted these applicants in working with the federal Exchange to resolve problems that were delaying adjudication of TennCare applicants. Overall, through this process the State received over two hundred inquiries from Plaintiffs' counsel and other advocacy groups, and the majority of individuals involved in this process had their applications adjudicated. *Id*. at ¶¶ 6-7.

* * *

In sum, none of the eleven Plaintiffs have "demonstrate[d] that irreparable injury is *likely* in the absence of an injunction." *Winter*, 555 U.S. at 22 (emphasis in original). Nine of the eleven Plaintiffs have already been enrolled in TennCare, and the other two have not alleged any impending injury.

B. Plaintiffs Have Not Demonstrated that Irreparable Harm Will Befall the Purported Class.

Plaintiffs have requested a preliminary injunction on behalf of not just themselves but on behalf of a broadly defined class of individuals that would include anyone who has had a TennCare application pending for more than 45 days and has not received a final eligibility determination. *See* Proposed Preliminary Injunction Order, D.E. 4-2. Even if the Court concludes that one or more of the 11 named Plaintiffs has demonstrated irreparable harm, Plaintiffs have submitted no evidence whatever suggesting that any other member of the broad, extremely diverse, group of individuals swept into the proposed class has or will suffer any harm, irreparable or otherwise. The specific circumstances of these individuals are not before the Court, and they cannot be inferred from the idiosyncratic circumstances of the named Plaintiffs. *See* Defs.' Mem. in Opp. to Pls.' Mot.for Class Cert. at 7-13, 17-18 (demonstrating that class certification is inappropriate because claims of irreparable harm must be assessed on an individual case-by-case basis and Plaintiffs' claims are not typical of the claims that individuals who fall into the broadly defined class may possess).

Plaintiffs cannot "demonstrate that irreparable injury is *likely* in the absence of an injunction" with respect to the broad class they have identified. *Winter*, 555 U.S. at 22 (emphasis in original). The Supreme Court has held that a mere "possibility of irreparable harm" is insufficient because it is "inconsistent with our characterization of injunctive relief as an extraordinary remedy that may only be awarded upon a clear showing that the plaintiff is entitled

to such relief." *Id*. Other than pure speculation that "others are incurring a loss of benefits to which they are entitled under federal law," Pls.' PI Br. at 16, there is no evidence in the record that the unnamed class members whose specific circumstances are not before the court have the same medical concerns as any of the named Plaintiffs and thus are likely to suffer irreparable injury if a preliminary injunction is not entered. *See, e.g.*, *Bruns v. Mayhew*, 931 F. Supp. 2d 260, 274-76 (D. Me. 2014) (rejecting claim of irreparable harm on a class basis when evidence in the record did not show that potential class members had similar medical conditions or need for medical care as named Plaintiffs).

As importantly, it is an inherently case-by-case specific inquiry as to whether any particular individual's application has been impermissibly delayed thus causing them any harm, irreparable or not. While the regulations set a 45-day standard for making a final eligibility determination, the regulations also make clear that adherence to that 45-day timeline is not required when a decision cannot be reached because the applicant fails to take a required action, such as submitting required verifications. *See* 42 C.F.R. § 435.912(e)(1); *see also* Purcell Decl. at ¶¶ 7, 17 (describing numerous factors that must be verified before a final eligibility determination can be made). Because individual circumstances predominate any analysis of whether there has been or is likely to be irreparable harm, this case does not lend itself to preliminary injunctive relief on a class-wide basis. *See also* Hagan Decl. at ¶ 8 (explaining numerous reasons why an application might be pending or appear to be pending more than 45 days).

Also undermining any claim of classwide irreparable harm are the numerous steps that the State has undertaken to address problems that other, unidentified class members may have experienced in enrolling in TennCare. The newborn members of Plaintiffs' broadly defined class

can apply for TennCare through the State's newly implemented presumptive eligibility program for children born to non-TennCare mothers. *See* Long Decl. at ¶ 3(d). Adult members of the purported class, who currently must apply through the FFM, will be able to take advantage of the Hospital Presumptive Eligibility program the State is working with CMS to implement. *See id.* at ¶ 3(g).

III. ENTRY OF THE INJUNCTION SOUGHT BY PLAINTIFFS WILL INFLICT SUBSTANTIAL HARM ON THE STATE, TENNCARE APPLICANTS, AND THE PUBLIC INTEREST.

Plaintiffs have asked the Court to enter an order requiring the State to develop and implement, immediately, a brand new system for assessing Medicaid eligibility that would be capable of adjudicating applications within 72 hours of receiving evidence suggesting that an individual had applied for Medicaid more than 45 days earlier. The State would be obliged to complete these adjudications even though in most cases it would not have the application;[9] it would not have any additional verifications of income, citizenship, Social Security number, etc., that were requested by the FFM (or any proof that those verifications were ever submitted); nor would it have any information gathered by the FFM from the IRS, the SSA, or from any other Data Hub source. *See* Long Decl. at ¶ 6. Furthermore, the State would have no way of ascertaining whether some portion of the alleged delay was attributable to the applicant's delay in providing requested verifications or other documentation. *Id*. at ¶ 13. In sum, the relief

[9] Although all the named Plaintiffs alleged that they filed an application with the FFM for a MAGI-eligibility determination, the class definition and requested relief that Plaintiffs propose are so broad that they also encompass applicants in non-MAGI eligibility categories for which there is no evidence in this record to suggest there are unreasonable delays. While, for all the reasons expressed herein, no injunctive relief should be imposed, at a minimum if any injunctive relief were to be entered it should be limited to the named Plaintiffs, or at most, a class of persons like Plaintiffs who applied for eligibility through the FFM.

Plaintiffs seek goes far beyond what is required in the Medicaid statute or the ACA, and seeks to create an eligibility process in Tennessee unlike anything existing in any other state.

A. The Proposed Injunction Would Impose a Substantial Burden on the State and Would Likely Be Impossible To Implement.

The relief Plaintiffs are seeking is wholly impracticable, and not just because of "budgetary considerations" as they would have the Court conclude. Pls.' PI Br. at 24. While certainly any attempted implementation of Plaintiffs' requested relief would require an enormous diversion of personnel resources and the expenditure of additional scarce funds, *see* Long Decl. at ¶ 9(d), the main harm to the State is the unrealistic, indeed impossible, nature of the requested relief. As noted, in the majority of cases the State does not have the relevant applications and verifications necessary to make an eligibility determination. *See id*. at ¶ 6. In most cases, the State does not even have the predicate information on whether an individual applied for Medicaid or whether that application has been impermissibly delayed so that a determination that the individual is even part of the class can be made. That information resides with CMS, and despite months of requests, CMS has yet to provide the State with the application files and FFM denial records. *See id.* at ¶ 3(h). Without this necessary information, it will be impossible for the State to carry out Plaintiffs' proposed order. *See, e.g.*, *Hughey v. JMS Dev. Corp.*, 78 F.3d 1523, 1532 (11th Cir. 1996) (improper to enter injunction where compliance is impossible).

Even if the State did have access to Plaintiffs' application files, entry of classwide relief would impose an all but impossible burden on the State. The State's legacy computer eligibility system, ACCENT, is not capable of performing MAGI calculations and the State's new eligibility system, TEDS, is still under development; as a result, the review and adjudication Plaintiffs seek would necessarily entail an entirely manual process. *See* Long Decl. at ¶ 7. Because Medicaid eligibility is so complex, manual review of an enrollment application would

be extremely time intensive. In a report attached as Exhibit 1 to the Brooke Declaration, D.E. 2-2, the Congressional Research Service ("CRS") explained that "[t]here are approximately 50 different eligibility 'pathways' into Medicaid," and "[i]ncome eligibility varies by category." *Id.* at 1. Eligibility further depends on citizenship status; unauthorized aliens and legal permanent residents of less than five years are not eligible for Medicaid, while legal permanent residents who have been in the country more than five years are eligible. *Id.* at 5. These are just a few of the eligibility issues that have to be explored on any given application. Further complicating matters, the State does not currently have access to the Federal Data Hub to enable the State to verify income, citizenship, Social Security number, and immigration status (including whether the individual is lawfully present in the United States) automatically. Purcell Decl. at ¶ 17. With all of these limitations, it will be impossible in almost any case to provide a final eligibility determination within 45 days, much less the 72 hours Plaintiffs have demanded. *See id.* at ¶ 21(b); Long Decl. at ¶¶ 6-9.

Moreover, the State could not create and implement the new eligibility system Plaintiffs envision overnight. The State would have to hire and train a substantial number of workers to conduct the manual reviews, a project that, as a practical matter, could not be accomplished for several months. Currently, the State does not have sufficient personnel with the expertise or availability to manually process MAGI applications without diverting staff from their current responsibilities processing non-MAGI applications, enrolling deemed newborns, overseeing the new PE process for newborns, and numerous other obligations required in operating the TennCare program. Long Decl. at ¶ 14. Thus, to make this manual process work with any degree of efficiency and timeliness, the State would be required to hire and train additional eligibility staff. Depending on the volume of applications and amount of time allowed for

processing, TennCare estimates it would have to hire between 100 and 700 additional workers, which in addition to being costly, would require at a minimum 4 months to accomplish. *See id.* at ¶ 9(d).

B. The Proposed Injunction Would Likely Impose a Substantial Burden on Applicants by Diverting Many from a Process that Is Largely Working.

The potential harm flowing from the injunction Plaintiffs have requested is not limited to the tremendous burden imposed on the State (even as it provides little, if any, appreciable benefit to individuals whose TennCare applications have been delayed by the FFM). In addition, there is a grave danger that a court-ordered eligibility process that requires the State to produce a result in 72 hours will lead to thousands—indeed, tens of thousand—of requests without regard to whether an application has actually been pending for more than 45 days. Applicants will naturally view this 72-hour process as a better option than applying to the FFM through HealthCare.gov, a process that could take up to 45 days. *See id.* at ¶¶ 7-8.

Having thousands, perhaps tens of thousands, of people try to access this new perceived "door" to TennCare eligibility will almost certainly create the sort of backlogs experienced in other states. *Id.* at ¶ 10; *see also* Phil Galewitz, *More than 1.7 Million Consumers Still Wait for Medicaid Decisions*, KAISER HEALTH NEWS (June 9, 2014), *available at* www.kaiserhealthnews.org/Stories/2014/June/09/More-Than-17-Million-Consumers-Still-Wait-For-Medicaid-Decisions.aspx (reporting backlogs of 900,000 applications in California, 283,000 in Illinois, 170,000 in North Carolina, 100,000 in Georgia, 65,000 in Ohio, 62,000 in South Carolina, 60,000 in Pennsylvania, 48,000 in Virginia, 44,000 in Arizona, and 42,000 in Nevada). It is no answer for Plaintiffs to argue that the State need only act on applications where there is evidence the application has been impermissibly pending for more than 45 days, because every single

request to use this 72-hour process will have to be evaluated to attempt to separate legitimate requests from the potential deluge of non-legitimate ones. Long Decl. at ¶ 15.

Tennessee has thus far avoided these kinds of backlogs as a result of the implementation of the State's CMS-approved Mitigation Plan and other workaround solutions. But entry of the relief requested by Plaintiffs threatens to undermine a system that is working for the vast majority of applicants by diverting those who would have been successfully enrolled through the FFM under the current system to this manual process advocated by Plaintiffs. To be sure, the actual number of applicants who have had their applications impermissibly delayed beyond 45 days at the FFM is currently unknown and unproven. But there is hard evidence of the number of individuals for whom the current eligibility processes are working and who have been enrolled in TennCare since January 1, 2014. *See* Purcell Decl. at ¶ 19 (in the first six months of 2014 the FFM approved approximately 89,000 applications for TennCare coverage and approximately 5,200 application for CHIP coverage and TennCare directly determined the eligibility or extended healthcare coverage to approximately 46,000 individuals, including 27,000 non-MAGI enrollees and 19,000 deemed newborns). TennCare's rate of enrollment in the first quarter of 2014 was third highest in the history of the program, and TennCare enrollment has risen at a greater percentage rate than even some states that expanded Medicaid this year. *Id.* If any significant number of applicants are lured into Plaintiffs' new proposed system by the false promise of a 72-hour response, Tennessee will almost certainly develop the same sort of backlogs that have plagued other states and this record enrollment will be jeopardized.

C. The Proposed Injunction Would Impose a Substantial Burden on the State and the Public Interest by Diverting Attention and Resources from Solving Problems Arising from the ACA Rollout to Implementation of the Injunction.

The preliminary injunction Plaintiffs seek would impose further harm to the State by impairing its ability to administer its Medicaid program and address the issues that have arisen from both the federal government's and the State's efforts to implement the sweeping and significant changes to the Medicaid program required by the ACA. The record is replete with examples of strategies and workarounds the State, working with CMS, has crafted to address the problems that have inevitably arisen with both the State's and federal government's efforts to implement the sweeping new changes to the Medicaid program required by the ACA:

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

- When the State learned there were problems with pregnant women retaining presumptive eligibility due to the FFM's inability to provide required information to the State, the State created a workaround that enabled these women to stay on the program. *See id*. at ¶ 3(c).

- When the State learned that the FFM was having difficulties processing Medicare Savings Programs ("MSP") applicants, the State amended its long term care application form to include MSP eligibility questions so that individuals could apply directly to the State. *See id.* at ¶ 3(b).

- When the State learned that newborn infants born to non-TennCare eligible mothers were encountering difficulties applying through the FFM as the result of an apparent problem with the FFM verifying their identify, the State designed and is now implementing a PE program for those newborns. The State has conducted affirmative outreach to over 3,000 families whose children might qualify under this new program. *Id.* at ¶ 3(f).

The relief requested by Plaintiffs threatens the State's ability to continue developing, negotiating with CMS, and implementing solutions to the problems that remain—both on an

interim basis and permanently. The injunction Plaintiffs seek would force TennCare management to divert its limited time and resources to the likely doomed effort to design and operationalize Plaintiffs' proposed eligibility system. TennCare's time and attention would be far better spent working with CMS on such projects as the development of the Hospital Presumptive Eligibility program that will enable qualifying individuals to immediately get 45 days of TennCare coverage by applying through a participating hospital. *See* Long Decl. at ¶ 3(g).

TennCare and CMS officials have the requisite expertise and in-depth knowledge of the State's and the FFM's current limitations, abilities, and resources necessary to make the system work as efficiently and smoothly as possible during this initial implementation phase of this new legislation. A preliminary injunction can only serve to divert those resources away from efforts to resolve problems and to jeopardize the many aspects of the system that are working extremely well. The Supreme Court has recognized that an extra measure of judicial deference is due to those " 'charged with the responsibility of setting [a new law's] machinery in motion; of making the parts work efficiently and smoothly while they are yet untried and new.' " *Power Reactor Dev. Co. v. International Union of Elec., Radio & Mach. Workers*, 367 U.S. 396, 408 (1961) (quoting *Norwegian Nitrogen Prods. Co. v. United States*, 288 U.S. 294, 315 (1933)). The Court has discouraged judicial intervention while a new program gets off the ground because "[p]roblems which seem insuperable now may be solved tomorrow." *Id*.; *see also Community Health Ctr. v. Wilson-Coker*, 311 F.3d 132, 138 (2d Cir. 2002) ("We take care not lightly to disrupt the informed judgments of those who must labor daily in the minefield of often arcane policy, especially given the substantive complexities of the Medicaid statute.").

CONCLUSION

For the foregoing reasons, we respectfully submit that the Court should deny Plaintiffs' motion for a preliminary injunction.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a true and accurate copy of the foregoing was served upon all counsel of record on this 14th day of August, 2014, via the Court's Electronic Case Filing system.

s/ Michael W. Kirk