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

MELISSA WILSON, et al., individually and on behalf of all others similarly situated, Plaintiffs, v. DARIN GORDON, et al., Defendants.	Civil Action No. 3:14-CV-01492 Judge Campbell Magistrate Judge Bryant **PLAINTIFFS' RESPONSE IN OPPOSITION TO DEFENDANTS' MOTION TO DISMISS**

INTRODUCTION

On September 1, 2014, the Court issued a Class Certification Order certifying this case as a class action (ECF No. 90) and a Preliminary Injunction Order entering a preliminary injunction (ECF No. 91). These Orders cover the arguments raised by Defendants' Motion to Dismiss, and based on the reasoning set forth in them, the Motion to Dismiss should be denied. Nevertheless, Plaintiffs respond to the Motion to Dismiss as follows:

STANDARD OF REVIEW

Defendants seek dismissal under Fed. R. Civ. P. 12(b)(1) and 12(b)(6). In considering a motion to dismiss pursuant to Rule 12(b)(6), the court must "'construe the complaint in a light most favorable to the plaintiff, accept all of the factual allegations as true, and determine whether the plaintiff undoubtedly can prove no set of facts in support of his claims that would entitle him to relief.'" *Riverview Health Instit. LLC v. Med. Mut. of Ohio*, 601 F.3d 505, 511 (6th Cir. 2010) (citation omitted).

Rule 12(b)(1) provides for the dismissal of an action for lack of subject matter jurisdiction. Challenges to subject matter jurisdiction under Rule 12(b)(1) "come in two varieties: a facial attack or a factual attack." *Gentek Bldg. Prod., Inc. v. Sherwin-Williams Co.*,

491 F.3d 320, 330 (6th Cir. 2007). Defendants' motion to dismiss appears to mount both facial and factual attacks against subject matter jurisdiction.

A facial attack questions if the allegations in the complaint are sufficient, and in ruling on a facial attack, the court takes the allegations of the complaint as true. *Id.* A factual attack challenges the factual existence of subject matter jurisdiction, and the court has broad discretion to "weigh the conflicting evidence to arrive at the factual predicate that subject-matter does or does not exist." *Id*. However, if the factual attack goes to the merits of the plaintiff's claim, the court should not make factual findings with respect to the jurisdictional issue. *Id.* Instead, when "an attack on subject-matter jurisdiction also implicates an element of the cause of action, then the district court should '*find that jurisdiction exists* and deal with the objection as a direct attack on the merits of the plaintiff's claim.'" *Id*. (internal citation omitted) (emphasis in original). *See also Carrier Corp. v. Outokumpu Oyj*, 673 F.3d 430, 443-44 (6th Cir. 2012). This provides a greater level of protection to plaintiffs who in truth face a challenge to the merits of their claim. *Gentek Bldg. Products, Inc.*, 491 F.3d at 330.

ARGUMENT

I. Plaintiffs Have Standing To Pursue Their Claims, So The Court Has Subject Matter Jurisdiction To Hear This Case.

Plaintiffs have previously explained why they have standing, and they incorporate these arguments by reference. *See* Reply Supp. Plfs.' Mot. Prelim. Inj. 18-20, ECF No.79. Plaintiffs additionally state as follows: Article III standing is established when the plaintiff has suffered an injury in fact, there is a causal connection between the injury and the conduct complained of, and it is likely that the injury will be redressed by a favorable decision. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992). The Plaintiffs have all suffered real injuries due to the lack of an adjudication of their TennCare applications, which is denying them access to health

care for which they are eligible. *Banks v. Sec'y Indiana Family & Soc. Servs. Admin.*, 997 F.2d 231, 238 (7th Cir. 1993) (recognizing an eligible recipient's concrete interest in Medicaid benefits).

Defendants do not question Plaintiffs' injuries, focusing instead on the causal connection and redressability prongs of Article III standing. Defs.' Mem. Supp. Mot. Dismiss (Mot. to Dismiss) 10-15, ECF No. 58. Plaintiffs' injuries are both caused by, and capable of redress by, the defendant officials of Tennessee's single state Medicaid agency. Plaintiffs have suffered concrete harm to their health from Defendants' failure to ensure timely determinations of their Medicaid applications and to provide a fair hearing when these determinations are delayed. These rights are not only central pieces of the Medicaid Act and a person's ability to access the benefits for which they are eligible, but they are also core duties of the single State Medicaid agency. As officials of the single State agency, Defendants are responsible for these duties owed to Plaintiffs, and these duties are not delegable nor have they been abrogated in any way by the Affordable Care Act (ACA).

Plaintiffs' injuries and those of the class can be redressed by a favorable decision against the Defendants because the Defendants have shown they are capable of promptly determining eligibility and have not offered any evidence that they cannot offer fair hearings, especially considering that these hearings may be *de novo.* 42 C.F.R. §§ 431.232, 431.233.

A. Defendants' challenged actions are the cause of Plaintiffs' harm.

"[T]he causation requirement in standing is not focused on whether the defendant 'caused' the plaintiff's injury in the liability sense; the plaintiff need only allege 'injury that fairly can be traced to the challenged action of the defendant, and not injury that results from the independent action of some third party not before the court.'" *Wuliger v. Mfr. Life Ins. Co.*, 567

F.3d 787, 796 (6th Cir. 2009) (quoting *Simon v. E. Ky. Welfare Rights Org.*, 426 U.S. 26, 41–42 (1976)). Defendants' failure to ensure Plaintiffs' rights to a prompt determination on their pending Medicaid applications and a fair hearing when determinations are overdue are the actions that have caused injury to Plaintiffs.

Plaintiffs' injuries can be traced to Defendants' decisions: to send almost all applicants to the Federally Facilitated Marketplace (FFM); to eliminate the role of DHS in providing certain eligibility determinations and eliminating the staff that worked in this role; to refuse to ensure timely adjudications; to refuse to ensure or provide fair hearings; and to continue to do very little to systemically address the problems that class members are experiencing right now. As the United States has pointed out in its Statement of Interest, regardless of the FFM's actions, Defendants maintain the ultimate responsibility to operate the Medicaid program, including the reasonable promptness requirements. Plaintiffs' injuries can be traced directly to Defendants' decisions when they do not make timely application decisions, *see* 42 U.S.C. § 1396a(a)(8); 42 C.F.R. § 435.912; grant an opportunity for a fair hearing when applications are not acted on with reasonable promptness, *see* 42 U.S.C. § 1396a(a)(3); or make timely hearing decisions, *see* 42 C.F.R. § 431.244(f).

Contrary to Defendants' assertions, Tennessee's status as a determination state does not alter their responsibilities under the Medicaid Act. *See* Statement of Interest U.S. 1, ECF No. 85. Defendants emphasize 42 C.F.R. § 431.10(c)(1), which authorizes delegation of Medicaid eligibility determinations to the FFM, but they do not address the provisions of the same regulation that require the "single State agency" to ensure that all federal laws are followed notwithstanding that delegation. *Id.* § 431.10(c)(3); *see* §§ 435.1200(b)(3)(iii), 435.1200(c)(3); *see also id.* at § 431.10(b)(3) (admonishing that "it is [t]he single State agency [that] is

responsible for determining eligibility for all individuals applying for or receiving benefits . . . and for fair hearings filed . . ..."); *id.* at § 431.10(c)(3) (instructing the single State agency to take appropriate measures if federal laws are not being followed, ensuring that it is the single State agency that remains in charge); *see also id.* at § 431.205 (requiring the State agency to provide a fair hearing instead of the FFM at the request of the individual).

In sum, Defendants' arguments are directly contrary to the ACA, which states that, "[n]othing in this title . . . shall be construed to modify any existing Federal requirement concerning the State agency responsible for determining eligibility for [programs including Medicaid]." 42 U.S.C. § 18118. The federal Marketplace thus plays a role, but the ACA was not an invitation to State Medicaid agencies to abdicate responsibilities for eligibility determinations and then sit on their hands when the citizens they serve encounter problems that the State can redress.

B. Defendants can redress Plaintiffs' injuries.

As officials of the State Medicaid agency, Defendants have both the power and the ability to redress the harm to Plaintiffs; redressability is simply "a likelihood that the requested relief will redress the alleged injury." *Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 103 (1998). Defendants' actions in determining eligibility for the named Plaintiffs and some of the class members whose names were forwarded to them by Plaintiffs' counsel illustrate that the relief requested by Plaintiffs, or a version of it, has and can redress the alleged injuries of class members. As officials of the single State Medicaid agency, Defendants are the appropriate party to ensure Medicaid applications are determined within 45 or 90 days, to provide a timely Medicaid fair hearing when one is requested, and to issue timely hearing decisions within 90 days of the request of a hearing. Defendants have performed the activities for over 40 years.

According to Defendants' own statements, they are able to obtain information from CMS regarding applications to the FFM. *See* Hagan Decl. ¶¶ 12–13; Long Supp. Decl. ¶¶ 6-8. Defendants and their agent, the Tennessee Health Connection, already initiate calls with the FFM to obtain additional information about applicants' pending applications. *See* Hagan Decl. ¶¶ 5, 7; J.P. Decl. ¶ 6. Tennessee is already required to request information related to financial eligibility from the Supplemental Nutrition Assistance Program (SNAP) when available to verify financial eligibility, which enabled the State to verify financial information for some applicants. *See* 42 C.F.R. § 435.948(a)(2). Another option is self-attestation. *See Id.* at § 435.945.[1] Notably, as these examples illustrate, the relief that Plaintiffs seek does not require Defendants to obtain applications from the FFM—it simply requires them to establish a system to comply with their requirements under the Medicaid Act.

Specifically with respect to the fair hearing, the problems asserted by Defendants, such as not having the file or data provided to the FFM, are not roadblocks because an individual has the right to request a *de novo* hearing. 42 C.F.R. §§ 431.232, 431.233. And when the single state Medicaid agency makes a determination of eligibility, regardless of whether a state allows the FFM to make eligibility determinations or assessments, the FFM must honor this decision. *See* 45 C.F.R. §§ 155.302(b)(5); 155.345(h); Fair Hearings and Appeal Processes, 78 Fed. Reg.

[1] Self-attestation is a way for states to make eligibility processes more efficient by establishing procedures that will permit accurate determinations while limiting the burden on applicants, as is required, and avoiding fraud and abuse. The state Medicaid agency is required to develop, update as modified, and submit to the Secretary, upon request, a verification plan describing the policies and procedures adopted by the state agency. 42 C.F.R. § 435.945(j). If a state relies on self-attestation, performance audits of the state will also rely on those attestations and the state will not be held liable. *Id.* at § 431.980(d). Although recovery from individuals is generally not allowed, it is permitted in the case of fraud or as set forth in § 431.230(b); *see also* Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 Fed. Reg. 17144, 17172 (Mar. 23, 2012) (discussing verification plans, accuracy, and fraud).

42160, 42167–68 (July 15, 2013). Clearly, the remedy is fully in the hands of the single State Medicaid agency.

II. This Case Is Not Moot.

After months of inaction, followed by a class action lawsuit, Defendants swiftly found the named Plaintiffs eligible for TennCare. Defendants also agreed to decide the eligibility of up to 92 additional applications (100 in total), and Plaintiffs' counsel have been forwarding cases to Defendants' counsel on a steady basis. Defendants are also deciding these cases swiftly—including, as Defendants explained to the Court at the hearing on August 29, during the overnight hours prior to the hearing. At the same time, Defendants argue that they are not violating the law. Mot. to Dismiss at 10-15, 26-27. Under these circumstances, Defendants' clearly cannot meet the "stringent" test for mootness. *United States v. W.T. Grant Co.*, 345 U.S. 629, 632 (1953).

First, Defendants' voluntary cessation of the challenged practices with respect to up to 100 waiting applications does not make the case moot. Moreover, the limited time period in which Plaintiffs' eligibility is to be determined and the haste with which Defendants are determining eligibility for the up to 100 applications of class members means that Plaintiffs' claims are inherently transitory in nature, and determinations of eligibility should not moot their claims. Finally, as explained in Plaintiffs' Reply in Support of Class Certification, even if the named Plaintiffs' claims were moot, they may continue to represent the class. Plaintiffs hereby incorporate by reference argument in Plaintiffs' Memorandum in Support of Class Certification at 16 (ECF No. 3) and Plaintiffs' Response to the Defendants' Supplementation of the Record at 1-3 (ECF No. 83) and supplement those arguments as follows.

A. Defendants' limited voluntary cessation of the challenged conduct does not establish mootness.

"Under well-established Supreme Court precedent, the 'voluntary cessation of allegedly illegal conduct does not deprive the tribunal of power to hear and determine the case, i.e., does not make the case moot,' *United States v. W.T. Grant Co.*, 345 U.S. 629, 632 (1953), because 'courts would be compelled to leave the defendant ... free to return to his old ways.'" *United States v. Concentrated Phosphate Export Ass'n*, 393 U.S. 199, 203 (1968)." *Am. Civil Liberties Union v. Nat'l Sec. Ag.*, 493 F.3d 694, 712 (6th Cir. 2007); *see also id*. (noting that the test is "demanding"). "The 'heavy burden of persuading the court that the challenged conduct cannot reasonably be expected to start up again lies with the party asserting mootness.'" *Id.* (citation omitted); *see Friends of the Earth v. Laidlaw*, 528 U.S. 167, 193-94 (2000) (finding case was not moot even when the facility at issue had closed because the defendant retained the permit). The burden to show mootness is increased when "the voluntary cessation only appears to have occurred in response to the present litigation, which shows a greater likelihood that it could be resumed." *Northland Family Planning Clinic, Inc. v.Cox*, 487 F.3d 323, 342-43 (6th Cir. 2007) (citation omitted); *see also, e.g., Blankenship v. Sec'y of HEW*, 587 F.2d 329, 333 (6th Cir. 1978).

Here, Defendants do not come close to meeting their heavy burden. After the complaint and motion for class certification were filed, Defendants took two steps: first, they swiftly found the named Plaintiffs eligible for TennCare, and second, they agreed to extend relief to additional class members—up to 100 applications in total identified for them by Plaintiffs' counsel. While TennCare eligibility is the direct line to health care for class members who are found eligible, these tightly circumscribed steps show that Defendants are, in fact, doing very little and what little they are doing in no way completely and irrevocably eradicates the alleged violation.

Indeed, Defendants have said the process they are using to process applications "will not work," Supp. Long Decl. ¶ 11. They have refused to abandon their stance of blaming the FFM for the determination delays, even though CMS only approved the use of the FFM "as a short-term measure, not a long-term solution," and even as they provide no date by which their promised solution, the TennCare Eligibility Determination System (TEDS), will be operational. Letter from Cindy Mann, CMS, to Darin Gordon, TennCare 3, June 27, 2014, ECF No. 41. Meanwhile, they continue to flatly refuse to acknowledge that waiting individuals who have applied through non-MAGI programs, such as CHOICES or MSP, are even a part of the case, Mot. to Dismiss at 5 n.2. In sum, it appears certain that, if this case is dismissed, Defendants will maintain the practices that originally caused harm to the Plaintiff Class. Mootness is not supported by Defendants' limited voluntary actions.

B. Defendants' actions to "pick off" Plaintiffs does not moot Plaintiffs' inherently transitory claims.

Plaintiffs incorporate by reference their briefing in support of class certification. ECF No. 3; ECF No. 62. Citing *Genesis Healthcare Corp. v. Synczyk*, 133 S. Ct. 1523 (2013), Defendants argue that Plaintiffs cannot rely on the "inherently transitory" exception to mootness by focusing on Defendants' litigation strategy. Defs.' Mot. Supp. R. 3, n. 3, ECF No. 80. Defendants are clearly picking off class members (up to 100) so that they can argue that the case is moot. In Plaintiffs' Response to Defendants' Supplementation of the Record at 1-3 (ECF No. 83), Plaintiffs have explained why *Genesis* does not control here. Plaintiffs additionally point out that, litigation strategy aside, they are basing their argument on the inherently transitory nature of applicants' claims. Plaintiffs' claims are, by nature, of a short duration, either 45 days or 90 days—clearly timeframes that expire before a court can decide a case. Moreover, as Medicaid recipients, Plaintiffs maintain a stake in the litigation because they will have to periodically

reestablish their Medicaid eligibility and, absent relief, can expect that they will experience delays similar to those they have just weathered. *Compare Roe v. Wade*, 410 U.S. 113 (1973) (holding conclusion of pregnancy did not moot challenge to a statute prohibiting abortions); *Anderson v. Celbrezze*, 460 U.S. 780 (1983) (litigation by candidates challenging ballot access restrictions did not become moot when the election was over). *See Gawry v. Countrywide Home Loans, Inc.*, 395 F. App'x 152, 158–59 (6th Cir. 2010) ("[T]he crux of the 'inherently transitory' exception is the uncertainty about the length of time a claim will remain alive.") (citation omotted); *see also Robidoux v. Celani*, 987 F.2d 931, 938-39 (2d Cir. 1993) (holding public benefits applicants' class action case did not become moot upon the applicants' receipt of the allegedly unlawfully delayed benefits after the case was filed because their claims were inherently transitory—delayed applications would almost always be processed before an applicant could obtain relief through litigation, and applicants would have to apply or be recertified for assistance again in the future); *see also Olson v. Wing*, 281 F. Supp. 2d 476, 483-84 (E.D.N.Y. 2003) (Medicaid class action not moot even though named plaintiff's benefits were continued by defendant pending appeal because allegedly unconstitutional acts against plaintiff's proposed class continued).

III. Plaintiffs Have A Right To A Prompt Determination Of Medicaid Eligibility That Is Enforceable Through Section 1983.

A. Sections 1396a(a)(3) and (a)(8) are enforceable under § 1983.

Citing *Gonzaga University v. Doe*, 536 U.S. 273 (2002), the Defendant Commissioner of the single State Medicaid agency argues that Plaintiffs cannot state a cause of action under 42 U.S.C. § 1983 to enforce the Medicaid reasonable promptness requirement, 42 U.S.C. § 1396a(a)(8). In the 12 years since *Gonzaga* was decided, the enforceability of this provision has been assessed by multiple federal circuit courts, with every single court upholding Medicaid

beneficiaries' right of enforcement. This court should follow this unblemished case history, and as the Sixth Circuit has already done, reject Defendants' argument that § (a)(8) is not enforceable.

Plaintiffs have addressed Defendants' arguments at pages 11-15 of their Reply in Support of Motion for Preliminary Injunction (ECF No. 79), incorporated by reference herein. Plaintiffs additionally respond as follows.

Section 1396a(a)(8) requires the single State Medicaid agency to ensure that "all eligible individuals should have the opportunity to apply for medical assistance," and that this assistance "shall be provided to the individual with reasonable promptness." *Westside Mothers v. Olszewski*, 454 F.3d 532, 540 (6th Cir. 2006) ("*Westside Mothers II*") (quoting 42 U.S.C. § 1396a(a)(8)). Since *Gonzaga* was decided, five courts of appeals have held that Medicaid beneficiaries have a federal right under § 1983 to enforce § 1396a(a)(8). *See Romano v. Greenstein*, 721 F.3d 373, 377–79 (5th Cir. 2013); *Doe v. Kidd*, 419 F. App'x 411 (4th Cir. 2011), *reaff'g*, 501 F.3d 348, 355-56 (4th Cir. 2007); *Sabree v. Richman*, 367 F.3d 180, 190–92 (3d Cir. 2004); *Bryson v. Shumway*, 308 F.3d 79 (1st Cir. 2002); *Westside Mothers II*, 454 F.3d at 540. Prior to *Gonzaga*, two other federal circuits had recognized the right. *See Lewis v. N.M. Dep't of Health*, 261 F.3d 970 (10th Cir. 2001); *Doe v. Chiles*, 136 F.3d 709 (11th Cir. 1997). All of the circuit courts to have decided the question have held § 1396a(a)(8) creates a federal right enforceable under § 1983. *Accord Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 18 (1981) (Rehnquist, J.) (quoting *King v. Smith*, 392 U.S. 309, 333 (1968) (Social Security Act creates a "federally imposed obligation [on the States] to furnish 'aid to families with dependent children ... with reasonable promptness to all eligible individuals") and noting that when Congress intends states to take certain actions it has proved capable of saying so explicitly).

Defendants ask the court to ignore this enforcement track record. First, they claim that *Westside Mothers II* had "no occasion to decide" whether the provision confers enforceable rights. Mot. to Dismiss at 16, n. 4. But this is not so. In that case, the court reviewed a district court decision holding, among other things: (1) section 1396a(a)(8) creates enforceable rights under § 1983 and (2) plaintiffs had failed to state a claim that the provision had been violated because they were seeking the direct provision of medical services. 454 F.3d at 537. The Sixth Circuit reviewed the district court's holding and held,

> We do not believe [the statute] requires the State to provide medical services directly. The most reasonable interpretation of § 1396a(a)(8) is that all eligible individuals should have the opportunity to apply for medical assistance . . . and that such medical assistance shall be provided with reasonable promptness. . . The regulations that implement [the statute] also indicate that what is required is a prompt determination of eligibility . . .

Id. at 540. The court affirmed the district court's dismissal of the § 1396a(a)(8) claim because plaintiffs sought relief that the statute did not confer. [2] *Id.* It did so without prejudice, however, stating that the plaintiffs "may be able to amend the complaint to allege" a different theory of how the provision had been violated. *Id.* at 541. Contrary to Defendants' contention, the Sixth Circuit was squarely presented with the question of whether § 1396a(a)(8) was enforceable because it was reviewing the district court's specific finding that it was. Moreover, it was not merely assuming without deciding that the provision was enforceable because it gave plaintiffs the right to amend their complaint to show how § 1396a(a)(8) was violated. If it had any doubt that the provision conferred an enforceable right, the court would not have expressly given permission for the plaintiffs to waste judicial resources making such an amendment.

Unable to reconcile their argument with the consistent enforcement history in the circuit courts, Defendants cite two district court cases from other circuits, *M.A.C. v. Betit*, 284 F. Supp.

[2] The statute has since been amended. *See* 42 U.S.C. § 1396d(a).

2d 1298 (D. Utah 2003) and *Sanders v. Kan. Dep't of Soc. & Rehab. Servs.*, 317 F. Supp. 2d 1233 (D. Kan. 2004). The Sixth Circuit has already concluded that *Betit*'s reasoning is not persuasive. *See Harris v. Oszewski*, 442 F.3d 456, 463 (6th Cir. 2006). *Harris*, decided at the same time as *Westside Mothers II*, held the Medicaid freedom of choice provision, 42 U.S.C. § 1396a(a)(23), is privately enforceable under § 1983, in part because it applies to "any individual." *Id.* at 461. Writing for the panel, Judge Sutton noted that his conclusion comports with decisions from other courts of appeals that have recognized federal rights stemming from similar statutory language. *Id.* at 463 (citing *Sabree*, *Bryon*, and *Doe* and quoting § 1396a(a)(8)). Defendants' other case relied on *Betit*, *see Sanders*, 317 F. Supp. 2d at 1250, and the district court decision in *Sabree*, which was reversed by the Third Circuit. *See also id.* at 1249 (noting that plaintiff's claim under § 1396a(a)(8) sought a "specific piece of equipment," thus finding "no guidance" from *Bryon* where the "essence of plaintiffs' claim was that state officials had failed to process their applications … in the timely manner required by federal law").

Not surprisingly, district courts in *this* circuit have had no difficulty holding that § 1396a(a)(8) is enforceable. *See Crawley v. Ahmed*, No. 08-14040, 2009 WL 1384147, at *16-19 (E.D. Mich. May 14, 2009) (citing *Westside Mothers II*); *Ability Ctr. of Greater Toledo v. Lumpkin*, 808 F. Supp. 2d 1003, 1019–22 (N.D. Ohio 2011) (citing *Westside Mothers II*); *A.M.H. v. Hayes*, No. C2-03-778, 2004 WL 7076444, *5 (S.D. Ohio Sept. 30, 2004).[3]

[3] Defendants cite *Cook v. Hairston*, 948 F.2d 1288 (6th Cir. 1991), an old, unpublished table decision finding (a)(8) was not enforceable. Mot. to Dismiss at 15-16. The Sixth Circuit, however, makes no mention of *Cook* in the *Westside Mothers* or *Harris* decisions. This court should disregard it as well. Defendants also cite *Cook* to support a passing argument that the Medicaid fair hearing requirement is not enforceable. Mot. to Dismiss at 16, n. 5. However, the Sixth Circuit has held otherwise. *See Gean v. Hattaway*, 330 F.3d 758, 773 (6th Cir. 2003). Worded similar to § 1396a(a)(8), the fair hearing provision requires the single state Medicaid agency to "provide for granting an opportunity for a fair hearing before the State agency to *any*

Finally, Defendants argue that "to the extent" Plaintiffs assert a regulatory right, the federal regulation can require nothing more than "reasonable promptness," not a right to receive disposition of their applications within a certain timeframe. Mot. to Dismiss at 16. Plaintiffs' claims for relief pursuant to § 1983 seek to enforce the Medicaid Act, 42 U.S.C. §§ 1396a(a)(8) and 1396a(a)(3). *See* Compl., ECF No. 1. However, this does not mean that Plaintiffs cannot cite the federal regulations to flesh out the statute or that the Court cannot bind Defendants to adhere to the timeframes set forth in the regulations.

The federal regulations implementing § 1396a(a)(8) flesh out the right to reasonable promptness and require states to set standards for timeliness regarding the "maximum period of time in which every applicant is entitled to a determination of eligibility" that may not exceed 45 days for most categories of eligibility and 90 days if based on disability, 42 C.F.R. §§ 435.912(a)(1), (c)(3). The Sixth Circuit has already found Defendants' argument that Plaintiffs cannot rely on such regulations "inapt." *Harris*, 442 F.3d at 464. As *Harris* points out, Defendants' argument would hold more weight if the underlying statute did not create a federal right; however, the statutory provisions that Plaintiffs rely upon do create enforceable rights. As a result, consistent with *Harris*, Plaintiffs can support their position that "reasonable promptness" requires the single state Medicaid agency to meet deadlines by pointing to the provisions of the

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individual whose claim for medical assistance … is not acted on with reasonable promptness." 42 U.S.C. § 1396a(a)(3) (emphasis added). Defendants attempt to sideline *Gean* by arguing that it is only assessing whether the "fair hearing" words of (a)(3) are enforceable. However, the *Gean* court says it is looking at plaintiffs' entitlement "to a 'fair hearing before the State agency' in the event that their 'claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness.' 330 F.3d at 773 (quoting § 1396a(a)(3)). *See also Shakhnes v. Berlin*, 689 F.3d 244 (2d Cir. 2012) (citing *Gonzaga* and holding (a)(3) and implementing regulation, 42 C.F.R. § 431.244(f) (requiring a hearing decision within 90 days of the request for a hearing) are enforceable pursuant to § 1983).

regulation that require processing within 45 or 90 days. *Id*. at 465 ("'regulations applying [a statute's ban on conduct] are covered by the cause of action to enforce that section' because '[s]uch regulations, if valid and reasonable, authoritatively construe the statute itself, and it is therefore meaningless to talk about a separate cause of action to enforce the regulations apart from the statute.'") (quoting *Alexander v. Sandoval*, 532 U.S. 275, 284 (2001)).

Importantly, courts have repeatedly interpreted the cited regulations as effectuating the mandate of § 1396a(a)(8) and relied on them to define the scope of reasonable promptness. *See, e.g.*, *Westside Mothers II*, 454 F.3d at 540–41 ("The regulations that implement these provisions also indicate that what is required is a prompt determination of eligibility and a prompt payment to eligible individuals to enable them to obtain the necessary medical services.") (citing 42 C.F.R. §§ 435.911; 435.930); *Romano*, 721 F.3d at 379 & n.35 (regarding § 1396a(a)(8) and citing 42 C.F.R. § 435.911); *Doe*, 136 F.3d at 717 ("section § 1396a(a)(8)—as further fleshed out by these regulations–creates a federal right to . . . assistance provided without unreasonable delay"); *Ability Ctr. of Greater Toledo*, 808 F. Supp. 2d at 1020 (defining "reasonable promptness" by reference to 42 C.F.R. §§ 435.911; 435.930); *see also Shakhnes*, 689 F.3d at ("42 U.S.C. § 1396a(a)(3)—as construed by the regulation [42 C.F.R. § 431.244(f)]—creates a right, enforceable under § 1983, to receive a fair hearing and a fair hearing decision '[o]rdinarily, within 90 days' of a fair hearing request.").

B. Plaintiffs' factual allegations establish a violation of the reasonable promptness requirement.

Defendants contend that reasonable promptness is a flexible concept. However, there is no plausible definition of the term that would encompass the delays that TennCare applicants are currently experiencing. Contrary to Defendants' cramped reading of the legislative history, the full history reveals the purpose of the provision. The reasonable promptness standards

throughout the Social Security Act, including in the Medicaid Act, were enacted at a time when eligible individuals were placed on waiting lists, and "[t]he statute was intended to prevent the States from denying benefits *even temporarily*…." *Jefferson v. Hackney*, 406 U.S. 535 (1972) (citing H. R. Rep. No. 1300, 81st Cong. 1st Sess., 48, 148 (1949); 95 Cong. Rec. 13934 (remarks of Rep. Forand)). This history simply does not support Defendants' contention that the law requires them to do only what they decide is reasonably practicable.

Defendants further contend that the "unusual circumstances" requirement applies here so they do not have to comply with reasonable promptness. As explained in Plaintiffs' Memorandum in Support of their Motion for Preliminary Injunction at 23-25 (ECF No. 5), incorporated by reference here, this exception does not apply. Plaintiffs make the following additional points: Administrative difficulties are not "unusual circumstances" when a state has options to alleviate the problems and is not taking advantage of them. *See Like v. Carter*, 448 F.2d 798, 803 (8th Cir. 1971). In *Like*, the court found that the reasonable promptness provisions for Aid to Families with Dependent Children (AFDC) benefits, which are substantially similar to the Medicaid provisions, were violated because of delays. The defendants argued that their administrative and staffing problems were sufficient circumstances to merit a delay. The court disagreed, finding that there was no indication the delays were caused by any fault of the applicants and that the defendants could have taken actions that would have greatly minimized the delays. *Id.* at 804. Moreover, *Like* affirmed that the burden is on the agency, not the applicant, to establish excusable delay; accordingly, plaintiffs do not have to plead and prove that delay was not caused by circumstances within their control. *Id.* (citing *Rodriguez v. Swank*, 318 F. Supp. 289 (N.D. Ill. 1970)). Finally, Defendants' contention regarding "unusual circumstances" carries even less weight for the non-MAGI eligible applicants, including

CHOICES and MSP applicants, whose eligibility is determined by the State and who have also been facing significant delays in violation of 42 C.F.R. § 435.912(c)(2).

Defendants further contend that breaches of legal duties by the FFM are not attributable to the State. *See* Mot. to Dismiss at 22. Plaintiffs do not contend otherwise. However, Plaintiffs' claims are based on *Defendants'* violations of federal law. Contrary to Defendants' assertion, the law does indeed require the single State Medicaid agency to ensure that Plaintiffs have access to prompt eligibility determinations and fair hearings.[4]

C. Plaintiffs have stated a claim that their statutory and constitutional rights to a fair hearing have been violated.

Defendants assert that Plaintiffs' right to a fair hearing under 42 U.S.C. § 1396a(a)(3) and the due process clause has not been triggered because their factual allegations do not show failure to act on their Medicaid applications with reasonable promptness. Mot. to Dismiss at 26. Plaintiffs alleged that, when the Complaint was filed, named Plaintiff Melissa Wilson had been waiting for 163 days for a decision on her Medicaid eligibility; April Reynolds, 154 days; Mohammed Mossa and Mayan Said, 155 days; T.V. and K.P., 185 days; S.P., 168 days; C.A. and D.A., 146 days; S.V., 194 days; S.G., 147 days. Plfs.' Mem. Supp. Prelim. Inj. 9-15, ECF No. 5. Plaintiffs' allegations are typical of the class. These delays far exceed the legal limits, thus giving rise to their requests for fair hearings because their claims for assistance have not been acted on with reasonable promptness.

[4] Defendants also assert that Plaintiffs' cases regarding delegation of authority are inapposite because they pre-date the ACA. Mot. to Dismiss at 24. In fact, Plaintiffs cited a Fourth Circuit case from last year. *See* Plfs.' Reply in Supp. of Preliminary Inj. 16, ECF No. 79, citing *K.C. ex rel. Africa H. v. Shipman*, 716 F.3d 107, 119 (4th Cir. 2013). Defendants' effort to draw a distinction between delegation to private third parties and governmental entities is also unwarranted, as Plaintiffs' cases stand for the proposition that the single State agency is always ultimately responsible for the Medicaid program.

Defendants contend that Plaintiffs fail to state a claim because they "are free to seek a fair hearing from the FFM." Mot. to Dismiss at 26. But, as Plaintiffs have explained, Defendants have an independent obligation to provide for Medicaid fair hearings. Section 1396a(a)(3) was unchanged by the ACA, and CMS has not amended the regulations requiring the state to provide an opportunity for a hearing when an application "is not acted upon with reasonable promptness." 42 C.F.R. § 431.220. *See also* Plfs.' Mem. Supp. Prelim. Inj. 17-18, ECF No. 79 (describing CMS correspondence with Defendants and commentary on appeals regulations). Defendants also claim that they cannot adjudicate appeals because they do not have access to the necessary information. Mot. to Dismiss at 27. As discussed above, this is simply not true. *See also* Plfs.' Mem. Supp. Prelim. Inj. 18, ECF No. 5.

Finally, Defendants argue that the due process claims fail because there is "no state action without 'an alleged constitutional deprivation'" caused by the State. Mot. to Dismiss at 27. However, Plaintiffs' Complaint sets forth numerous allegations of just such deprivation *by the State*. *See* Compl. ¶ 4, ECF No. 1 ("Defendants' policies and practices violate the federal Medicaid requirement to 'grant[] an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness.' 42 U.S.C. § 1396a(a)(3). Defendants' refusal to afford applicants a hearing further deprives the Plaintiffs of their right to Due Process of Law in violation of the Fourteenth Amendment to the United States Constitution."); *id*. ¶ 40 (alleging that Defendants' duties to provide a hearing for any individuals whose applications are not acted upon with reasonable promptness, are nondelegable); *id*. ¶ 64; *id*. ¶ 83 ("TennCare discontinued granting any opportunity for a fair hearing within the State agency for an applicant to challenge the refusal of TennCare to act on the applicant's application with reasonable promptness, as required

by the Medicaid Act."); *id*. ¶¶ 100, 105,111, 117, 125, 131, 137 (allegations by named plaintiffs that after waiting for months and months for decisions, they contacts the State to request a hearing and were informed by Defendants that there were no hearings); *id*. ¶¶ 158-59 (alleging that "Defendants are knowingly and repeatedly failing to adhere to their duty to provide individuals with the opportunity for a hearing as required by the Medicaid Act" and "Defendants' failure to provide for any appeal or hearing when determinations on TennCare applications are not made reasonably promptly, or when applications are simply impossible to complete, violates the Plaintiffs' and class members' right to a fair hearing to review their denial of eligibility and receipt of medical assistance."); *id*. ¶ 162 (alleging that "Defendants' policy and practice of failing or refusing to provide a fair hearing when Defendants have exceeded the time permitted by law for a determination of eligibility for Medicaid violates Plaintiffs' and class members' rights under the Due Process Clause of the Fourteenth Amendment of the United States Constitution."). *See Hernandez v. Medows*, 209 F.R.D. 665, 668 (S.D. Fla. 2002) (finding plaintiffs had standing to sue state Medicaid agency, since "each named Plaintiff is a Florida Medicaid recipient whose prescription drug coverage is or will be denied, *delayed*, terminated, or reduced without notice and the opportunity for a fair hearing") (emphasis added); *see generally*, *King v. Fallon*, 801 F. Supp. 925, 938 (D.R.I. 1992) (where Rhode Island Medicaid agency acknowledged that some patients had not received written statements about the status of their requests or of their rights to a hearing, court required written notices because the Medicaid Act does not allow applicants to be "kept in administrative limbo, unsure of where they stand and what they should do next.").

As they have with respect to every other aspect of this case, Defendants argue that there is no state action because the delays are attributable to the FFM. Mot. to Dismiss at 27.

Plaintiffs' have filed their Complaint against the state Defendants, not the FFM. The Medicaid Act and the Constitution make the state Defendants responsible for providing fair hearings when claims are not acted on with reasonable promptness. *See* 42 U.S.C. § 1396a(a)(3); *Goldberg v. Kelly*, 397 U.S.254 (1970). As Plaintiffs have already explained, Defendants' duties are non-delegable. The ACA reaffirms this, stating that "[n]othing in this title . . . shall be construed to modify any existing Federal requirement concerning the State agency responsible for determining eligibility for [programs including Medicaid]." 42 U.S.C. § 18118. So too, the non-party United States of America, on behalf of the Secretary of Health and Human Services, has confirmed that "Under the Medicaid statute, 42 U.S.C. § 1396a *et seq*., it is the state Medicaid agency, in this case TennCare, that at all times retains the ultimate responsibility to ensure that a reasonably prompt decision is made on applications, including ones that have been submitted in the first instance to the federally facilitated Exchange." Statement of Interest U.S., Aug. 29, 2014, ECF No. 85; *cf. N.B. ex rel. Peacock v. District of Columbia*, 682 F.3d 77, 82, 86 (D.C. Cir. 2013) (finding actions traceable to D.C. Medicaid agency, not third parties). Defendants' notion that, where there is state inaction, there is no state action is without merit.

Moreover, Plaintiffs' right to a fair hearing is also guaranteed by the Due Process Clause. *See Hamby v. Neel*, 368 F.3d 549, 559–60 (6th Cir. 2004) (Due Process Clause requires appropriate notice and hearing). In *Hamby*, the Sixth Circuit held that applicants had a property interest in TennCare that triggered due process rights when their application was denied. *Id.* As Defendants have noted, "due process is flexible and calls for such procedural protections as the particular situation demands." *Morrissey v. Brewer*, 408 U.S. 471, 481 (1972). Plaintiffs have effectively been denied services by TennCare for many months while their eligibility has not been determined, and thus are entitled to a hearing. Due process will not allow Defendants to

skirt their obligations by indefinitely delaying application decisions, and in the meantime, failing to provide services to those applicants. *See Fuentes v. Shevin*, 407 U.S. 67, 84-86 (1972) ("[I]t is now well settled that a temporary, nonfinal deprivation of property is nonetheless a 'deprivation'"; "[t]he Fourteenth Amendment draws no bright lines around three-day, 10-day or 50-day deprivations of property. Any significant taking of property by the State is within the purview of the Due Process Clause. While the length and consequent severity of a deprivation may be another factor to weigh in determining the appropriate form of hearing, it is not decisive of the basic right to a prior hearing of some kind.").

IV. The Federal Government Is Not A Necessary Party Under Rule 19.

Plaintiffs claim that Defendants have violated their obligations under the Medicaid Act and the Due Process Clause. These claims can be resolved without making the federal government a party to this case and without subjecting Defendants to inconsistent obligations. Plaintiffs have already replied to Defendants' Rule 19 arguments, which are incorporated by reference herein. Reply Supp. Plfs.' Mot. Prelim. Inj. 20-22, ECF No. 79. Plaintiffs additionally respond as follows.

A person's joinder is "necessary" if the court cannot provide complete relief among existing parties without them; or the absent person claims an interest in the action and disposing of the action without them may either impair or impede their ability to protect their interest or leave an existing party subject to a "substantial risk" of incurring multiple or inconsistent obligations. Fed. R. Civ. P. 19(a). To show that an existing party would be exposed to inconsistent obligations, the absent party must have a legally cognizable interest in the subject matter of the suit. *Northrop Corp. v. McDonnell Douglas Corp.*, 705 F.2d 1030 (9th Cir. 1983).

The federal government is not an indispensable party when plaintiffs are challenging the State's implementation of federal legislation, not the legislation itself. *Milwaukee Cnty. Pavers Ass'n v. Fielder*, 731 F. Supp. 1395, 1407-8 (W.D. Wis. 1990), *aff'd*, 922 F.2d 419 (7th Cir. 1991). Neither CMS nor the Secretary of HHS need to be joined in this case because, while they have an interest in federal laws being enforced, Plaintiffs are not challenging those laws but rather Defendants' unlawful implementation of them.

In *Jones v. Blinziner*, the plaintiffs challenged the state's implementation of changes to eligibility standards for government benefits (AFDC). The court held the federal government was not a necessary party because the plaintiffs were not challenging the new law or the rules enunciated by the federal Secretary. Moreover, the court held that the state would not be subject to inconsistent obligations because, despite the defendants' claims that they might be in violation of the new law if relief were granted, they had not indicated that it was likely that the Secretary would institute proceedings against the state, that those proceedings would result in inconsistent obligations, or that the state would not be able to readily obtain relief in the future. 536 F. Supp. 1181, 1195 (N.D. Ind. 1982); *see also Ralabate v. Bane*, No. 93-0035E, 1993 WL 232338 (W.D.N.Y. June 22, 1993) (holding that the federal government was not a necessary party in a Medicaid case because the plaintiffs were challenging compliance with the laws, not the validity of such laws). Similarly, the Defendants here have presented no evidence that they would be subject to any proceedings by the federal government. In fact, the evidence presented indicates the ongoing desire of the federal government to work with the states to redress problems.[5] Letter

[5] There is no risk that Defendants will be subjected to conflicting requirements because CMS cannot contradict its own regulations or authorizing statutes. *See Service v. Dulles*, 354 U.S. 363, 372 (1957) ("regulations validly prescribed by a government administrator are binding upon him as well as the citizen, and . . . this principle holds even when the administrative action under

from Mann to Gordon, June 24, 2014, ECF No. 124; Letter from Kahn to Allen 2, Jan. 30, 2014, ECF No. 54-2 (noting additional assistance available to Pennsylvania from CMS).

Defendants mischaracterize 42 C.F.R. § 435.1200(d)(2) by implying that submission of the applicant's information to the State is not allowed. While this regulation does not permit a determining agency to *request* information that has already been submitted and is part of an application file, it does not prohibit an applicant from *voluntarily resubmitting* their application information. Plaintiffs are merely seeking an opportunity that citizens in other states have always had—the opportunity to submit information to their State Medicaid agency for an eligibility determination. As part of the relief, they ask that the original application date to the FFM be used as the date of application. When a remedy can be crafted such that a party is not indispensable, the motion to dismiss for failure to join a party under Rule 19 should be dismissed. Fed. R. Civ. P. 19(b); *PaineWebber, Inc. v. Cohen*, 276 F.3d 197, 202 (6th Cir. 2001).

Finally, dismissal of a case for nonjoinder, as Defendants request, is a drastic remedy that should be used sparingly. *Nat'l Union Fire Ins. Co. v. Rite Aid of S. C., Inc.*, 210 F.3d 246, 250 (4th Cir. 2000). Rule 19 does not require that all possible relevant parties be before the court, but instead calls for a pragmatic approach—the entire suit should not be dismissed if meaningful relief can still be accorded. *Keweenaw Bay Indian Cmty v. State*, 11 F.3d 1341, 1346 (6th Cir. 1993) (citations omitted). Defendants have not met their burden to demonstrate that the federal government is a necessary party, therefore, Defendants Motion to Dismiss for failure to join a necessary party should be denied.

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review is discretionary in nature."); *see also Doe v. Schachter*, 804 F. Supp. 53, 63 (N.D. Cal. 1992).

CONCLUSION

For the foregoing reasons, Plaintiffs respectfully ask the Court to deny Defendants' Motion to Dismiss.

DATED September 3, 2014.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing has been filed with the Court through the CM/ECF filing system, and that by virtue of this filing notice will be sent electronically to all counsel of record, this 3rd day of September, 2014.

/s/ Jane Perkins_____

2004 WL 7076544
Only the Westlaw citation is currently available.
United States District Court,
S.D. Ohio,
Eastern Division.

A.M.H., By and through her parent, P.H., et al., Plaintiffs,
v.
Thomas J. HAYES, in his capacity as Director of the Ohio Department of Job and Family Services, Defendant.

No. C2–03–778. | Filed Sept. 30, 2004.

Attorneys and Law Firms

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OPINION AND ORDER

GEORGE C. SMITH, District Judge.

***1** Both plaintiffs in this action are minors. Plaintiff A.M.H. proceeds by and through her parent, P.H. Plaintiff C.W. proceeds by and through her next friend, Ohio Legal Rights Services ("OLRS"), pursuant to 42 U.S.C. § 15041 and Ohio Revised Code ("ORC") § 5123 .60(G). Plaintiffs bring this action against defendant, Thomas J. Hayes, in his official capacity as Director of the Ohio Department of Job and Family Services ("ODJFS"), an agency of the State of Ohio. The Court has jurisdiction pursuant to 28 U.S.C. § 1331.

Plaintiff's allege that Hayes, as Director, is responsible for ODJFS's oversight of the Medicaid program in Ohio, and that ODJFS has violated several sections of Title XIX of the Social Security Act ("the Medicaid Act"), 42 U.S.C. § 1396 et seq., as well as Title II of the Americans with Disabilities Act, 42 U.S.C. § 12131 et seq., in enforcing the Medicaid Act in Ohio. Plaintiffs seek various remedies for the alleged violations of the Medicaid Act through 42 U.S.C. § 1983.

Defendant purportedly moves to dismiss plaintiff's complaint for failure to state a claim, pursuant to Fed.R.Civ.P. 12(b)(6). However, by his arguments, defendant moves only to dismiss plaintiffs' claims under the Medicaid Act that pertain to their alleged entitlements regarding "community based services." He avers that the language of the Medicaid Act does not create a private cause of action. Even if the Court finds that it does, however, defendant still moves to dismiss plaintiffs' Medicaid Act claims involving plaintiffs' alleged rights to community based services, on grounds that such services are not required under the Medicaid Act in Ohio. Defendant also moves to defer, or stay, this action to the extent that Title II of the Americans with Disabilities Act, 42 U.S.C. § 12131 et seq., is involved until another case in this district concerning the same issues is resolved. For the reasons that follow, the Court GRANTS defendant's motion to dismiss, and DENIES defendant's motion to stay.

I. Facts

A. Introduction

A.M.H. is a fourteen year-old. Physicians have diagnosed A.M.H. with Mental Retardation, Severe Tuberous Sclerosis, Seizure Disorder, recurrent Methicillin–Resistant Staphylococcus Aureus ("MRSA") (a bacterial staphylococcus infection). A.M.H. is possibly Autistic as well. A.M.H. is eligible for Medicaid benefits.

P.H. is A.M.H.'s natural guardian. P.H. voluntarily admitted A.M .H. to Springview, a state operated intermediate care facility for the mentally retarded ("ICF/MR") on October 28, 2002. P.H. agreed to a temporary placement at Springview for A.M.H for evaluation and assessment. The placement was to last for thirty to sixty days.

C.W. is a thirteen year-old. Physicians have diagnosed C.W. with Autism and Mental Retardation. C.W. is also non-verbal. C.W. is eligible for Medicaid benefits. C.W. also has significant behavioral issues, making a typical foster care placement inappropriate. Thus, C.W. has been in the custody of Shelby County Children's Services ("SCCS") since September 2002. SCCS admitted C.W. to Springview on September 26, 2002 for a thirty to sixty day evaluation and assessment period.

***2** Both A.M.H. and C.W. received the initial screening required by Medicaid. The Interdisciplinary Teams and Dr. G. Thomas Fazio, the Medical Director at Springview, have indicated that the services and treatments discussed in

the interdisciplinary assessments and recommendations are medically necessary. [1]

On August 27, 2003, P.H. removed A.M.H. from Springview and admitted A.M.H. to a private ICF/MR. C.W. remains at Springview.

B. Medicaid

Medicaid is a jointly funded cooperative program between the states and the federal government that provides federal funding to participating states to assist those states in providing medical assistance to low income persons and individuals with disabilities. *See Wilder v. Virginia Hosp. Ass'n,* 496 U.S. 498, 502, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990).*See also*42 U.S.C. § 1396 et seq. State participation in the Medicaid program is voluntary, however, once a state elects to participate it must comply with certain requirements imposed by both the Act itself, and regulations promulgated by the Secretary ("the Secretary") of Health and Human Services ("HHS").*Id.*"[A] state must submit to the Secretary and have approved a 'plan for medical assistance' that contains a comprehensive statement describing the nature and scope of the State's Medicaid program."*Id.* (quoting § 1396a) (internal citation omitted). A state which fails to comply with its medical assistance plan risks a revocation of federal funding by the Secretary. *Sabree*, 367 F.3 d at 182. The Medicaid act further provides that certain services may be provided at the option of the state. *Id.*

If a Medicaid eligible individual is younger than a certain age, as chosen by state, then the Medicaid Act mandates that early and periodic screening, diagnostic, and treatment services ("EPSDT"), as defined in § 1396d(r), be provided to that individual. 42 U.S.C. § 1396d(a)(4)(B).

Ohio participates in the Medicaid program. ODJFS is the state agency overseeing the medicaid program in Ohio, pursuant to O.R.C. § 5111.01 and O.A.C. § 5101:1–37–01. Ohio's EPSDT program is called "HealthChek." O.A.C. §§ 5101:3–14–01, 5101:3–13–22. HealthChek requires EPSDT be provided to eligible persons below the age of twenty.

II. Discussion

A. Standard of Review

A motion to dismiss for failure to state a claim "should not be granted unless it appears beyond a doubt that the plaintiff can prove no set of facts in support of his claim that would entitle him to relief."*Conley v. Gibson,* 355 U.S. 41, 45–46, 78 S.Ct. 99, 2 L.Ed.2d 80 (1957). All well-pleaded allegations must be taken as true and be construed most favorably toward the non-movant. *Schuer v. Rhodes,* 416 U.S. 232, 236, 94 S.Ct. 1683, 40 L.Ed.2d 90 (1974). A 12(b)(6) motion to dismiss is directed solely to the complaint and any exhibits attached to it. *Roth Steel Prod. v. Sharon Steel Corp.,* 705 F.2d 134, 155 (6th Cir.1983). The merits of the claims set forth in the complaint are not at issue on a motion to dismiss for failure to state a claim. Consequently, a complaint will be dismissed pursuant to Fed.R.Civ.P. 12(b)(6) only if there is no law to support the claims made, or if the facts alleged are insufficient to state a claim, or if on the face of the complaint there is an insurmountable bar to relief. *See Rauch v. Day & Night Mfg. Corp.,* 576 F.2d 857, 858 (6th Cir.1976).Rule 12(b)(6) must be read in conjunction with Fed.R.Civ.P. 8(a) which provides that a pleading for relief shall contain "a short and plain statement of the claim showing that the pleader is entitled to relief."5A Wright & Miller, Federal Practice and Procedure § 1356 (1990). The moving party is entitled to relief only when the complaint fails to meet this liberal standard. *Id.*

***3** On the other hand, more than bare assertions of legal conclusions are required to satisfy the notice pleading standard. *Scheid v. Fanny Farmer Candy Shops, Inc.,* 859 F.2d 434, 436 (6th Cir.1988)."In practice, a complaint must contain either direct or inferential allegations respecting all the material elements to sustain a recovery under *some* viable legal theory."*Id.* (emphasis in original, quotes omitted).

> [W]e are not holding the pleader to an impossibly high standard; we recognize the policies behind rule 8 and the concept of notice pleading. A plaintiff will not be thrown out of court for failing to plead facts in support of every arcane element of his claim. But when a complaint omits facts that, if they existed, would clearly dominate the case, it seems fair to assume that those facts do not exist.

Id.

B. Defendant's Motion to Stay Proceedings Pending the Outcome of *Martin v. Taft,* C2–89–362

Defendant moves that the Court "defer," or stay, these proceedings insofar as the Americans with Disabilities Act is involved because another case pending in the Southern District of Ohio, *Martin v. Taft*, addresses the same issues.

The Court notes that *Martin v. Taft*, Case No. C2–89–0362 (S.D .Ohio), is in the process of settlement, and likely will not proceed to trial. It is highly unlikely, therefore, that the Court, in *Martin*, will issue any opinions ruling on matters raised in the instant case. In this light, the Court finds that it would be pointless, and moreover, prejudicial to the plaintiffs, to stay these proceedings pending the outcome of *Martin v. Taft.*Defendant's motion to stay is therefore denied.

C. Plaintiffs' Causes of Action

Plaintiffs' first three counts allege that defendants conduct violated several sections of the Medicaid Act. Those sections are as follows: 42 U.S.C. §§ 1396a(a)(8), (10)(B), (19), (43); 42 U.S.C. §§ 1396d(a)(19), (r)(5); and 42 C.F.R. §§ 440.240, 440.50. Plaintiffs' allege in their fourth claim that the violations just enumerated deprived them of their rights under the Constitution and laws of the United States in violation of 42 U.S.C. § 1983. Defendant avers that no private right of enforcement, or private cause of action, exists by which plaintiffs' may seek relief under the Medicaid Act in light of the Supreme Court's recent decision in *Gonzaga University v. Doe*, 536 U.S. 273, 122 S.Ct. 2268, 153 L.Ed.2d 309 (2002). Thus, a determination of whether a private cause of action is implied within the Medicaid Act or provided pursuant to § 1983 is the appropriate place to begin the analysis.

i. *Gonzaga*

"That plaintiffs merit sympathy does not escape [the Court's] notice, but neither does it govern [the Court's] reasoning. Rather, *Gonzaga University* provides the dispassionate lens through which this matter must be viewed."*Sabree v. Richman*, 367 F.3d 180,183 (3d Cir.2004).

The Supreme Court's decision in *Gonzaga* has prompted discussion in courts across the country; it has forced courts to reassess all prior holdings as to whether or not Congress intended statutes that do not expressly provide a private cause of action, to nonetheless imply a private cause of action, or allow a cause of action under section 1983. *Gonzaga* was meant to clarify the Court's position on, and the appropriate test for, this situation. While it seems to have done that to a great extent, some discord still exists, and some areas have not yet been addressed in light of *Gonzaga*, including many subsections of the Medicaid Act.

***4** The Court notes that, in light of *Gonzaga*, it cannot simply rely on Sixth Circuit precedent on the issue as announced in *Westside Mothers v. Haveman*, 289 F.3d 852 (6th Cir.2002), a case decided before *Gonzaga.*Rather, the Court is required to carefully analyze the statutes at issue here to determine whether *Gonzaga* has altered the holding in *Westside Mothers.*

Prior to *Gonzaga*, cases deciding whether a cause of action existed under § 1983 relied on the framework set forth in *Blessing v. Freestone*, 520 U.S. 329, 117 S.Ct. 1353, 137 L.Ed.2d 569 (1997).*Westside Mothers* was decided using the *Blessing* framework. *Blessing* espoused a three part analysis to determine whether a statute creates a right privately enforceable under § 1983:(1) The statutory section must show an intent "to benefit the putative plaintiff;" (2) The statute must set a "binding obligation on a government unit, as opposed to "merely expressing a congressional preference;" and (3) the interests asserted by a plaintiff must not be so "vague and amorphous" that enforcement of the statute "would strain judicial competence." *Westside Mothers*, 289 F.3d at 862–63 (internal quotations omitted).

In *Gonzaga*, the Supreme Court rejected the notion that *Blessing*"permit [s] anything short of an unambiguously conferred right. *Gonzaga*, 536 U.S. at 282. The *Gonzaga* Court indicated concern over the first factor of the *Blessing* framework to the extent that many lower courts interpreted *Blessing* to mean that a plaintiff may enforce a statute, under § 1983, if that plaintiff "falls within the general zone of interest that the statute intend[s] to protect; something less than what is required for a statute to create rights enforceable directly from the statute itself under an implied right of action."*Sanders v. Kansas Dep't of Soc. and Rehab. Services*, 317 F.Supp.2d 1233, 1249 (D. Kansas 2004).

The *Gonzaga* Court noted, however, that *Blessing* clearly indicated that "only violations of *rights*, not *laws,*" give rise to § 1983 actions.*Gonzaga*, 536 U.S. at 283 (emphasis in original). The Court continued, explicitly rejecting any

interpretation of *Blessing* suggesting that "implied right of action cases are separate and distinct from ...§ 1983 cases. To the contrary, [the Court's] implied right of action cases should guide the determination of whether a statute confers rights enforceable under § 1983."*Id.* While distinct inquiries differentiate the determination of implied causes from causes under § 1983, the *Gonzaga* Court noted that the two "inquiries overlap in one meaningful respect—in either case [a court] must first determine whether Congress *intended to create a federal right."Id.* at 284.

Thus, *Gonzaga* provides as follows: "For a statute to create such private rights, its text must be 'phrased in terms of the persons benefitted.' " *Id.* (quoting *Cannon v. University of Chicago*, 441, U.S. 677, 692, n. 13 (1979). Other statutes have created individual rights "because those statutes are phrased " 'with an *unmistakable focus* on the *benefitted class.*' " *Id.* (emphasis added). For example, the Court noted that it has found that Title VI, 42 U.S.C. § 2000d, provides a private right by the following language: "*No person* in the United States *shall ... be subjected* to discrimination under any program or activity receiving Federal financial assistance on the basis of race color or national origin." *Id.* at 284, n. 3 (emphasis in original). Similarly, the Court noted that it had found that Title IX, 20 U.S.C. § 1681(a) provided a private right by the following language: "*No person* in the United States *shall*, on the basis of sex, ...*be subjected* to discrimination under any education program or activity receiving federal financial assistance ." *Id.* (Emphasis in original). Such statutes are clearly "phrased in terms of," and with "an unmistakable focus on," the benefitted persons. The requirement of rights creating language seems to be the only significant alteration that *Gonzaga* has made to the *Blessing* test.

***5** The Court noted, however, that where a statute is phrased in such "explicit rights-creating language," a plaintiff seeking relief under an implied right of action must still prove that congressional intent also provides a private remedy, while a plaintiff seeking relief under § 1983 need not. *Id.* This is in accord with the settled principle that § 1983 generally provides a remedy for suits properly within its ambit.

The *Gonzaga* majority concluded as follows: "In sum, if Congress wishes to create new rights enforceable under § 1983, it must do so in clear and unambiguous terms—no less and no more than what is required for Congress to create new rights enforceable under an implied private right of action."*Id.* at 290.

ii. Interpretation of the Medicaid Act

Plaintiffs' rely on the following statutes and regulations in their argument: 42 U.S.C. §§ 1396a(8), 10(B), (19), (43); 42 U.S.C. §§ 1396d(r)(5), (a)(19); and 42 C.F.R. §§ 440.240, 440.50. [2]

§ 1396a(a)(8) provides as follows:

> A state plan for medical assistance must provide that *all individuals* wishing to make application for medical assistance under the plan *shall have the opportunity* to do so, and that such assistance *shall* be furnished with reasonable promptness to all *eligible individuals.*

Comparing this section to the rights providing statutes quoted in *Gonzaga*, the Court notes that the language is unmistakably focused on the individuals to be benefitted by the plan. The language also sets a binding requirement on the government and the rights available under the statute are not so vague and amorphous as to strain judicial competence. This section clearly indicates that anyone has the right to apply for Medicaid, and if deemed eligible, shall receive aid under Medicaid within a reasonably prompt time frame. The Court finds that 42 U.S.C. § 1396a(a)(8) creates a private right of enforcement for remedy under § 1983. *See Sabree*, 367 F.3d at 183–91 (holding that section 1396a(a)(8) confers a private right).*But see M.A. C. v. Betit*, 284 F.Supp.2d 1298 (D.Utah 2003) (finding that neither the authorizing provision nor any other section of the Medicaid Act examined confers a private right).

§ 1396a(a) (10)(B) provides as follows:

> A state plan for medical assistance *must* provide that the medical assistance made *available to any individual* described in subparagraph (A)-(i) *shall not be less* in amount, duration, or scope than the medical assistance made available to any other such individual, and (ii) *shall not be less* in amount, duration, or scope than the medical assistance made

> available to individuals not described in subparagraph (A).

The Court finds, for the same reasons as above, that this section also creates a private cause of action. This section clearly indicates a requirement that various Medicaid recipients have a right to receive certain amounts of service relative to other recipients. It is counterintuitive to say that Congress will provide notice to persons of the level of aid they shall receive, but deny them the opportunity to remedy apparent deficiencies. It in no way strains judicial competence to find that this section provides a private cause of action. *See Sabree*, 367 F.3d at 183–91 (holding that section 1396a(a)(10) confers a private right).

***6** § 1396a(a)(19) provides as follows:

> A state plan for medical assistance must provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients.

Comparing this subsection to the rights granting statutes quoted in *Gonzaga*, the Court finds that the language falls short of creating a right. It appears, in large part, to be focused on the administrative aspects of the plan, or on the government, as opposed to on the recipients. While states are certainly obligated under this section to provide safeguards, precisely what is required is too vague and amorphous to grant a right of enforcement to the general public. It is more likely that this section was intended by Congress to prompt state legislatures and oversight agencies to discuss, determine, and implement appropriate safeguards. A finding that this subsection creates a private cause of action would, in the Court's opinion, strain judicial competence. *See Bruggeman ex rel. Bruggeman v. Blagojevich*, 324 F.3d 906, 911 (7th Cir.2003) (finding that section 1396a(a)(19) does not confer a private right or cause of action).

§ 1396a(43) provides, in relevant part, as follows:

> A state plan for medical assistance must provide for-
>
> **(A)***informing all persons* in the state who are under the age of 21 and who have been *determined to be eligible* for medical assistance including the services described in section1 396d(a)(4)(B) of this title, *of the availability* of early and periodic screening, diagnostic, and treatment services, as described in section 1396d(r) of this title and ...,
>
> **(B)***providing or arranging* for the provision of such screening services in all *cases where they are requested*,
>
> **(C)***arranging for* (directly or through referral to appropriate agencies, organizations or individuals) corrective *treatment*, the need for which is disclosed by such child health screening services, and
>
> **(D)** reporting to the secretary ....

The language of this subsection speaks clearly to the interests of the benefitted persons. It creates a right for those persons to be informed that they have been determined eligible for certain services, as well as a right to have the state provide or arrange for provision of such services in all cases where they are requested, presumably by the eligible person. A right to corrective treatment when such a need is disclosed by the screening services provided to the eligible person is also created. These rights are mandated by Congress; the states have no choice. The rights are not vague and amorphous. Despite that subparagraph (D) speaks in terms of the government's administrative duties, the larger focus of this subsection is on the benefitted persons, thus, this subsection creates a private cause of action for remedies under § 1983.

***7** § 1396d(a)(19) provides, in relevant part, as follows:

> For purposes of this subchapter—
>
> **(a)***The term* "medical assistance" *means* payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance ...) for individuals, and [to certain individuals in certain circumstances], who are—
>
> **(i)** under the age of 21 ..., but whose income and resources are insufficient to meet all of such cost—
>
> ...
>
> **(19)** case management services (as defined in section 1396n(g)(2) of this title) ....

§ 1396d(r)(5) provides that:

> *the term*"early and periodic screening, diagnostic, and treatment services"*means* the following items and services: Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Subsections 1396d(a)(19) and 1396d(r)(5) are simply definitional. Although they do obligate the state in certain ways, they do not speak in terms of the benefitted persons in the same way as some of the other subsections examined, supra. They simply provide information to assist readers, whether government officials or medicaid recipients, in interpreting other sections of the statute incorporating the defined terms; they do not create private rights, or private causes of action, in the benefitted persons.

42 C.F.R. § 440.240 provides as follows:

> Except as limited in § 440.250–(a) The plan *must* provide that the services *available to any* categorically needy *recipient* under the plan are *not less in amount, duration, and scope* than those services available to a medically needy recipient; and (b) The plan *must* provide that the services *available to any individual* in the following groups *are equal* in amount, duration, and scope for all recipients within the group: (1) The categorically needy. (2) A covered medically needy group.

This section clearly speaks to, and provides a right to, the benefitted individual. It provides the recipient with knowledge that his or her benefits must be of a certain amount, duration, and scope. It seems illogical to assume that Congress would provide such knowledge to the individual, yet prevent them from acting in the case where they are slighted in the amount, duration, and scope of whatever services they are provided with. Such a tease would indeed be contrary to providing such individuals with assistance at all.

42 C.F.R. § 440.50 provides, in relevant part, as follows:

> *"Physicians' services,"* whether furnished in the office, the recipient's home, a hospital, a skilled nursing facility, or elsewhere, *means* services furnished by a physician—(1) Within the scope of practice of medicine or osteopathy as defined by state law; and (2) By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

***8** This section, like 42 U.S.C. §§ 1396d(a)(19), (r)(5), is simply definitional and cannot be read to provide a private right of enforcement to a medicaid recipient. It seems to the Court that such definitional statutes may strengthen a party's argument in certain circumstances, but do not, in and of themselves, provide an avenue to remedy.

Because the Court finds that many of the cited Medicaid statutes in this case do provide for a private cause of action, the question then becomes whether access to community based services is required under the Medicaid Act in Ohio.

D. Community Based Services Under The Medicaid Act

Plaintiffs aver that they are entitled to "community based services" under the Medicaid Act. They assert that 42 U.S.C. § 1396d(r)(5) makes the provision of such services mandatory. Defendant asserts that community based services fall under that section of the Medicaid Act that allows states to implement waiver programs, § 1396d(n)(c), and thus, that Ohio is not required to provide community based services to Medicaid recipients through other sections of the Medicaid Act. Defendant also asserts that community based services do not fall within the section of the Medicaid Act made mandatory by § 1396d(r)(5) because the Center for Medicaid and Medicare Services ("CMS"), the federal agency under the Department of Health and Human Services charged with overseeing Medicaid at the federal level has interpreted the Medicaid Act as such. Defendant asserts that as the oversight agency, CMS is entitled to deference in its interpretation, pursuant to *Chevron U .S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984).

The Supreme Court, in *Chevron*, stated as follows:

> When a court reviews an agency's construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at issue. If the

> intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. If, however, the court determines Congress has not directly addressed the precise question at issue ... the question for the court is whether the agency's answer is based on a permissible construction of the statute.

Chevron U.S.A., 467 U.S. at 842–43. As defendant points out, the Supreme Court then revisited the issue in *Auer v. Robbins*, 519 U.S. 452, 117 S.Ct. 905, 137 L.Ed.2d 79 (1997), and confirmed the approach espoused in *Chevron*.In *Auer*, the Court quoted *Chevron*:"Because Congress has not 'directly spoken to the precise question at issue,' a court must sustain the Secretary's approach so long as it is 'based on a permissible construction of the statute.'"*Id.* at 457.

Here, it seems that plaintiffs' argument focuses on the first of the two *Chevron* questions, while defendant's argument focuses, primarily, on the second *Chevron* question. The Court will address the arguments in turn.

a. Congress

***9** 42 U.S.C. § 1396d(r)(5) states that EPSDT means, inter alia, "such other necessary health care, diagnostic services, treatment, and other measures *described in subsection (a) of this section* to correct or ameliorate defects and physical and mental illnesses and conditions *discovered by the screening services*, whether or not such services are covered under the state plan."42 U.S.C. § 1396d(r)(5) (emphasis added).

42 U.S.C. § 1396d(a) provides that "medical assistance" means payment of part or all of the cost of the following care and services ...." Subsection (a) goes on to list twenty-seven services. Of those twenty-seven services, only seven of those services are mandatory for adult Medicaid recipients. However, as the parties agree, all twenty-seven services must be provided to children eligible for Medicaid.

Plaintiffs aver that subsection (a)(19), one of the twenty-seven mandated services, is relevant to the case at bar. That section requires, in relevant part, provision of "case-management services (as defined in section 1396n(g)(2) of this title) ...." 42 U.S.C. § 1396d(a)(19).Section 1396n(g)(2) provides that "[f]or purposes of this subsection the term case management services means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services." This simply does not speak to the issue of whether community based services have been made mandatory by § 1396d(r)(5). Moreover, plaintiffs have not indicated, nor has the Court discovered, which other subsections of § 1396d(a) may indicate that community based services are mandatory per § 1396d(r)(5). Thus, it is clear to the Court that "community based services" are not referred to by § 1396d(r)(5), but are addressed, explicitly, elsewhere in the statute.

Community based services are addressed, specifically, in § 1396n(c)."The Secretary *may by waiver* provide that a State plan approved under this subchapter *may* include as 'medical assistance' under such plan payment for part or all of the cost of home or community based services (other than room and board) approved by the secretary."42 U.S.C. § 1396n(c) (emphasis added). The language of the statute indicates the non-mandatory nature of community based services waivers. Moreover, § 1396n(c) does not refer to § 1396r, or § 1396d. [3]

The Medicaid Act provides that the state *may* apply for a waiver such that it may offer its Medicaid-eligible residents funding for particular services not otherwise covered under the Medicaid program. 42 U.S.C. § 1396n(b), (c). Such waiver programs are in addition to the requirements, and the optional portions, of the Medicaid Act. A state must submit an additional plan to the Secretary, and have that waiver plan approved before it may offer funding for such services to its Medicaid-eligible residents. *Id.*

Thus, the Court finds that Congress has indeed spoken to the precise question at issue. Though Congress could have referenced community based services in § 1396d(r)(5), as it referenced § 1396d(a), and thus, made them mandatory, Congress did not. Rather, Congress included a separate subsection within the Medicaid Act clearly making community based services optional.

b. CMS

***10** Even if the Court found that Congress had not spoken on the issue, defendant's argument further supports the holding of the Court above. Indeed, even if the Court found that the statute was ambiguous as to whether or not § 1396d(r)(5)

mandates community based services, the Court must defer to the interpretation given to the statute by CMS in accordance with *Chevron.*

CMS, as the oversight agency for Medicaid at the federal level, publishes various guides and manuals that explain Medicaid, including "The State Medicaid Manual." [4] In the MedManual, CMS expressly stated that the services made mandatory by § 1396d(r) (5) [5] do not include home and community based services authorized by § 1396n(c), [6] simply because home and community based services are not included under § 1396d(a). [7] The Court finds this to be a permissible construction of the statute. Indeed, it is precisely the construction, albeit much more succinct, that the Court developed in its own analysis.

Based on the foregoing, the Court finds that the Medicaid Act does not make offering community based services mandatory, and thus, plaintiff's can prove no set of facts in support of their claim that would allow the Court to order ODJFS to provide such services.

III. Disposition

For all of the foregoing reasons, defendant's motion to dismiss pursuant to Fed.R.Civ.P. 12(b)(6) is granted in part, and denied in part.

Plaintiff's claims arising under the Medicaid Act, 42 U.S.C. § 1396 et seq., are hereby dismissed with prejudice, insofar as they request that the Court order defendant to provide "community based services."

The parties may proceed on all other issues.

The Clerk shall remove Doc. 7 from the Court's pending motions list.

IT IS SO ORDERED.

Footnotes

1 Presumably, it is in these assessments and recommendations that the physicians at Spring view state, as alleged by plaintiffs, that Springview is an inappropriate location for plaintiffs to remain on any long-term basis, and that the appropriate setting for plaintiffs is in a facility offering community based services.

2 The Court notes that any emphasis in the quoted statutes below is added.

3 The parties have not indicated, and the Court does not consider, whether or to what extent a waiver program exists in Ohio.

4 Defendant provided the Court with a copy of the relevant portion of this manual that he obtained from the website of a private corporation. The Court, however, relies on the same manual as found on the website of CMS and HHS.

5 Cross-referenced as § 1905(r)(E) of the SSA.

6 Cross-referenced as § 1915(c) of the SSA.

7 Cross-referenced as § 1905(a) of the SSA.

2009 WL 1384147
Only the Westlaw citation is currently available.
United States District Court,
E.D. Michigan,
Southern Division.

Chande CRAWLEY, Penny Carson, Linda Birmingham, and Brittany Lockert, on behalf of themselves and all other similarly situated, Plaintiffs,
v.
Ismael AHMED, in his official capacity as Director of the Michigan Department of Human Services, and Janet Olszewski, in her official capacity as Director of Michigan Department of Community Health, Defendants.

No. 08–14040. | May 14, 2009.

Attorneys and Law Firms

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ORDER AND MEMORANDUM OPINION CERTIFYING CLASS ACTION, AND DENYING DEFENDANTS' MOTION TO DISMISS/SUMMARY JUDGMENT, AND GRANTING PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION, AND GRANTING LOCKERT'S MOTION TO INTERVENE AND MOOTING LOCKERT'S MOTION FOR EX PARTE TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

DENISE PAGE HOOD, District Judge.

I. INTRODUCTION

***1** This matter is before the Court pursuant to Plaintiffs' Motion for Immediate Class Certification **[Docket No. 5, filed Sept. 19, 2008].** On October 20, 2008, the Defendants filed a Response **[Docket No. 17],** to which the Plaintiffs filed a Reply **[Docket No. 21, filed Oct. 29, 2008].** This matter is also before the Court on Plaintiffs' Motion for Preliminary Injunction **[Docket No. 6, filed Sept. 19, 2008].** On October 20, 2008, the Defendants filed a Response **[Docket No. 16],** to which the Plaintiffs filed a Reply **[Docket No. 20, filed Oct. 29, 2008].** This matter is also before the Court on Defendants' Motion to Dismiss and/or Summary Judgment **[Docket No. 15, filed Oct. 16, 2008],** to which the Plaintiffs filed a Response **[Docket No. 19, filed Oct. 29, 2008],** and the Defendants filed a Reply **[Docket No. 23, filed Nov. 7, 2008].** A motion hearing was held on November 14, 2008.

On May 7, 2009, Proposed Intervenor Brittany Lockert simultaneously filed a Motion to Intervene as a Plaintiff and Class Representative **[Docket No. 24],** and a Motion for *Ex Parte* Temporary Restraining Order and Preliminary Injunction **[Docket No. 25].** The Court now finds that Proposed Intervenor Lockert has established the requirements of Rule 24(a) of the Federal Rules of Civil Procedure, and is therefore entitled to intervene. [1] Because the Motion for *Ex Parte* Temporary Restraining Order and Preliminary Injunction raises grounds identical to those being resolved below, the Court deems it moot.

II. STATEMENT OF FACTS

A. Brief Overview

The Named Plaintiffs are individuals with disabilities whose Medicaid was terminated by the Defendants, officials within the Michigan Department of Human Services and the Michigan Department of Community Health. Plaintiffs aver that their Medicaid benefits were terminated, without a determination of whether Plaintiffs were eligible under a disability-based category. More specifically, the Defendants terminated the Plaintiffs' Medicaid because they no longer qualified for Medicaid under the "FIP-related" eligibility categories—that cover children, young adults, parents and other caretaker relatives who are parenting a dependent child in their care—without reviewing their eligibility under disability-based categories. The Plaintiffs also claim that they did not receive any meaningful, pre-termination notice or opportunity to be heard regarding their eligibility for Medicaid based on disability. In particular, the Complaint alleges the following two counts:

> (1) Defendants' pattern and practice of terminating Plaintiffs' Medicaid benefits without first determining whether they are eligible for Medicaid benefits under disability-based categories, violates Plaintiffs' rights under 42 U.S.C. 1396(a)(a)(8) and (10), and under the federal regulations implementing those statutory requirements, 42

C.F.R. 416.916(c) and 435.930(b)... [and that these rights] are enforceable under 42 U.S.C.1983.

***2** (2) Defendants' pattern and practice of terminating Plaintiffs' Medicaid benefits without providing them a meaningful pre-termination opportunity to be heard violates Plaintiffs' rights to due process under the Fourteenth Amendment to the United States Constitution and the federal Medicaid laws, 42 U.S.C. 1396a(a)(3) and under the federal regulations implementing those Constitutional and statutory requirements, 42 C.F.R. 431.206–.211 and 435.919. Plaintiffs' right to a meaningful opportunity to be heard under the Due Process Clause of the Fourteenth Amendment, 42 U.S.C. 1396a(a) (3), and 42 C.F.R. 431.206–.211 and 435.919, are enforceable under 42 U.S.C.1983.

As the requested relief challenges the distribution and termination requirements of federal Medicaid law, the Court will provide a brief overview of the agencies responsible for Medicaid and regulations governing the distribution of Medicaid resources.

B. Administrative Agencies Responsible for Medicaid

Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, *et seq* ., established the federal Medicaid program which is intended to provide financial assistance to needy individuals seeking medical care and treatment. The legislation creates a cooperative health insurance program jointly funded and administered by the state and federal governments, "to furnish....medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of medical services[.]"42 U.S.C. 1396–1. "Although participation in the program is voluntary, participating States must comply with certain requirements imposed by the Act and regulations promulgated by the Secretary of Health and Human Services."*Westside Mothers v. Olszewski,* 454 F.3d 532, 535 (6th Cir.2006).

Michigan has authorized its participation in the federal Medicaid program through Mich. Comp. Laws. ("MCL") §§ 400.105, *et seq.* The United States Department of Health and Human Services ("HHS") oversees the state's administration of Medicaid benefits to ensure that the state is in compliance with federal law and therefore should receive matching federal funds. *See Harris v. McRae,* 448 U.S. 297, 301, 100 S.Ct. 2671, 65 L.Ed.2d 784 (1980). Defendant, Janet Olszewski, is the Director of the Michigan Department of Community Health ("MDCH"), which is the single state agency responsible for administration of the federal and state jointly funded Medicaid Program. 42 U.S.C. § 1396a(a)(5). Defendant, Ismael Ahmed, is the Director of the Michigan Department of Human Services ("DHS"), which is responsible for administration of public assistance programs at local levels including making determinations of whether applicants meet the eligibility requirements of Medicaid. These Medicaid eligibility policies and procedures are jointly developed by DCH and DHS and are published in the DHS policy manuals, including the Program Eligibility Manual ("PEM"), the Program Administrative Manual ("PAM") and the Program Reference Tables. [2]

C. Medicaid Eligibility Requirements and Pertinent Classifications

***3** Generally, the Medicaid program provides payments for medical costs incurred by individuals that fall within the statutory eligibility requirements, including certain low-income children, families with children, pregnant women, disabled adults, and elderly people who meet financial and non-financial eligibility criteria. *See*42 U.S.C. 1396a(a)(10)(A), 1396a(a)(10)(C), 1396a(e), 1396a(1)(2)(A)–4(A), 1396d(a), 1396r–6(a), 1396u–1(b). The Michigan Department of Human Services applies the same eligibility requirements to determine if an applicant qualifies for one of the many health care programs that are administered by the Michigan Department of Community Health. While there are several such Medicaid sub-programs, they are generally grouped in two broad subdivisions: Family Independence Program ("FIP") and Supplemental Security Income ("SSI"). The FIP category usually covers families with dependent children, caretaker relatives of dependant children, persons under age 21, and pregnant and recently pregnant women. PEM 105 at 1. The SSI category covers persons who are elderly, disabled, or blind.*Id.* Eligibility based on such a disability further requires a determination by the Social Security Administration, or by a state Medical Review Team, accordingly, individuals who receive SSI income are automatically eligible for Medicaid. 42 C.F.R. § 435.120. To be eligible for Medicaid disability benefits, an applicant must meet "the eligibility standards for supplemental security income under title XVI [of the Social Security Act]."MCL 400.106(1)(b)(vi) (citing 42 U.S.C. §§ 1381–1385). [3] Of particular importance in the instant action is whether a recipient may transition from an FIP-related category to an SSI-related category upon termination of FIP eligibility.

In either the SSI or FIP category, a recipient of benefits may be classified as "categorically needy" or "medically needy." If an applicant is "categorically needy," he or she is entitled to both financial and medical assistance. This group includes individuals who automatically qualify for Medicaid, like SSI recipients, and people who qualify as a "Low Income Family," under the AFDC program.[4] In Michigan, families with children that receive FIP cash assistance automatically qualify for Medicaid under the categorically needy designation as a Low Income Family. A "medically needy" designation means that the recipient is only eligible for medical benefits, and does not receive SSI or FIP cash benefits.

D. Application for Medicaid Benefits

When applying for Medicaid in Michigan, individuals can apply for all Medicaid categories pursuant to the DHS Assistance Application (form DHS 1171). This application seeks general information regarding the applicant's residence, family, medical history, medical coverage, assets, vehicles, employment, income, disability benefits, dependent care expenses, and voter registration. [*See, e.g.* DHS Assistance Application, Form DHS 1171, Compl. Ex. A]. The application helps the state to determine whether a person qualifies under a particular Medicaid category and for a particular sub-program. Michigan Medicaid Policy provides that, "Persons may qualify under more than one MA [Medicaid Assistance] category. Federal law gives them the right to the most beneficial category. The most beneficial category is the one that results in the eligibility or the least amount of excess income."PEM 105 at 2.

***4** DHS has additional procedures for obtaining and reviewing medical information when an individual's eligibility for a disability-based Medicaid category is being considered. PEM 260, PAM 815. These additional procedures are employed when the applicant is not automatically qualified because he or she is already been found disabled by the Social Security Administration under the SSI or the Social Security Retirement, Survivors, and Disability Insurance programs. PEM 150, and 260; PAM 815. Michelle Best, a State Administrative Manager for the Michigan DHS, testifies that claimants who are not automatically approved for disability-based Medicaid category, must fill out an application for disability-based benefits. [Affidavit of Michelle A. Best, Oct. 20, 2008 ("Best Affidavit")] On this form, the claimant lists doctors and any other relevant information that would assist in making a determination for Medicaid, and also signs blank medical releases in order to obtain medical records. This may result in a referral to a clinic or doctor for an evaluation. The application is then referred to a Medical Review Team, composed of a physician and a medical consultant, who reviews the file and either finds disability or denies the application. However, Plaintiffs contend that there is no additional application for Medicaid benefits other than the initial DHS 1171 form, and that Defendants' caseworkers are instructed to request any additional information if it is needed to review the applicant's eligibility for Medicaid based on disability.

E. Named Plaintiffs

Plaintiffs claim that at the time of the filing of this action each of the Named Plaintiffs had been terminated from their FIP-related Medicaid and were forced to rely Genesee Health Plan B ("GHP–B") for medical coverage, despite their eligibility for SSI-related Medicaid benefits. Plaintiffs posit that GHP–B provides very limited medical coverage for uninsured residents of Genesee County. GHP–B does not cover many of the medical services that are available under Medicaid, including inpatient and outpatient hospital care, emergency room services, medical transportation assistance, dental or optical services. While GHP–B does provide for some specialist care, diagnostic testing, mental health services, and prescription medications, it requires higher payments and increased co-payments than most Medicaid recipients pay. At the time of filing, the following three Plaintiffs were unable to work because of their medical problems, and were relying on GHP–B medical coverage:

(1) *Chande Crawley*

Chande Crawley is a Genesse County, Michigan resident, who lives with her husband and 18–year–old daughter. Crawley applied for Medicaid on April 28, 2008, after two hospitalizations for liver failure and severe abdominal infections. Crawley indicates that prior to her liver failure that her family was suffering financial hardship, despite the fact that both she and her husband were employed. Crawley claims that throughout the months of April, May, and June of 2008, she left messages with her DHS casework in an effort to obtain Medicaid coverage so that she could receive treatment for her liver failure and abdominal infections. Crawley would occasionally receive notices from DHS regarding her Medicaid eligibility, but around June 2008 her caseworker notified her that she "would no longer be able to qualify by submitting bills showing that [she] had met [her] deductible or spenddown amount, because [her] daughter was 18 and

was graduating from highschool."[Declaration of Chande Crawley, September 18, 2008 ("Crawley Declaration"), Mot. for Prel. Inj., Ex. A]. On July, 18, 2008, DHS officially notified Crawley that her Medicaid coverage would end for the same reason.

***5** Crawley avers that her caseworker requested that she complete a new Medicaid application, but not to mail it in until the end of July 2008. Crawley claims that her caseworker was aware of her liver failure as early as April 2008, "but never asked [her] for any medical records or release forms until [she] sent in the new application at the end of July."[Crawley Declaration]. Crawley claims that the lapse in Medicaid coverage caused her to miss a series of appointments at the Henry Ford Hospital Transplant Institute that were necessary to be placed on the liver transplant waiting list. At that time, Crawley was relying on GHP–B, which did not cover treatment at Henry Ford Hospital Transplant Institute, nor certain prescription medications.

On August 28, 2008, the Social Security Administration sent Crawley a notice that indicated she was disabled pursuant to the SSI guidelines. After conversations with counsel, Crawley gave the notice to her DHS caseworker on September 3, 2008. The Defendants contend that Crawley was approved for disability related Medicaid on September 17, 2008, and is a current Medicaid recipient. [Best Affidavit].

(2) *Penny Carson*

Penny Carson is a Genesee County, Michigan resident, who lives with her elderly brother, and 18–year–old son. Penny Carson claims that she has "both mental and physical problems that make it impossible for [her] to work, including glaucoma, depression and bi-polar disorder, high blood pressure, sleep apnea, high cholesterol, low thyroid, diabetes, and joint problems."[Declaration of Penny Carson, September 18, 2008 ("Carson Declaration"), Mot. for Prel. Inj., Ex. B]. Carson also received surgery on her left foot and right knee, which restricts her ability to walk.

According to Carson, DHS stopped her cash assistance and Medicaid because her son graduated from high school. She claims that her only income since June 2008 has been $298.00 a month in food stamps because her FIP-related cash benefits were terminated. Carson alleges that during an annual review of her eligibility assistance in March 2008, she indicated that she was disabled and appealing her SSI case. Carson further avers that no one from DHS asked her for her medical records or to sign a medical release form.

Carson alleges that her GHP–B medical coverage does not permit her to continue treatment with her usual therapist. Carson also indicates that GHP–B does not cover all of her medications, specifically those prescribed for her depression and leg cramps. After speaking with counsel, Carson reapplied for Medicaid and state disability assistance on September 5, 2008. Defendants contend that if her application based on disability is approved, she may obtain retroactive coverage to July 1, 2008. [Best Affidavit].

(3) *Linda Birmingham*

Linda Birmingham received Medicaid and FIP cash assistance for several years beginning in 2005. She qualified for cash assistance because of her 13–year–old son. Linda claims to be disabled because of a "degenerative disk disease in [her] neck, which causes numbness in [her] arms and hands; lower back problems that result in severe pain down [her] left hip, leg, knee and ankle; bipolar disorder and depression; osteoarthritis; and carpal tunnel syndrom."[Declaration of Linda Birmingham, September 18, 2008 ("Birmingham Declaration"), Mot. for Prel. Inj., Ex. C]. Birmingham also had two lower back surgeries for lumbar laminectomy with fusion, in 1988 and 1990.

***6** In June of 2008, Birmingham received a notice from DHS indicating that she was no longer eligible for Medicaid because the court had removed her son from her home. Birmingham claims that her Medicaid was terminated despite indicating that she was disabled in her 2007 Medicaid application. Birmingham further avers that after seeking information about receiving Medicaid and cash assistance based on her disability, the case worker responded that "she didn't know what [Birmingham] was talking about and [she] could not get Medicaid or cash assistance now that [her] son [was] not living with [her]." [Birmingham Declaration]. Birmingham states that it has been much more difficult to get her necessary health care under the GHP–B, and that she had to stop seeing her usual doctor. Birmingham further alleges that she now is unable to afford all of her prescription medication because of the increased co-payment rates.

The Defendants contend that Ms. Birmingham applied for disability related Medicaid on July 23, 2008. This application was denied by the Medical Review Team on September 15, 2008, based on a finding that Birmingham was not disabled. [Best Affidavit].

III. STANDARD OF REVIEW

The Defendants' motion to dismiss is brought pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure which allows a defendant to move for dismissal of all or part of a complaint if it fails to state a claim upon which relief may be granted. When analyzing the sufficiency of a complaint, the Court applies the principle that a complaint must plead "enough facts to state a claim to relief that is plausible on its face."*Bell Atlantic Corp. v. Twombly*, 550 U.S. 554, 570, 127 S.Ct. 1955, 167 L.Ed.2d 929 (2007). A plaintiff is not required to provide "heightened fact pleading of specifics," but must allege facts sufficient to "raise a right to relief above the speculative level."*Id.* at 555.Additionally, all of a plaintiff's factual allegations must be taken as true in considering a motion to dismiss. *Ricco v. Potter*, 377 F.3d 599, 603 (6th Cir.2004).

In the alternative, the Defendants have also brought a motion for summary judgment under Rule 56. Summary judgment is appropriate when "the pleadings, the discovery and disclosure materials on file, and any affidavits show that there is no genuine issue as to any material fact and that the movant is entitled to judgment as a matter of law."Fed.R.Civ.P. 56(c); *Celotex Corp. v. Catrett*, 477 U.S. 317, 322–323, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986). A dispute over a material fact is not "genuine" unless a reasonable jury could return a verdict for the nonmoving party.

In reviewing a party's motion for summary judgment, all evidence must be viewed in a light most favorable to the nonmoving party, and summary judgment is appropriate whenever the nonmoving party "fails to make a showing sufficient to establish the existence of an element essential to the party's case, and on which that party will bear the burden of proof at trial."*Celotex*, 477 U.S. at 332.Ultimately, the standard for determining whether summary judgment is appropriate is "whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law."*Booker v. Brown & Williamson Tobacco Co.*, 879 F.2d 1304, 1310 (6th Cir.1989) (quoting *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 251–52, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986)).

IV. LAW & ANALYSIS

A. Class Certification

***7** Plaintiffs proffer that the instant action would best be brought as a class action suit pursuant to Fed.R.Civ.P. 23, as the proposed class meets all of the requirements under the rule. However, the Defendants contend that the Plaintiffs' proposed class does not establish numerosity, commonality, typicality, or adequacy of representation, and as such class certification is unwarranted.

The principal purpose of class actions is to achieve efficiency and economy of litigation, both with respect to the parties and the courts. *See Gen. Tel. Co. v. Falcon*, 457 U.S. 147, 159, 102 S.Ct. 2364, 72 L.Ed.2d 740 (1982). The Supreme Court has observed that, as an exception to the usual rule, litigation is conducted by and on behalf of individual named parties, "[c]lass relief is 'peculiarly appropriate' when the 'issues involved are common to the class as a whole' and when they 'turn on questions of law applicable in the same manner to each member of the class.'"*Id.* at 155 (quoting *Califano v. Yamasaki*, 442 U.S. 682, 700–701, 99 S.Ct. 2545, 61 L.Ed.2d 176 (1979)). The Supreme Court directs that, before certifying a class, district courts must conduct a "rigorous analysis" of the prerequisites of Rule 23 of the Federal Rules of Civil Procedure. *See Falcon*, 457 U.S. at 161.The Sixth Circuit has stated that district courts have broad discretion in deciding whether to certify a class, but courts must exercise that discretion within the framework of Rule 23. *Coleman v. General Motors Acceptance Corp.*, 296 F.3d 443, 446 (6th Cir.2002); *In re Am. Med. Sys., Inc.*, 75 F.3d 1069, 1079 (6th Cir.1996). Plaintiffs' proposed class must first satisfy the four threshold requirements of Rule 23(a): numerosity, commonality, typicality, and adequacy of representation. If each of these four prerequisites is established for the class, Plaintiffs must then show that the class can be maintained under one of the theories available under Rule 23(b).*Senter v. Gen. Motors Corp.*, 532 F.2d 511, 522 (6th Cir.1976). The burden of establishing all of the necessary requirements rest on the party seeking class certification. *In re Am. Med. Sys. Inc.*, 75 F.3d at 1086.

Although a court considering class certification may not inquire into the merits of the underlying claim, a class action may not be certified merely on the basis of its designation as such in the pleadings. *See Eisen v. Carlisle & Jacquelin*, 417 U.S. 156, 178, 94 S.Ct. 2140, 40 L.Ed.2d 732 (1974); *In re Am. Med. Sys., Inc.*, 75 F.3d at 1069.In evaluating whether class certification is appropriate, "it may be necessary for the court to probe behind the pleadings ...", as the issues concerning whether it is appropriate to certify a class are often "enmeshed" within the legal and factual considerations raised

by the litigation. *Falcon*, 457 U.S. at 160;*see also In re Am. Med. Sys., Inc.*, 75 F.3d at 1079; *Weathers v. Peters Realty Corp.*, 499 F.2d 1197, 1200 (6th Cir.1974).

(1) *Class Definition*

***8** The Named Plaintiffs seek an order certifying this matter to proceed as a class action, the proffered class is described as follows:

> all former, current and future Michigan Medicaid recipients with disabilities whose Medicaid eligibility was terminated within three years prior to the date of this complaint (or will be terminated in the future) because they no longer qualify for Medicaid under FIP-related eligibility categories, without first being evaluated for eligibility for Medicaid based on disability, and without being provided a pre-termination notice and opportunity for a hearing concerning their eligibility for Medicaid based on disability.

However, as a preliminary matter, the Defendants contend that the above referenced class definition is overly broad. In particular, Defendants argue that because the class definition incorporates individuals who only allege their disability, the proposed class may contain members who have not been, and will not be, harmed by the acts of the Defendants. As a result the Defendants submit that a proper class will exclude persons who have not been harmed by the challenged actions. In sum, Defendants claim that not all FIP-related Medicaid recipients who allege disabilities will be found disabled for the purposes of SSI-related Medicaid. In response, Plaintiffs argue that a determination of an applicant's disability, regardless of the outcome, has no bearing on his or her pre-termination right to continued benefits "while the state reviews and determines whether the individual is eligible under other categories."Plaintiffs further submit that all of the individuals in the proposed class have been harmed because all have been prematurely terminated from Medicaid, without pre-termination review and without notice that gives them an opportunity to be heard on the issue of disability, in violation of the law.

"In order for there to be a proper class action it is ... axiomatic that there must be a class."*Barnes v. Board of Trustees*, 369 F.Supp. 1327, 1332 (W.D.Mich.1973). Before engaging in a "rigorous analysis" of the Rule 23(a) factors, this Court must first determine that a sufficiently defined "class" exists. 7A Charles Alan Wright & Arthur R. Miller, *Federal Practice & Procedure* § 1760 (3d ed.2006)."In order to determine whether the class action is proper, the district court must determine whether a class exists and if so what it includes. Although not specifically mentioned in the rule, the definition of the class is an essential prerequisite to maintaining a class action ."*Roman v. ESB, Inc.*, 550 F.2d 1343, 1348 (4th Cir.1976). Consequently, this Court must first examine whether a precisely defined class exists and then examine whether the Named Plaintiffs are members of the proposed class. *Turner*, 2008 U.S. Dist. Lexis 2410 at *26 (citing *East Texas Motor Freight Sys. Inc. v. Rodriguez*, 431 U.S. 395, 403, 97 S.Ct. 1891, 52 L.Ed.2d 453 (1977) (discussing membership in a proposed class)).

***9** While class definitions vary depending on the particular situations of the case, important elements of defining a class include: (1) specifying a particular group that was harmed during a particular time frame, in a particular location, in a particular way; and (2) facilitating a court's ability to ascertain its membership in some objective manner. *See Crosby v. Social Sec. Admin.*, 796 F.2d 576, 580 (1st Cir.1986). The class definition is of "critical importance as it identifies the persons (1) entitled to relief, (2) bound by the judgment, and (3) entitled to notice in a Rule 23(b)(3) action."*Zapata v. IBP, Inc.*, 167 F.R.D. 147, 156 (D.Kan.1996). Where extensive factual inquiries are required to determine whether individuals are members of a proposed class, class certification is likely improper. *Snow v. Atofina Chemicals, Inc.*, 2003 U.S. Dist. Lexis 27295, 2006 WL 1008002, at *8–9 (E.D.Mich. March 31, 2003). Greater precision is required in defining a class when compensatory relief is sought, rather than injunctive or declaratory relief. *Zapata*, 167 F.R.D. at 156.

Under the present circumstances, the Court finds that Plaintiffs have advanced a sufficiently defined class for the purposes of a Rule 23(b)(2) class. Contrary to Defendants' assertions, the class appears to be limited to individuals that are harmed by a premature termination of Medicaid benefits. The Court does recognize that it includes prospective members, but only those who "will be terminated in the future."However, the inclusion of persons who may not be identifiable at present, or even the fact that class membership may change by the end of trial does not serve as an impediment to class certification. *Caroline C. ex rel. Carter*

v. Johnson, 174 F.R.D. 452, 461 (D.Neb.1996) (listing cases in which courts have certified or affirmed the certification of classes that included persons who would be subjected to unlawful policies in the future). The Court also finds that the Defendants' argument inappropriately limits the alleged harm to individuals whose FIP-related Medicaid was terminated despite being eligible for the SSI-related category; yet, the alleged harm is a termination of FIP-related Medicaid benefits, regardless of the final adjudication of disability.

The Court is also unpersuaded by the Defendants' reliance on *Baxter v. Mintner*, 378 F.Supp. 1213 (D.Mass.1974), as that court specifically noted that "[t]he plaintiff did not press for formal certification of the class, nor did she seek discovery to assist her in establishing the existence of a class."*Id.* at 1215.That court was forced to rely on stipulated facts, a single statistical reference, and mere allegations of the existence of a class. *Id.* at 1215–16.Conversely, the Named Plaintiffs in the instant action have submitted a sufficiently defined class, additional statistics, and have formally moved for class certification. This Court finds merit in the Plaintiffs' reliance on *Crippen v. Kheder*, 741 F.2d 102 (6th Cir.1984). In *Crippen*, the Sixth Circuit ruled that persons who receive benefits under the Medicaid Act are entitled to the continued receipt of Medicaid benefits pending a final determination of ineligibility. *Id.* at 107.In so ruling, the Court permitted the certification of a similar, if not more broadly defined class:

> ***10** ... any and all persons who are treated by the state as presumptively ineligible for medicaid solely because their SSI has been terminated, regardless of whether such persons receive the due process notice and opportunity for hearing.

Id. at 104.As such, this Court finds that the Plaintiffs' proffered class is well-defined and not overly broad.

(2) *Numerosity*

Rule 23(a)(1) requires that the class be "so numerous that joinder of all members is impracticable."Fed.R.Civ.P. 23(a) (1). In *Senter*, the Sixth Circuit explained that there is "no specific number below which class action relief is automatically precluded."532 F.2d at 523 n. 24 (6th Cir.1976). Likewise, there is "no automatic cut off point at which the number of plaintiffs make joinder impractical."*Bacon v. Honda of Am. Mfg., Inc.*, 370 F.3d 565, 570 (6th Cir.2004). However, the "sheer number of potential litigants in a class, especially if it is more than several hundred, can be the only factor needed to satisfy [numerosity]."*Id.*Apart from class size, other case-specific factors that courts should consider in determining whether joinder is impracticable include: judicial economy, geographical dispersion of class members, ease of identifying putative class members, and practicality with which individuals putative class members could sue on their own. *See* Alba Conte & Herbert Newberg, 1 Newberg on Class Actions § 3:6 (4th ed. 2003) ("Newberg"); *see also Cannon v. GunnAllen Fin., Inc.*, 2008 WL 4279858, 2008 U.S. Dist. Lexis 86623, at *12 (M.D.Tenn. Sept.15, 2008).

In the instant matter, Plaintiffs assert that the exact number of class members is in the exclusive control of the Defendants, but still provide the following:

> Upon information and belief, at least 5% of the individuals who are terminated from full coverage under FIP-related Medicaid categories each year are applying for SSI or Social Security disability benefits and/or have disclosed to DHS that they are disabled or unable to work. Therefore, at least 200 individuals each year are subjected to the policy and practice challenged in this case and at least 600 individuals have been subjected to the policy and practice within the past 3 years.

The Plaintiffs arrive at the above figure based upon: (1) the total number of Michigan adults who receive Medicaid based upon FIP-related eligibility categories; (2) an approximate number of individuals who are on FIP-related Medicaid who are also in the process of qualifying for a disability through the Social Security Administration; (3) an approximate number of individuals who are terminated from various FIP-related Medicaid categories because they no longer have dependent children, or no longer qualify as a child or young adult; (4) an approximate number of individuals who are terminated from various FIP-related Medicaid categories because they are no longer financially eligible under FIP-related methodologies. [5] The Plaintiffs further argue that the numerosity requirement has been met based upon other factors such as the fluidity, geographic diversity, and the financial inability of the class members to bring individual claims.

***11** The Defendants contend that the Plaintiffs' class is unable to establish numerosity by relying on speculative data. The Defendants also rely on *Hill v. Heckler*, 592 F.Supp. 1198 (W.D.Okla.1984) to demonstrate that a similar numerosity rationale had been rejected by that court. The Defendants also provide their own statistical data in order to establish that Plaintiffs' proffered class is "statistically unlikely" to establish a medical disability for purposes of SSI-related Medicaid benefits. This Court is unpersuaded by the Defendants' arguments. The Court first notes that the Defendants' reliance on *Hill v. Heckler* is misplaced, as it again rests on the assumption that the proffered harm is the wrongful termination of Medicaid benefits when an applicant would properly qualify as disabled, instead of the termination of Medicaid benefits prior to a determination that the applicant would have qualified under a disability-based Medicaid benefits. Moreover, the Defendants' Response provides further statistical data that in itself appears to establish the element of numerosity.

On balance, the Plaintiffs are correct in that a conservative reading of statistics, combined with other realties, demonstrate that joinder would be impracticable. After combining both parties' statistical data, the Plaintiffs submit the following figures:

> (1) the MRT would decide that 50 of the 200 recipients (25%) claiming disability, are in fact disabled, and thus were entitled to Medicaid even under the Defendants' analysis of the law.
>
> (2) the MRT would decide that 100 of the 200 recipients claiming disability are not entitled to disability-based Medicaid; but those recipients nevertheless would be entitled to continued Medicaid while the review was being conducted and they would be entitled to a pre-termination notice and opportunity to be heard before the termination based on lack of disability went into effect.

The proffered class is also composed of individuals across the state of Michigan, as the challenged policy is a statewide policy. Another factor in favor of numerosity is the practicality by which putative class members could sue on their own, under the instant circumstances most of the class members have little to no income, which most likely makes it difficult to sue on their own. Consequently, this Court finds that the element of numerosity has been met, as "the class is so numerous that joinder of all members is impracticable."

(3) *Commonality*

In order to establish commonality, the Plaintiffs must demonstrate that "there are questions of law or fact common to the class."Fed.R.Civ.P. 23(a)(2). The Sixth Circuit has characterized the commonality requirement as "qualitative rather than quantitative" and has observed that "[v]ariations in the circumstances of class members are acceptable, as long as they have at least one issue in common."*See In re Am. Med. Sys., Inc.*, 75 F.3d at 1080; *Bacon*, 370 F.3d a 570. This common issue must be one "the resolution of which will advance the litigation."*See Sprague v. Gen. Motors Corp.*, 133 F.3d 388, 397 (6th Cir.1998).

***12** Plaintiffs assert that there are two questions of law that are common to the class:

> (1) Whether the Defendants' termination of full coverage Medicaid without a review of the class members' eligibility based on disabilities violates their rights under the federal Medicaid statute, 42 U.S.C. 1396a(8) and (10) as implemented by C.F.R. 435.916(c) and .930(b); and
>
> (2) whether the Defendants' termination of Medicaid without providing pre-termination notice and opportunity to be heard regarding disability-based eligibility violates class members' rights under the due process clause of the Fourteenth Amendment to the Constitution, the federal Medicaid statute, 42 U.S.C. 1396(a) (3), and implementing regulations, laws implementing that provision, and 42 C.F.R. 431.2

The Defendants again surmise that to fit within the Plaintiffs' proffered class would "require a separate adjudication of disability" as to each class member. [Resp. to Mot. to Certify Class, p. 6]. Defendants further argue that the potential factual distinctions between the proffered class members "are more varied and disparate than is appropriate to the class action device."[*Id.*, p. 8]. This Court finds Defendants' reasoning unpersuasive.

The Defendants continue to insist that the class definition proposed by Plaintiffs requires an adjudication as to whether a putative member would qualify for disability under 20 C.F.R. § 416.920(a)(4)(i)-(4)(v) (setting forth a five step determination of disability for purposes of the Social Security Administration). While not yet addressing the merits of this argument, the Court finds that the Plaintiffs are not advancing the *legal* definition of disability for the purposes of class certification. Under the Plaintiffs' proposed class definition,

no adjudication as to legal disability is required; instead, Plaintiffs seek to represent a group of recipients "who have indicated or 'claimed' that they have a disability that prevents them from working."[Reply to Resp. to Certify Class, p. 3]. As such, Defendants' arguments regarding separate adjudications for each class member are inapposite. The Court also notes that the Defendants' cited factual variations between the class members will not affect the Court's resolution of the proposed legal question. Accordingly, this Court finds that the proposed legal questions are common to the class for purposes of Rule 23(a)(2).

(4) ***Typicality***

Rule 23(a)(3) requires that "claims or defenses of the representative parties are typical of claims or defenses of the class."Fed.R.Civ.P. 23(a)(3).Rule 23(a)(4)'s typicality requirement ensures that the representative party adequately protects the interests of the proposed class. *See*Newberg § 3:13 ("Typicality determines whether a sufficient relationship exists between the injury to the named plaintiff and the conduct affecting the class, so that the court may properly attribute a collective nature to the challenged conduct."). The Sixth Circuit has similarly concluded a proposed class representative's claim is typical if "it arises from the same event or practice or course of conduct that gives rise to the claims of other class members, and if his or her claims are based on the same legal theory."*In re Am. Med. Sys. Inc.*, 75 F.3d at 1082.Consequently, in situations where typicality is found, "the representative's interests will be aligned with those of the represented group, and in pursuing his own claims, the named plaintiff will also advance the interest of the class members."*Id.* In *Sprague*, the Sixth Circuit described the typicality requirement, "as goes the claim of the named plaintiff, so go the claims of the class."133 F.3d at 399.

***13** Plaintiffs submit that the position of the Named Plaintiffs is no way antagonistic to the unnamed class, as both share a common interest in "having continued Medicaid health care coverage and in having it terminated only in accordance with the protections of the federal Constitution and Medicaid laws."[Motion to Certify Class, p. 10] However, the Defendants contend that because the potential class includes so many factual variations, and complex policies and programs, the interest of one Medicaid sub-group may come into conflict with the interest of another sub-section. In support of this contention, the Defendants provide several potential distinctions: (1) the myriad of reasons eligibility may terminate; (2) certain classes of eligibility that automatically open based on the termination of a specific FIP-related sub-groups; (3) the "categorically needy" and "medically needy" group designations; (4) and a federally mandated priority that is accorded to categorically needy Medicaid recipients. The Defendants further allege that these conflicts extend to the three Named Plaintiffs as Carson and Birmingham are categorically needy, but Crawley was only medically needy. The Court finds Defendants' reasoning unpersuasive.

After examining the requested relief of the Named Plaintiffs and putative class, it appears that it arises in response to the Defendants allegedly unlawful conduct of terminating Medicaid benefits prior to a determination of disability. While the Court notes Defendants' multiple divisions and cited differences, it is unable to ascertain how these differences make the representative parties' claims atypical, or create a conflict in regards to the legal claims asserted by the Plaintiffs. In particular, it appears that both the representative parties and the proffered class members would benefit from sustained Medicaid benefits during the determination period, regardless of their particular categorization, or the priority accorded to their specific designation as either categorically needy or medically needy. Accordingly, this Court finds that the claims and defenses of the representative parties are typical of the claims and defenses of the class. *See Beattie v. CenturyTel, Inc.*, 511 F.3d 554, 561–62 (6th Cir.2007) (where the Sixth Circuit found that, despite variations in the individual circumstances of each class member, where the claims of the proposed class (1) arose from the same "allegedly deceptive" conduct and (2) were premised on the same "allegation," the alignment between the interests of the class representatives and the proposed class was sufficient for the typicality threshold to be satisfied.).

In reference to this proposed class, the requirements of typicality are satisfied. The claims of the class representatives and the claims of the proposed class arise from the same alleged unlawful termination of Medicaid benefits. Further, the claims of the Named Plaintiffs and the claims of the proposed class proceed on the basis of the same legal theory —that the Defendants' termination of the Medicaid benefits prior to a determination that the applicant is disabled, without first being evaluated for eligibility based on disability, and without first being provided a pre-termination notice and opportunity for a hearing concerning their eligibility for Medicaid based on disability—violates federal Medicaid law and the Constitution. All of the Named Plaintiffs' declarations evidence an identical harm based on this alleged unlawful conduct. Accordingly, the interest of the class representatives

and the class align and, by bringing this litigation, the class representatives will necessarily advance the interests of the absent class members. Consequently, the Plaintiffs have met their burden of establishing typicality. *See In re Am. Med. Sys. Inc.*, 75 F.3d at 1082.

(5) ***Adequate Representation***

***14** Rule 23(a)(4) requires that "the representative parties will fairly and adequately protect the interests of the class."Fed.R.Civ.P. 23(a)(4). The Rule 23(a)(4) inquiry "serves to uncover conflicts of interest between named parties and the class they seek to represent."*Beatie*, 511 F.3d at 562.To alleviate these conflict of interest concerns, the plaintiffs must show that (1) the class representatives have a common interest with the rest of the class; and (2) the class representatives will vigorously prosecute the interests of the class through qualified counsel. *Id.* at 562–63.The common interest criterion necessitates the absence of antagonism or conflict of interest between the class representatives and the other members of the class they seek to represent. *See In re Am. Med. Sys.*, 75 F.3d at 1083.The second criterion inquires into the competency of the counsel. *See id.*

As to the first criterion, the Plaintiffs argue that there is no antagonism between the class representatives and the rest of the proposed class because all of the Plaintiffs seek to prove that Defendants' alleged actions violate both federal Medicaid law and the federal Constitution. However, Defendants contend that the "sub-groups in the proposed class will potentially be at war with one another in competition for scarce medical assistance resources," as evidenced by the distinctions between the three named Plaintiffs. [Resp. to Mot. to Certify Class, p. 11]. The Defendants further allege that the subgroups differ in terms of notice. More specifically, Defendants argue that depending on the type of FIP-related benefits being received that some notice is inherent, like parents whose benefits are terminated because their child reaches the age of 18, while other terminations may be unforeseeable, like when the courts remove a child from the parent's home. As discussed in the typicality requirement, the Court is unable to ascertain how these distinctions create a conflict of interest between the representative parties and the unnamed class members. The Plaintiffs' challenge does not appear to contest the priority that Defendants accord to those designated categorically needy, but instead focuses on the termination of pre-set benefits, regardless of the amount. Nor does the Court find that there is any conflict based on notice, inherent or actual, that would place the parties in conflict.

As to the second criterion, the Plaintiffs assert that the class counsel has experience in class actions, and has provided resumes that demonstrate sufficient experience in class action suits related to Medicaid. The Defendants do not challenge the Plaintiffs on this issue. Accordingly the Plaintiffs have satisfied the requirements of Rule 23(a)(4).

Having found that the Plaintiffs have demonstrated the existence of each Rule 23(a)'s prerequisites, the Court must now determine whether the Plaintiffs' case also falls within at least one of the subcategories of Rule 23(b).*See In re Am. Med. Sys.*, 75 F.3d at 1079.

(6) ***Certification under Rule 23(b)***

***15** In addition to meeting the four requirements of Rule 23(a), a proposed class must meet at least one of the requirements of Rule 23(b). Here, the Plaintiffs suggest that the certification of their proposed class is appropriate under Rule 23(b)(2). Certification under Rule 23(b)(2) is appropriate where "the party opposing the class has acted or refused to act on grounds that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole."Fed.R.Civ.P. 23(b)(2).

The Plaintiffs assert that this case should be certified under Rule 23(b)(2) because the Defendants have exhibited an unlawful pattern and practice that applies to all of the proposed class members. The Plaintiffs further assert that Rule 23(b)(2) certification is appropriate as Plaintiffs only seek injunctive and declaratory relief, in particular that Medicaid benefits would continue for class members until the Defendants determine if class members are entitled to benefits under a disability-based category, and institute notice, and an opportunity to be heard regarding disability-based eligibility. The Defendants contend that certification under Rule 23(b)(2) is not proper because the members of the proposed class are not uniformly injured or uniformly treated.

This Court finds that the proposed class is well-suited for certification under Rule 23(b)(2). The Plaintiffs ask this Court to determine whether the Defendants' actions constitute violations of Medicaid related statutes and the Due Process clause of the Fourteenth Amendment. The putative class members request that this Court order Defendants to cease the alleged violations. Additionally, the Plaintiffs only seek declaratory and injunctive relief. Accordingly, the Court finds that Rule 23(b)(2) certification is appropriate.

B. Preliminary Injunction & Motion to Dismiss/ Summary Judgment

The decision to grant injunctive relief is within the discretion of the district court. *Golden v. Kelsey–Hayes Co.*, 73 F.3d 648, 653 (6th Cir.1996). A preliminary injunction serves to protect the status quo pending a final determination of the lawsuit. *University of Texas v. Camenisch*, 451 U.S. 390, 395, 101 S.Ct. 1830, 68 L.Ed.2d 175 (1981). In granting a preliminary injunction, a court must determine whether: (1) the plaintiff has shown a strong likelihood of success on the merits; (2) irreparable harm could result to the plaintiff if the preliminary injunction is not issued; (3) the threatened harm to the plaintiff outweighs the threatened harm that the injunction may inflict upon the defendant; and (4) the granting of the preliminary injunction will serve the public interest. *Jones v. City of Monroe*, 341 F.3d 474, 476 (6th Cir.2003). Although these four considerations are not obligatory, they are factors that must be balanced in order to weigh the claims of irreparable harm and likelihood of success on the merits by the aggrieved party. *Id.* The Sixth Circuit Court of Appeals has described the issuance of a preliminary injunction as an "extraordinary remedy" that "should be granted only if the movant carries [its] burden of proving that the circumstances clearly demand it."*Overstreet v. Lexington–Fayette Urban Co. Gov't*, 305 F.3d 566, 573 (6th Cir.2002). The Court is not required to make specific findings as to each of the factors if fewer factors are dispositive of the motion. *Jones v. City of Monroe*, 341 F.3d 474, 476 (6th Cir.2003) (citing inter alia *In re De Lorean Motor Co.*, 755 F.2d 1223, 1228 (6th Cir.1985)). As the Defendants have moved for summary dismissal, the Court will consider the pending motion under the first prong of the preliminary injunction analysis.

(1) *Likelihood of Success on the Merits*

(a) *Count I*

***16** In reference to Count I, Plaintiffs submit that federal law requires Defendants to review the Plaintiffs' eligibility for disability-based SSI-related Medicaid eligibility categories when they no longer are eligible to receive Medicaid under FIP-related eligibility categories, before terminating their Medicaid. In essence, Plaintiffs argue that federal Medicaid law prohibits the state from terminating an individual's Medicaid benefits based solely on the fact that they no longer qualify under one particular category, unless eligibility under the other categories has been ruled out as well. In support of this legal theory, Plaintiffs rely on 42 U.S.C. 1396(a)(8) and (a)(10), which provide:

> (a) (8) [A State plan for medical assistance must]—provide that all individuals wishing to make an application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals
>
> ...
>
> (a) (10)(A) [A state plan for medical assistance must—] provide for making medical assistance available, including at least the care and services listed in paragraphs (1) through(5), (17) and (21) of Section 1396(d)(a) of this title to ... all individuals [qualifying under the enumerated provisions (i)(I)-(VII)].

Plaintiffs further rely on the accompanying Department of Health and Human Services' regulation, which indicates that, "[t]he agency must—[c]ontinue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible."42 C.F.R. 435.930(b). Plaintiffs argue that Defendants' failure to adhere to the above laws, Sixth Circuit precedent upholding these provisions, and their own internal policies warrants the imposition of the requested injunctive relief. However, Defendants argue that Plaintiffs are not entitled to the relief requested as neither the regulations nor the implementing statutes on which they rely are enforceable under § 1983.

(i) Whether §§ 1396(a)(8) and (a)(10) Create Enforceable Rights in Plaintiffs

In both their Response and Motion for Summary Judgment, Defendants contend that § 1983 does not support such an action because the statutes on which the Plaintiffs rely were not intended to confer a private enforceable right of action. Defendants further contend that in the absence of a clear and unambiguous right conferred by the proffered statute, the administrative regulation is insufficient to confer a private right. However, this Court finds Defendants' reasoning unpersuasive.

Section 1983 does not create substantive rights; it merely serves as a vehicle to enforce deprivations of "rights[,] privileges, or immunities secured by the Constitution and laws [of the United States]."*Oklahoma City v. Tuttle*, 471 U.S. 808, 816, 105 S.Ct. 2427, 85 L.Ed.2d 791 (1985); *Gonzaga Univ. v. Doe*, 536 U.S. 273, 285, 122 S.Ct. 2268, 153 L.Ed.2d 309 (2002) (" § 1983 merely provides a mechanism for enforcing individual rights 'secured' elsewhere, *i.e.*, rights independently 'secured by the Constitution and laws' of the

United States"). The Supreme Court has further noted that cases like this one, regarding whether federal programs can be privately enforced, frequently arise in the context of legislation enacted pursuant to Congress's spending authority. *See Gonzaga,* 536 U.S. at 279–282.However, the Supreme Court and the Sixth Circuit have held on more than one occasion that certain provisions of the Medicaid statute can be enforced by its intended beneficiaries by actions brought pursuant to § 1983. *Wilder v. Virginia Hosp. Ass'n,* 496 U.S. 498, 508–10, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990); *Westside Mothers v. Haveman,* 289 F.3d 852, 863 (6th Cir.2002); *Markva v. Haveman,* 317 F.3d 547, 553–554 (6th Cir.2003); *Harris v. Olszewski,* 442 F.3d 456, 463 (6th Cir.2006) ("Our conclusion, moreover, comports with decisions of the Supreme Court, [Sixth Circuit Court of Appeals], and other courts of appeals that have recognized privately enforceable rights under § 1983 stemming from similar statutory language in the Medicaid Act.")

***17** In *Harris v. Olszewksi,* the Sixth Circuit held that Medicaid's freedom-of-choice provision, 42 U.S.C. § 1396a(a)(23) (A), confers a private right that may be enforced under § 1983. 442 F.3d at 459.In so holding, the Sixth Circuit further clarified the analysis required of this Court when determining if a statute and its enabling regulations confer a privately enforceable right under § 1983:

> In ascertaining 'whether Congress intended to create a federal right'... the [Supreme] Court has directed us to look at three factors ...'First, Congress must have intended that the provision in question benefit the plaintiff.'In answering this initial inquiry, courts look for a statutory right or ' *individual* entitlement' that is 'unambiguously conferred,' by the use of 'rights-creating language.' An 'aggregate focus' unconcerned 'with whether the needs of any particular person have been satisfied' is insufficient; the statute must be 'phrased in terms of the persons benefited,' and use 'individually focused terminology.' 'Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so vague and amorphous that its enforcement would strain judicial competence.''Third, the statute must unambiguously impose a binding obligation on the States. In other words, the provision giving rise to the asserted right must be couched in mandatory, rather than precatory, terms.'These three inquiries do not end the matter, however. 'Even after' a plaintiff demonstrates 'that the federal statute creates an individually enforceable right in the class of beneficiaries to which he belongs[,] ... there is only a rebuttable presumption that the right is enforceable under § 1983.''The defendant may defeat this presumption by demonstrating that Congress did not intend that remedy for a newly created right' by pointing to 'evidence of such congressional intent [that] may be found directly in the statute creating the right, or inferred from the statute's creation of a comprehensive enforcement scheme that is incompatible with individual enforcement under § 1983.'

Harris v. Olszewski, 442 F.3d at 461 (internal citations omitted).

This Court need not engage in all of the aforementioned analysis as the Sixth Circuit has already held, albeit ambiguously, that a private right of action exist under § 1983 for §§ 1396a(a)(8) and (a)(10).*See Westside Mothers v. Haverman,* 289 F.3d 852, 862–63 (6th Cir.2002) (*"Westside Mothers I"*); *Westside Mothers v. Olszewski,* 454 F.3d 532, 540 (6th Cir.2006) (*"Westside Mothers II"*). The plaintiffs in the *Westside Mothers* series of cases alleged that defendants, director of the Michigan Department of Community Health, and the deputy director of the Michigan Medical Services Administration, refused or failed to implement the Medicaid Act, its enabling regulations, and its policy requirements. *Westside Mothers I,* 289 F.3d at 855–56.However, the district court granted the defendants' motion to dismiss by holding that Medicaid was only a contract between a state and the federal government, and that it lacked jurisdiction over the suit because Michigan was the real defendant, and therefore possessed sovereign immunity against the suit. *Id.* at 857.In *Westside Mothers I,* the Sixth Circuit Court of Appeals reversed the lower court, although focusing predominately on jurisdictional grounds, the Court of Appeals also considered "whether there is a private right of action under § 1983" for the alleged noncompliance with the Medicaid Act. *Id.* at 862–863.The Sixth Circuit proceeded to broadly apply a precursor [6] of the above enumerated test, and ultimately indicated that "[p]laintiffs have a cause of action under § 1983 for alleged noncompliance with the screening and treatment provisions of the Medicaid Act", and remanded the case to the court below. *Id.* at 863.On remand, the district court granted in part and denied in part the defendants' second motion to dismiss pursuant to Rule 12(b)(6).*Westside Mothers II,* 454 F.3d at 537.

***18** Specifically, the district court reconsidered whether specific provisions of the of the Medicaid Act created enforceable rights under § 1983. *Id.* In so doing, the district court examined whether §§ 1396a(a)(8) and (a)(10) create enforceable rights in plaintiffs, in light of the then

recent *Gonzaga* ruling. *Westside Mothers v. Olszewski*, 368 F.Supp.2d 740, 757–63 (E.D.Mich.2005). With respect to the subject statutory provisions, and relying upon the Sixth Circuit's previous analysis utilizing the *Blessing* factors, and the Supreme Court's ruling in *Wilder* (regarding a similar provision of the Medicaid Act), the district court concluded that the plaintiffs may sue the defendants under 42 U.S.C. § 1983 to obtain the medical assistance for which they qualify:

> Likewise [comparing statutory language of the Medicaid provision examined in *Wilder*], § 1396a(a)(8) states that Michigan's state plan "must provide that all individuals wishing to make application for medical assistance under the plan shall have an opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals."Here, the statutory provision refers to identifiable benefits in the form of "medical assistance" and the language refers to eligible individuals, providing that the States must provide an opportunity for "all individuals wishing to make application for medical assistance."The text goes on to require State plans to furnish "medical assistance" "with reasonable promptness" to those who make application and who are eligible. Similarly, § 1396a(a)(10) requires that Michigan's plan "provide for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21) of 1396(d) (a) ... to all individuals [who qualify]."... Although this language is not the type of rights conferring language that would undoubtedly foreclose debate on this issue, it is sufficient in light of the Supreme Court's continued approval of *Wilder*.This provision of the Medicaid Act refers to an identifiable benefit of "medical assistance" and identifies individuals who qualify as the benefited class. While a different conclusion might result if this court were writing on a clean slate, *Gonzaga*'s approval of § 1396a(a)(13) in *Wilder* results in the conclusion that Plaintiffs may sue Defendants under 42 U.S.C. § 1983 to obtain the "medical assistance" for which they qualify.

Id. (internal citation omitted). After holding that an enforceable right exists under § 1983, the district court examined the scope of the enforceable rights to "medical assistance." *Id* . at 762–770.During which, the district court held that the term "medical assistance" as used in 1396a(a)(8) and (a)(10) "does not require the direct provision of medical services," but rather "financial assistance." *Id.* at 765.The district court then dismissed the plaintiffs' claims relative to these provisions as the defendants had provided financial assistance as required by the statute. *Id.*

***19** The case was again appealed to the Sixth Circuit, where the plaintiffs argued that the district court's reconsideration of whether the screening and treatment provisions of the Medicaid Act create enforceable rights under § 1983 was barred by the law of case doctrine, and the district court therefore had no power to deviate from the *Westside Mothers I* holding. *Westside Mothers II*, 454 F.3d at 539.In *Westside Mothers II*, the Sixth Circuit held that the law of the case doctrine did not foreclose the lower court from reconsidering whether a right of action under § 1983 to enforce the subject provisions. *Id.* In reviewing the district court's holding the court of appeals again examined §§ 1396a(a)(8) and 1396a(a)(10):

> The most reasonable interpretation of § 1396a(a)(8) is that all eligible individuals should have the opportunity to apply for medical assistance, i.e. financial assistance, and that such medical assistance, i.e., financial assistance, shall be provided to the individual with reasonable promptness. The most reasonable interpretation of § 1396a(a)(10) is that medical assistance, i.e., financial assistance, must be provided for at least the care and services listed in paragraphs (1) through (5), (17) and (21) of § 1396(d)(a). The regulations that implement these provisions also indicate that what is required is a prompt determination of eligibility and prompt payment to eligible individuals to enable them to obtain necessary medical services.

Id. at 540 (internal citations omitted). The appellate court then affirmed the district court's dismissal of the claim for violations of the subject provisions, but modified the judgment to a dismissal "without prejudice to the filing of a motion to amend along with a proposed amendment to the complaint."*Id.* at 541.

In light of the *Westside Mothers'* analysis of the §§ 1396a(a) (8) and 1396a(a)(10), this Court is persuaded that a private cause of action exists under § 1983. These cases, when read in concert, reject the Defendants' argument that Plaintiffs only rely on pre-*Gonzaga* authority, and appear to demonstrate that at a minimum these provisions

support a private right of action under § 1983 in regards to "medical assistance, i.e., financial assistance, and that such financial assistance will be provided to the individual with reasonable promptness" and that "medical assistance, i.e. financial assistance, must be provided for at least the care and services listed in paragraphs (1) through (5), (17) and (21) of § 1396d(a)."*Westside Mothers II*, 454 F.3d at 540.The Sixth Circuit further enunciated, "that the regulations that implement these provisions also indicate that what is required is a prompt determination of eligibility and a prompt payment to eligible individuals to enable them to obtain necessary medical services,"*Id.* (citing 42 C.F.R. §§ 435.911, and 435.930); and in a later opinion approvingly cited *Sabree v. Richman*, 367 F.3d 180, 190, 192 (3d Cir.2004), as holding that 42 U.S.C. § 1396a(a)(8)—as creating an enforceable right under § 1983. *Harris v. Olszewksi*, 442 F.3d at 463;*see also Brown v. Tennessee Dept. of Finance and Admin.*, 561 F.3d 542, 543–545 (6th Cir.2009) (wherein the Sixth Circuit recently summarized the holding of *Westside Mothers II*.). Having concluded that §§ 1396a(a)(8) and 1396a(a) (10) of the Medicaid Act create rights privately enforceable under § 1983, the Court now examines whether the supplementing regulations are equally enforceable.

(ii) Duty imposed by 42 C.F.R. §§ 435.930(b) and .916(c)

***20** As to Count I, Plaintiffs maintain that 42 C.F.R. § 435.930(b) is also individually enforceable under § 1983, as its "effectuates the express mandate of the controlling statute and provides the specifics for implementing obligations that are imposed generally by the controlling statute."[Resp. to Mot. for Summ. J., p. 10]. Plaintiffs further contend that the Sixth Circuit has interpreted this regulation as requiring state agencies to continue to provide Medicaid to an individual whose eligibility under one Medicaid category has ended, while the state determines whether the individual is eligible under the other categories. Finally, Plaintiffs submit that the Defendants' own policies support such an outcome based on specific sections of the PEM. In response, Defendants maintain that the regulations are unable to support a private right of action under § 1983, in the absence of a clear and unambiguous mandate.

"Language in a regulation may invoke a private right of action that Congress through statutory text created, but it may not create a right that Congress has not."*Alexander v. Sandoval*, 532 U.S. 275, 271, 121 S.Ct. 1511, 149 L.Ed.2d 517 (2001) ("Agencies may play the sorcerer's apprentice but not the sorcerer himself."). It is undisputed that a private plaintiff "cannot enforce a regulation through a private cause of action generally available under the controlling statute if the regulation imposes an obligation or prohibition that is not imposed generally by the controlling statute ."*Ability Ctr. v. City of Sandusky*, 385 F.3d 901, 906 (6th Cir.2004); *see e.g. Caswell v. City of Detroit Hous. Comm'n*, 418 F.3d 615, 620 (6th Cir.2005) ("Because neither we nor Caswell can point to a specific statutory provision in the Housing Act that confers a right relevant to DHC's alleged violation of 24 C.F.R. § 982.311(b), Caswell cannot pursue his claim under § 1983."). However, "[o]n the other hand, if the regulation simply effectuates the express mandates of the controlling statute, then the regulation may be enforced via the private cause of action available under the statute."*Ability Ctr.*, 385 F.3d at 906; *Harris*, 442 F.3d at 465 ("Because '[a] Congress that intends the statute to be enforced through a private cause of action intends the authoritative interpretation of the statute to be so enforced as well.").

Having concluded that §§ 1396a(a)(8) and 1396a(a)(10) impose such a private right of action, this Court must now determine whether the supplementing regulations "effectuates the express mandates of the controlling statute."This Court finds that 42 C.F .R. § 435.930(b) and .916(c) effectuate and supplement the mandate of 42 U.S.C.1936a(a)(8) and (a)(10), and are therefore enforceable through the private right of action available under § 1983. The subject regulation requires that a state medicaid agency "must ... [c]ontinue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible,"42 C.F.R. § 435 .930(b), and derives its enforcement authority directly from the controlling statute. This regulation merely supplements and defines the broad mandate of §§ 1396a(a)(8) and (a)(10)—*i.e.* to furnish medical assistance with reasonable promptness—by further defining the duration and scope of the promised medical assistance. *See Doe, 1–13 v. Chiles*, 136 F.3d 709, 717 (11th Cir.1998) (finding that § 435.930(b)"further define[s] the contours of the statutory right to reasonably prompt provision of assistance."); *Westside Mothers II*, 454 F.3d at 540 ("The regulations [including § 435.930(b)] that implement these provisions [§§ 1396a(a)(8) and (a)(10)] also indicate that what is required is a prompt determination of eligibility and a prompt payment to eligible individuals to enable them to obtain the necessary medical services."). The subject regulations —by requiring continued aid and pretermination reviews—ensure that eligible individuals are not denied prompt Medical assistance to which they are entitled. In view of the foregoing, the Court finds Defendants' opposition to the enforcement of § 435.930(b) and .916(c) unpersuasive.

(iii) Merits

***21** Having resolved Defendants' threshold challenges to the preliminary injunction, the Court now concludes that Plaintiffs have demonstrated a substantial likelihood of success on the merits of Count I. Defendants' pattern and practice of terminating Plaintiffs' Medicaid benefits without first determining whether they are eligible for Medicaid benefits under disability-based categories, violates Plaintiffs' rights under 42 U.S.C. § 1396a(a) (8) and (a)(10), and the attendant regulations. The federal Medicaid statutes require state Medicaid agencies to "provide that all individuals wishing to make application for medical assistance under the [State Medicaid] plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals."42 U.S.C. § 1396a(a)(8). As noted above, the Plaintiffs' enforceable rights under this statute incorporate the regulations that it implements, and therefore, the agency must also "[c]ontinue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible."42 C.F.R. § 435.930(b). Indeed, this supplementing regulation most certainly condemns Defendants' practice of terminating Plaintiffs' Medicaid because they no longer qualify under FIP-related eligibility, without first determining if these individuals meet any of the other categories of Medicaid eligibility. As such, the Defendants' appropriate course of conduct after determining that Plaintiffs were no longer eligible for FIP-related categories was to conduct an automatic review of other Medicaid categories, without the re-application for Medicaid assistance.

Further buttressing the above conclusion, the Court relies on the reasoning of *Crippen v. Kheder,* where (after being confronted with facts similar to those at bar) the Sixth Circuit held that persons who receive benefits under the Medicaid Act are entitled to the continued receipt of Medicaid benefits pending a final determination of ineligibility. 741 F.2d 102, 106–07 (6th Cir.1984). In that case, the plaintiff's eligibility for SSI benefits was terminated when the defendants Michigan Medicaid agencies revoked the Adult Foster Care license for the home in which she resided. *Id.* at 104.The defendant agency notified the plaintiff that her Medicaid benefits would be terminated because her SSI benefits had been terminated, and that she could seek a hearing, whereupon her benefits would continue until the hearing was held. *Id.* In lieu of requesting a hearing, plaintiff reapplied for Medicaid and filed a class action suit "seeking declaratory and injunctive relief against the Department's policy of automatically terminating individuals from medicaid solely upon receipt of information that SSI benefits have been terminated without making prior determination of the individual's eligibility as a medically needy person."*Id.* The plaintiffs' class, similar to those in the present matter, asserted that defendants' policy ran afoul of its responsibility to "continue to furnish medicaid regularly to all eligible individuals until they are found to be ineligible ..."*Id.*(citing 42 C.F.R. § 435.930(b)).

***22** After refuting the state agency's arguments, many of which are similar to those made in the present action, the *Crippen* Court held:

Where the only basis for a recipient's eligibility assistance has been eliminated it logically follows that eligibility must cease. The regulations at issue here, however, provide alternative bases for medicaid eligibility ... The most that was determined by the Department was that one of those bases for medicaid eligibility, i.e ., the receipt of SSI benefits, had been eliminated. Thus [plaintiff] was no longer eligible for medicaid as a categorically needy person. There remained the possibility, indeed, in this case the *fact*, that she was still eligible as a medically needy person. As noted earlier, the Department made no effort to determine [plaintiff's] eligibility for medicaid as a medically needy person before terminating her from the program. Thus the Department could not have found [plaintiff] to be ineligible for medicaid prior to terminating her from the program as it was required to do by 42 C.F.R. § 435.930(b).

Id. at 106.

Likewise, especially in light of the similarity of circumstances, the Court is bound to conclude that Plaintiffs' in the present case are entitled to continuing Medicaid benefits while the Defendants review the Plaintiffs' eligibility under the disability-based or SSI-related Medicaid categories. The factual scenario that confronted the *Crippen* Court is the mirror image of that facing the undersigned. In that matter, the Sixth Circuit held—based primarily on the identical regulation—that plaintiffs' class was entitled to continuing Medicaid benefits once their SSI-related benefits were terminated, until the agency determined whether they were entitled to Medicaid benefits on other grounds. In this action, the Plaintiffs are seeking continued Medicaid benefits once their FIP-related eligibility has ended, until the agency has determined that they are not entitled to Medicaid benefits under SSI or disability related categories. Toward this end, the Court similarly holds that the Defendants'

termination of the Plaintiffs' FIP-related Medicaid should trigger an automatic review of Plaintiffs' eligibility under other Medicaid categories. *Id.* at 107.("upon receipt of notice that an individual has been terminated from the SSI program, the Department must promptly determine *ex parte* the individual's eligibility for medicaid independent of his eligibility for SSI benefits. While this determination is being made, the state must continue to furnish benefits to such individuals."); *See also Massachusetts Assoc. of Older Americans,* 700 F.2d at 753 ("these regulations require the state agency, upon receipt of notification of an individual's termination from SSI, to reconsider the recipient's eligibility for Medicaid benefits. Pending this *ex parte* determination the state must continue to furnish such individuals with Medicaid benefits, and if it determines that an individual is ineligible, it must give notice and an opportunity for a hearing before termination.").

***23** Contrary to Defendants' assertions, the Court finds no persuasive reason to distinguish the holding of *Crippen.*As resolved above, Defendants' contention that the *Crippen* Court's holding is *wholly* dependent on the HHS-issued regulations is without merit. Although the *Crippen* Court did not specifically connect its holding to the statutory authority of §§ 1396a(a)(8) and 1396a(a)(10), other Sixth Circuit precedent has done so. *See, e.g. Westside Mothers II,* 454 F.3d at 540.This same authority rejects Defendants' other argument that certain *Crippen* dicta should bind this Court to conclude that no such statutory authority exists. *See Crippen,* 741 F.2d at 104 ("As the parties concede, there is no specific regulation or section of the statute which covers this particular dispute."). Defendants' arguments extend the dicta beyond its reasonable bounds. This prefatory statement does not bind the Court to conclude that § 435.930(b) should not be enforced especially when this Court's previous analysis demonstrates otherwise. Rather, this statement, when placed in the context of the overall opinion, simply illustrates that the appellate court was being called upon to interpret the statutory and regulatory law in the context of a particular fact situation that was not *explicitly* addressed by the legislature or regulatory agency. If this Court were to read this sentence as Defendants urge, it would undermine the ultimate conclusion of the *Crippen* Court, which held—based partially on § 435.930(b)—that "the Department's policy of automatically terminating the benefits of medicaid recipients solely because their SSI benefits have been terminated without determining whether they qualify as medically needy individuals *violates the regulations promulgated under the Social Security Act."Crippen,*741 F.2d at 106–07 (emphasis added).

By no means should this ruling be considered unusual or unexpected as Defendants' own internal policies and procedures bear witness to the proper course of conduct. Specifically, the Program Eligibility Manual instructs caseworkers that "[m]ost terminations of FIP or SSI benefits must include an evaluation of MA eligibility ..." [PEM 105, p. 4]. In this same vein, the PEM instructs caseworkers to "[c]onsider eligibility under all other MA-only categories before terminating benefits under a specific category."[*Id.*] The testimony of the Named Plaintiffs in this action demonstrate that the Defendants have failed to comply with not only their own internal procedures, but more importantly 42 U.S.C.1936a(a)(8) and (a)(10) and its corresponding regulations. Contrary to Defendants' arguments, the requirement of a pre-termination review is not only limited to those whose SSI or disability-related eligibility has terminated, but this duty should be afforded "to individuals who qualified for Medicaid under *any eligibility category."Massachusetts Association of Older Americans,* 700 F.2d at 753 (emphasis added); *see also Stenson v. Blum,* 476 F.Supp. 1331, 1339 (S.D.N.Y.1979)*aff'd without opinion,*628 F.2d 1345 (2d Cir.), *cert denied,*449 U.S. 885, 101 S.Ct. 239, 66 L.Ed.2d 111 (1980) ("Many of the Federal regulations relating to whether Medicaid payments should continue pending redetermination of eligibility are applicable to a recipient who previously has been eligible for Medicaid under any of the categories ..."). In view of the foregoing analysis, the Court concludes that Plaintiffs have demonstrated a substantial likelihood of success on the merits as to Count I.

(b) *Count II*

***24** In Count II, Plaintiffs claim that Defendants must provide them with a meaningful, pre-termination notice and opportunity to be heard, after the mandated review of eligibility is complete. Consistent with this request, Plaintiffs submit that after the Defendants have determined that an individual is ineligible for all categories of Medicaid, then a pre-termination notice should be sent to the recipient. This notice, Plaintiffs claim, should detail the reasons for the determination that he or she is no longer eligible for Medicaid, and include a hearing date if one was requested. Importantly, in addition to providing the legal and factual reasons why the recipient is no longer eligible for Medicaid based on the particular category for which he or she qualified in the past, recipients would also be

provided an opportunity to be heard about their eligibility for disability-based Medicaid categories. In an effort to enforce these rights under 42 U.S.C. § 1983, Plaintiffs rely on the Due Process Clause of the Fourteenth Amendment. Additionally, Plaintiffs find support under 42 U.S.C. § 1396a(a) (3) and its accompanying regulations, namely, 42 C.F.R. § 431.206–.211 (setting forth right to a hearing, and content of notice requirements), .230 (maintaining service while awaiting hearing), and 435.919 (requiring timely and adequate notice of proposed terminations, discontinuance, or suspensions of Medicaid eligibility). In response to Plaintiffs' arguments, Defendants submit that 1396a(a)(3) unambiguously applies to individuals who have both applied for Medicaid and been denied Medicaid, or applied and are still waiting for a decision. Because Plaintiffs have not applied for "disability based benefits," Defendants aver that this provision is inapplicable to them. Further, Defendants state that "unless an individual applies and/or has an application denied for disability-related Medicaid, there is no statutory entitlement to an opportunity to be heard on the matter."[Def.'s Resp. to Prel. Inj ., p. 5–6]. In their Motion to Dismiss, Defendants further argue that the framework created by the regulations, and currently being carried out by Defendants, provides greater procedural safeguards than are demanded by due process. Finally, Defendants provide that the type of notice which Plaintiffs are requesting does not fall within the scope of the enforceable rights incorporated under 1396a(a)(3).

Prior to dealing with Defendants' contentions, the Court finds it useful to detail the statutory and regulatory authority that form the basis of the Plaintiffs' requested relief. 42 U.S.C. § 1396a(a) (3) is the statutory foothold on which Plaintiff's regulatory support hinges:

A State plan for medical assistance must—

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

42 U.S.C. § 1393a(a)(3).

***25** The regulations, in pertinent part, provide:

> A notice required under § 431.206(c)(2), (c)(3), or (c)(4) of this subpart must contain—
>
> (a) A statement of what action the State ... intends to take;
>
> (b) The reasons for the intended action;
>
> (c) The specific regulations that support, or the change in Federal or State law that requires, the action;
>
> (d) An explanation of—
>
> > (1) The individual's right to request an evidentiary hearing if one is available, or a State agency hearing; or
> >
> > (2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted, and
>
> (e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

42 C.F.R. § 431.210

....

> The State or local agency must mail notice at least 10 days before the date of action ....

42 C.F.R. § 431.211.

....

> (a) If the agency mails the 10–day or 5–day notice as required under § 431.211 or § 431.214 of this subpart, and the recipient requests a hearing before the date of the action, the agency may not terminate or reduce services until a decision is rendered after the hearing unless—
>
> > (1) It is determined at the hearing that the sole issue is one of Federal or State law or policy; and
> >
> > (2) The agency promptly informs the recipient in writing that services are to be terminated or reduced pending the hearing decision.
>
> (b) If the agency's action is sustained by the hearing decision, the agency may institute recovery procedures against the applicant or recipient to recoup the cost of any services furnished the recipient, to the extent they were furnished solely by reason of this section.

42 C.F.R. § 431.230.

....

> (a) The agency must give recipients timely and adequate notice of proposed action to terminate discontinue, or suspend, their eligibility or to reduce or discontinue services they may receive under Medicaid.
>
> (b) The notice must meet the requirements of Subpart E of Part 431 of this subchapter.

42 C.F.R. § 435.919.

The dispute arising from Count II requires the Court to resolve whether the procedures employed by the Defendants are sufficient to satisfy the constitutional, statutory, and regulatory requirements of due process, specifically, sufficient notice, and the right to a pre-termination hearing.

(i) ***Statutory and Regulatory Requirements***

Defendants' primary challenge to the proposed injunctive relief is that neither § 1396a(a)(3) or its attendant regulations support the relief that Plaintiffs seek. In arriving at this conclusion, Defendants argue that the statutory and regulatory language narrows the scope of the enforceable right to individuals who have both applied for Medicaid and been denied Medicaid. Because Plaintiffs (individuals receiving Medicaid benefits based on FIP) neither applied for, or were denied, *disability-related* Medicaid, Defendants claim that these provisions do not confer "a right to a pre-termination opportunity to be heard on a matter that has neither been the subject of a Medicaid application nor a denial by Defendants."[Defs.' Mot. for Summ. J., p. 19]. In regards to Count II, the Court concludes that Plaintiffs have demonstrated a substantial likelihood of success on the merits.

***26** 42 U.S.C. § 1396a(a)(3) requires that state Medicaid plans must "provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness."As noted above, the statute's attendant regulations require the state agency to notify applicants of the right to obtain a hearing and the method of obtaining one when the applicant first applies to Medicaid, *and* when any action is taken which affects the applicant's claim. 42 C.F.R. § 431.206. The regulations also govern the specific contents of the notice, which must include: (1) a statement of the actions being taken, (2) reasons for the intended actions, (3) specific regulations that support or require the intended action, and (4) an explanation of the right to a hearing, and under what circumstances Medicaid benefits will continue during the pendency of the requested hearing. 42 C.F.R. § 431.210. This notice must, unless an exception applies, be mailed "at least 10 days before the date of action."§ 431.211. It is uncontested that Plaintiffs, as Medicaid beneficiaries, are entitled to enforce their § 1396a(a)(3) right to a "fair hearing" under § 1983. *Gean v. Hattaway*, 330 F.3d 758, 772–773.

Plaintiffs allege, and this Court agrees for the purposes of the preliminary injunction motion, that the notice Plaintiffs received was insufficient because it only detailed the reasons why they were no longer eligible for FIP-related Medicaid, which was not the "sole" basis for terminating their Medicaid. By way of example, Named Plaintiff Chande Crawley demonstrates such insufficient notice. On July 18, 2009, DHS notified Crawley that, effective 7–30–2008, her Medicaid Coverage will be cancelled; under the heading, "the reason for this action," the letter simply states "child is age 18 or 19 and has completed highschool."[7–18–2008 Notice of Case Action, Prel. Inj., Ex. A]. The reason for the termination of Medicaid benefits was restricted to the termination of FIP-related benefits, and as such, Plaintiffs were unable to dispute the factual reason given by the Defendants. In so doing, the Defendants denied Crawley, and similar situated individuals, the right to a "fair hearing" under § 1396a(a)(3). More specifically, this insufficient notice renders § 435.919's[7] requirement of "timely and *adequate notice* of proposed action to terminate, discontinue, or suspend eligibility" otiose. Such notice can hardly qualify as "adequate" because it does not include a determination of eligibility on all relevant grounds, thereby undermining any opportunity for a fair hearing. A truly fair hearing would allow Plaintiffs an opportunity to challenge the termination by proving that they are eligible for Medicaid based on disability. *Stenson v. Blum*, 476 F.Supp. at 1339.

The Court also finds that Defendants' distinction based upon the failure to apply for *disability*-based benefits unavailing. The Court sees no reason to distinguish between termination of disability-based benefits on an initial application, and the termination of FIP-based assistance. Both events implicate the denial of Medicaid benefits, and as such should necessitate notice and hearing rights under 42 U.S.C. § 1396a(a)(3). The Court is cognizant that the determination based on disability, under the usual circumstances, will require additional medical verification. However, the Defendants' obligation to conduct a pretermination review is not limited by the type of application that a recipient initially

filed. *See Crippen,* 741 F.2d at 105–06; *Massachusetts Association of Older Americans,* 700 F.2d at 752. In any event, it appears from the record before this Court that all applicants fill out the same initial DHS Assistance Application 1171 form; PEM, p. 2, on which an applicant is only required to check a box labeled "medical assistance" or "medical" and is not required to designate Medicaid eligibility categories. Fatal to Defendants' argument, there is no separate application for "disability-based Medicaid." In this same vein, Defendants' internal procedures appropriately require the trained caseworkers, and not potential Medicaid recipients, to determine eligibility:

Choice of Category

> ***27** Persons may qualify under more than one MA category. Federal law gives them the right to the most beneficial category. The most beneficial category is the one that results in eligibility or the least amount of excess income ...
>
> However, clients are not expected to know such things as:
>
> * Ine[ ]ligibility for a FIP grant does not mean MA coverage must end ...
>
> * The most beneficial category may change when a client's circumstances change.
>
> Therefore, you must consider all the MA category options in order for the client's right of choice to be meaningful.
>
> [PEM 105, p. 2., Compl., Ex. I]. Defendants' own internal policies usually place on the caseworkers the burden of requesting the information or documents that are needed to determine whether a particular eligibility criterion has been met. PAM 115, p. 12; PAM 130, p. 1. As such, Plaintiffs have demonstrated a substantial likelihood of success on the merits as it relates to Count II.

(ii) ***Constitutional Requirements***

In view of the foregoing analysis, the Court quickly dispenses with the parties' due process contentions having resolved the matter on statutory grounds. *Boatman v. Hammons,* 164 F.3d 286, 289 (6th Cir.1998) ("Plaintiffs also assert that Medicaid recipients are entitled to written notice under the Due Process Clause of the Fourteenth Amendment ... Since we have resolved this issue on plaintiffs' statutory claim, we need not address the constitutional question.").

(2) ***Irreparable Harm to the Plaintiff***

The plight of Chande Crawley, Penny Carson, Linda Birmingham and other similarly situated individuals unequivocally demonstrate the irreparable harm that will ensue if a preliminary injunction is not issued in this matter. "By hypothesis, a welfare recipient is destitute, without funds or assets. [ ] Suffice it to say that to cut off a welfare recipient in the face of [ ] 'brutal need' without a prior hearing of some sort is unconscionable, unless overwhelming considerations justify it."*Goldberg v. Kelly,* 397 U.S. 254, 261, 90 S.Ct. 1011, 25 L.Ed.2d 287 (1970). Echoing the Supreme Court, this Court does not question the sufficiency of the hearings procedure on constitutional grounds, but stresses the vital necessity that Medicaid programs provide, and that a "controversy over eligibility may deprive an eligible recipient of the very means by which to live while he waits."*Id.* at 264.Toward this end, "[f]or qualified recipients, welfare provides the means to obtain essential food, clothing, housing, and *medical care."Id.* (emphasis added).

The Named Plaintiffs in this action will undoubtedly—if not already—suffer irreparable harm because they are receiving or will receive medical benefits that are far below those provided under Medicaid, to which they are entitled. In the case of some Plaintiffs, who have serious medical disabilities, a lapse in Medicaid benefits could result in permanent injury or even death. As most clearly demonstrated in the lives of the Named Plaintiffs, the unwarranted lapse in Medicaid coverage has lead to severe restrictions in medically necessary healthcare which they otherwise are unable to afford. *See Markva v. Haveman,* 168 F.Supp.2d 695, 718–719 (E.D.Mich.2001), *aff'd*317 F.3d 547 (6th Cir.2003) (citing cases where "Other courts have held that delay or denial of Medicaid benefits can amount to irreparable harm."); *Massachusetts Association of Older Americans,* 700 F.2d at 753 ("Plaintiffs presented affidavits of several class members who, since termination, have been financially unable to obtain necessary medical treatment. Termination of benefits that causes individuals to forgo such necessary medical care is clearly irreparable injury.").

***28** While the Defendants concede that a denial of benefits may rise to the level of irreparable harm, they contest that the instant facts do not demonstrate such an injury. In their view, Plaintiffs' harm is self-imposed because Plaintiffs did not take advantage of the appeal process which would have extended

their benefits for the duration of the appeal. Similarly, Defendants aver that the instant claims are redressable pursuant to their policy of retroactive coverage from the date when the disabled individual applied for disability-based benefits. However, the previous portions of this order refute these contentions. To begin, Plaintiffs cannot be expected to take full advantage of an appeals process where the commencing notice only covers a single basis for Medicaid ineligibility. As such, the Plaintiffs were unaware that they could even bring evidence demonstrating that they qualified for Medicaid under the disability-based benefits. Nor is the Court persuaded by Defendants' reliance on a retroactive coverage policy. In effect, what Defendant argues, and the record substantiates, is a system where once an individual's FIP-based benefits end, he or she is encouraged to reapply (in most cases using an identical form) with an emphasis on their disability. Yet this system subverts the purpose of a *pre-termination* review, which is to prevent unwarranted lapses in Medicaid coverage.

The heart of the irreparable injury analysis requires "the party seeking injunctive relief ... [to] show that there is no other adequate remedy at law."*U.S. v. Miami University*, 294 F.3d 797, 816 (6th Cir.2002). Here, it is undeniable that the unpaid bills, loss of needed medical assistance, and ultimately poor health suffered by Plaintiffs, cannot be adequately addressed by the promise of future Medicaid coverage. In this same vein, the state's Eleventh Amendment Immunity bars any award of monetary damages against the Defendants. *Markva*, 168 F.Supp.2d 719 ("There is no adequate remedy at law for individuals suing a state in federal court because the Eleventh Amendment bars the award of damages.").

(3) *Threat of Harm to Plaintiffs Outweighs Threat of Harm to the Defendants/Third Parties*

This third consideration also weighs in favor of the Plaintiffs. Generally speaking, the relief sought requires Defendants to provide Medicaid to Plaintiffs while Defendants determine eligibility for SSI-related categories. This Court would be remiss not to acknowledge that the requested relief would have some impact on the state budget; however, principles of equity and due process are not without their cost. And in this instance, the balance of the harms weighs in favor of issuing a preliminary injunction.

The challenge to the relief requested rest primarily on administrative delays and costs that Defendants forecast as a result of the requested injunctive relief. Particularly, Defendants predict that the injunctive relief will require extended/unwarranted coverage of individuals who are not in fact disabled, while their eligibility is being determined. Similarly, Defendants posit that many applicants will disingenuously claim disability and needlessly prolong the determination period to extend their benefits by not providing verifying medical data. This in turn will have the effect of increasing delays and depriving resources from applicants who in reality are qualify for SSI-related Medicaid benefits. All of which, Defendants estimate, will cost an additional $1.4 to $1.7 million each month. [8]

***29** While the problem of additional expense must be kept in mind, it does not justify denying Plaintiffs a right to meaningful notice and the continued receipt of Medicaid benefits to which they are entitled pending a final determination of disability-based eligibility. *Massachusetts Association of Older Americans*, 700 F.2d at 754 ("Defendant's claimed injury from the loss of public funds to ineligible individuals is, in reality, no injury at all, just a remote possibility of injury. Thus the harm to plaintiffs far outweighs that of defendant and preliminary injunction must issue."). Many of the purported harms that Defendants assert are well-within their power to remedy. To start, Defendants exert substantial control over the length of time benefits might be continued pending a review of disability eligibility. The Defendants' existing policy and concession of the Plaintiffs, both provide that Medicaid can be terminated if an individual has not cooperated in responding to a request for additional information within a reasonable time. DHS PAM 130, p. 4 (Allowing the applicant 10 calender days to provide verifying information, if neither the caseworker or applicant does so —with the possibility of at least one to three extensions— the benefits may be terminated or denied.). Also mitigating Defendants' concern are the federal regulations which require the Medicaid agency to conduct a review of eligibility when a change in a recipient's circumstances is anticipated. 42 C.F .R. § 435.916(c). Consequently, Defendants should begin to review the Medicaid recipient's file to determine their eligibility, and if needed request additional verification, in advance of the date that the recipient's eligibility under their current Medicaid category is expected to end. Further, many of the Defendants' financial projections rest upon an apparent inflation of the relief requested. The requested relief is not applicable to *all* individuals terminated from FIP-related categories (approximately 4,000), but rather only those who have indicated or demonstrated a claim of disability (approximately 200). Accordingly, the Court finds that the threatened harm to the Plaintiffs outweighs the threatened

harm that the injunction may inflict upon the Defendants or third parties.

(4) *Public Interest*

On this final consideration, the Court finds that the public interest is served by the issuing of a preliminary injunction. It is evident that the public interest would be served if individuals who were rightfully entitled to Medicaid benefits actually received those benefits without unwarranted interruption or unnecessary delay. It logically follows—based on this above analysis—that the public interest is best served when the state agency endowed with the duty of dispensing Medicaid benefits to deserving individuals is in compliance with the federal Medicaid statutes and their attendant regulations.

Weighing the factors set forth above, the Court concludes that Plaintiffs are entitled to a preliminary injunction.

V. CONCLUSION

***30** Accordingly,

IT IS ORDERED that Plaintiffs' Motion to Certify a Class **[Docket No. 5, filed Sept. 19, 2008]** is **GRANTED**

IT IS FURTHER ORDERED that Defendants' Motion to Dismiss and/or Summary Judgment **[Docket No. 15, filed Oct. 16, 2008]** is **DENIED.**

IT IS FURTHER ORDERED that Plaintiffs' Motion for Preliminary Injunction **[Docket No. 6, filed Sept. 19, 2008]** is **GRANTED.**

IT IS DECLARED:

(A) Defendants are preliminarily enjoined from violating Plaintiffs' and similarly situated individuals rights under 42 U.S.C. § 1396a(a)(8) and (a)(10)(A) as interpreted and implemented by 42 C.F.R. § 435.930(b), and federal Medicaid law, 42 U.S.C. § 1396a(a)(3), as implemented by 42 C.F.R. § 431.206–.211;

(B) Defendants are preliminarily enjoined from failing to continue Medicaid to each of the Named Plaintiffs and similarly situated class members, unless and until they have reviewed and ruled out the Plaintiff's eligibility for Medicaid under all eligibility categories, including disability related categories, and specifically require that before terminating Medicaid eligibility the Defendants must:

(1) Conduct an individual *ex parte* review of each Named Plaintiff's, and similarly situated class member's DHS case file and information available electronically from the Social Security Administration to determine whether there is information indicating that they have a medical condition or disability that prevents them from working—including information that they are applying for or pursuing SSI or Social Security disability benefits,

(2) If their continued eligibility is not verified by the *ex parte* review, identify and request additional information that may be needed to evaluate eligibility under other Medicaid categories, including disability-based categories, and then,

(3) Take action to initiate termination of the individual's Medicaid only if the individual has not cooperated in responding to Defendants' request to the individual for additional information within a reasonable time, or if the information available to Defendants following their efforts to obtain all necessary information establishes that the Named Plaintiff or class member is not eligible for Medicaid under any of the Michigan Medicaid eligibility categories, including disability based categories.

(C) Defendants are preliminarily enjoined from initiating termination of Medicaid to the Named Plaintiffs and class members without first providing them with a meaningful pre-termination notice and opportunity to be heard regarding the proposed termination of their Medicaid, including written notice that:

(1) details the factual reasons why their eligibility ended under the category for which they previously had been eligible and the policy items under which the eligibility criteria they did not meet are spelled out;

(2) details the factual reasons why they are not eligible under other relevant eligibility categories, including disability-based categories, and the policy items under which the eligibility criteria they failed to meet are spelled out;

***31** (3) an explanation of their right to a pre-termination hearing if DHS receives their original hearing request before the date that their Medicaid will in fact end.

IT IS FURTHER ORDERED that Proposed Intervenor Brittany Lockert's Motion to Intervene as Plaintiff and Class Representative **[Docket No. 24, filed May 7, 2009]** is **GRANTED.**

IT IS FURTHER ORDERED that Proposed Intervenor's Motion for *Ex Parte* Temporary Restraining Order and Preliminary Injunction **[Docket No. 25, filed May 7, 2009]** is **MOOT.**

Parallel Citations

Med & Med GD (CCH) P 302,949

Footnotes

1 The Sixth Circuit Court of Appeals has explained that "a proposed intervenor must establish four factors before being entitled to intervene: (1) the motion to intervene is timely; (2) the proposed intervenor has a substantial legal interest in the subject matter of the case; (3) the proposed intervenor's ability to protect their interest must be impaired in the absence of intervention; and (4) the parties already before the court cannot adequately protect the proposed intervenor's interest."*Coalition to Defendant Affirmative Action v. Granholm,* 501 F.3d 775, 779 (6th Cir.2007). Lockert's claim falls squarely within the ambit of Fed.R.Civ.P. 24, which itself must be "broadly construed in favor of potential intervenors."*Id.*

2 All of the above named manuals are available on the Department of Human Services website, Policy and Procedure Manuals, http://www.michigan.gov/dhs-manuals (last updated Nov. 1, 2008).

3 Defendants follow the same disability eligibility determination regulations as promulgated by the Social Security Administration. 20 C.F.R. § 416.920(a)(4)(i)(4)(v) provides the five step inquiry required to determine if an applicant is disabled.

4 AFDC stands for Aid to Families with Dependent Children (the name of the cash assistance program under Title IV–A of the Social Security Act prior to the passage of the Temporary Assistance for Needy Families block grant program on July 16, 1996).

5 Plaintiffs submit that the above approximations were derived from the DHS report on Medical Assistance (MA) Closures from Jan. 2007 through August 2007.

6 The analysis employed by the Sixth Circuit relied on the framework set forth in *Blessing v. Freestone,* 520 U.S. 329, 117 S.Ct. 1353, 137 L.Ed.2d 569 (1997), which was the predominate analysis prior the analysis announced by the Supreme Court in *Gonzaga. Westside Mothers I* was decided using the *Blessing* framework. *Blessing* espoused a similar three part analysis to determine whether a statute creates a right privately enforceable under § 1983:(1) the statutory section must show an intent "to benefit the putative plaintiff;" (2) the statute must set a "binding obligation on a government unit, as opposed to "merely expressing a congressional preference;" and (3) the interest asserted by a plaintiff must not be so "vague and amorphous" that enforcement of the statute "would strain judicial competence." The Sixth Circuit "has recognized that the *Gonzaga* decision has altered the landscape of § 1983 claims. The courts of this circuit have continued to apply the three-factor *Blessing* test, albeit acknowledging that *Gonzaga* clarified application of the first 'benefit' factor and underscored that the central focus of this factor should be on whether the statutory provision contains 'rights-creating' language critical to showing the requisite congressional intent to create new rights. *Johnson v. City of Detroit,* 446 F.3d 614, 621 (6th Cir.2006).

7 Defendants correctly point out that § 1396a(a)(3) is not among the list of sections of the Act implemented by 42 C.F.R. § 435.919. *See*42 C.F.R. § 435.3. However, the Court notes that § 435.919(b) does expressly refer back to Subpart E of Part 431 (regarding the notice requirements), which does implement the sections of the Act dealing with an opportunity for a fear hearing. *See*42 C.F.R. § 431.200.

8 These projected calculations appear to rest on the assumption that *all individuals* terminated from FIP-related categories (approximately 4,000), will "allege disability to continue their Medicaid coverages pending a determination on the disability claim."[Affidavit of Neil Oppenheimer, Defs.' Resp. to Prel. Inj., Ex. 3].

1993 WL 232338
United States District Court, W.D. New York.

Louis RALABATE, Joseph Ralabate, Doris Benton and Charles Wooten, by his next friend Marguerite Wooten on behalf of themselves and all others similarly situated, Plaintiffs,
v.
Mary Jo BANE, in her capacity as the Commissioner of the New York State Department of Social Services, and Karen Schimke, in her capacity as the Commissioner of the Erie County Department of Social Services, Defendants.

No. 93–CV–0035E(H). | June 22, 1993.

Attorneys and Law Firms

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Mark R. Walling, Asst. Atty. Gen., Buffalo, NY, for Mary Jo Bane.

Richard N. Ippolito, Buffalo, NY, for Karen Schimke.

MEMORANDUM and ORDER

ELFVIN, District Judge.

***1** Defendant Bane moves pursuant to Fed.R.Civ.P. rule 19 for an order directing the plaintiffs to join the Secretary of the United States Department of Health and Human Services ("HHS") and dismissing the action if they fail to do so. She argues that the plaintiffs' challenge to her policies that are included in the state Medicaid Plan is, in effect, a challenge to HHS's approval of such plan, that the relief sought by the plaintiffs is directly contrary to such plan and to the federal Medicaid laws and regulations and therefore complete relief cannot be granted without HHS being joined and that the failure to join HHS would subject her to inconsistent obligations if this Court were to find in favor of the plaintiffs.

The plaintiffs respond that HHS is not needed for a just adjudication because they are not challenging federal Medicaid or Medicare laws or the regulations promulgated pursuant to such but are challenging Bane's practices as being inconsistent with such.

As this Court reads the Amended Complaint, the plaintiffs are alleging that Bane's method for paying for custom wheelchairs for recipients of both Medicare and Medicaid ("dual-eligible recipients") violates various provisions of the federal and state Medicaid laws and regulations and the state Medicaid Plan. If the plaintiffs challenge Bane's compliance with such laws and not the validity of such laws, there is no need to make HHS a party to the action. If Bane's policies are mandated by such laws and regulations, the plaintiffs will not be entitled to relief. If Bane's policies violate such laws or regulations, relief can be granted by ordering compliance therewith.

If, as the litigation develops, the plaintiffs seek to challenge the constitutionality of any federal Medicaid law or the validity of any regulation, joinder of HHS might be necessary and a renewal of the present motion can be had to determine such.

Accordingly, it is hereby *ORDERED* that the defendant's motion to compel the plaintiffs to add the Secretary of the United States Department of Health and Human Services is denied without prejudice.

Parallel Citations

Med & Med GD (CCH) P 41,778