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

MELISSA WILSON, et al., individually and on behalf of all others similarly situated, Plaintiffs, v. DARIN GORDON, et al., Defendants.	Civil Action No._____ **PLAINTIFFS' MEMORANDUM IN SUPPORT OF MOTION FOR CLASS CERTIFICATION**

Plaintiffs bring this action to challenge the State of Tennessee's unreasonable and illegal policies that deny individuals the ability obtain Medicaid assistance in a timely manner, or obtain a fair hearing to challenge that failing. Tennessee has created an array of bureaucratic barriers to enrolling in TennCare and obtaining any determination of eligibility. The State's acts and omissions deprive thousands of low-income Tennesseans of all ages access to essential medical care for which they are eligible under state and federal law.

Pursuant to Federal Rule of Civil Procedure 23(a) and (b)(2), Plaintiffs hereby seek to certify a class. Through the class, referred to as the Delayed Adjudication Class, all Plaintiffs seek to represent individuals who have suffered from (1) Defendants' unlawful failure to process Medicaid applications in a timely manner and (2) Defendants' unlawful failure to provide fair hearings when applicants' claims are not acted upon with reasonable promptness.

CLASS DEFINITIONS

Plaintiffs seek to certify a class, referred to as the "Delayed Adjudication Class," which is defined as:

All individuals who have applied for TennCare on or after October 1, 2013, who have not received a final eligibility determination in a timely manner, and who have contacted the Tennessee Health Connection or its successor entity for assistance with that application.

All Plaintiffs seek to represent the Delayed Adjudication Class.

FACTUAL BACKGROUND

I. Medicaid (TennCare) Background

The federal Medicaid program is "designed to provide medical assistance to persons whose income and resources are insufficient to meet the costs of necessary care and services." *Atkins v. Rivera*, 477 U.S. 154, 156 (1986). Though Medicaid participation is voluntary, states who elect to accept federal Medicaid funds must comply with requirements imposed by federal law. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2581 (2012); *Atkins*, 477 U.S. at 157. Tennessee has participated in Medicaid continuously since 1968, *see* Tenn. Pub. Acts of 1968, Chapter 551, and presently operates a demonstration program called TennCare.

Every "State plan for medical assistance must" establish or designate "a single State agency to administer or to supervise the administration of the plan . . . ." 42 U.S.C. § 1396a(a)(5). That State agency—here, the Tennessee Department of Finance and Administration—"may not delegate, to other than its own officials, the authority to supervise the plan . . . ." 42 C.F.R. § 431.10(e). The State agency may delegate certain eligibility determinations to certain other parties, § 431.10(c)(i), but it retains the obligation to ensure that all federal laws are followed notwithstanding that delegation of eligibility determinations, § 431.10(c)(3).

To enroll in Medicaid, individuals have traditionally been required to meet specific eligibility criteria. They must meet so-called "categorical eligibility" rules by showing that they are aged, blind, disabled or pregnant, or that they are children or parents of dependent children.

They must show that their income is below certain limits, which vary depending on the categorical eligibility group to which they belong. Finally, individuals in a few categorical eligibility groups must meet additional limits on the amount of resources, or assets, they own. *See* Cong. Research Svc., *Medicaid Checklist: Considerations in Adding a Mandatory Eligibility Group* 1 (Sept. 21, 2010) (attached as Ex. 1 to Brooke Decl.).

A state Medicaid plan "must . . . provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals." 42 U.S.C. § 1396a(a)(8). The state "must afford an individual wishing to do so the opportunity to apply for Medicaid without delay." 42 C.F.R. § 435.906. Determinations of eligibility for Medicaid must be made within 45 days after the application was submitted or within 90 days if eligibility is based on a disability, 42 C.F.R. § 435.912(c)(3), and state plans must "[f]urnish Medicaid promptly to beneficiaries without any delay caused by the agency's administrative procedures." § 435.930(a). The Medicaid statute also requires that state Medicaid plans must "provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness." 42 U.S.C. § 1396a(a)(3). The appeal process must satisfy the requirements of federal regulations and the Due Process Clause of the Constitution. 42 C.F.R. § 431.205.

II. Changes to Medicaid under the Affordable Care Act

In March 2010, Congress enacted the Patient Protection and Affordable Care Act, Pub. L. 111-148, (hereinafter "Affordable Care Act" or "ACA"), and also amended that Act through passage of the Health Care and Education Reconciliation Act, Pub. L. 111-152. The ACA

implemented several changes to Medicaid, including simplifying the method of calculating income eligibility.

The ACA introduced a new standard methodology to calculate income and financial eligibility for most categories of Medicaid,[1] called Modified Adjusted Gross Income (MAGI). *See* ACA, Pub. L. No. 111-148, § 2002 (2010) (codified at 42 U.S.C. § 1396a(e)(14)); 42 U.S.C. § 1397bb(b)(1)(B)(v). Previously, states used diverse income-counting methodologies, including deductions and income disregards that varied across states. The new methodology for counting income adapts longstanding Internal Revenue Service rules applicable to the reporting and calculation of income on personal income tax returns, and slightly modifies the "adjusted gross income" calculated on a tax return. *See* 26 U.S.C. § 62. As the federal agency overseeing Medicaid, the Centers for Medicare & Medicaid Services ("CMS"), has noted, "The adoption of MAGI-based methodologies to determine income represents a significant simplification for the Medicaid program." Eligibility Changes Under the ACA, 76 Fed. Reg. 51148-01, 51155 (Aug. 17, 2011).

These rules provide a uniform method for both counting income and for determining household composition. *See* 26 U.S.C. § 36B(d); 42 U.S.C. § 1396a(e)(14); 42 C.F.R. §§ 435.603; 457.315(a). MAGI methodology eliminates the disparate deductions and income disregards that were applied in various states, and instead introduces a standard disregard of 5% FPL and the elimination of all asset tests. *See* 42 U.S.C. § 1396a(e)(14)(B), (C), (I)(1); 42 C.F.R. § 435.603(d)(4), (g)(2).

[1] Though most categories of eligibility are now determined pursuant to MAGI rules, some categories do not follow MAGI methodology. These include persons eligible on the basis of disability; elderly, and blind individuals; Medicaid's cost sharing supports for Medicare enrollees; and foster children.

III. Modifications to Application and Determination Process for TennCare

For over 40 years, until January 1, 2014, the TennCare Bureau contracted with DHS to administer the eligibility process. Most individuals who were eligible for TennCare coverage applied in person at local DHS offices, which are located in all 95 counties of Tennessee. Applicants were interviewed by social workers, who took their information and keyed it into a DHS computer system known by the acronym "ACCENT." *See* Letter from Darin Gordon to Cindy Mann, Attachment at 2, n.3 (July 14, 2014) (attached as Ex. 2 to Brooke Decl.). Eligibility determinations were made and communicated to the applicant promptly, and the caseworker was required to assist the applicant in obtaining verification documents if the applicant encountered difficulties. *See* Tenn. Dep't of Human Svcs., *TennCare Medicaid and TennCare Standard Policy Manual,* at 409–23 (excerpt attached as Ex. 3 to Brooke Decl.).

Defendants have failed to satisfy their legal obligations under the Medicaid Act and the ACA to adjust their own processes to accommodate the MAGI financial eligibility standard. 42 U.S.C. § 18083(c). As a "temporary" work-around, the State authorized the federal Marketplace to determine eligibility for MAGI-based categories. CMS approved this plan with a letter on August 16, 2013, documenting this plan and the State's representations that it would create a new computer system that could calculate the MAGI determination by or before January 1, 2014. Letter from Jessica Kahn to Darin Gordon at 1 (Aug. 16, 2013) (attached as Ex. 4 to Brooke Decl.). Notwithstanding these representations, Tennessee continues to violate this obligation to have an operable system, and instead has continued its temporary work-around to send all of its TennCare applicants to the federal Marketplace to apply.

IV. Plaintiffs' Delayed Attempts to Access TennCare Benefits[2]

Plaintiff Melissa Wilson is a caretaker of her three grandchildren. Wilson Decl. ¶ 1. She suffers from renal kidney failure, lupus, high blood pressure, osteoporosis, and needs regular blood transfusions. *Id.* ¶ 2. She does all she can to make ends meet, including working about 32 hours a week, but her typical monthly household income is only about $1056. *Id.* ¶ 3. Due to her severe medical complications, doctors have advised Ms. Wilson that she should be regularly seeing several specialists as well as a primary care doctor, and should be taking 17 prescriptions. *Id.* ¶¶ 8-9. Because she does not have medical insurance, she has not been able to see her doctors, instead relying on a limited community health clinic, and she cannot afford her prescriptions—she is only able to get three of the 17 that are prescribed. *Id.* ¶¶ 8-10. Her doctor was so concerned that he called TennCare on her behalf and told officials there that she may die if they do not enroll her promptly. *Id.* ¶ 11. She is still waiting.

Ms. Wilson applied for TennCare on about February, 10 2014, and like all class members, has been waiting well beyond the 45-day period required by federal law to receive an adjudication. (In her case, she has been waiting 163 days. *Id.* ¶ 4.) When Ms. Wilson most recently contacted Tennessee Health Connection in the week of July 14, she was told that her application "remains in limbo," and when she asked for a fair hearing regarding the delay, she was told that the State does not provide those types of hearings. *Id.* ¶ 7.

Plaintiff April Reynolds is a wife and mother of three. Reynolds Decl. ¶ 1. Ms. Reynolds suffered a near-heart attack in March of 2014, which left her hospitalized in critical condition for three days. *Id.* ¶ 4. Ms. Reynolds accrued more than $20,000 in debt from that hospital visit. *Id.* ¶ 4. Ms. Reynolds was told that she would need monthly health checkups

[2] Plaintiffs' Declarations are attached to the original Complaint.

following her hospital stay, but has only visited a doctor once since the incident due to her fear of accumulating more healthcare related debt. *Id.* ¶ 9. Ms. Reynolds and her family live on only $1,374 a month from her husband's Social Security Disability Insurance, as well as some social security benefits for her children. *Id.* ¶ 2. Ms. Reynolds applied for TennCare on about February 19, 2014, and like all class members, has been waiting well beyond the 45-day period required by federal law to receive an adjudication. (In her case, she has been waiting 154 days. *Id.* ¶ 3.) When Ms. Reynolds most recently contacted Tennessee Health Connection in the week of July 14, she was told that her application was not in the system, and when she asked for a fair hearing regarding the delay, she was told that she could not have a hearing. *Id.* ¶ 8.

Plaintiffs Mohammed Mossa and Mayan Said are parents to five young children, between the ages of 2 and 14. Mossa Decl. ¶ 1. Mr. Mossa was diagnosed with leukemia in December of 2011 and also lives with a debilitating back injury, high blood pressure, issues with his hands and problems with his eyesight. *Id.* ¶ 3. Ms. Said suffers from diabetes, anemia, high blood pressure and kidney stones. *Id.* Due to his illnesses, Mr. Mossa is unable to work, and because of this his family scrapes by on approximately $2,000 a month from Social Security Disability Insurance and Social Security Dependent Benefits. *Id.* ¶ 4. Ms. Said is forced to seek care at a health clinic, with each visit costing the family $45, a difficult amount of money to afford. *Id.* ¶ 8. The cost of Mr. Mossa's medication is a burden, with each prescription costing between $50-$100 per drug. *Id.* One of Mr. Mossa's medications costs between $2,000 and $3,000, but to date he has been able to receive it for free, though he is unsure if he will be able to continue to do so. *Id.*

Mr. Mossa and Ms. Said applied for TennCare on about February 18, 2014, and like all class members, they been waiting well beyond the 45-day period required by federal law to

receive an adjudication. (In their case, they have been waiting 155 days. *Id.* ¶ 6.) When they most recently contacted Tennessee Health Connection in the week of July 14, they were told that there had not been a determination regarding their application, and when they asked for a fair hearing regarding the delay, they were told that the State does not provide hearings for cases like theirs. *Id.* ¶ 10.

Plaintiff T.V. gave birth to **Plaintiff K.P.** in late April, 2014. T.V. Decl. ¶ 14. She applied for TennCare in January while she was pregnant, and was told that K.P. would automatically receive coverage when he was born and when her application for TennCare was approved. *Id.* ¶¶ 2, 10. Both T.V. and K.P. are still waiting. T.V. is presently unemployed, and the costs for her prenatal care (and for K.P.'s current medical care) have been substantial and far beyond what she can afford. *Id.* ¶¶ 13–15. Due to the lack of insurance and inability to pay, T.V. has been forced to postpone medical care for K.P., and may need to do so again if the TennCare coverage does not materialize. *Id.* ¶ 16.

T.V. applied for TennCare on about January 24, 2014, and like all class members, has been waiting well beyond the 45-day period required by federal law to receive an adjudication. (In their case, they have been waiting 180 days. *Id.* ¶ 2.) When T.V. most recently contacted Tennessee Health Connection in the week of July 14, she was told that her application could not be found in their system. When she asked for a fair hearing she was told that her application had "already been escalated," and that there was no possibility for a hearing. *Id.* ¶ 12.

Plaintiff S.P. was born in late January 2014. J.P. Decl. ¶ 2. She and her parents live off of approximately $1,600 per month in income, which is not enough to cover all of the family's needs, particularly S.P.'s medical care. *Id.* ¶ 14.

In May, S.P. became critically ill, having a very high fever that caused her entire body to shake. *Id.* ¶ 12. She was taken to the emergency room, and doctors discovered that she had a severe bacterial infection, with e-coli present in her blood. *Id.* S.P. received intensive care over the next four days, including a spinal tap, CT scan and extensive testing. *Id.* Without insurance to cover S.P.'s hospitalization, the family received bills totaling over $17,000. The family cannot afford to pay these bills. *Id.* ¶ 13.

The family of S.P. applied for TennCare for S.P. on about February 5, 2014, and like all class members, they been waiting well beyond the 45-day period required by federal law to receive an adjudication. (In their case, they have been waiting 168 days. *Id.* ¶ 3.) When they most recently contacted Tennessee Health Connection in the week of July 14, they were told they had to continue waiting, that no determination on S.P.'s application had been made, and that they could not have a hearing regarding the delay because the application was still not resolved. *Id.* ¶ 11.

Plaintiffs C.A. and D.A. are members of a family who applied for TennCare on February 27, 2014. D.P. Decl. ¶ 2. C.A. is an infant who was born in late February. *Id.*

Shortly after his birth, D.A. and his wife brought C.A. to a pediatrician for a routine checkup, incurring a $1,300 bill in the process. *Id.* ¶ 4. D.A. and his family survive on approximately $1,850 a month and cannot afford to pay the pediatrician's bill. *Id.* ¶¶ 1, 4. When C.A.'s parents tried to schedule another appointment for him with the pediatrician's office, they were told they could not do so until they had proof of insurance for C.A. *Id.* ¶ 4.

D.A. has incurred significant debt due to his lack of healthcare coverage. On Easter Sunday, April 5, 2014, D.A. was admitted to the hospital with a severe MRSA infection. *Id.* ¶ 5. D.A. was so concerned about the cost of healthcare that he delayed seeking treatment, resulting

in an infection so severe that doctors told him he was hours away from dying from the infection. *Id.* ¶ 5. Even still, D.A. and his family selected a hospital based on their determination that the medical bills would be smaller. *Id.* ¶ 5. Bills from his four day stay in the hospital are now going to debt collectors. *Id.* ¶ 5.

D.A. applied for TennCare for himself, his wife, and C.A. on about February 27, 2014, and like all class members, they have been waiting well beyond the 45-day period required by federal law to receive an adjudication. (In their case, they have been waiting 146 days. *Id.* ¶ 3.) When they most recently contacted Tennessee Health Connection in the week of July 14, they were told that there was no record of their application, and that they could not have a fair hearing regarding the delay because the State does not provide such hearings. *Id.* ¶ 6.

Plaintiff S.V. was born on December 17, 2013. M.M. Decl. ¶ 1. Since his birth six months ago, S.V. has fallen ill several times, and has not had health insurance. *Id.* ¶¶ 8-9. S.V.'s family has been asked to pay over $500 for his care, what they believe to be a reduced amount, but they cannot afford to pay the bills. *Id.* ¶ 10. S.V.'s parents are concerned that treatment for S.V. will be stopped due to his family's inability to pay the medical costs. *Id.*

The family of S.V. applied for TennCare for S.V. in early January 2014, and like all class members, they been waiting well beyond the 45-day period required by federal law to receive an adjudication. (In their case, they have been waiting about 194 days. *Id.* ¶ 3.) They applied again on about May 5, 2014—approximately 79 days ago. *Id.* ¶ 4. When they most recently contacted Tennessee Health Connection in the week of July 14, they were told that S.V. still does not have coverage, and that they could not have a fair hearing regarding the delay because there was no such process until he is denied. *Id.* ¶ 7.

Plaintiff S.G. was born two months prematurely, in February of 2014. L.G. Decl. ¶ 2. S.G. has an urgent need for healthcare coverage. As a premature child he is at a higher risk of respiratory and airway virus, also known as RSV. *Id.* ¶ 8. For the first year of his life, S.G. requires a monthly regimen of shots to prevent this illness and to insure his healthy physical development, with each shot costing approximately $3,000. *Id.* ¶ 8. S.G. is a member of a family of 7 that lives on less than $2,000 per month, and they are unable to afford the costs of his healthcare. *Id.* ¶ 9.

The family of S.G. applied for TennCare for S.G. on about February 26, 2014, and like all class members, they been waiting well beyond the 45-day period required by federal law to receive an adjudication. (In their case, they have been waiting 147 days. *Id.* ¶ 4.)

ARGUMENT

For a class to be certified, Plaintiffs must satisfy the requirements of Rule 23(a) and at least one of the three criteria for certification under Rule 23(b). Fed. R. Civ. P. 23(b); *Sprague v. Gen. Motors Corp.*, 133 F.3d 388, 397 (6th Cir. 1998); *In re Am. Med. Sys., Inc.*, 75 F.3d 1069, 1079 (6th Cir. 1996). Class certification is a procedural question, distinct from the merits of the case. *Weathers v. Peters Realty Corp.*, 499 F.2d 1197, 1201 (6th Cir. 1974). "In determining the propriety of a class action, the question is not whether the plaintiff or plaintiffs have stated a cause of action or will prevail on the merits, but rather whether the requirements of Rule 23 are met." *Id*. (quoting *Miller v. Mackey Int'l.*, 452 F.2d 424, 427 (5th Cir. 1971)). The party seeking class certification bears the burden of proof. *Id*.

As demonstrated below, Plaintiffs satisfy the Rule 23 requirements here.

I. Plaintiffs Satisfy the Requirements of Rule 23(a)

To be certified, a class must satisfy all four prerequisites of Rule 23(a). The threshold requirements for class certification set forth in Rule 23(a) are met if: (1) the class is so numerous that joinder of all members would be impracticable; (2) there are questions of law or fact common to the class; (3) the claims or defenses of the class representatives are typical of those of the class; and (4) the class representatives will fairly and adequately protect the class's interests. Fed. R. Civ. P. 23(a); *see also Am. Med. Sys., Inc.*, 75 F.3d at 1079.

Plaintiffs, individually and on behalf of the Delayed Adjudication class, have raised three claims against all Defendants:

(1) Failure to promptly determine eligibility for TennCare under 42 U.S.C. § 1983 and 42 U.S.C. § 1396a(a)(8);

(2) Failure to provide a fair hearing when determinations of eligibility for TennCare are not made reasonably promptly under 42 U.S.C. § 1983 and 42 U.S.C. § 1396a(a)(3); and

(3) Failure to provide a hearing when eligibility is not determined promptly under 42 U.S.C. § 1983 and the Fourteenth Amendment to the U.S. Constitution.

Compl. at ¶¶ 157–63.

A. The Delayed Adjudication Class satisfies the numerosity requirement because joinder would be impracticable.

The numerosity requirement of Rule 23(a) is satisfied because the number of potential plaintiffs is "so numerous that joinder of all members" of the class would be "impracticable." Fed. R. Civ. P. 23(a). There is "no strict numerical test for determining impracticability of joinder." *Am. Med. Sys., Inc.*, 75 F. 3d at 1079 (citation omitted), but "substantial" numbers will satisfy this requirement. *Daffin v. Ford Motor Co.*, 458 F.3d 549, 552 (6th Cir. 2006). Courts have not hesitated to certify classes with "as few as 18 to 25 members," *Roman v. Korson*, 152 F.R.D. 101, 105 (W.D. Mich. 1993) (citation omitted), and when the number of members reaches 40, there is a "presumption that joinder is impracticable." *City of Goodlettsville v.*

Priceline.com, Inc., 267 F.R.D. 523, 529 (M.D. Tenn. 2010) (citation omitted); *see also Phillips v. Philip Morris Co. Inc.*, 298 F.R.D. 355, 362 (N.D. Ohio 2014) ("[T]he numerosity requirement is fulfilled when the number of class members exceeds forty.") (citations omitted). The numerosity requirement is also satisfied where "'the exact size of the class is not known, but general knowledge and common sense indicate that it is large.'" *Olden v. LaFarge Corp.*, 203 F.R.D. 254, 269 (E.D. Mich.) (citation omitted), *aff'd*, 383 F.3d 495 (6th Cir. 2004). "Where the numerosity question is a close one, a balance should be struck in favor of a finding of numerosity, since the court has the option to decertify pursuant to Rule 23(c)(1)." *Evans v. U.S. Pipe & Foundry Co.*, 696 F. 2d 925, 930 (11th Cir. 1983).

Here, the Delayed Adjudication Class satisfies the numerical standard because joinder of all members would be impossible. The precise size is unknown by Plaintiffs, but is substantial. Ten individuals who are a part of this lawsuit are members of this class, and it is logical to assume that many more also exist. Indeed, in a letter dated July 14, 2014, from Deputy Commissioner for Health Care Finance & Administration, and Defendant, Darin Gordon to Cindy Mann, the Director of CMS, Gordon complains that there are "numerous case examples from Tennessee" that are not being resolved within the statutory 45-day period required by federal law. Letter from Darin Gordon to Cindy Mann 1 (July 14, 2014) (attached as Ex. 5 to Brooke Decl.). Each of these "numerous case examples" constitutes a member of the Delayed Adjudication Class,[3] and thus common sense would countenance that the class size is substantial and joinder would be impracticable.

[3] Deputy Commissioner Gordon was specifically complaining that the federal marketplace was not processing applications from Tennessee within the allotted time period. Since Tennessee has elected to require all of its applications to be processed first through the federal marketplace, this

Finally, even if there were any doubt on the practicality of joinder based on the size of the class alone, other considerations clearly demonstrate the difficulty of joinder and support class certification. "[I]n determining whether joinder is impracticable [courts should consider] judicial economy, the geographical dispersion of class members, the ease of identifying putative class members, and the practicality with which individual putative class members could sue on their own." *Mays v. Tenn. Valley Auth.*, 274 F.R.D. 614, 631 (E.D. Tenn. May 10, 2011). In its assessment, the court "may make common sense assumptions in examining the numerosity requirement." *French v. Essentially Yours Indus., Inc.*, 1:07-CV-817, 2008 WL 2788511, at *3 (W.D. Mich. July 16, 2008).

Here, the class spans the geographic scope of Tennessee, complicating joinder. Furthermore, members of the class are individuals who are seeking medical coverage because they are on the razor's edge of poverty (which is one of their bases for receiving TennCare coverage), which belies the prospect that absent class members could marshal the resources to bring separate individual actions absent this class action. *See Robidoux v. Celani*, 987 F.2d 931, 936 (2d Cir. 1993) ("They are also economically disadvantaged, making individual suits difficult to pursue."); *McDonald v. Heckler*, 612 F. Supp. 293, 300 (D. Mass. 1985) ("These individuals claim to be disabled and of low income. It is therefore impracticable for these persons to bring individual lawsuits challenging the Secretary's policies."), *modified on other grounds*, 795 F.2d 1118 (1st Cir. 1986). These factors strongly favor certification.

B. Common questions of law and fact predominate.

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means that each of these cases also are outside of the federal statutory period by which Tennessee has to adjudicate their claims.

Rule 23(a)(2) requires that there be "questions of law or fact common to the class." "The threshold of 'commonality' is not high." *Bradshaw v. Pfizer, Inc.*, NO. 1:93 CV 1619, 1997 WL 33446663, at *7 (N.D. Ohio Oct. 31, 1997) (quoting *Jenkins v. Raymark Indus., Inc.*, 782 F.2d 468, 472 (5th Cir. 1986)). This requirement is expressed in the disjunctive and "is satisfied if there is a single factual or legal question common to the entire class." *Powers v. Hamilton County Public Defender Comm'n*, 501 F.3d 592, 619 (6th Cir. 2007) (citation omitted). "What we are looking for is a common issue the resolution of which will advance the litigation." *Sprague*, 133 F. 3d at 397.

Nor are factual discrepancies fatal to a showing of commonality. *See Am. Med. Sys., Inc.*, 75 F.3d at 1080. Rather, the rule requires that "common questions 'predominate over any questions affecting only individual [class] members.'" *In re Whirlpool Corp. Front-Loading Washer Products Liab. Litig.*, 722 F. 3d 838, 858 (6th Cir. 2013). Nevertheless, "[c]ommonality requires the plaintiff to demonstrate that the class members 'have suffered the same injury.'" *Wal-Mart Stores, Inc. v. Dukes*, 131 S. Ct. 2541, 2551 (2011) (citation omitted).

In the instant case, the essential legal and factual questions do not vary among the members of the class. As Defendant Gordon has made plain in his July 14, 2014, correspondence to CMS, the delays of which Plaintiffs complain are of a systemic nature.[4] Common questions of fact include: (1) whether Defendants have in place an effective process to ensure that class members' applications are adjudicated with reasonable promptness; and (2)

[4] Defendant Gordon both acknowledges that delays are affecting many people, and contends that they are occurring as a result of systemic failings and "ongoing operational challenges" on the part of the federally facilitated marketplace, which the State has steadfastly chosen as its exclusive agent for purposes of processing most TennCare applications. Gordon July 14, 2014 Letter 1 (Ex. 5). Whatever the source of the systemic failures, they subject class members to a common fate: the delayed determination of their TennCare eligibility.

whether Defendants have in place an effective process for class members to receive a fair hearing after their claim is not acted upon with reasonable promptness. Common questions of law include: (1) whether Defendants' failure to adjudicate the class members' applications with reasonable promptness, and in any event within 45 days (or 90 days if eligibility is based on a disability) violates 42 U.S.C. § 1396a(a)(8); (2) whether Defendants' failure to have in place an effective process for class members to receive a fair hearing after their claim is not acted upon with reasonable promptness violates 42 U.S.C. § 1396a(a)(3) and/or the Due Process Clause; and (3) whether injunctive and declaratory relief is appropriate and, if so, what the terms of such relief should be.

Accordingly, the resolution of the claims in this case will involve legal theories and facts common to all members of the class, and will materially advance the litigation, in satisfaction of Rule 23(a)(2).

C. The claims of Plaintiffs are typical of the class they seek to represent.

The named Plaintiffs' claims are also "typical of the claims . . . of the class," thereby satisfying Fed. R. Civ. P. 23(a)(3). The typicality requirement examines whether a "'sufficient relationship exists between the injury to the named plaintiff and the conduct affecting the class, so that the court may properly attribute a collective nature to the challenged conduct.'" *Stout v. J.D. Byrider*, 228 F.3d 709, 717 (6th Cir. 2000) (quoting *Sprague*, 133 F.3d at 399). In other words, "'[a]s goes the claim of the named plaintiff, so go the claims of the class.'" *Id.* (modification in original). "In government benefit class actions, the typicality requirement is generally satisfied when the representative plaintiff is subject to the same statute, regulation, or policy as class members." *Carr v. Wilson-Coker*, 203 F.R.D. 66, 75 (D. Conn. 2001) (quoting 5 *Newberg on Class Actions*, § 23.04 (3d ed. 1992) (citations omitted)).

Typicality is established here. All Plaintiffs are members of the Delayed Adjudication Class, and thus if Plaintiffs' claims succeed—if they establish that the delay beyond 45 days or the failure to provide a fair hearing is illegal, and thus that they are entitled to a prompt determination or to a hearing—the claims of the class will succeed as well, and be subject to the same relief.

D. The class representatives will adequately protect the interests of the class.

The named Plaintiffs will also "fairly and adequately protect the interests of the class." Fed. R. Civ. P. 23(a)(4). This inquiry typically centers around whether there is any conflict of interest between the plaintiffs and the members of the class (sometimes characterized as "the presence of common interests and injury"), and whether there is an adequate assurance of vigorous representation. *Rutherford v. City of Cleveland*, 137 F.3d 905, 909 (6th Cir. 1998).

Here, the interests of Plaintiffs and the class they seek to represent are completely aligned. All members of the Delayed Adjudication Class have a common interest in the relief sought in this case—to ensure that applications for TennCare are promptly adjudicated in no more than 45 or 90 days, as required by federal law, and to ensure that a fair hearing is available for any circumstances where the adjudication is not resolved within that timeframe. Moreover, Plaintiffs recognize that this lawsuit involves injustices to persons throughout Tennessee, and though they are interested in having their own hardship relieved, they also desire to see a systemic solution that will spare others from having to endure the suffering they have experienced. *See* Wilson Decl. ¶ 13; Mossa Decl. ¶ 11; D.P. Decl. ¶ 9; M.M. Decl. ¶ 12; L.G. Decl. ¶ 11; Reynolds Decl. ¶ 13; J.P. Decl. ¶ 17; T.V. Decl. ¶ 19.

Counsel for the named Plaintiffs are experienced in federal class action litigation and will vigorously prosecute this matter on behalf of the class. The Southern Poverty Law Center,

National Health Law Project, and Tennessee Justice Center have been approved as class counsel in a number of cases and have experience in this area of law. Brooke Decl. ¶¶ 3–4; Perkins Decl. ¶ 5; Bonnyman Decl. ¶¶ 5–6. Plaintiffs' counsel are advancing costs for this litigation and have sufficient funds available to finance the case. Brooke Decl. ¶ 5.

II. Plaintiffs Meet the Requirements for Certification Under Rule 23(b)(2).

Because Plaintiffs satisfy Rule 23(a), the Court should certify the proposed class if one or more of the grounds for maintaining a class action under Rule 23(b) is met. Here, certification is most clearly appropriate under Rule 23(b)(2) because the Defendants have "acted or refused to act on grounds that apply generally to the class[es], so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole." Fed. R. Civ. P. 23(b)(2). Cases such as this one, where Defendants are charged with "class-wide discrimination[,] are particularly well-suited for 23(b)(2) treatment since the common claim is susceptible to a single proof and subject to a single injunctive remedy." *Senter*, 532 F.2d at 525.

In the instant case, Defendants have acted or refused to act in precisely the same way to all members of the class. All members of the Delayed Adjudication Class have had TennCare applications pending for longer than 45 days, in violation of federal law, and Defendants have not remedied this situation by adjudicating these applications. Furthermore, Defendants have refused to provide any ability for members of the class to have a fair hearing regarding the delay. Thus the actions of Defendants to members of the class are common and consistent. For the same reason, the injury of the class may be remedied by an injunctive order.

III. The Class Definitions are Sufficiently Definite.

Finally, "[b]efore a court may certify a class pursuant to Rule 23, the class definition must be sufficiently definite so that it is administratively feasible for the court to determine

whether a particular individual is a member of the proposed class." *Young v. Nationwide Mut. Ins. Co.*, 693 F.3d 532, 537–38 (6th Cir. 2012) (citations omitted). Thus the class must be defined using "objective criteria" "so that it is administratively feasible for the court to determine whether a particular individual is a member." *Id.* at 538 (citations and quotations omitted).[5]

Here, the class is definite and objectively measureable. It is time-limited ("since October 1, 2013"). The Delayed Adjudication Class refers to persons who have submitted a TennCare application and who have not received a resolution within a timely manner. Federal law requires adjudication of all applications with "reasonable promptness," defined as 45 or 90 days, depending on the claimed basis stated in the TennCare application. 42 U.S.C. 1396a(a)(8); 42 C.F.R. § 435.912(c)(3); *see also Westside Mothers v. Olszewski*, 454 F.3d 532, 540–41 (6th Cir. 2006) (citing 42 C.F.R. §§ 435.911[6]; 435.930). Moreover, members of the class have already identified themselves to Defendants, or will do so in the future, by contacting Defendants' agent, the Tennessee Health Connection. Thus the definition is sufficiently definite so that it is administratively feasible for the Court to determine whether a particular individual is a member of the proposed class.

[5] Nevertheless "[i]t is not necessary that the members of the class be so clearly identified that any member can be presently ascertained." *Carpenter v. Davis*, 424 F.2d 257, 260 (5th Cir. 1970); *see also Young v. Nationwide Mut. Ins. Co*, 693 F.3d 532, 540 (6th Cir. 2012) (certifying a class despite defendants' assertions that it would "entail a large number of individual determinations" and review of individual files to identify the members of the class). Rather, the question is whether, when a person presents herself, is it administratively feasible for the court to determine if she is a class member.

[6] The regulations defining reasonable promptness have been redesignated from 42 C.F.R. § 435.911 to § 435.912 after the implementation of the Affordable Care Act. Eligibility Changes Under the ACA, 77 Fed. Reg. 17144-01, at 17161**,** 17209 (Mar. 23, 2012).

CONCLUSION

For the reasons set forth in this memorandum and other supporting materials, the Court should permit this matter to proceed as a class action under Fed. R. Civ. P. 23(b)(2). Plaintiffs respectfully request that the Court certify the Delayed Adjudication Class, and appoint Plaintiffs' counsel to represent this class.

DATED this twenty-third day of July, 2014.

Respectfully submitted,

/s/ Christopher E. Coleman
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On Behalf of Counsel for Plaintiffs

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* *Application for Pro Hac Vice Admission Forthcoming*

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing has been filed with the court (in paper form and via cd-rom). I further certify that true and correct copy of the foregoing will be served on the office of the Attorney General and Reporter, along with the summons, pursuant to Fed. R. Civ. P. 4(e)(1) and Tenn. R. Civ. P. 4.04(6):

Office of the Attorney General and Reporter
425 5th Ave N #2
Nashville, TN 37243

Dated: July 23, 2014

/s/ Sara Zampierin