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*,**	**Civil Action No. 3:14-CV-01492**
v.	**Judge William L. Campbell, Jr.** **Magistrate Judge Newbern**
WENDY LONG, *et al*.,	
***Defendants*.**	

DEFENDANTS' PROPOSED FINDINGS OF FACT

HERBERT H. SLATERY III
Attorney General and Reporter

Linda A. Ross (TN BPR 4161)
Senior Deputy Attorney General
Carolyn E. Reed (TN BPR 22248)
Special Counsel
OFFICE OF TENNESSEE ATTORNEY GENERAL
P.O. Box 20207
Nashville, Tennessee 37202
Phone: (615) 532-9632
Fax: (615) 532-1120

Michael W. Kirk
Nicole Jo Moss
Nicole Frazer Reaves

COOPER & KIRK, PLLC
1523 New Hampshire Avenue, N.W.
Washington, D.C. 20036
Phone: (202) 220-9600
Fax: (202) 220-9601

Counsel for Defendants

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Pursuant to this Court's Order (Oct. 11, 2018), Doc. 251, Defendants respectfully submit these proposed findings of fact in opposition to Plaintiffs' request for declaratory and permanent injunctive relief, *see* Complaint for Declaratory and Injunctive Relief (July 23, 2014), Doc. 1 ("Compl."); Plaintiffs' Proposed Declaratory and Injunctive Relief (Oct. 29, 2018), Doc. 255, and in support of their request that the Court vacate all outstanding injunctive relief and dismiss this case with prejudice, *see* Defendants' Pretrial Brief at 15 (Oct. 3, 2018), Doc. 249 at 15.

I. Procedural History.

1. Plaintiffs filed the instant suit on July 23, 2014, during the initial months following the effective date of the Affordable Care Act ("ACA"). *See* Compl.; *see also* Agreed Factual and Evidentiary Stipulations at 4, No. 13 (Sept. 17, 2018), Doc. 244 ("Agreed Stipulations"); *see infra* ¶ 16.

2. On September 2, 2014, the Court certified the following class: "All individuals who have applied for Medicaid (TennCare) on or after October 1, 2013, who have not received a final eligibility determination in 45 days (or in the case of disability applicants, 90 days), and who have not been given the opportunity for a 'fair hearing' by the State Defendants after these time periods have run." Class Certification Order (Sept. 2, 2014), Doc. 90.

3. On September 2, 2014, the Court also issued a preliminary injunction. Preliminary Injunction Order (Sept. 2, 2018), Doc. 91 ("PI Order"); *see* Agreed Stipulations at 4, No. 14.

a. The preliminary injunction directed the State "to provide the Plaintiff Class with an opportunity for a fair hearing on any delayed adjudication." PI Order at 8 (footnote omitted); *see* Agreed Stipulations at 4, No. 14.

b. Under the terms of the injunction, the State must hold a hearing on a delayed adjudication within 45 days (or 90 days, for applications based on disability) after a class member

requests a hearing and provides proof of having filed a delayed TennCare application. PI Order at 8–9; *see* Agreed Stipulations at 4, No. 14.

c. In certifying the class, the Court explained that the delayed adjudication hearings are "for the purpose of determining the cause of the delay, not to appeal a denial of a claim." Class Certification Order at 4.

4. On May 23, 2016, a divided Sixth Circuit panel upheld the Court's grant of a preliminary injunction, citing the "deferential" standard by which a court of appeals reviews a district court's grant of a preliminary injunction. *Wilson v. Gordon*, 822 F.3d 934, 952 (6th Cir. 2016) ("We review the overall determination of whether a preliminary injunction is warranted . . . for an abuse of discretion.").

5. On October 9 and October 10, 2018, this Court held a bench trial. *See* Transcript of Proceedings Volume I (Nov. 9, 2018), Doc. 256 ("Day 1 Trial Tr."); Transcript of Proceedings Volume II (Nov. 9, 2018), Doc. 257 ("Day 2 Trial Tr.").

II. The Enactment of the ACA Dramatically Changed Medicaid Eligibility Processing.

6. The Centers for Medicare and Medicaid Services ("CMS") is part of the federal government's Department of Health and Human Services. Day 1 Trial Tr. at 142:23–143:1 (Long).

7. Medicaid is a program that provides health insurance coverage to low-income individuals within certain categories. It is operated as a joint venture between the federal government and state governments, but it is administered on a day-to-day basis by the states. Day 1 Trial Tr. at 189:12–17 (Long); *see* Agreed Stipulations at 1, No. 1.

8. The basic rules regarding eligibility are set by the Medicaid statute and CMS regulations. Day 1 Trial Tr. at 189:20–23 (Long).

9. Medicaid is jointly funded by the states and the federal government. For the majority of expenses, the federal government contributes 65 percent of the funding for Tennessee's Medicaid program, and the State contributes 35 percent. Day 1 Trial Tr. at 189:17–19 (Long).

10. Tennessee has participated in Medicaid since shortly after the program's inception in the 1960s, and currently, with CMS approval, operates a Medicaid program called TennCare. Agreed Stipulations at 1, No. 2; *see* Day 1 Trial Tr. at 142:19–22 (Long).

11. CMS is the primary federal agency that the State interacts with in administering TennCare. Day 1 Trial Tr. at 143:2–4 (Long).

A. Before the ACA Was Enacted, TennCare Applications Were Processed Solely In-State.

12. Prior to the enactment of the ACA, the federal government had no involvement in assessing eligibility for Medicaid. And prior to the enactment of the ACA, an individual could apply for Medicaid only by applying with the state in which he lived; there was no federal avenue for applying for Medicaid. Day 1 Trial Tr. at 194:16–22 (Long).

13. Prior to the enactment of the ACA, there was great variation among the states in the methodology for determining whether an individual met the income requirements for Medicaid. For example, different states might consider different sorts of income or count family sizes differently. Day 1 Trial Tr. at 193:4–9 (Long).

14. Prior to the enactment and subsequent implementation of the ACA, the State of Tennessee ran all applications for TennCare through a computer system called ACCENT. ACCENT is a 1990s-era mainframe computer system that supported an application process that required large numbers of staff to operate. Day 1 Trial Tr. at 191:14–17 (Long).

15. Prior to the implementation of the ACA, TennCare applicants would apply at an office of the Tennessee Department of Human Services, which has at least one office in each

county in Tennessee. The applicant would bring the documents needed to verify their income, residency, citizenship, and other facts bearing on eligibility for Medicaid. Once all of the necessary documentation was provided, an employee of the Department of Human Services would enter this information into the ACCENT computer system, and if the person had provided the correct documents, the program would determine whether or not that person was eligible for TennCare. Day 1 Trial Tr. at 191:10–25 (Long).

B. **The ACA Subjected TennCare to a New Set of Requirements and Processes.**

16. Congress passed the ACA in 2010, although most of the provisions pertinent to this case became effective January 1, 2014. Day 1 Trial Tr. at 203:24–204:1 (Long); *see also* Agreed Stipulations at 2, No. 5.

17. The ACA established the federal insurance exchange (also called the "Federally Facilitated Marketplace" or "FFM"). Agreed Stipulations at 2, No. 5.

18. Any time that an individual comes to the FFM to purchase insurance, the FFM automatically evaluates whether the individual is eligible for Medicaid, the Children's Health Insurance Program ("CHIP"), and tax subsidies. Day 1 Trial Tr. at 195:1–24 (Long); *see* Agreed Stipulations at 2, No. 7.

19. The ACA attempted to standardize across all states the methodology for determining whether an individual met the income requirements for Medicaid. The ACA did so by mandating a new methodology for calculating income called the modified adjusted gross income ("MAGI") methodology. MAGI is used to calculate income eligibility for Medicaid for certain categories of individuals, such as children, pregnant women, and parents of dependent children. Such groups are referred to as "MAGI categories." Day 1 Trial Tr. at 146:7–20 (Long); *id.* at 193:9–14 (Long); *see* Agreed Stipulations at 2, No. 8.

20. Approximately 80 percent of TennCare's total enrollment is eligible in a MAGI category. Day 1 Trial Tr. at 146:21–23 (Long); *see* Agreed Stipulations at 2, No. 8.

21. The remaining 20 percent of enrollees are eligible in non-MAGI categories of Medicaid—which means that eligibility for them does not require a MAGI determination. Day 1 Trial Tr. at 146:24–147:6 (Long); *see* Agreed Stipulations at 2, No. 11.

22. Whether an individual applies to a state or the FFM, the applicant must first be screened for MAGI categories. If the individual is not eligible for coverage in a MAGI category but has included information in her application that indicates that she may be eligible for non-MAGI categories or has requested a full Medicaid determination, the State will then determine eligibility in the non-MAGI categories. Day 1 Trial Tr. at 153:8–154:1 (Long); *see* Agreed Stipulations at 2–3, No. 11.

23. The ACA created a data hub that aggregated information from a variety of federal sources, such as the Social Security Administration, the Internal Revenue Service, and Department of Homeland Security. The ACA created the data hub to allow states and the federal government to run checks against this data when processing an application online, in order to verify in real time whether the information on an application matches the information on the data hub. Day 1 Trial Tr. at 193:19–194:2 (Long); *see also* 42 U.S.C. § 18083(c); 42 C.F.R. § 435.949.

24. Another one of the changes that the ACA mandated was the use of a streamlined application that would allow applicants to be considered for multiple programs, such as Medicaid, CHIP, state-level programs, and premium tax credits, by filing a single application. Day 1 Trial Tr. at 144:18–23 (Long); *see* Agreed Stipulations at 2, No. 6.

25. The ACA also mandated a "no-wrong-door" approach to such applications. Under this approach, when an individual applies to any program, the individual is automatically

considered for all of the other programs. Similarly, if an individual applies with a state, the individual is automatically considered for federal benefits, and if the individual applies with the FFM, she is automatically considered for state benefits. Day 1 Trial Tr. at 144:24–145:23 (Long); *see also* Agreed Stipulations at 2, Nos. 6–7.

26. The ACA also required states to have an online application for Medicaid. Day 1 Trial Tr. at 193:17–19 (Long); *see also* Agreed Stipulations at 2, Nos. 5–6.

27. The ACA gives states two options for structuring their Medicaid eligibility determinations. A state may elect to be a "determination state," which means that an FFM determination of MAGI eligibility is binding on the state. In the alternative, a state may elect to be an "assessment state," which means that although the FFM will make a preliminary assessment of MAGI eligibility for every individual who applies for MAGI-based coverage with the FFM, the state will make the final determination of MAGI eligibility. (Of course, in both systems, the state is generally responsible for determining Medicaid eligibility for non-MAGI categories.) Tennessee has been a determination state at all times relevant to this lawsuit. Day 1 Trial Tr. at 196:2–25 (Long); Agreed Stipulations at 2, No. 10.

28. When an individual who is a resident of a determination state applies for Medicaid with the FFM, the FFM may do three different things. First, it may approve the applicant for MAGI-based Medicaid coverage. Second, the FFM may deny coverage upon finding that the applicant is not MAGI-eligible and that the applicant did not request a full determination of Medicaid eligibility or provide information indicating she may be eligible in a non-MAGI category. Third, the FFM may find that the individual is not eligible for MAGI-based Medicaid coverage but *might* be eligible for coverage in a non-MAGI category. In this third situation, the application is sent to the State to further determine whether the individual is eligible for coverage

in a non-MAGI category. Day 1 Trial Tr. at 196:19–198:1 (Long); *see* Agreed Stipulations at 2–3, No. 11.

III. The State Closely Cooperated With the Federal Government To Implement the ACA.

29. The Medicaid eligibility changes mandated by the ACA became effective on January 1, 2014, and states were required on October 1, 2013, to begin applying the MAGI rules to determine Medicaid coverage that would commence on January 1, 2014. Day 1 Trial Tr. at 147:23–148:17 (Long); *see* PX3 at 1 (Original Mitigation Plan); *see also* Agreed Stipulations at 3, No. 12.

30. The State had a year, and in some instances less than a year, to implement the various rules that were adopted under the ACA to govern the new application processes and eligibility determinations. Day 1 Trial Tr. at 147:14–22 (Long).

31. Enrollment in TennCare substantially increased following the enactment of the ACA, from around 1.2 million before the ACA was enacted to a high of 1.5 million after the ACA was enacted. Day 2 Trial Tr. at 71:2–5 (Hagan).

A. The State's Existing Computer System Could Not Handle MAGI Determinations, so the State and CMS Agreed to a Temporary Mitigation Plan Under Which the FFM Makes All MAGI Determinations.

32. The State's pre-ACA eligibility system, ACCENT, did not have the ability to make MAGI determinations. Day 1 Trial Tr. at 198:2–8 (Long).

33. However, the State's ACCENT system could continue to process non-MAGI Medicaid categories, because the ACA did not alter the rules governing coverage for non-MAGI categories. Day 1 Trial Tr. at 200:5–12 (Long).

34. The State's technology experts assessed whether the ACCENT system could be modified to make MAGI determinations and accept online applications and found that there was

no way to do so on such an antiquated system. The technology experts also found that attempting to do so would come with a high degree of risk of corrupting the system for making eligibility determinations in other non-Medicaid benefit programs (Supplemental Nutrition Assistance Program and Temporary Assistance for Needy Families), which the State needed to continue to use ACCENT for after the ACA was implemented. Day 1 Trial Tr. at 198:8–24 (Long); *see id.* at 157:10–11 (Long).

35. The State intended to comply with the ACA's requirement that states implement changes in how they process applications, including by using the new MAGI methodology, by October 1, 2013, by developing and implementing a new computer eligibility system called the Tennessee Eligibility Determination System, or "TEDS," but was ultimately unable to do so by October 1, 2013 (when open enrollment began at heathcare.gov) or by January 1, 2014 (when the use of MAGI rules for determining Medicaid eligibility commenced). Agreed Stipulations at 3, No. 12; Day 1 Trial Tr. at 198:22–24 (Long).

36. The State was in constant communication with CMS concerning this problem throughout this period. Day 1 Trial Tr. at 199:17–18 (Long).

37. To address the fact that TEDS was not yet operational, the State entered into a Mitigation Plan with the federal government that provided, *inter alia*, that the State would direct applicants to the FFM to be processed for MAGI eligibility. Agreed Stipulations at 3, No. 12. If the FFM found that an applicant was not MAGI-eligible but might be eligible for a non-MAGI category of Medicaid coverage, the FFM would refer the application to TennCare. TennCare would process that application in its ACCENT system, because the rules governing coverage for non-MAGI categories were not altered by the ACA. Day 1 Trial Tr. at 200:5–12 (Long).

38. In the first instance, the FFM processes the vast majority of applications under the Mitigation Plan, but a number of TennCare applicants may submit their applications directly to the State; the FMM plays no role in the acceptance or processing of such applications. These applicants include: (1) applicants for long term supports and services ("LTSS"); (2) applicants for the Medicare Savings Programs ("MSP"); (3) applicants for Emergency Medical Services; and (4) a number of other groups. *See* Agreed Stipulations at 3–4, No. 12 (fully describing these categories); *see also* DX1 (2016 Mitigation Plan).

39. The Mitigation Plan was necessary was because the State did not have a MAGI-compliant computer system capable of making MAGI-based eligibility determinations. Day 1 Trial Tr. at 165:2–3 (Long).

40. This Mitigation Plan has been amended and re-approved by CMS in the years since 2014, and it remains in effect through today. Agreed Stipulations at 3, No. 12; *see* Day 1 Trial Tr. at 148:17–149:3 (Long); DX1 (2016 Mitigation Plan).

41. The federal government approved every version of the Mitigation Plan. *See* Day 1 Trial Tr. at 161:12 (Long); *id.* at 161:19–22 (Long); PX3 (Original Mitigation Plan); DX1 at 1 (2016 Mitigation Plan) ("[T]he Centers for Medicare & Medicaid Services (CMS) is approving Tennessee's mitigation plan submitted on April 25, 2016.").

42. CMS has not expressed any concerns about how the State is implementing the Mitigation Plan since approving the most recent version of the mitigation plan in April 2016. Day 2 Trial Tr. at 69:18–23 (Hagan).

B. <u>The State Could Not Have Created a Workable, Temporary In-State Program for Making MAGI Determinations</u>.

43. The State could not have feasibly implemented a manual in-state MAGI eligibility determination process in lieu of TEDS or while TEDS was being developed. Day 1 Trial Tr. at

187:12–18 (Long); *id.* at 200:23–202:1 (Long); Day 2 Trial Tr. at 61:18–25 (Hagan); *see also id.* at 62:13–63:19 (Hagan).

44. At the point when the State and CMS entered into the original Mitigation Plan, approximately 80 percent of individuals applying through the FFM were being automatically processed—without having to provide paper verifications or similar documents—and were receiving a prompt eligibility determination. The vast majority of individuals who apply to this day move quickly through the FFM process and, if eligible, are able to access their TennCare benefits in a matter of days. Day 1 Trial Tr. at 201:8–15 (Long); Day 2 Trial Tr. at 62:2–5 (Hagan).

45. If the State had adopted a manual in-state MAGI eligibility determination process, every individual who applied for Medicaid coverage directly with TennCare would have had to be processed manually, and every applicant would have been required to produce paper verifications for every application. Day 1 Trial Tr. at 201:16–19 (Long); Day 2 Trial Tr. at 62:5–9 (Hagan); *id.* at 130:18–23 (Hagan).

46. A manual in-state MAGI eligibility determination process would have created unnecessary and enormous backlogs of applicants unable to get timely eligibility determinations. Tens, if not hundreds, of thousands of applicants who otherwise would have received a timely MAGI eligibility determination by applying through the FFM would instead have been subjected to lengthy delays that inevitably would have resulted from a prolonged paper-based process at the State. Day 1 Trial Tr. at 201:23–202:1 (Long); Day 2 Trial Tr. at 62:5–9 (Hagan).

47. CMS agreed that the State should adopt Mitigation Plans that did not require a manual paper-based MAGI determination process. Day 1 Trial Tr. at 202:2–203:8 (Long); *see* PX3 (Original Mitigation Plan). In other words, in each version of the Mitigation Plan approved by CMS, no requirement for the State to create a manual in-state MAGI eligibility determination

process (with the exception of the handful of MAGI eligibility categories the State does process directly) was ever included.

48. CMS's approval of a Mitigation Plan that does not contain a requirement for a manual in-state MAGI eligibility determination process reflects its judgment that such a manual process was not necessary and would not be effective or in the best interests of Tennessee Medicaid applicants.

49. It was and remains state officials' reasoned judgment that a manual in-State MAGI eligibility determination process would not be effective or in the best interests of Tennessee Medicaid applicants. Day 1 Trial Tr. at 187:12–18; *id.* at 200:23–202:6 (Long).

50. The application process approved by CMS in the Mitigation Plan, which avoided the use of a manual in-state MAGI eligibility determination process, ultimately proved the State's and CMS's judgment to be correct as evidenced by the fact that at the same time the State was developing its Mitigation Plan with CMS, other states had enormous backlogs in processing Medicaid applications—to the tune of tens and even hundreds of thousands of applications—yet such backlogs did not occur in Tennessee because the State was not required to conduct manual in-state MAGI determinations. Day 1 Trial Tr. at 200:23–202:1 (Long).

C. **TEDS Is Projected to Be Fully Operational by Mid-2019.**

51. The State had difficulties with the original vendor it hired to develop the TEDS system; these difficulties forced the State to eventually replace the vendor and resulted in delays in implementing TEDS. Day 2 Trial Tr. at 70:22–71:1 (Hagan).

52. The State rolled out the first phase of TEDS in October 2018 and plans to fully implement TEDS by mid-2019, contingent on the success of the initial phases of the rollout. When it is fully operational, TEDS is intended to permit the State to process and consider applications

for all MAGI categories and non-MAGI categories. The State will thus no longer require that applications be submitted to the FFM, but applicants will be free to continue applying via the FFM if they so choose. *See* Agreed Stipulations at 7, No. 34; *see also* Day 2 Trial Tr. at 28:24–30:25 (Hagan).

53. Once TEDS is fully operational, Tennessee intends to become an "assessment state." The FFM will make a preliminary assessment of MAGI eligibility for everyone who applies for a state health subsidy program via the FFM, but the final determination of MAGI eligibility will be made by the State. The State will continue to determine TennCare eligibility in non-MAGI categories, regardless of whether the application is submitted to the FFM or directly to the State. *See* Agreed Stipulations at 7, No. 35.

IV. TennCare Faced Unexpected and Unusual Issues During the First Year of the ACA's Implementation.

54. The problems that were experienced by the named plaintiffs in 2014 were the result of three extraordinary developments, all of which were beyond the State's control and were rectified within a year.

55. First, the ACA mandated that financial eligibility for most categories of Medicaid be assessed using the new MAGI rules. *Supra* ¶ 19.

56. Second, the ACCENT computer system that the State had used for TennCare eligibility determinations before 2014 was incapable of doing MAGI assessments and could not be reprogrammed to apply the new MAGI rules. To implement the mandated MAGI rules, the State entered into a Mitigation Plan with CMS to direct most TennCare applicants to apply through the FFM. *Supra* ¶¶ 37–42.

57. Third, the FFM did not have the ability to process a subset of cases that it received: inconsistency cases. Day 1 Trial Tr. at 208:16–210:7 (Long); *see also* DX1 at 5 (2016 Mitigation

Plan). And, the FFM did not initially tell the states that this problem existed until July of 2014, or how big the problem was until late into 2014, and did not begin routinely providing states with information about these inconsistency cases until several months later. Day 1 Trial Tr. at 166:4–167:19; *id.* at 211:19–212:15 (Long).

a. An "inconsistency case" is when the information provided by the applicant does not match the information in the federal data hub, creating an "inconsistency." When an inconsistency occurs, the application cannot be immediately approved or denied. The applicant must submit additional documentation in order to resolve the inconsistency. Day 1 Trial Tr. at 194:6–14 (Long).

b. In July 2014, CMS informed the State that when the federal data hub identified an inconsistency case, and verifications were needed to finish processing the application, CMS would request verifications but then do no further work on the case. Day 1 Trial Tr. at 208:16–209:3 (Long); *id.* at 209:11–20 (Long); *see also* DX1 at 5 (2016 Mitigation Plan).

c. Up until July 2014, Tennessee was unaware of this problem. Day 1 Trial Tr. at 208:16–20 (Long); *see id.* at 187:23–188:3 (Long); *see also* DX1 at 5 (2016 Mitigation Plan). As a matter of fact, Tennessee was monitoring some cases, and saw that CMS was requesting verifications—and thus assumed that CMS was using those requested verifications to process those applications. Day 1 Trial Tr. at 209:12–20 (Long).

d. When the State first learned that CMS was not processing inconsistency cases, it immediately asked CMS to send the State information about them so that the State could resolve the inconsistencies and provide an eligibility determination. Day 1 Trial Tr. at 209:21–210:2 (Long); *see also* DX1 at 5 (2016 Mitigation Plan).

e. CMS declined to share comprehensive information on inconsistency applications or was unable to do so for two months, despite the fact that the State begged for CMS to find a way to share the information. Day 1 Trial Tr. at 210:3–7 (Long); *id.* at 210:16–19 (Long); *see also* DX1 at 5 (2016 Mitigation Plan).

f. Because CMS was not providing the State with essential data, the State—through no fault of its own—was unable to process the applications that had become delayed due to data inconsistencies.

g. In August 2014, after the State sent CMS the names of a small number of individuals who, the State had learned, had delayed applications pending with the FFM, CMS sent some information to the State about those cases. Day 1 Trial Tr. at 210:19–25 (Long). Although the State requested information on the entire set of inconsistency applications, CMS would only send along information on a small number of individuals at that time. *Id.* at 211:17–23 (Long).

h. This information, on a limited set of individuals, was contained in a "special flat file," which is essentially a spreadsheet containing applicants' names, the dates that they applied, and other data relevant to the application. Day 1 Trial Tr. at 210:16–211:6 (Long). Over a period of several weeks, CMS worked with the State to train State officials on how to read these flat files—and understand whether income inconsistency or citizenship inconsistency or both were holding up the processing of an application. *Id.* at 211:6–15 (Long).

i. CMS did not provide the State with information on the entire group of inconsistency applications until fall 2014—around two months after notifying the State of the problem. At that point, CMS sent the State a flat file with the full population of individuals that had been pended since January 2014. CMS then began sending updated flat files on a regular basis. Day 1 Trial Tr. at 211:20–212:15 (Long); *see id.* at 188:4–7 (Long).

j. To this day, the FFM continues to be unable to carry out the verification function, which means that the State must process all inconsistency applications. *See* DX1 at 5 (2016 Mitigation Plan).

58. Plaintiffs filed this suit less than a month after the federal government made TennCare aware of this problem. *See* Day 1 Trial Tr. at 210:8–12 (Long); DX1 at 5 (2016 Mitigation Plan).

59. Had the FFM been able to process inconsistency cases, the issues underlying the named plaintiffs' complaints never would have arisen.

V. The State Has Fully Complied With the Court's Preliminary Injunction.

60. As discussed above, this Court entered a preliminary injunction, *see supra* Section I, and the State worked diligently to comply with it.

61. Plaintiffs have stipulated that they have no evidence that the State is not currently complying with the Preliminary Injunction. Agreed Stipulations at 6, No. 31.

62. The State has been able to comply with the preliminary injunction only because CMS in late 2014 began routinely and systematically providing the State with data concerning Medicaid applications the FFM was unable to adjudicate.

A. The State Adopted a Delayed Application Appeals Process.

63. The State implemented a delayed application appeals process that allows individuals who wish to appeal a delay in the processing of their Medicaid application to do so. *See* Agreed Stipulations at 4–6, No. 15.

64. Delayed application processing appeals may be submitted to the State through the State's contractor, the Tennessee Health Connection (TNHC), via phone, fax, or mail. Agreed Stipulations at 5, No. 16.

65. When a delayed application processing appeal is received by TennCare, appeals workers will first determine if the appellant is already eligible in interChange (the State's Medicaid Management Information System) and receiving the highest level of benefits available to that person. If so, TennCare will send the appellant a resolution notice informing him/her of their eligibility and closing the appeal. If the appellant is not already eligible in a category that gives him/her the highest available level of benefits, appeals workers will then search for proof of a delayed application. Agreed Stipulations at 5, No. 17.

66. In order for a delayed application processing appeal to be processed by TennCare, there must be proof that an application was submitted to either the FFM or the State, depending on the type of application, and that the application was filed at least 45 days prior to the appeal if the application was for anything other than Institutional eligibility. If the application was for Institutional coverage, the application must have been filed at least 90 days prior to the appeal for the appeal to be accepted. Agreed Stipulations at 5, No. 18.

a. The State looks for proof of a delayed application in multiple databases that house information about MAGI applications, non-MAGI applications, and LTSS/MSP applications. *See* Agreed Stipulations at 5, No. 19; *see also infra* ¶ 213.

b. If the State cannot locate proof of a delayed application in any of its records, the State will request proof of a delayed application from the appellant. Agreed Stipulations at 5, No. 20.

c. The State will accept the following forms of proof of a delayed application from an appellant: an FFM results letter, any correspondence from the FFM indicating the individual applied at an earlier date, proof of a mailed or faxed LTSS/MSP application to TNHC, a screen shot of a healthcare.gov account showing appellant's specific name and clear indication

that he or she applied more than 45 days prior, and/or proof the appellant mailed or faxed an application to TNHC. Agreed Stipulations at 5, No. 21.

67. If the State receives information that an application has been filed by an appellant but that application has not been delayed beyond the 45 or 90 day processing deadlines, TennCare's Eligibility Operations Group ("EOG") will be notified of an application that needs to be processed. Agreed Stipulations at 5, No. 22.

B. The State Went Further Than Required by the Preliminary Injunction by Actively Working To Resolve Applications Prior to the Delayed Application Hearing.

68. The State went above and beyond in complying with the preliminary injunction. Instead of waiting to move forward with processing a delayed application until after the conclusion of a hearing on the reason for the delay, the State adopted an administrative process to attempt to actually resolve the application before the hearing. Day 2 Trial Tr. at 109:22–110:10 (Hagan).

69. Once the State has proof of a delayed application that has not yet been processed (or that the State cannot conclude definitively has been processed), TennCare appeals workers will work to finish processing that application; they will attempt to resolve the application before the date required for a hearing. *See* Agreed Stipulations at 5, No. 23, Doc. 244 at 5; *see also* Day 1 Trial Tr. at 235:10–236:13 (Long).

70. The State's goal is to process applications quickly to ensure that individuals who are eligible are enrolled as soon as possible. Day 2 Trial Tr. at 110:4–6 (Hagan).

71. If additional information is needed in order for the State to finish processing a delayed application and that information cannot be found in the data sources available to the State, the appellant will be asked to provide paper verifications to be returned within ten (10) days, but

the State allows an extra five (5) days for processing returned mail and faxes. Agreed Stipulations at 5–6, No. 24.

72. If the additional information requested in order to finish processing a delayed application is not returned within fifteen (15) days from the date of the notice requesting verifications, on the 16th day the application is denied, the delayed application appeal is closed, and notice of the closure of the appeal and the denial of the application is sent to the appellant. Agreed Stipulations at 6, No. 25.

73. If the additional information requested in order to finish processing a delayed application is returned after the delayed application appeal has been closed, the State will send the late-received verifications to EOG for EOG to process that application. Agreed Stipulations at 6, No. 26.

74. If the additional information requested in order to finish processing a delayed application is timely returned, that information will be evaluated and the State will finish processing the delayed application by making an eligibility determination and issuing an eligibility approval or denial notice to the appellant as appropriate. The State will also close the delayed application appeal once a determination has been made on the delayed application. Agreed Stipulations at 6, No. 27.

75. If a delayed application has not been disposed of by the 30th day of the appeals clock, appeals workers will schedule a hearing. On the 33rd day of the appeals clock, the appellant is mailed an Information Packet and a Notice of Hearing informing the appellant of the date and time of his/her hearing. Agreed Stipulations at 6, No. 28.

76. Appeals workers continue to process delayed applications even after an appeal has been set for hearing and a Notice of Hearing issued with the goal of resolving the appeal by

providing an eligibility determination to the appellant prior to the date of the hearing. Agreed Stipulations at 6, No. 29.

77. In the vast majority of delayed application appeals, the hearing on the cause of the delay ends up being unnecessary because the State is able to adjudicate the underlying application before the 45-day deadline, thus mooting the dispute. Day 1 Trial Tr. at 216:5–8 (Long).

78. The State has codified the delayed application appeals process in its regulations. *See* DX15 (TENN. COMP. R. & REGS. 1200-13-19 *et seq*.); *see also infra* ¶¶ 127–30.

79. When there is delay in processing an application, but the individual is ultimately approved for TennCare coverage, the effective date of coverage is the date of the application. If the individual has incurred medical costs between the effective date of coverage and the date on which they are informed of their coverage, they may submit medical bills to their managed care organization for payment or reimbursement. Day 2 Trial Tr. at 91:4–13 (Hagan).

80. The parties agree that "[t]he delay-appeal process . . . has been effective and is working . . . ." Day 1 Trial Tr. at 8:22–23 (statement of Plaintiffs' counsel). *See also* Agreed Stipulations at 6–7, Nos. 30, 31, 33.

VI. The State Has a Functioning Process To Identify and Fix Systemic Issues Going Forward.

81. As discussed in detail below, the State has multiple mechanisms in place to identify systemic issues. These mechanisms have been highly-successful in identifying systemic issues in the past. There is thus no factual basis to require the State to engage in any additional activities to identify and fix systemic issues.

A. **<u>TennCare Managers, Supervisors and Directors Closely Watch the Management Reports To Identify Systemic Problems</u>.**

82. The State tracks every application for TennCare eligibility from the moment it is received by the State to the moment it is resolved. The State relies on management reports to monitor how well the systems are processing the applications. Day 1 Trial Tr. at 169:18–20 (Long); *infra* ¶ 120.

83. Scores of TennCare managers, supervisors, and directors use these management reports and other data to monitor the eligibility process, issues that may arise in that process, and applicants or groups of applicants who are approaching a deadline. They are engaged in constant review of the TennCare system. Day 1 Trial Tr. at 236:23–237:1 (Long); *id.* at 238:1–15 (Long).

84. These employees are required to raise any systemic or large-scale problems with Dr. Long, who is the director of TennCare. Day 1 Trial Tr. at 236:23–237:3 (Long).

85. The State also proactively watches the number of applications being transferred from the FFM to TennCare. This allows the State to be prepared for the incoming volume and also to raise any potential problems with CMS. For example, if the State does not receive any applications from the FFM on a given day, Ms. Hagan will contact CMS and ask why that has occurred. Day 2 Trial Tr. at 80:1–10 (Hagan).

86. Dr. Long, the Director of TennCare, has concluded that this system appropriately monitors for and identifies systemic issues. Day 1 Trial Tr. at 239:11–16 (Long) ("I feel that what we are doing is appropriately monitoring what is going on in the system, and that it would alert us to any problems that we needed to take action on. And I think we've demonstrated over a period of years that those processes do exactly that, they raise issues to our attention and we deal with those.").

87. Ms. Hagan, the Director of Member Services for TennCare, has concluded that this system appropriately monitors for and identifies systemic issues. Day 2 Trial Tr. at 79:13–16 (Hagan) ("I believe [the management reports] would be an indicator" of "systemic problem[s] in any of [the] application processing.").

B. The State Closely Watches the Delayed Application Appeals Data.

88. Ms. Hagan and other managers, supervisors, and directors watch the delayed application appeals data. If they see a sudden spike in appeals, the State investigates the underlying causes for those appeals, determines whether there are any systemic issues that are occurring, and directs resources to solve any systemic issues. Day 2 Trial Tr. at 80:11–81:6 (Hagan).

89. The appeals data is "the ultimate indicator" of whether there are systemic issues occurring within TennCare because the State directs applicants to the appeal process when they have a problem. Day 2 Trial Tr. at 80:11–12, 24-25 (Hagan).

C. The State Receives Feedback From Advocacy Groups, Government Officials, Healthcare Providers, and Other Groups.

90. Advocacy groups frequently send letters to the State raising issues with TennCare. When the State receives such letters, the State investigates, and if there is a problem, the State solves it. Day 1 Trial Tr. at 244:8–24 (Long); *see* Day 2 Trial Tr. at 82:12–14 (Hagan).

91. Applicants may call their state legislators, federal legislators, or the governor if they are having problems with their TennCare applications. Those government representatives will then notify a response team within TennCare, and when the response team sees the same issue multiple times, they will raise that issue with Ms. Hagan who will ultimately raise it with Dr. Long. Day 1 Trial Tr. at 245:6–7 (Long); Day 2 Trial Tr. at 80:12–17 (Hagan); *id.* at 81:7–14 (Hagan). For example, the response team, acting on communications with legislators, alerted Ms. Hagan and TennCare of the issue that arose in April 2017, when neither pregnant women nor the State

were receiving notifications that the women had been approved for Medicaid by the FFM. Day 2 Trial Tr. at 81:20–23 (Hagan); *see* PX9 (Apr. 2017 Email Correspondence); *see infra* ¶ 146–50.

92. The State works with healthcare provider groups to identify systemic issues. Day 1 Trial Tr. at 245:12–13 (Long).

93. The Tennessee Department of Health will also notify TennCare if they are aware of individuals having problems with TennCare. Day 1 Trial Tr. at 244:25–245:6 (Long); Day 2 Trial Tr. at 82:8–11 (Hagan).

94. TennCare has a unit that accepts general complaints, and issues related to TennCare applications may be identified by that unit. Day 1 Trial Tr. at 245:7–8 (Long).

95. TennCare's call center, TNHC, will also identify recurring issues and escalate them to higher-level TennCare managers. Day 2 Trial Tr. at 82:5–7 (Hagan).

96. In short, the State obtains information about potential problems from a wide variety of external and internal sources, and works to investigate and resolve any problems that are brought to its attention; it does not ignore the data it receives from these various sources. Day 1 Trial Tr. at 245:10–15 (Long).

D. Plaintiffs' Assumption That TennCare Still Must Have Systemic Issues Has No Basis in Evidence.

97. There are no systemic issues in the processing of TennCare applications today; in other words, there are no issues that are regularly impacting some subset of the population that applies for TennCare and has similar characteristics. Day 1 Trial Tr. at 179:8–9 (Long) ("We don't see any systemic problem that exists today."); *id.* at 179:18–21 (Long) ("[U]nlike back in 2014, when we were identifying these sort of systemic problems and developing systemic solutions, we don't see these sorts of [systemic] problems anymore.").

98. The occasional delays that occur are attributable to one-off, individual issues—rather than systemic issues. *See* Day 1 Trial Tr. at 179:11–17 (Long); *see also id.* at 217:11–16 (Long).

99. A case may be delayed because the eligibility worker is actively trying to help an applicant. As a general matter, an individual whose application is pended due to inconsistencies only has a limited time frame to respond to verification requests from the State. *Supra* ¶¶ 71–72. If the applicant fails to send the verification within the appropriate time frame, the application is normally denied. However, in some instances, if an eligibility worker has been working with a responsive applicant for days or weeks, but has not received a necessary document within the required response time, the eligibility worker may choose to leave the case open to help the applicant out—and prevent the application from being denied for failure to provide a required verification. Day 1 Trial Tr. at 217:17–218:21 (Long); *see id.* at 180:22–181:5 (Long).

a. Although this might result in what is technically a delayed application, this ultimately helps the applicant, because it prevents him from having to re-apply.

b. What is more, most Medicaid coverage is deemed to begin on the date that a successful application was filed, so forcing an individual to re-file would mean that the applicant loses his more favorable and earlier application date. An eligibility worker thus may choose to wait on a late-sent verification rather than closing the case in order to ensure that the applicant has coverage from the earliest-possible date. Day 1 Trial Tr. at 218:22–219:17 (Long).

100. A case may be delayed because of caseworker error. In such instances, TennCare will catch the error and quickly fix it shortly after the applicant files a delayed application appeal. Day 2 Trial Tr. at 12:22–13:9 (Hagan); *id.* at 64:15–65:5 (Hagan); *id.* at 89:8–18 (Hagan).

101. A case may be delayed because there was a delay in receiving the case file from the FFM—which is something that the State has no control over. Day 2 Trial Tr. at 12:19 (Hagan); *see supra* ¶ 57.

102. Cases may be delayed when there is an unanticipated increase in TennCare applications during a short period of time.

a. One such instance occurred following the extraordinarily high number of applications during the open enrollment period from November 1, 2017, to December 15, 2017. Despite the fact that open enrollment in 2017 was 6 weeks long instead of 3 months long (the length of time in 2016), the State received nearly twice as many applications in 2017 than in 2016. Although the State had increased its staff in anticipation of the open enrollment period, the 2017 volume was much greater than the State reasonably anticipated. Day 2 Trial Tr. at 94:6–95:7 (Hagan). The State reasonably viewed this increase in volume as outside of its control. *Id.* at 97:1–3 (Hagan).

b. Another such instance occurred when the State had an unexpected increase in applications for the Medicare Savings Plan. Day 2 Trial Tr. at 39:25–40:3 (Hagan).

c. When there is an exceptionally high volume of applications, the State will shift resources to focus on the new applications, including by approving overtime for workers; it did so following the 2017 open enrollment period. Day 2 Trial Tr. at 95:10–11 (Hagan); *id.* at 96:24–25 (Hagan).

d. TennCare will also attempt to prioritize applications that appear to be more likely to be approvable for Medicaid coverage; it did so following the 2017 open enrollment period. Day 2 Trial Tr. at 95:11–96:17 (Hagan).

e. Similarly, when there is an exceptionally high volume of applications, TennCare generally sends out a notice to individuals whose applications are delayed, explaining that the delay is due to unexpectedly high numbers of applications and highlighting the availability of the delayed application appeal. Day 2 Trial Tr. at 40:4–16 (Hagan); *id.* at 41:7–10 (Hagan); DX12 (TennCare Notice of Delayed Applications).

f. TennCare sends out these notices in order to notify individuals that their applications have not been lost or forgotten. Day 2 Trial Tr. at 90:12–15 (Hagan).

103. Plaintiffs, who bear the burden of proof, have presented no credible evidence of ongoing systemic problems with the TennCare application processes.

104. Plaintiffs' only evidence on the number of individuals with potentially delayed applications was based on the testimony of Michael Warner who analyzed the delayed application appeals reports produced in discovery. Day 1 Trial Tr. at 122:14–18 (Warner).

a. Mr. Warner did not analyze or present testimony on any of the myriad of other reports and data elements produced to Plaintiffs in discovery in this case. Day 1 Trial Tr. at 122:19–123:10 (Warner). If there was evidence of systemic problems with the processing of TennCare applications, Plaintiffs could have developed it and presented it to the Court but they did not.

b. Mr. Warner did not analyze whether the "delayed" applications he identified were actually delayed beyond the period permitted by the governing Medicaid regulations, for he offered no evidence or analysis on the reasons why an application may have taken more than 45 or 90 days to process. Day 1 Trial Tr. at 123:16–22 (Warner); *id.* at 124:2–125:16 (Warner).

c. Mr. Warner's analysis did not attempt to account for how long the State was in possession of an application before a delayed application appeal was filed. Day 1 Trial Tr. at 126:20–23 (Warner).

d. Mr. Warner's analysis did not identify or differentiate between applications that should have been processed in 45 days versus those that should have been processed in 90 days. Day 1 Trial Tr. at 128:9–16 (Warner). Plaintiffs did not present a single witness or other evidence to demonstrate that applications based on disability that the State processes directly and has 90 days to adjudicate have experienced delays.

e. Mr. Warner's analysis did not account for instances in which the FFM may have already denied an application that is the subject of a delayed application appeal but for which the State has no information about the denial. Day 1 Trial Tr. at 129:10–130:1 (Warner).

f. Mr. Warner's analysis made no attempt to compare the number of delayed applications he purportedly identified with the total number of applications filed each year. *See infra* ¶ 158.

g. Mr. Warner could offer no opinions on whether the number of individuals with delayed applications was inconsistent with a program the size of TennCare or how this compares to other states. Day 1 Trial Tr. at 130:2–12 (Warner).

h. Mr. Warner agreed that his analysis shows that the average number of delayed appeals with an underlying delayed application is trending down. Day 1 Trial Tr. at 130:18–22 (Warner); *see infra* ¶ 157.

i. Mr. Warner further admitted that it is speculation on his part that there may be individuals who experienced a delayed application but lack proof or did not file an appeal because they did know about the delay appeal process. Day 1 Trial Tr. at 133:1–134:2 (Warner).

VII. The State Has Permanently Solved the Issues That Formed the Basis of Plaintiffs' Complaint.

105. As a result of the State's implementation of a variety of new processes, the facts on the ground today bear no resemblance to the facts alleged in the original complaint filed during the summer of 2014, and the processes that the State has implemented have resolved the problems alleged in that complaint.

106. As discussed in detail below, the State (1) has developed a successful monitoring system, which allows the State to quickly resolve inconsistency applications; (2) has implemented and codified a new delayed application appeals process; (3) has successfully identified and resolved numerous systemic problems with the FFM's processing of TennCare applications by implementing state-controlled solutions; and (4) has significantly decreased the number of delayed applications such that the number of such applications is now *de minimis*. For these reasons, the TennCare system has completely and permanently transformed from what it was when the named plaintiffs filed their complaint in July 2014.

107. In order to solve the problems identified by Plaintiffs in their complaint, the State has hired an exceptionally large number of eligibility workers. TennCare had around 500 employees in mid-2013 and has 1200 employees today. Approximately 700 of those employees perform eligibility-related work. Day 1 Trial Tr. at 213:19–214:5 (Long).

108. Since August 2015, every delayed application processing appeal for which there was proof of a delayed application has been closed because (1) the appellant failed to provide the requested information necessary to process his/her application; (2) the delayed application was processed and an eligibility determination was provided to the appellant thereby mooting out the need for a hearing; or (3) a fair hearing on the reason for the delay in processing the appeal has been provided within 45 days. *See* Agreed Stipulations at 6, No. 30.

A. <u>The State Has Developed a Successful Monitoring System, Which Allows the State to Quickly Resolve Inconsistency Applications</u>.

1. <u>CMS Now Routinely Provides the State with Data on Applications Pended Due to a Data Inconsistency</u>.

109. When named plaintiffs filed this suit, CMS was not providing data to the State that the State needed to monitor and process pended TennCare applications. *Supra* ¶ 57–59.

110. Medicaid applicants whose applications are "pended" by the FFM today receive State assistance because CMS now provides the State with information concerning these applications on a regular basis and the State adjudicates them. CMS now sends "flat files" to the State weekly, which allows the State to identify inconsistency applications and resolve them. Day 1 Trial Tr. at 212:21–23 (Long); Day 2 Trial Tr. at 13:24–14:7 (Hagan); *id.* at 73:12–18 (Hagan); DX1 at 5 (2016 Mitigation Plan).

111. The State's process for resolving these pended TennCare applications has been approved by CMS and is included in the approved Mitigation Plan. *See* DX1 at 5 (2016 Mitigation Plan).

112. The approved Mitigation Plan also identifies myriad of other types of applications the State processes, many of which are accepted and processed by the State directly. *See* DX1 at 2–6 (2016 Mitigation Plan); *see also supra* ¶ 38.

113. CMS has not expressed any concerns about the speed at which TennCare is adjudicating applications and has not expressed any concerns about the State's compliance with the approved Mitigation Plan. Day 2 Trial Tr. at 69:24–70:5 (Hagan).

114. One piece of evidence that the CMS-approved Mitigation Plan is working is the spike in TennCare enrollment post-ACA versus pre-ACA, which indicates that individuals are able

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to successfully navigate the application processes the State has implemented. Day 2 Trial Tr. at 71:2–8 (Hagan).

2. <u>The State Has Developed a System To Process Information From the FFM and Monitor Applications That Prevents the Vast Majority of Applications From Becoming Delayed</u>.

115. The State begins processing the information received from the FFM on applications with data inconsistencies as soon as it obtains it from CMS. Within one day of receiving the files, the State completes its initial evaluation of the data and approves many applicants for Medicaid benefits. Day 2 Trial Tr. at 73:21–74:15 (Hagan).

116. During that same timeframe, if an applicant could not be automatically approved for TennCare, the type of data inconsistency at issue (income, citizenship or immigration status, or both) is identified and the applicant is sent a letter requesting verifications addressing the specific type of inconsistency involved in the application. *See* DX4 at 6 (MAGI Inconsistency Desk Guide); *see also* Day 1 Trial Tr. at 221:18–222:21 (Long); Day 2 Trial Tr. at 73:21–74:15 (Hagan).

117. Applicants are given 20 days to return the requested verifications, and if they fail to do so, the application is denied for no-response. However, if the requested verifications are received after the 21st day, but before the 45th day, the MAGI Inconsistency Unit within TennCare will manually process the verifications received and approve or deny the application. *See* DX4 at 6–7 (MAGI Inconsistency Desk Guide).

118. If an applicant returns requested verifications timely, that information is promptly reviewed. An eligibility worker may query additional systems for more information if necessary, and once all of the information necessary to make an eligibility determination is acquired, the application is approved or denied. *See* DX4 at 20–28 (MAGI Inconsistency Desk Guide).

119. The State closely monitors the progress of all applications that TennCare processes to ensure timely adjudication. TennCare supervisors, who have access to the systems in which applications are processed, monitor the progress of TennCare eligibility workers and intervene whenever an application appears to be taking too long to process compared to established processing schedules. Day 2 Trial Tr. at 75:19–24 (Hagan); DX8 (EOG Management Reports).

120. TennCare generates and reviews management reports from the systems used to process applications.

a. For example, the State runs a report to identify all MAGI applications that were sent to the State from the FFM that are approaching 40 days—in other words, applications that are in danger of becoming delayed in the near future. Day 2 Trial Tr. at 75:24–76:12 (Hagan); *id.* at 77:13–18 (Hagan); DX8 at 8 (EOG Management Reports).

b. The State runs similar management reports for all the types of applications that it is processing to track whether any applications are approaching their deadlines. Day 2 Trial Tr. at 77:19–78:13 (Hagan); *see also* DX8 (EOG Management Reports).

c. Supervisors and high-level managers—all the way up to Kimberly Hagan, the Director of Member Services for TennCare—receive and review these management reports. Day 2 Trial Tr. at 78:14–18 (Hagan).

d. Supervisors and high-level managers use these reports to identify potential areas where delays are likely to happen absent intervention and identify bottlenecks—and then shift resources accordingly. Day 2 Trial Tr. at 78:21–79:12 (Hagan).

3. Additional Reports on Delayed Applications Would Serve No Purpose.

121. Were the State to be forced to create any additional reports on pending applications—such as tracking the time since the application was filed with the FFM—those

reports would serve no purpose and would not assist the State or applicants in any way. Doc. 257, Tr. 100:2–21 (Hagan).

122. The State already begins processing applications as soon as they are received, and the State has determined that additional reports on delayed applications would not improve the system or speed up the resolution of applications. *See* Day 1 Trial Tr. at 168:2–11 (Long); Day 2 Trial Tr. at 100:3–11 (Hagan).

123. The State has explained that it is helpful to generate management reports listing applications that are close to the 45-day mark (which it already generates and utilizes, *see supra* ¶ 120), because such reports are used by the State to immediately focus its attention on applications that are at risk of becoming delayed. Additional reports will not assist the State in processing applications any more quickly. Day 2 Trial Tr. at 100:2–11 (Hagan).

124. What is more, it would be impossible for the State to create a complete and accurate report of all applications that are delayed because (1) the FFM sometimes forwards applications that are already delayed—and the State had no prior way of knowing that such applications existed—and (2) the State does not know about and is not notified of FFM denials. Day 2 Trial Tr. at 100:12–21 (Hagan).

125. Additionally, the State does not perform tracking based on the date that the application was filed with the FFM because federal regulations measure timeliness from the time an entity (such as TennCare) receives an application transferred from another insurance affordability program (such as the FFM). Day 2 Trial Tr. at 15:35–11 (Hagan); *see* 42 C.F.R. § 435.912(c)(1) ("The timeliness . . . standards . . . must cover the period from the date of application *or transfer from another insurance affordability program* to the date the agency

notifies the applicant of its decision or the date the agency transfers the individual to another insurance affordability program." (emphasis added)).

126. The State provided Plaintiffs with extensive data on the number of applications with data inconsistencies received from the FFM, the date those applications were filed with the FFM, and the time it took the State to process them. To the extent Plaintiffs believed that this information was relevant, they could have presented evidence on these issues, but they chose not to do so. Day 2 Trial Tr. at 74:24–75:17 (Hagan).

B. The State Has Implemented and Codified a New Delayed Application Appeals Process.

127. Unlike the situation the named plaintiffs faced in early 2014, Medicaid applicants in Tennessee today have access to the State administrative appeals system discussed above in the unlikely event that an application becomes delayed. *See supra* ¶ 63–67.

128. Although the State was initially required to develop and implement this system by the preliminary injunction, it has since adopted permanent TennCare regulations that require the State to follow this appeals system regardless of the preliminary injunction. DX15 (TENN. COMP. R. & REGS. 1200-13-19 *et seq.*).

129. The delayed application appeals process is available to all TennCare applicants upon request when their applications for Medicaid are not acted on with reasonable promptness. *See* Agreed Stipulations at 7, No. 31.

130. The State will not abandon the delayed application appeals process if the Court vacates the preliminary injunction.

a. Senior TennCare officials credibly testified that the State will continue to maintain the delayed application appeals process regardless of what happens in this case. Day 1 Trial Tr. at 220:9–21 (Long); *id.* at 239:17–23 (Long); *id.* at 240:15–19 (Long).

b. Plaintiffs have provided no evidence that the State is likely to abandon the delayed application appeals process if the Court vacates the preliminary injunction.

c. The State also recognizes that its own regulations require it to have a delayed application appeals process, and that the current delayed application appeals process fulfills that requirement. Day 1 Trial Tr. at 220:18–21 (Long); *id.* at 241:3–5 (Long).

d. The State also intends to keep the process because it is working well. The State has found that the process provides a benefit to both applicants and the State because it helps the State to identify and fix any potential problems. Day 1 Trial Tr. at 220:13–17 (Long); *id.* at 241:2–3 (Long); *id.* at 242:3–4 (Long).

e. The State has built the delayed application appeals process as-is into the TEDS computer system, and the appeals process will remain functionally identical to what it is now after TEDS is implemented. Day 1 Trial Tr. at 241:4–6 (Long); *id.* at 242:4–5 (Long); Day 2 Trial Tr. at 31:1–32:4 (Hagan).

f. The State does not plan to lengthen the time period within which the State must complete a delayed application appeal. Day 1 Trial Tr. at 241:15–18 (Long).

C. **<u>The State Has Successfully Identified and Resolved Numerous Systemic Problems with the TennCare Application Process</u>.**

131. The State has successfully identified and resolved several large-scale, systemic problems with the FFM's processing of TennCare applications and an early issue with the State's delayed application appeals process by implementing in-State solutions. *See* Day 1 Trial Tr. at 239:14–16 (Long). This track record supports the State's contention that there are no currently existing systemic problems with the processing of TennCare applications or delayed application appeals.

1. The State Successfully Identified and Resolved a 2014 Issue With the FFM's Processing of Eligibility for Pregnant Women.

132. In March 2014, the Tennessee Department of Health alerted TennCare of a potential problem regarding presumptive TennCare eligibility for pregnant women who applied for and received an initial period of presumptive coverage. Day 1 Trial Tr. at 204:14–17 (Long).

133. The State provides immediate but temporary Medicaid coverage to pregnant women based on a finding of "presumptive eligibility." This program allows a pregnant woman to walk into any office of the Tennessee Department of Health and answer a few questions without providing verifications. If she appears to qualify based on her answers to the questions, she is temporarily enrolled in TennCare for a 45-day period. The woman will then need to fill out an application for full TennCare coverage in order to continue to receive coverage after that 45-day period ends. Day 1 Trial Tr. at 204:18–205:10 (Long).

134. In March 2014, the State discovered that women who had presumptive coverage and timely applied to the FFM for full TennCare coverage nevertheless had their presumptive coverage terminated before they received a determination of eligibility from the FFM. Day 1 Trial Tr. at 205:17–21 (Long).

135. This problem was occurring on CMS's side, and was not the fault of the State.

136. The State immediately contacted CMS about this problem, sending examples of applicants who had faced this issue. Day 1 Trial Tr. at 205:23–206:5 (Long).

137. CMS was unable to explain why this was occurring, and was also unable to share information about pending cases with the State. Day 1 Trial Tr. at 206:2–5 (Long); DX1 at 7 (2016 Mitigation Plan).

138. Thus, in April 2014, the State began extending the presumptive eligibility period for pregnant women to ensure that there was no break in coverage for individuals who had

applications that were pending with the FFM. This meant that presumptive eligibility did not end at 45 days; rather, presumptive eligibility was open-ended so that a pregnant woman would continue to have coverage until the FFM processed her application. DX1 at 7 (2016 Mitigation Plan); Day 1 Trial Tr. at 206:7–21 (Long).

139. The State also re-opened the cases of pregnant women whose presumptive eligibility period had ended without receiving coverage through the FFM. Day 1 Trial Tr. at 206:21–23 (Long).

140. The State continued providing indefinite presumptive eligibility for pregnant women until sometime in 2016 when it resumed standard presumptive eligibility processing. At that time, TennCare had successfully implemented a process for resolving inconsistency cases received from the FFM, including those of pregnant women. Day 1 Trial Tr. at 245:21–246:12 (Long).

2. The State Successfully Identified and Resolved a 2014 Issue With the FFM's Processing of TennCare Eligibility for Citizen Babies of Non-Citizen Mothers.

141. Around May 2014, the State identified and addressed another issue—related to citizen babies born to non-citizen mothers. Day 1 Trial Tr. at 206:24–208:8 (Long).

142. Many immigrant women are not eligible for TennCare, but when they have a child in the United States, the citizen child is potentially eligible for TennCare. Day 1 Trial Tr. at 207:15–21 (Long).

143. In May 2014, the State was informed that newborn children of non-citizens were having difficulty in getting Medicaid eligibility determinations from the FFM. Day 1 Trial Tr. at 207:3–5 (Long).

144. This problem was occurring on CMS's side, and was not the fault of the State.

145. When CMS could not explain why this problem was recurring, the State proposed that it implement a new eligibility category of presumptive eligibility for newborns. This newborn presumptive eligibility program would function like the pregnant woman presumptive eligibility program: the State would determine temporary Medicaid eligibility for the newborn based on the answers to a few questions. Although CMS originally rejected this proposal, after a month or two they agreed to it and the State implemented this program. Day 1 Trial Tr. at 207:3–5 (Long); *id.* at 207:22–208:8 (Long).

3. The State Successfully Identified and Resolved a 2017 Issue With the FFM's Processing of TennCare Eligibility for Pregnant Women.

146. Around April 2017, the TennCare response team, *see supra* ¶ 91, acting on communications with legislators, alerted TennCare of an issue impacting a number of pregnant women who were not receiving notification that they had been approved for Medicaid by the FFM. The women had been approved by the FFM, but those approvals were not being communicated to TennCare. Day 2 Trial Tr. at 81:20–23 (Hagan); PX9 at 2 (Apr. 2017 Email Correspondence); *see also* Day 2 Trial Tr. at 15:2–8 (Hagan).

147. As designed, the eligibility process for pregnant women should proceed as follows: The State Department of Health determines presumptive eligibility for the pregnant woman, but the woman must timely file a full application with the FFM. If the FFM approves the application, CMS notifies the State, and the State closes the presumptive coverage and places the individual on full coverage—without a break in coverage. If, however, the FFM forwards the application to the State as a non-MAGI referral or as an inconsistency, the State will continue the presumptive coverage indefinitely until the State is able to resolve the non-MAGI referral or inconsistency issue. Day 2 Trial Tr. at 86:18–87:9 (Hagan). If the woman does not timely file a full application

with the FFM, coverage terminates at the end of the presumptive period. Day 1 Trial Tr. at 246:9–12 (Long).

148. In April 2017, because CMS was not forwarding MAGI-based TennCare approvals to the State, the State was unable to close the presumptive coverage and place the woman on full coverage and was terminating coverage at the end of the presumptive period based on the woman's failure to timely file a full application. This was due to issues at CMS, and was not due to any fault of the State.

149. Ms. Hagan, the Director of Member Services for TennCare, immediately informed CMS of this issue. Day 2 Trial Tr. at 14:22–15:22 (Hagan); PX9 (Apr. 2017 Email Correspondence).

150. In response to this email, CMS stated that it would look into this issue, and CMS resolved the issue on May 1, 2017. PX9 at 1 (Apr. 2017 Email Correspondence); Day 2 Trial Tr. at 87:10–13 (Hagan).

4. <u>The State Successfully Identified and Resolved a 2015 Issue With the Delayed Application Appeals Process</u>.

151. On or about March 2, 2015, in the process of investigating individual cases identified by Plaintiffs to Defendants, the State identified a number of delayed application appeals that had either not been resolved or had not gone to a hearing within 45 days. The State took immediate corrective action and made changes to the design structure of the delayed application appeals process to address that specific issue that had caused the problem. The problem has not recurred since. Agreed Stipulations at 6–7, No. 32.

152. Since August 2015, every delayed application processing appeal has been timely resolved within 45 days and in compliance with the preliminary injunction. Agreed Stipulations at 6, Nos. 30, 31.

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D. <u>The State Has Significantly Decreased the Number of Delayed Applications, and the Percentage of Applications That Are Delayed Is Now *De Minimis*</u>.

153. As a result of the new systems that the State has implemented, including but not limited to the creation of the MAGI inconsistency application process, the State has dramatically decreased the number of individuals experiencing delays as reflected in the number of delayed appeals being filed. At most, a *de minimis* percentage of the over 40,000 TennCare applications processed per month are delayed.

154. Due to multiple programmatic complexities, including the fact that the State has extremely limited visibility into what the FFM is doing, the State cannot readily calculate precisely how many applications have been delayed more than 45 or 90 days, and such a calculation would provide no benefit to applicants. Day 1 Trial Tr. at 220:5–221:9 (Long); Day 2 Trial Tr. at 65:9–24 (Hagan); *see* Day 2 Trial Tr. at 24:25–25:1 (Hagan); *id*. at 133:7–18 (Hagan).

155. When CMS sends the State an application that is already delayed, the State immediately begins work on the case. Within two or three days, the State will review the application and send out verification requests. Compiling a list of applications that are delayed would do nothing to impact this process or benefit the State or applicants. *Id*. at 221:18–222:21 (Long).

156. In the past three fiscal years, the State is aware of 1,145,450 individuals who have applied for TennCare. Day 2 Trial Tr. at 102:22–25 (Hagan); DX9 (Applications Received — July 2015–June 2018).

157. It is undisputed that the number of individuals experiencing delayed applications as reflected in the delayed application appeals being filed has gone down every year for the past three fiscal years (2015, 2016, and 2017). Day 2 Trial Tr. at 104:19–105:1 (Hagan); DX16

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(TennCare Application Adjudications Taking More Than 45 or 90 Days); Day 1 Trial Tr. at 120:16–18 (Warner); *id.* at 130:23–131:5 (Warner).

158. This drop in the number of delayed applications coincided with an enormous increase in the total number of applications. In 2015, there were 310,678 applicants that the State was aware of and 10,141 "delayed" applications. In 2016, there were 341,786 applicants that the State was aware of and 5,032 "delayed" applications. In 2017 there were 492,986 applicants that the State was aware of and 4,279 "delayed" applications. DX16 (TennCare Application Adjudications Taking More Than 45 or 90 Days).

159. In the last fiscal year (2017) an average of over 40,000 TennCare applications per month were submitted and over 99 percent were adjudicated on a timely basis. Only 0.87 percent of applicants were delayed in 2017. Day 2 Trial Tr. at 105:19–21 (Hagan); DX16 (TennCare Application Adjudications Taking More Than 45 or 90 Days).

160. The percentage of delayed applications is likely lower than 0.87 percent for several reasons. First, the regulation that Plaintiffs rely on to argue that applications should be adjudicated within 45 or 90 days provides that the 45- or 90-day time period does not govern in unusual circumstances. *See* 42 C.F.R. § 435.912(e). Plaintiffs have provided no evidence to show that this exception does not apply to most, if not all, of the applications identified as "delayed."

161. Second, the total number of TennCare applicants—the denominator in the percentage of delayed applications calculation—is substantially higher than the figures reported in DX16 because the State has no record of applications submitted to, and timely denied by, the FFM. There are likely tens of thousands of applicants within this group because individuals who apply to the FFM to purchase insurance on the exchange—even those who undoubtedly will not be eligible for Medicaid—must be automatically assessed for Medicaid eligibility. Day 2 Trial Tr. at

102:9–21 (Hagan). Plaintiffs' speculation that the percentage of delayed applications might be higher than 0.87 percent is not supported by the evidence.

162. There is no evidence that there is a significant number of individuals who had a delayed application but did not file an appeal. Plaintiffs did not provide any estimate of the numbers of applicants—or even an example of a single applicant—who had a delay beyond 45 or 90 days and thus could have filed an appeal but failed to come forward with an appeal.

163. There likewise is no evidence that there is a significant number of individuals who had proof of a delayed application that was rejected by the State and were thus unable to appeal. Plaintiffs did not provide any estimate of the numbers of applicants—or even an example of a single applicant—who had proof of a delayed application that was rejected by the State and thus the individual was not allowed to appeal. *See* Day 1 Trial Tr. at 132:12–25 (Warner, conceding that he did not provide an example of an individual who had proof of an application but that proof was rejected by the State).

164. Regardless of the precise percentage of delayed applications—whether it is slightly lower or slightly higher than 0.87 percent—that percentage is *de minimis*. *See* Day 1 Trial Tr. at 180:6–9 (Long); *id.* at 214:22–215:1; *see also* Day 2 Trial Tr. at 167:11–17 (Hagan).

165. The small number of delayed application appeals does not reflect a systemic problem in the processing of TennCare applications. Day 2 Trial Tr. at 101:2–8 (Hagan); *see id.* at 105:22–23 (Hagan).

166. It is not possible for TennCare to decrease the number of delayed applications to zero. Day 1 Trial Tr. at 180:9–10 (Long); Day 2 Trial Tr. at 105:24–105:3 (Hagan).

E. <u>Because the State Has Successfully Implemented These Various Changes, the Testimony of Plaintiffs' Witnesses at Trial Is Irrelevant to the Current Situation, and the Issues that Plaintiffs Faced Are Unlikely to Recur</u>.

167. As discussed above, the State has implemented a number of processes and changes in order to solve the problems that the named plaintiffs faced and other problems that have arisen since.

168. All of Plaintiffs' witnesses who testified at trial faced issues that were permanently solved by the State's implementation of these new processes and changes.

169. Their testimony is thus irrelevant to the current state of the TennCare application processing system and cannot form the basis for any relief.

1. <u>Donald Adams</u>

170. Mr. Adams, who was one of the original named plaintiffs in this case, applied for TennCare for himself and his newborn son on February 27, 2014. Day 1 Trial Tr. at 34:9–12 (statement by Plaintiffs' counsel).

171. Mr. Adams was enrolled in TennCare in July 2014. Day 1 Trial Tr. at 43:16–18 (Adams).

172. Mr. Adams's delay in enrollment occurred during the time period when the FFM was failing to process inconsistency applications and failing to give the State the necessary information to process such applications. *Supra* ¶ 57.

173. Mr. Adams's case was an inconsistency application. After finding inconsistencies between his application and the federal data hub, the FFM sent him a letter asking for paper verifications. However, the FFM neither processed those verifications nor informed the State that it was not processing them. Day 2 Trial Tr. at 97:19–24 (Hagan).

174. Mr. Adams has not submitted any additional applications for TennCare since his 2014 application and enrollment, and he has no information about the TennCare application process or the appeals process as it exists today. Indeed, Mr. Adams and his son are not currently enrolled in TennCare and do not live in the State. Day 1 Trial Tr. at 44:18–45:4 (Adams).

175. Were Mr. Adams to file a TennCare application today, it would be handled in a completely different way. The FMM would likely send the State notice of any inconsistencies within days of the application being filed, and the State would then request paper verifications and process the application in a timely manner. Day 2 Trial Tr. at 98:3–8 (Hagan).

176. Similarly, if Mr. Adams had a newborn son in Tennessee today, his son would be eligible for presumptive coverage, which could be conferred either by a participating hospital or by Mr. Adams calling and submitting a newborn presumptive application. Day 2 Trial Tr. at 98:9–20 (Hagan).

177. Mr. Adams's testimony is thus irrelevant; it has no bearing on the system for handling inconsistency cases, identifying systemic problems, managing delayed applications, and considering appeals that the State has adopted in the four years since he was approved for TennCare.

2. Amy Foster

178. Ms. Foster testified about her experience applying for TennCare as a conservator on behalf of her cousin, Mr. Foster. Day 1 Trial Tr. at 45:20–46:3 (statement by Plaintiffs' counsel).

179. Ms. Foster applied to TennCare via the FFM on Mr. Foster's behalf in late December 2017. Day 1 Trial Tr. at 51:24–52:14 (Foster).

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180. In a letter dated March 6, 2018, TennCare informed Mr. Foster that TennCare had experienced an unexpected increase in applications and might not be able to make a decision within 45 days from when the application was received. The letter also notified Mr. Foster that he could request a delayed application appeal, either by calling the Tennessee Health Connection (which the letter provided the phone number for) or by submitting an appeal in writing (which the letter provided instructions on how to do). Day 1 Trial Tr. at 73:12–74:4 (Foster); Day 2 Trial Tr. at 90:9–17 (Hagan); *see* Day 1 Trial Tr. at 53:23–54:5 (Foster).

181. Before she filed the appeal, Ms. Foster was again notified of the right to appeal when she called the Tennessee Health Connection. Day 2 Trial Tr. at 38:25–39:4 (Hagan); *id.* at 158:6–17 (Hagan); *see id.* at 156:16–157:8 (Hagan).

182. Ms. Foster submitted a delayed application appeal by mail on April 6, 2018—a month after TennCare informed Mr. Foster of the increase in applications and reminded him of his right to appeal. Day 1 Trial Tr. at 74:18–23 (Foster); *id.* at 76:14–17 (Foster).

183. Mr. Foster was approved for TennCare on May 18, 2018, less than 45 days after Ms. Foster placed the delayed application appeal in the mail. Day 1 Trial Tr. at 64:22 (Foster); *id.* at 75:8–20 (Foster); *id.* at 76:14–17 (Foster); Day 2 Trial Tr. at 91:1–3 (Hagan).

184. Had Ms. Foster filed an appeal sooner, TennCare would have resolved Mr. Foster's application and approved him for TennCare coverage sooner. Day 2 Trial Tr. at 90:23–25 (Hagan).

185. As discussed in detail above, Mr. Foster's case arose during a rare period of unanticipated and unavoidable increase in TennCare applications. Day 2 Trial Tr. at 89:21–90:8 (Hagan); *see supra* ¶ 102.

186. Mr. Foster's case was more complicated than the ordinary TennCare case because it involved two conservators with two different addresses and phone numbers and because it fell into a complicated eligibility category. Day 2 Trial Tr. at 93:22–94:5 (Hagan).

187. Ms. Foster's testimony is thus irrelevant; it does not speak to any ongoing or systemic issues with TennCare because (1) Mr. Foster's delay arose during a rare and unique increase in TennCare applications that has been resolved; (2) his case involved numerous unique complications; and (3) his delayed application appeal was timely resolved, the underlying TennCare application was adjudicated, and he was enrolled in TennCare before a delayed application appeal hearing took place, thus mooting it.

3. Kayla Krouse

188. Ms. Krouse learned that she was pregnant on November 1, 2016. Day 1 Trial Tr. at 78:5–6 (Krouse).

189. Ms. Krouse applied for, and received, presumptive eligibility for TennCare as a pregnant woman on December 13, 2016. Day 1 Trial Tr. at 97:16–98:1 (Krouse); DX17 (Krouse Presumptive Eligibility Application); DX18 (Letter to Krouse).

190. The application form that Ms. Krouse filled out informed her that her presumptive coverage would automatically end and that she would need to apply again to obtain full TennCare. Day 1 Trial Tr. at 98:10–13 (Krouse); Day 2 Trial Tr. at 85:2–5 (Hagan); DX17 at 2 (Krouse Presumptive Eligibility Application); *see also* DX18 (Letter to Krouse).

191. Ms. Krouse had presumptive coverage from December 13, 2016, through February 12, 2017. This means that she had full Medicaid health insurance for this entire period. Day 1 Trial Tr. at 97:25–98:9 (Krouse); Day 2 Trial Tr. at 84:6–85:1 (Hagan); *id.* at 85:11–16 (Hagan).

192. Ms. Krouse filed an application for TennCare through the FFM on February 13, 2017—the last day of her presumptive eligibility. Day 1 Trial Tr. at 98:14–20 (Krouse); Day 2 Trial Tr. at 85:6–11 (Hagan).

193. Ms. Krouse never called the Tennessee Health Connection about her application. Day 2 Trial Tr. at 38:23–24 (Hagan); *id.* at 85:23–25 (Hagan).

194. On April 4, 2017, Ms. Krouse filed a delayed application appeal. Day 1 Trial Tr. at 99:2–4 (Krouse); *id.* at 100:2–4 (Krouse); *id.* at 102:10–14 (Krouse); Day 2 Trial Tr. at 83:22 (Hagan).

195. TennCare first learned of the existence of Ms. Krouse's application when it received her appeal, because the application had been held up at the FFM, along with numerous other applications from pregnant women. Day 2 Trial Tr. at 83:9–84:2 (Hagan). This delay resulted from a systemic problem at the FFM that the State has since resolved that was impacting numerous pregnant women at the time through no fault of the State. *Supra* ¶ 146–50. TennCare had no visibility into the fact that Ms. Krouse had filed an application with the FFM or that there was a delay in processing the application until it received her appeal.

196. Ms. Krouse was approved for full TennCare coverage on April 11, 2017—one week after filing her appeal. Day 1 Trial Tr. at 92:13–15 (Krouse); *see id.* at 100:8–14 (Krouse).

197. At trial, Ms. Krouse misremembered when she applied for and received presumptive eligibility for TennCare coverage. She initially stated that she applied for and received presumptive coverage in mid-November 2016, Day 1 Trial Tr. at 79:7–80:4 (Krouse), but when her recollection was refreshed by documents she corrected her testimony to state that she actually applied for and received presumptive coverage on December 13, 2016, *id.* at 97:16–98:2 (Krouse); Day 2 Trial Tr. at 84:3–6 (Hagan).

198. At trial, Ms. Krouse misremembered when she applied for and received full TennCare coverage. She initially stated that she applied for full TennCare coverage in mid-November 2016, Day 1 Trial Tr. at 79:22–80:4 (Krouse), but when her recollection was refreshed by documents she corrected her testimony to state that she actually applied for full TennCare coverage on February 13, 2017, *id.* at 98:14–16 (Krouse).

199. Ms. Krouse has not submitted any additional applications for TennCare since her 2017 application and enrollment, and she has no information about the presumptive coverage process, the general application process, or the appeals process as they exist today. Day 1 Trial Tr. at 100:12–22.

200. The issue that caused the delay that Ms. Krouse experienced in early 2017 was solved as of May 1, 2017, so her testimony at trial is irrelevant because it has no bearing on how TennCare applications for pregnant women are handled today. Day 2 Trial Tr. at 86:11–17.

201. What is more, since the time that Ms. Krouse filed her appeal, TennCare has changed the delay appeal desk guide to provide clear direction about the extension of presumptive pregnancy eligibility while a delayed application appeal is pending. Today, the desk guide instructs TennCare eligibility workers who receive an appeal where a pregnant woman's presumptive eligibility was not automatically extended to manually extend the coverage while the delayed application is pending. The eligibility worker will reopen the presumptive coverage on the date the appeal was filed, and then continue that coverage until a final determination has been made. Day 2 Trial Tr. at 87:25–88:22 (Hagan).

VIII. The State's Delayed Application Appeals Process Is Functioning in a Healthy Way.

202. The State is properly handling the small number of delayed application appeals that it currently faces in the improved system.

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203. The State has codified the appeals process and has no plans to change that process. *Supra* ¶¶ 127–30.

204. The State provides appropriate notice of the right to appeal, and the State properly requires proof that an individual has actually filed an application before proceeding with the individual's delayed application appeal.

A. <u>The State Provides Appropriate Notice of the Right to Appeal</u>.

205. The State provides notice of the right to file a delayed application appeal when an applicant calls the TennCare call center.

a. TennCare has a call center through the Tennessee Health Connection (TNHC), which is the primary method by which individuals can communicate with TennCare. Day 2 Trial Tr. at 35:11–20 (Hagan).

b. If an individual calls TNHC and mentions that they have an application that has been pending for a long period of time, the operator is required to advise the applicant of the right to file a delayed application appeal if it has been 45 (or 90) days, and that if it has not been 45 (or 90) days she can call back and file a delayed application appeal after the application has hit the 45- (or 90-) day mark. Day 2 Trial Tr. at 37:4–25 (Hagan); *id.* at 38:11–17 (Hagan); *id.* at 110:19–21 (Hagan). In some cases, when an individual is near to but has not yet reached the 45- (or 90-) day mark, the operator will take the appeal immediately. *Id.* at 38:2–44 (Hagan).

c. Multiple documents, forms, and processes direct individuals to call TNHC if they have any questions or concerns. For example, the Tennessee Department of Human Services provides TNHC's phone number on handouts and has posters in every county office that include the phone number. Similarly, workers at the Tennessee Department of Health will direct individuals to call TNHC. And the phone number is included on presumptive eligibility notices

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that are sent to pregnant women and numerous other presumptive eligibility categories. Day 2 Trial Tr. at 111:4–24 (Hagan).

d. TNHC does not have persistent problems with long wait times or dropped calls. Day 2 Trial Tr. at 67:20–24 (Hagan).

e. The State has numerous quality assurance checks in place to ensure that the vendor that runs TNHC follows the State's strict guidelines. The State has service-level agreements with the vendor that require daily measurements of wait times, length of calls, and caller abandonment rates. The State has a team that listens to random calls to measure quality. The State drafts the scripts for the vendor, and part of the State's review process involves confirming that the scripts are being followed on the phone. Day 2 Trial Tr. at 155:22–156:15 (Hagan). All calls to TNHC are recorded. *Id.* at 156:23 (Hagan).

206. The State provides notice of the right to file a delayed application appeal on its website.

a. TennCare has a website, www.tn.gov/tenncare. On the page for "Members / Applicants" the website has a paragraph which states as follows: "If you do not have TennCare now, call Tennessee Health Connection at **1-855-259-0701**. Tell them you want to file a **delayed application appeal**." PX11 at 3 (TennCare Website Screenshots) (emphasis in original); Day 2 Trial Tr. at 69:1–11 (Hagan).

b. Additionally, in another place on the page for "Members / Applicants" the website has a link entitled "Are You Waiting for a Decision on Your Application for Medicaid?" If an applicant clicks this link, the website informs the applicant of her right to an appeal. Day 2 Trial Tr. at 44:17–46:7 (Hagan); *see* PX11 at 4 (TennCare Website Screenshots).

c. Similarly, in a third separate place on the "Members / Applicants" page, there is a link entitled "How to file an eligibility appeal?" If the applicant clicks this link, the website again contains information about how to file a delayed application appeal. PX11 at 6 (TennCare Website Screenshots); *see* Day 2 Trial Tr. at 69:12–14 (Hagan).

d. And, as a general matter, TNHC's phone number is in numerous places on the website, and individuals are instructed to call TNHC if they have any questions or concerns. Day 2 Trial Tr. at 110:15–21 (Hagan). If an individual who is experiencing a delay calls TNHC, that individual will be informed of his appeal rights. *Supra* ¶ 205.

207. There is no evidence that these methods are not effective in giving actual notice to applicants experiencing delays.

208. Plaintiffs have not been able to identify anyone who suffered a delay but was not able to access the delayed application appeals process because they did not know about it.

209. There is no factual basis for requiring the State to send delayed application notices to every individual whose application has been pending beyond 45 or 90 days.

a. A mandatory, manually-generated notice could possibly delay TennCare's decision on the application. If TennCare is already working on the application, stopping the process to send out a manual notice might delay the process rather than allowing the caseworker to focus on finishing the application. Day 2 Trial Tr. at 99:12–17 (Hagan).

b. TennCare has valid concerns about creating "saturation" problems by sending applicants too many notices. TennCare already experiences a high rate of individuals who do not open their mail. By sending more notices of appeal rights, that might further exacerbate the problem. Day 2 Trial Tr. at 99:18–100:1 (Hagan).

210. The State thus has valid bases for its conclusion that it should not send delayed application notices to every individual whose application has been pending beyond 45 or 90 days. Plaintiffs' claims that more or different types of notice would be helpful have no basis in the record; rather, Plaintiffs' arguments are based on pure speculation. *See* Day 2 Trial Tr. at 229:4–230:4 (Hagan); *see also* Day 1 Trial Tr. at 133:8:2–134:2 (Warner); *id.* at 138:22–24 (Warner).

B. <u>The State Appropriately Requires Proof That an Individual Appealing Has Actually Filed an Application</u>.

211. When an individual files a delayed application appeal, the State appropriately requires proof that the individual has actually filed an application. *See supra* ¶ 66.

212. Before asking an applicant to provide proof that they have filed an application for TennCare, the State searches for proof within its own databases that the individual has actually filed an application.

213. The State looks for proof of a delayed application in multiple databases that house information about MAGI applications, non-MAGI applications, and LTSS/MSP applications. Agreed Stipulations at 5, No. 19. The State will look at ACCENT (the system used to process many non-MAGI applications), FileBound (another database used by TennCare), Health Track (the system used by TNHC), the "CMS file" (where all the flat files from CMS are held), and other databases. Day 2 Trial Tr. at 106:21–107:21 (Hagan).

214. TennCare's Delayed Appeal Desk Guide, which is the document that delineates the process that workers must follow when resolving delayed application appeals, requires workers to exhaust all of these sources before requesting proof of a delayed application from the applicant. Although this is not required by the preliminary injunction, the State does so because it is the quickest way to resolve the application; if the State has proof of an application, the State can

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immediately move forward with the next steps involved in making a decision on an application. Day 2 Trial Tr. at 107:22–108:10 (Hagan).

215. Only if the State cannot locate proof of a delayed application in any of its records will the State request proof of a delayed application from the applicant. Day 2 Trial Tr. at 107:22–108:1 (Hagan); *see* Agreed Stipulations at 5, No. 20.

216. The State accepts numerous different forms of proof of a delayed application from an appellant. *Supra* ¶ 66-c.

217. The requirement that applicants provide proof of a delayed application is not onerous and was explicitly authorized by the preliminary injunction. Applicants receive proof that they have applied for TennCare when they apply to the FFM. Day 2 Trial Tr. at 109:1–6 (Hagan).

218. The State's proof requirement is similar to other requirements that Tennessee has in place in other appeals processes. For example, TennCare has a separate appeals group that handles medical service appeals—which enrollees use to appeal denial of a requested medical service. As part of that process, TennCare requires proof that the enrollee asked for the service before they can go through the appeals process. Day 2 Trial Tr. at 109:14–21 (Hagan).

219. Forcing the State to accept self-attestations as proof would lead to problems without any demonstrable advantages.

a. If the State permitted self-attestation, a large percentage of applicants would improperly use the appeals process to file an application. This would overwhelm the appeals process—preventing TennCare workers from focusing on delayed application appeals in which the individual actually filed an underlying application that has been delayed. Day 2 Trial Tr. at 108:15–22 (Hagan). Again, over 40,000 individuals apply to TennCare each month, while less than 1 percent file delayed application appeals. DX16 (TennCare Application Adjudications

Taking More Than 45 or 90 Days). If even a small fraction of applicants are diverted to the appeal system, it would be overwhelmed by the volume and significant delays would be introduced into the system.

b. Forcing the State to accept self-attestations sworn under penalty of perjury would not change the calculus. Even well-meaning individuals may frequently forget whether they actually applied to TennCare or on what date they did so. Plaintiffs' own witness—Ms. Krouse—demonstrated this fact at trial when, while under oath, she mistakenly stated that she had applied for both presumptive eligibility and full TennCare months before she actually did. *Supra* ¶ 198.

c. Given all the methods by which an individual can currently provide proof that they filed an application, it is highly unlikely that a substantial number of individuals are unable to provide proof that they filed an application. Plaintiffs have provided no evidence to the contrary.

d. What is more, Plaintiffs have provided no evidence that there is a significant number of individuals—or even a single individual—whose appeal was rejected by the State for lack of acceptable proof, but who could have honestly and accurately attested to having filed a delayed application.

December 14, 2018

Respectfully submitted,

HERBERT H. SLATERY III
Attorney General and Reporter

Linda A. Ross (TN BPR 4161)
Senior Deputy Attorney General
Carolyn E. Reed (TN BPR 22248)
Special Counsel
OFFICE OF TENNESSEE ATTORNEY GENERAL

/s /Michael W. Kirk
Michael W. Kirk
Nicole Jo Moss
Nicole Frazer Reaves

COOPER & KIRK, PLLC
1523 New Hampshire Avenue, N.W.
Washington, D.C. 20036

P.O. Box 20207
Nashville, Tennessee 37202
Phone: (615) 532-9632
Fax: (615) 532-1120

Phone: (202) 220-9600
Fax: (202) 220-9601

Counsel for Defendants

CERTIFICATE OF SERVICE

I hereby certify that a true and accurate copy of Defendants' Proposed Findings of Fact was served upon the following counsel of record on this 14th day of December, 2018, via the Court's Electronic Case Filing system:

Micah West
Samuel Brooke
Sara Zampierin
SOUTHERN POVERTY LAW CENTER
Immigrant Justice Project
400 Washington Avenue
Montgomery, AL 36104

James M. Knoepp
SOUTHERN POVERTY LAW CENTER
Immigrant Justice Project
233 Peachtree Street, NE
Suite 2150
Atlanta, GA 30303

Elizabeth Edwards
Jane Perkins
NATIONAL HEALTH LAW PROGRAM
101 E. Weaver Street
Suite G-7
Carrboro, NC 27510

Christopher E. Coleman
Gordon Bonnyman, Jr.
Michele M. Johnson
TENNESSEE JUSTICE CENTER
301 Charlotte Avenue
Nashville, TN 37201

Counsel for Plaintiffs

/s/ Michael W. Kirk
Michael W. Kirk