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

MELISSA WILSON, *et al.*, ***Plaintiffs,*** **v.** **DARIN GORDON, in his official capacity as Deputy Commissioner of the Tennessee Department of Finance & Administration and Director of the Bureau of TennCare, *et al*.,** ***Defendants*.**	)	**No. 3-14-1492** **Judge Campbell** **Magistrate Judge Bryant**

DEFENDANTS' MEMORANDUM IN
SUPPORT OF THEIR MOTION TO DISMISS

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DEFENDANTS' MEMORANDUM IN
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Defendants (the "State") respectfully submit this Memorandum in Support of their Motion To Dismiss.[1]

INTRODUCTION

At bottom, Plaintiffs' complaint is quite straightforward: they allege that they submitted applications for enrollment into Medicaid to the federal government and they have not received a timely decision from the federal government on their applications. What is not straightforward is their decision to seek redress from Tennessee state officials for the federal government's alleged

[1] Most of the arguments supporting the State's motion to dismiss also appear in the State's opposition to Plaintiffs' motion for a preliminary injunction. They are included in full here to provide the Court with a complete, free-standing brief setting forth all of the reasons supporting the State's respectful submission that the Court should dismiss the Complaint with prejudice.

failure to act on their applications in a timely manner. In this unusual posture, dismissal is required under three different sub-paragraphs of FED. R. CIV. P. 12(b).

First, the Court lacks subject matter jurisdiction. The claims of nine of the eleven named Plaintiffs are moot because they have been enrolled in TennCare. The remaining two Plaintiffs cannot satisfy two of the three bedrock requirements for standing under Article III. Plaintiffs' alleged injury in fact—the delay in the adjudication of their Medicaid applications—was caused by the federally facilitated marketplace ("FFM" or "federal marketplace") operated by the Secretary of Health and Human Services ("HHS") acting through the Centers for Medicare and Medicaid Services ("CMS"), not by the State. And Plaintiffs' alleged injury in fact cannot be redressed by relief imposed against the State. The Medicaid applications were submitted to the FFM, not to the State, and the State has no control over the FFM and cannot order the FFM to release, much less adjudicate, the applications that have been submitted to it. Accordingly, the case must be dismissed for lack of subject matter jurisdiction pursuant to FED. R. CIV. P. 12(b)(1).

Second, Plaintiffs' claims all fail on the merits as a matter of law for multiple reasons:

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

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

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

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

Accordingly, the case must be dismissed for failure to state a claim upon which relief may be granted pursuant to FED. R. CIV. P. 12(b)(6).

Third, the State has no legal or practical way of adjudicating applications in the sole possession of the federal Exchange operated by the Secretary through CMS. Because neither the Secretary nor CMS have been joined as Defendants, "the court cannot accord complete relief among existing parties." *See* FED. R. CIV. P. 19(a)(1)(A). In addition, there is a very "substantial risk" that the State will be "subject to . . . inconsistent obligations" if the Secretary and CMS are not joined. *See id*. 19(a)(1)(B)(ii). The Secretary and CMS are therefore required parties, and Plaintiffs cannot succeed on the merits without joining them as defendants. Absent joinder, the case must be dismissed for failure to join a necessary party pursuant to FED. R. CIV. P. 12(b)(7).

STATEMENT

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

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

Tennessee's Medicaid program, known as TennCare, is administered by the Bureau of TennCare, which is housed within the Division of Health Care Finance and Administration, which itself is part of the State's Department of Finance and Administration. *See* Complaint, D.E. 1, at ¶ 21.

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

The ACA made several significant changes to the Medicaid program that became effective January 1, 2014. As noted above, the ACA provided for the establishment of "Exchanges" through which individuals could apply for health care coverage in a number of different programs, including Medicaid. *See* 42 U.S.C. §§ 18031, 18041, 18083(a). The statute authorized states to operate their own Exchange, and instructed the Secretary to establish a federally operated Exchange in all states that choose not to establish their own Exchange. *See* 42 U.S.C. § 18041(c); *see also National Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2665 (2012). As of mid-2014, only 14 states and the District of Columbia have established state Exchanges. *See* Richard Cauchi, *State Actions To Address Health Insurance Exchanges*, Nat'l Conference of State Legislatures (May 9, 2014), www.ncsl.org/research/health/state-actions-to-implement-the-health-benefit.aspx. Accordingly, CMS established and operates a federal Exchange known as the federally-facilitated marketplace ("FFM") or HealthCare.gov in the 36 remaining states, including Tennessee. *Id.*; *see also* Complaint ¶¶ 55-56.

The ACA also revised the process for applying for Medicaid by (i) mandating the creation of a streamlined application that could be used to apply for a number of health care assistance programs including Medicaid, *see* 42 U.S.C. § 18083(b); and (ii) requiring both states

and the federal government to determine eligibility using data that could be queried electronically from agencies such as the Internal Revenue Service ("IRS") and the Social Security Administration ("SSA"), *see id*. § 18083(c); *see also* 42 C.F.R. § 435.949. To facilitate this process, CMS created the Data Services Hub, which CMS describes as "provid[ing] one connection to the common federal data sources needed to verify consumer application information for income, citizenship, immigration status, access to minimum essential coverage, etc." Kathleen Sebelius, *What's Working in the Marketplace: The Data Services Hub* (Oct. 26, 2013), *available at* www.hhs.gov/digitalstrategy/blog/2013/10/marketplace-data-services-hub.html. The ACA requires the use of a new methodology, known as Modified Adjusted Gross Income ("MAGI"), for calculating income and financial eligibility for most categories of Medicaid. *See* 42 U.S.C. § 1396a(e)(14).[2] Finally, the ACA prohibits a state from asking for information beyond what is on the streamlined application (or an alternative State application approved by CMS) unless the applicant seeks a determination of eligibility in a non-MAGI category. *See id*. § 18083(b)(1)(C).

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

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

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

not yet operational, *see* Complaint ¶ 66, all TennCare applications requiring MAGI eligibility determinations must be submitted for adjudication to the FFM. CMS approved the use of "the FFM to receive and process [all MAGI] applications on the state's behalf as a short-term measure, not a long-term solution." Letter from Cindy Mann of CMS to Darin Gordon of TennCare at 3 (June 27, 2014) (attached as Ex. 14 to the Declaration of Samuel Brooke (hereinafter "Brooke Decl."), D.E. 4-1).

Under the Mitigation Plan, the State elected to use a "determination model" whereby the Federal Exchange would make final determinations of Medicaid MAGI-eligibility and transmit those decisions to the State. *See* Complaint ¶¶ 60, 68; *see also* 42 C.F.R. § 435.1200(c) (states may either elect to have an Exchange make final Medicaid eligibility determinations or elect to have an Exchange assess likely eligibility for Medicaid, leaving the final determination to the state). CMS approved the Mitigation Plan. *See* Brooke Decl., D.E. 2-2, Ex. 4 (CMS approval letter); Letter from Cindy Mann of CMS to Darin Gordon of TennCare at 3 (June 27, 2014) (attached as Ex. 14 to Brooke Decl., D.E. 4-1) (CMS approved use of "the FFM to receive and process [all MAGI] applications on the state's behalf as a short-term measure, not a long-term solution."). Most recently, in response to a request from CMS, the State submitted for CMS review and approval an updated Mitigation Plan on July 14, 2014. *See* Brooke Decl., D.E. 4-1, Ex. 4. This updated Mitigation Plan provides that Tennessee will continue to operate in a "Determination" model with CMS, through the FFM, determining MAGI eligibility for all Tennessee applicants until TEDS becomes operational. *See id.* at 1.

The regulations implementing the ACA require the FFM to promptly transmit to the State Medicaid agency all information concerning a Medicaid application (i.e., the application, any information the Exchange has received from the IRS and the SSA through the Data Hub, and

supplementary documentation submitted by the applicant) whenever the FFM has (i) determined the applicant to be MAGI eligible, (ii) assessed the applicant as eligible, leaving the final eligibility determination to the State, (iii) assessed the applicant as non-eligible and the applicant has requested that her application be considered for a non-MAGI category, or (iv) denied a Medicaid application and the applicant wishes to appeal the FFM's decision to the State Medicaid agency. *See* 45 C.F.R. §§ 155.302(b)(3), 155.310(d)(3), 155.345(d)(1), 155.505(b)(1)(ii). Notably, there is no regulation that requires the FFM to provide *pending* application files to the State Medicaid agency. Moreover, the FFM does not presently have the capability to provide to the states either pending application files or the application files associated with FFM denials (regardless of whether the applicant wishes to appeal to the State). *See* Declaration of Wendy Long (hereinafter "Long Decl.") at ¶ 3(h).

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

The FFM also currently lacks the capability to reliably and consistently provide the State with several other important categories of data: (i) information on whether or when an individual has applied at the FFM; (ii) information on FFM denials of Medicaid applications; and

(iii) information on what verifications or other information is missing from an applicant's file or the reason why a file has not been adjudicated. *See id*. ¶¶ 3(c) & (h). The State has brought these concerns to CMS's attention numerous times and is continuing to work with CMS to find solutions, but as of now CMS has not been able to provide the State with any assurance as to when these problems will be rectified. *See id*.

ARGUMENT

I. THE COURT LACKS SUBJECT MATTER JURISDICTION.

A court must first determine that it has jurisdiction before turning to consider the merits of the case. *Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 94-95 (1998); *CDI Info. Servs. v. Reno*, 278 F.3d 616, 618 (6th Cir. 2002) (noting that it is "incumbent" on the court "to verify the existence of subject matter jurisdiction"). This "requirement that jurisdiction be established as a threshold matter 'springs from the nature and limits of the judicial power of the United States' and is 'inflexible and without exception.' " *Steel Co.*, 523 U.S. at 94-95 (alteration in original) (*quoting Mansfield, C. & L. M. Ry. Co. v. Swan*, 111 U.S. 379, 382 (1884)). The plaintiff bears the burden of establishing that the court has jurisdiction. *DLX Inc. v. Kentucky*, 381 F.3d 511, 516 (6th Cir. 2004).

A. The Claims of Nine of the Eleven Named Plaintiffs Are Moot.

Nine of the eleven named Plaintiffs (Melissa Wilson, April Reynolds, Mohammed Mossa, Mayan Said, S.P., K.P., S.V., C.A., and S.G.) were enrolled in TennCare shortly before or shortly after the complaint in this case was filed. *See* Declaration of Kim Hagan at ¶ 13. C.A., S.G., and K.P. were enrolled in TennCare pursuant to the new presumptive eligibility ("PE") program for newborn children of non-TennCare mothers. *See id*. at ¶¶ 12-13. CMS recently informed the State that it will favorably consider the program for approval, and the State

has decided to implement the program in anticipation of this approval. Accordingly, the State provided Plaintiffs' counsel with PE applications for these newborns and promptly adjudicated those applications and enrolled these children when the applications were returned by Plaintiffs' counsel. *See id.* Accordingly, the claims of these nine plaintiffs are moot, and they must be dismissed for lack of subject matter jurisdiction. *See Mosley v. Hairston*, 920 F.2d 409, 414 (6th Cir. 1990) ("The issue of mootness implicates the court's subject matter jurisdiction inasmuch as federal courts are limited by Art. III of the Constitution to deciding cases and controversies. This requirement refers to 'live' controversies, those that persist in 'definite and concrete' form even after intervening events have made some changes in the parties' circumstances.").

B. The Plaintiffs All Lack Standing.

A related element of a federal court's jurisdiction is the plaintiff's Article III standing. *See Harker v. Troutman (In re Troutman Enters., Inc.)*, 286 F.3d 359, 364 (6th Cir. 2002) ("Standing is a jurisdictional requirement and we are under a continuing obligation to verify our jurisdiction over a particular case."). In order to establish standing, the plaintiff must show: (i) injury in fact, (ii) causation, and (iii) redressability. *Steel Co.*, 523 U.S. at 102-03 (1998) (identifying these factors as the "irreducible constitutional minimum of standing"); *see also Smith v. Jefferson Cnty. Bd. of Sch. Comm'rs*, 641 F.3d 197, 206 (6th Cir. 2011) (en banc); *Coyne v. American Tobacco Co.*, 183 F.3d 488, 494 (6th Cir. 1999). "Injury in fact" is a harm suffered by plaintiff that is "concrete and actual or imminent, not conjectural or hypothetical." *Steel Co.*, 523 U.S. at 103 (quotation marks omitted) (*citing Whitmore v. Arkansas*, 495 U.S. 149, 155 (1990)). "Causation" is "a fairly traceable connection between the plaintiff's injury and the complained-of conduct of the defendant." *Id.* (*citing Simon v. Eastern Ky. Welfare Rights*

Org., 426 U.S. 26, 41-42, (1976)). "Redressability" is "a likelihood that the requested relief will redress the alleged injury." *Id*. (*citing Warth v. Seldin*, 422 U.S. 490, 505 (1975)).

Plaintiffs' alleged injuries in fact all spring from the alleged failure of the FFM to timely adjudicate their TennCare enrollment applications. Plaintiffs have not alleged that any action or inaction by the State has caused the FFM's delays in processing their applications. And the relief they have requested will not redress their injuries because it will not result in the release of their applications from the federal Exchange. Plaintiffs demand instead that the State develop and implement, immediately, a brand new manual system for assessing Medicaid eligibility that would be capable of adjudicating applications within 72 hours of receiving evidence suggesting that an individual had applied to the federal government's Exchange more than 45 days earlier. Although Plaintiffs have requested the sort of impossible relief that equity simply does not provide, it is also a form of relief that does not suffice to establish Article III standing. Absent action by the federal government, Plaintiffs' applications will remain, unadjudicated, in the federal Exchange. Thus, no redress of Plaintiffs' alleged injuries can be provided absent the action by this absent third party.

Plaintiffs have not met their burden, therefore, of alleging that they have suffered the type of "concrete, particularized, and imminent injury in fact caused by the defendant that a favorable judicial outcome would likely remedy" that would satisfy the standing requirements of Article II. *Kroll v. White Lake Ambulance Auth.*, 691 F.3d 809, 813 (6th Cir. 2012). Their suit must therefore be dismissed for lack of jurisdiction.

1. The Plaintiffs have failed to allege that they have suffered an injury in fact that is fairly traceable to the challenged action of Defendants.

The plaintiffs seek to establish standing based upon an injury that was caused not by the State, but by the FFM. To establish causation for purposes of Article III standing, a plaintiff

must allege "a causal connection between the injury and the conduct complained of—the injury has to be 'fairly . . . trace[able] to the challenged action of the defendant, and not . . . th[e] result [of] the independent action of some third party not before the court.' " *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992) (alterations in original) (quoting *Simon*, 426 U.S. at 41-42). Plaintiffs' claims in this case fail to meet this basic requirement. Each alleges that he or she submitted an application to the FFM. *See* Complaint ¶¶ 99, 103, 109, 115, 120, 127, 133-34, 141. Each alleges that he or she has not received a timely adjudication of that application. *See id*. ¶¶ 99, 104, 111, 115, 122, 131, 135, 141. It necessarily follows that Plaintiffs' alleged injuries are "the result [of] the independent action of some third party not before the court," the FFM.

Plaintiffs seek to gloss over this jurisdictional defect in their complaint by asserting that the State "remains responsible for ensuring that all eligibility determinations, including those delegated to the FFM, comply with applicable laws and regulations." *Id.* ¶ 62. Plaintiffs are mistaken. Neither the ACA nor any other law grants the State the authority to superintend the Secretary of HHS and CMS as they carry out their responsibility to operate the FFM. The ACA unambiguously commands the Secretary, not the State, to "take such actions as are necessary to implement" all of the requirements the ACA imposes on the Exchange in states, like Tennessee, that have elected not to establish an Exchange. 42 U.S.C. § 18041(c)(1). Among those requirements is the obligation to make Medicaid eligibility determinations. *See id.* § 18083(a) & (b)(1)(A)(iii).

Federal regulations do not say otherwise when they forbid the states to "delegate . . . the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters." 42 C.F.R. § 431.10(e). The State could not delegate the power to "supervise" the

federal Exchange because neither Tennessee nor any other state has the power to "supervise" or to "develop or issue policies, rules, and regulations" for the federal Exchange. *See* 42 U.S.C. § 18041(c) (vesting authority to establish and operate federal exchanges, "directly or through agreement with a not-for-profit entity," in the Secretary of HHS). To be sure, Tennessee has delegated to the federal Exchange responsibility for Medicaid eligibility determinations and appeals. *See* 42 C.F.R. § 431.10(c) (authorizing such delegations). But Plaintiffs concede that this delegation is lawful, Complaint ¶ 55, and *supervision* of how the federal Exchange carries out its functions is not the State's to delegate. The federal government is responsible for the federal Exchange.

Further confirmation that the ACA contemplates no role whatever for the State Medicaid agency while an application for Medicaid enrollment is pending with the FFM may be found in the regulations setting forth when the FFM must provide application file data to the State Medicaid agency. As explained above, the FFM must provide the State with all information that it has gathered with respect to an application whenever it has (i) determined the applicant to be MAGI eligible, (ii) assessed the applicant as eligible, leaving the final eligibility determination to the State, or (iii) assessed the applicant as non-eligible and the applicant has requested that her application be considered for a non-MAGI category. *See* 45 C.F.R. §§ 155.310(d)(3), 155.302(b)(3) & (b)(4)(ii), 155.345(d)(1), 155.510(c). But there is no regulation that requires the FFM to provide *pending* application files to the State Medicaid agency, confirming that the ACA does not contemplate any State actions while an unresolved application is pending with the FFM.

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

Medicaid program. *See* 42 U.S.C. § 1396a(b) (State Medicaid plan must be approved by CMS). It has long been settled that states lack the authority to supervise or regulate the activities of the federal government. *See, e.g.*, *Johnson v. Maryland*, 254 U.S. 51, 57 (1920) (Holmes, J.) (noting "the immunity of the instruments of the United States from state control"). The Court should not find such an extraordinary reversal of traditional federal-state relations absent an exceedingly clear statement from Congress. *See Gregory v. Ashcroft*, 501 U.S. 452, 460-61 (1991). Notably, Plaintiffs are unable to cite *any* Act of Congress or other authority supporting the extraordinary proposition that state officials have the authority to supervise the Secretary and CMS in their operation of the federal Exchange. And if such a statute existed, it would raise profound separation of powers questions. *See, e.g., Free Enter. Fund v. Public Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3151-55 (2010) (vesting of federal Executive power in anyone other than the President violates Article II of the Constitution).

In short, Plaintiffs allege an injury that results directly from the actions or inactions of the FFM. They have not alleged any State participation in the activities of the FFM, and the State does not oversee the FFM. Accordingly, Plaintiffs' alleged injuries in fact were caused by parties other than the State, and as a result, Plaintiffs lack Article III standing.

2. Plaintiffs lack standing to sue because they have not alleged an injury in fact that would be redressed by the relief they request.

Plaintiffs also fail to satisfy the third prong of the standing inquiry because they have alleged an injury that could be redressed only by the action of a third party not now before this Court. The relief sought must remedy the injury alleged. "Relief that does not remedy the injury suffered cannot bootstrap a plaintiff into federal court; that is the very essence of the redressability requirement." *Steel Co.*, 523 U.S. at 107. Redressability thus requires "that prospective relief will remove the harm," *Warth*, 422 U.S. at 505, and the plaintiff must show

"that he personally would benefit in a tangible way from the court's intervention," *id*. at 508; *see also Morrison v. Board of Educ. of Boyd Cnty.*, 521 F.3d 602, 610-11 (6th Cir. 2008) (no standing where nominal damages would not redress past injury).

Plaintiffs' alleged injury results from the FFM's failure to adjudicate their applications for enrollment into TennCare. Until the FFM issues its determination, no relief awarded in this suit would redress the injury Plaintiffs have alleged. Simply put, the State cannot provide Plaintiffs with a decision on their applications because the State does not have those applications; it does not have any of the data gathered from other federal databases to address those applications; and it does not have any supplemental information or documentation submitted by the applicants to the FFM in support of their applications. The FFM operated and overseen by CMS has those materials, all of which are necessary to adjudicate the applications and redress the alleged injury. The State has neither the authority nor the practical ability to review and adjudicate applications that are in the possession of the FFM.[3]

"When causation hinges on independent third parties, the plaintiff has the burden of showing that the third parties' choices 'have been or will be made in such a manner as to produce causation and permit redressability of injury.' " *ACLU v. NSA*, 493 F.3d 644, 666-67 (6th Cir. 2007) (quoting *Lujan*, 504 U.S. at 562). Plaintiffs have not met their burden of pleading that federal regulators would act in such a manner as to permit the redress of their injuries.

Any relief that would redress Plaintiffs' injury, finally, would have to conform to the federal Medicaid statutes and regulations and would require the approval of federal regulators.

[3] The State cannot simply abandon the statutory scheme and begin providing ad hoc decisions without regard to the Medicaid eligibility requirements in federal law and regulation. Federal law requires more than that a State provide benefits promptly; the States must also provide those benefits lawfully to eligible persons.

Indeed, as even a cursory review of the material attached to Brooke Declaration reveals, crafting a remedy that will redress the injuries being suffered by Plaintiffs is a task that Congress intended for HHS and other agencies to accomplish by working in cooperation with the States and their agencies. While they are still in the midst of performing the task entrusted to them by statute and by executive action, the matter is not a case or controversy for the decision of the courts.

II. PLAINTIFFS FAIL TO STATE A CLAIM UPON WHICH RELIEF MAY BE GRANTED.

Plaintiffs have alleged three causes of action. First, they claim that the FFM's failure to timely adjudicate their TennCare applications violates the "reasonable promptness" requirement set forth in 42 U.S.C. § 1396a(a)(8). Second, they claim that the State has violated the "reasonable promptness" requirement set forth in 42 U.S.C. § 1396a(a)(3) by failing to consider Plaintiffs' attempts to appeal the FFM's failure to timely consider their TennCare applications. Third, they claim that the State has violated their Constitutional due process rights by failing to consider Plaintiffs' attempts to appeal the FFM's failure to timely consider their TennCare applications. These claims all fail as a matter of law for multiple reasons.

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

Plaintiffs' Section 1396a(a)(8) claim fails because this provision of the Medicaid Act is not enforceable under 42 U.S.C. § 1983. The Sixth Circuit so held in an unpublished decision, explaining that the provision was not "sufficiently specific" to create a right enforceable under Section 1983, but rather merely "expresses general policy goals." *Cook v. Hairston,* 948 F.2d 1288, 1991 WL 253302, at *5 (6th Cir. 1991) (unpublished table decision). One district court in this circuit has followed *Cook*, *see Wood v. Wallace*, 825 F. Supp. 177, 184 (S.D. Ohio 1993), *rev'd on other grounds*, 33 F.3d 600 (6th Cir. 1994), and other federal district courts have

reached the same result in more recent years, *see Sanders ex rel. Rayl v. Kansas Dep't of Soc. & Rehab. Servs.*, 317 F. Supp. 2d 1233, 1250 (D. Kan. 2004); *MAC v. Betit*, 284 F. Supp. 2d 1298, 1307 (D. Utah 2003).[4] To be sure, the federal courts have divided over whether Section 1396a(a)(8) confers judicially enforceable rights. *See, e.g.*, *Doe ex rel. Doe v. Chiles*, 136 F.3d 709, 713-19 (11th Cir. 1998) (holding that Section 1396a(a)(8) gives rise to a federal right enforceable under 42 U.S.C. § 1983). But the better view, especially after the Supreme Court's decision in *Gonzaga University v. Doe*, 536 U.S. 273, 282-83 (2002), which held that the right to bring an individual cause of action under Section 1983 must be unambiguously conferred, is that the "reasonable promptness" provision of Section 1396a(a)(8) merely "expresses general policy goals" and is not individually enforceable, *Cook*, 1991 WL 253302, at *5. As Section 1396a(a)(3) uses the same general, non-specific term ("reasonable promptness"), Plaintiffs likewise may not bring a Section 1983 action to enforce that provision.[5]

Plaintiffs err at the outset to the extent that they assert a *regulatory* right, under 42 C.F.R. § 435.912(c)(3), to have their applications processed within 45 days rather than a *statutory* right

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

[5] In *Gean v. Hattaway*, 330 F.3d 758, 773 (6th Cir. 2003), the Sixth Circuit held that because "a right to a fair hearing," granted by Section 1396a(a)(3), "is not so vague and amorphous that its enforcement is beyond the abilities of a competent judiciary," it is enforceable under Section 1983. That holding in no way undermines the unpublished ruling in *Cook* because the ruling in that case turned on the amorphous nature of the term "reasonable promptness," which appears in both Section 1396a(a)(3) and (8).

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

B. Plaintiffs' Factual Allegations Do Not Establish a Violation of the "Reasonable Promptness" Requirement of Section 1396a(a)(8).

1. "Reasonable promptness" is a flexible standard that permits delays in unusual circumstances.

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

Section 1396a's legislative history confirms this analysis. The phrase "reasonable promptness" was borrowed from a provision of the Social Security Act that became law in 1950 as part of Pub. L. No. 81-734, 64 Stat. 477, at 548 (Aug. 26, 1950). *See generally Sobky v.*

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

In deciding what constitutes "reasonable promptness" under the present circumstances, the Court should give substantial weight to State officials' judgment. The Court always owes deference to the judgment of those responsible for implementing an Act of Congress, but an extra measure of judicial deference is due to those " 'charged with the responsibility of setting [a new law's] machinery in motion; of making the parts work efficiently and smoothly while they are yet untried and new.' " *Power Reactor Dev. Co. v. International Union of Elec., Radio & Mach. Workers*, 367 U.S. 396, 408 (1961) (quoting *Norwegian Nitrogen Prods. Co. v. United States*, 288 U.S. 294, 315 (1933)); *see also United States Air Force v. FLRA*, 681 F.2d 466, 467 (6th Cir. 1982).

Any doubt as to the "reasonableness" of the efforts to implement the ACA in Tennessee is removed when one compares the bottom-line results the State has achieved with the status of Medicaid enrollment in other states. Enrollment in TennCare has increased substantially since January 1—approximately 89,00 have been approved by the FFM between January 1, 2014 and

the end of June, and the State has directly approved the enrollment or extended healthcare coverage to approximately 46,000 individuals during that period. The rate of enrollment in 2014 is the third highest in the 20-year history of the TennCare program, and the growth in TennCare enrollment is more than double the average rate of increase experienced by other States that, like Tennessee, have not expanded their Medicaid programs. *See* Declaration of Tracy Purcell ("Purcell Decl.") at ¶ 19. And the State has avoided the substantial backlogs that have plagued many other state Medicaid programs. *See* Phil Galewitz, *More than 1.7 Million Consumers Still Wait for Medicaid Decisions*, KAISER HEALTH NEWS (June 9, 2014), *available at* www.kaiserhealthnews.org/Stories/2014/June/09/More-Than-17-Million-Consumers-Still-Wait-For-Medicaid-Decisions.aspx.

2. The regulation Plaintiffs rely upon confirms that they have not <u>been denied the reasonably prompt processing of their applications.</u>

Plaintiffs repeatedly assert that "Federal law requires Medicaid eligibility determinations to be made with 'reasonable promptness' within 45 days of applying or, in the case of an individual applying on the basis of disability, 90 days." Complaint ¶ 63 (citing 42 U.S.C. § 1396a(a)(8) and 42 C.F.R. § 435.91[2](a)).[6] But the statute does not impose any requirement beyond the general "reasonable promptness" standard, and the regulation they rely upon does not impose a rigid, unyielding 45-day deadline. Instead, the regulation adopts a flexible understanding of "reasonable promptness" that permits exceptions in "unusual circumstances" such as those created by the implementation of the ACA. And CMS has confirmed that the problems experienced by the FFM constitute "unusual circumstances" justifying such an exception.

[6] The regulation addressing the timeliness of eligibility determinations is set forth at 42 C.F.R. § 435.912, not Section 435.911 as cited in Plaintiffs' complaint.

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

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

Id. § 435.912(e).

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

Significantly, the federal agency responsible for administering these regulations has expressed the view that problems with the federal Exchange constitute "unusual circumstances" that excuse compliance with the 45-day standard. Not long ago, Pennsylvania officials wrote to CMS to request a waiver of that standard because, among other things, problems with the federal

Exchange had resulted in "a large number of applications in the queue to be processed." Letter from Leesa M. Allen, Pa. Exec. Medicaid Dir., to Jessica P. Kahn, Acting Dir., Div. of State Sys., Dep't of Health & Human Servs. at 1 (Nov. 25, 2013) (attached in Long Decl., Ex. A). CMS responded that "a waiver is not necessary as our regulations provide for circumstances in which timelines are affected for reasons outside the state's control," citing the regulation now codified at 42 C.F.R. § 435.912(e). Letter from Jessica P. Kahn, Dir., Div. of State Sys., Dep't of Health & Human Servs. to Leesa M. Allen, Pa. Exec. Medicaid Dir. at 1 (Jan. 30, 2014) (attached in Long Decl., Ex. B).

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

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

Even if the delays Plaintiffs have allegedly experienced violated federal law, and even if there is a private right of action under Section 1983 to redress that alleged violation of federal law, Plaintiffs' claims against the State fail as a matter of law because the FFM, not the State, has allegedly failed to timely adjudicate Plaintiffs' TennCare applications. Even though it is undisputed that federal officials established and maintain the federal Exchange, Plaintiffs contend that its flaws are legally attributable to the State. That is not the law. The ACA assigns legal responsibility for the exchange's expeditious processing of Medicaid applications to the

governmental entity that supervises its operation, and Plaintiffs' only remedy is against the federal agency responsible for the delays they have experienced.

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

Plaintiffs resist this commonsense understanding of the assignment of legal duties, arguing that the State "remains responsible for ensuring that all eligibility determinations, including those delegated to the [federal Exchange], comply with applicable laws and regulations." Complaint ¶ 62. But when a state declines to establish its own exchange, federal officials succeed by operation of law to all state legal duties associated with exchange operations. The ACA unambiguously commands the Secretary, not the State, to "take such actions as are necessary to implement" all of the requirements the ACA imposes on the Exchange in states, like Tennessee, that have elected not to establish an Exchange. 42 U.S.C. § 18041(c)(1). Among those requirements is the obligation to make Medicaid eligibility determinations. *See id.* § 18083(a) & (b)(1)(A)(iii). The law does not contemplate a role for the State Medicaid agency while an application is pending with the FFM. *See supra* at pp. 6-7.

The cases Plaintiffs cite for the proposition that the State has non-delegable duties under the Medicaid Act are not to the contrary. Plaintiffs' Memorandum in Support of Their Motion for a Preliminary Injunction, D.E. 5 ("Pl. PI Br."), at 20 (citing *Catanzano v. Dowling*, 60 F.3d 113, 118 (2d Cir. 1995); *Carr v. Wilson-Coker*, 203 F.R.D. 66, 75 (D. Conn. 2001); *McCartney ex rel. McCartney v. Cansler*, 608 F. Supp. 2d 694, 701 (E.D.N.C. 2009); and *J.K. ex rel. R.K. v. Dillenberg*, 836 F. Supp. 694, 699 (D. Ariz. 1993)). All of those cases pre-date the ACA, and all involved delegations of authority to private entities or other state agencies—not a federal agency that the states are powerless to control. Plaintiffs' cases rest on the proposition that "it is patently unreasonable to presume that Congress would permit a state to disclaim federal responsibilities by contracting away its obligations *to a private entity*," *Catanzano*, 60 F.3d at 118 (emphasis added) (internal quotation marks omitted), but the same reasoning does not apply to state transfers of federal responsibilities back to the federal government that Congress has authorized.[7]

Perhaps recognizing that direct state supervision of the federal Exchange is a statutory and constitutional nonstarter, Plaintiffs step back in their preliminary injunction request and ask that the Court order the State to create and implement a back-up system for processing Medicaid applications and appeals whenever the federal Exchange takes too long to adjudicate the applications submitted to it. *See* Plaintiffs' Draft Preliminary Injunction Order, D.E. 4-2, at 2. Nothing in the Medicaid statute, the ACA, or the implementing regulations requires the State, in 48 or 72 hours no less, to adjudicate a Medicaid application submitted to the federal Exchange that has not been adjudicated by the FFM on a timely basis. Rather than ordering the State to

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

create and implement such an unauthorized back-up system to address the federal Exchange's problems, the far simpler solution—albeit a solution unavailable to the Court because Plaintiffs have not joined the Secretary and CMS as parties—would be to order the FFM to adjudicate any applications that have not been timely resolved.

Plaintiffs are mistaken when they suggest that the State's current reliance on the federal Exchange to make eligibility determinations violates provisions of the ACA regarding how a state should accept and process Medicaid applications. *See* Pl. PI Br. at 21. The State is in compliance with the provision they cite because Medicaid applications "may be filed . . . with State officials." 42 U.S.C. § 18083(b)(1)(A)(iii). As explained above, when applications are filed with TennCare, the State forwards them to the FFM for eligibility determinations. And 42 U.S.C. § 18083(c)(3)(A) makes clear that states are only required to make their own Medicaid eligibility determinations using data matching "to the maximum extent practicable." As explained above, challenges associated with the need to replace ACCENT have so far prevented the State from bringing its own data-matching system online, *see* Complaint ¶ 66, but the State and its contractor are working diligently to that end. In the meantime, CMS has approved the State's decision "to leverage the FFM to receive and process applications on the state's behalf," Letter from Cindy Mann, CMS, to Darin Gordon, TennCare, at 3 (June 27, 2014), attached as Ex. 14 to the Brooke Decl., D.E. 4-1—a stopgap solution that has worked well for the vast majority of Medicaid applicants in Tennessee. The State's CMS-approved reliance on the federal Exchange while it works to complete implementation of TEDS fully complies with the requirement that it implement its own data-matching system "to the maximum extent practicable." 42 U.S.C. § 18083(c)(3)(A).

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

The foregoing discussion focuses on the requirements of Section 1396a(a)(8), but Plaintiffs' Section 1396a(a)(3) and due process claims necessarily fail for the same reasons. Plaintiffs' hearing rights under Section 1396a(a)(3) are only triggered if their applications are "denied or . . . not acted upon with reasonable promptness," and neither of those events has yet occurred. Plaintiffs do not allege that their applications were denied, and for the reasons explained above, Plaintiffs' factual allegations do not support the legal conclusion that the FFM has failed to act upon the applications with reasonable promptness. Similarly, due process requires no more than "such procedural protections as the particular situation demands," *Mathews v. Eldridge*, 424 U.S. 319, 334 (1976) (quoting *Morrissey v. Brewer*, 408 U.S. 471, 481 (1972)), and Plaintiffs are unable to cite any authority for the proposition that a hearing is required before an application is denied or not adjudicated with "reasonable promptness." In the end, Plaintiffs' three claims reduce to the single contention that the State should have already acted upon Medicaid applications that are in the sole possession of federal officials the State does not control. That contention fails for the reasons explained above.

Even if a right to a hearing had been triggered, Plaintiffs' statutory and due process claims fail because they are free to seek a fair hearing from the FFM. *See* 45 C.F.R. § 155.505 (right to appeal Exchange determinations to the HHS appeals entity). To be sure, the State is required to adjudicate appeals of FFM eligibility determinations when an applicant chooses to appeal to the State Medicaid agency, *see* 42 C.F.R. § 431.205(b)(1)(ii), but that obligation is implicitly contingent upon CMS fulfilling its obligation to provide the State with the application files. As a practical matter, the State cannot adjudicate appeals when it does not have the application, it does not have the additional data provided by other federal agencies through the

Data Services Hub, it does not have any supplemental verification documentation submitted by the applicant, and it does not have the FFM's decision on the application. *See* Long Decl. at ¶ 3(h) (FFM does not presently have the capability to provide pending application files or denials to the States). The federal Exchange is required to share an applicant's application files with the State whenever that applicant wishes to appeal to the State, 45 C.F.R. § 155.510(b)(1)(ii), and its doing so is a necessary predicate to any duty on the State's part to hear appeals. Indeed, any adjudication of Plaintiffs' appeals without that information would itself risk depriving Plaintiffs of due process. *See Living Care Alts. of Utica, Inc. v. United States*, 411 F.3d 621, 625 (6th Cir. 2005) (observing that "normal review of administrative decisions requires the existence of a record"). Again, whatever relief Plaintiffs are owed must run against the federal agency responsible for the delays they have allegedly experienced.

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

III. PLAINTIFFS HAVE FAILED TO JOIN PARTIES WHOSE PRESENCE IS REQUIRED BY RULE 19.

This suit cannot go forward as pleaded for one final reason: Plaintiffs have failed to join two required parties, the Secretary of HHS and CMS (collectively, the "United States"). While the general rule is that "the plaintiff is 'the master of the complaint,' " *Holmes Grp., Inc. v. Vornado Air Circulation Sys., Inc.*, 535 U.S. 826, 831 (2002) (citation omitted), this power of "determin[ing] who may, or must, be parties to a suit," *Philippines v. Pimentel*, 553 U.S. 851, 863 (2008), cannot be left to the sole discretion of Plaintiffs. Because the choice of defendants "has consequences for the persons and entities affected by the judgment; for the judicial system and its interest in the integrity of its processes and the respect accorded to its decrees; and for society and its concern for the fair and prompt resolution of disputes," *id.*, the Federal Rules provide several exceptions to the plaintiff's general control. One such exception appears in Rule 19(a)(1):

> A person who is subject to service of process and whose joinder will not deprive the court of subject-matter jurisdiction must be joined as a party if: (A) in that person's absence, the court cannot accord complete relief among existing parties; or (B) that person claims an interest relating to the subject of the action and is so situated that disposing of the action in the person's absence may: (i) as a practical matter impair or impede the person's ability to protect the interest; or (ii) leave an existing party subject to a substantial risk of incurring double, multiple, or otherwise inconsistent obligations because of the interest.

FED. R. CIV. P. 19(a)(1).

In the Sixth Circuit, determining "whether joinder is proper under Rule 19 is a three-step process." *Glancy v. Taubman Ctrs., Inc.*, 373 F.3d 656, 666 (6th Cir. 2004). "First, the court must determine whether the person or entity is a necessary party" by applying the three criteria listed in Rule 19(a). *Id.* Second, if any of those three criteria are satisfied and "personal jurisdiction is present, the party *shall* be joined." *Keweenaw Bay Indian Cmty. v. Michigan*, 11

F.3d 1341, 1345 (6th Cir. 1993) (quoting *Local 670 v. International Union, United Rubber, Cork, Linoleum & Plastic Workers of America*, 822 F.2d 613, 618 (6th Cir. 1987)). But "in the absence of personal jurisdiction (or if venue as to the joined party is improper)," the court must "proceed[] to the third step, which involves an analysis of the factors set forth in Rule 19(b) to determine whether the court may proceed without the absent party." *Id.* at 1345-46 (quoting *Local 670*, 822 F.2d at 618).

Since neither personal jurisdiction nor venue presents an obstacle to the joinder of the United States in this case, there is no need to consider the Rule 19(b) factors. *See* 28 U.S.C. § 1391(e) (providing for permissive venue and nationwide service of process in cases against the United States and its Officers acting in an official capacity); 5 U.S.C. § 702 (waiving sovereign immunity for suits "seeking relief other than money damages and stating a claim that an agency or an officer or employee thereof acted or failed to act in an official capacity"). Accordingly, if the Court concludes that the presence of the United States is required by any of Rule 19(a)'s three prongs, it should order Plaintiffs to promptly amend their complaint to include the United States as a defendant on pain of dismissal under Rule 12(b)(7). *See Joint Mktg. Int'l, Inc. v. L&N Sales & Mktg., Inc*., 2006 WL 1995130, at *5 (E.D.N.Y. July 14, 2006) ("The [Rule 12(b)(7)] motion to dismiss is granted, but dismissal is stayed. The action will be dismissed with prejudice if . . . twenty days lapse without joinder of [the absent party].").

The moving party bears the initial burden of "showing the nature of the interest possessed by an absent party and that the protection of that interest will be impaired by the absence," *Citizen Band Potawatomi Indian Tribe of Okla. v. Collier*, 17 F.3d 1292, 1293 (10th Cir. 1994), but once "an initial appraisal of the facts reveals the possibility that an unjoined party is arguably indispensable, the burden devolves upon the party whose interests are adverse to the unjoined

party to negate the unjoined party's indispensability to the satisfaction of the court," *Boles v. Greeneville Hous. Auth.*, 468 F.2d 476, 478 (6th Cir. 1972). "A failure to meet this burden results in the necessity of either joinder or dismissal." *Id.*

A. The United States' Presence Is Required Because in Its Absence, This Court Cannot Accord Complete Relief Among the Existing Parties.

Rule 19(a)(1)(A)'s requirement that a person or entity must be joined if "in that person's absence, the court cannot accord complete relief among existing parties" focuses on "whether in the person's absence the court would be obliged to grant partial or 'hollow' rather than complete relief to the parties before the court." *Gateway Assocs., Inc. v. Essex-Costello, Inc.*, 380 F. Supp. 1089, 1095 (N.D. Ill. 1974). In this case, the relief Plaintiffs seek requires the independent action of the United States; thus, the United States' joinder is necessary before this Court can accord Plaintiffs any relief at all.

To begin with, as explained *supra* at pp. 10-15, the State is practically and legally incapable of granting Plaintiffs the relief they seek—adjudication of their TennCare applications—unless and until the FFM releases the application files to the State. Since Defendants have "no power to grant the relief sought by [Plaintiffs], issuance of a decree against [them] would be a useless act." *Dombrovskis v. Esperdy*, 321 F.2d 463, 465 (2d Cir. 1963). In these circumstances, joinder under Rule 19(a)(1)(A) or dismissal under Rule 12(b)(7) is required. *Cf. Focus on the Family v. Pinellas Suncoast Transit Auth.*, 344 F.3d 1263, 1279-80 (11th Cir. 2003) (where Plaintiff sought to compel the Transit Authority to post its advertisements in bus shelters but a third-party contractor held all authority over the selection of advertising, joinder of contractor was required to grant complete relief); *Dombrovskis*, 321 F.2d 464-65 (where an alien sued the INS seeking adjustment of status, Department of State was a necessary party because a

"prerequisite to the granting of such relief is the immediate availability of a visa," and the INS "has no power over the issuance of visas").

B. The United States' Presence Is Required Because There Is a Substantial Risk that the State Will Be Subjected to Multiple Inconsistent Obligations.

Joinder of the United States is also required pursuant to Rule 19(a)(1)(B)(ii): absent joinder, there is a very "substantial risk" that Defendants will find themselves "subject to . . . inconsistent obligations." Currently, the TennCare application process is subject to the Mitigation Plan that has been approved by CMS. Plaintiffs' proposed relief would potentially expose the State to inconsistent obligations if the State were required to implement a process that has not been approved by CMS. Moreover, Plaintiffs' proposed relief arguably violates existing federal regulations by requiring that members of the proposed class resubmit to the State the information in support of their application that has already been submitted to the FFM. 42 C.F.R. § 435.1200(d)(2) (double submission of applicant's information to FFM and State not permitted); *see also Pegues v. Mississippi State Emp't Serv.*, 57 F.R.D. 102, 104 (D. Miss. 1972) (holding that the Secretary of Labor was a necessary party to a suit to change state employment "classification, testing and referral procedures" since such changes "would require defendants to violate the regulations of the Secretary," leaving them "subject to substantial risk of incurring double, multiple or otherwise inconsistent obligations by reason of his interest").

More generally, the Secretary has the ultimate authority to approve or decline Tennessee's state plan, 42 U.S.C. § 1396a(b), and she can revoke her approval at any time, *id.* § 1396c. Thus, if this Court orders the State to alter its Mitigation Plan but the Secretary declines to approve the changes, the State will be faced with an intolerable choice: obey this Court's order and risk the loss of federal contributions to TennCare or follow the Secretary's demands and face a contempt order from this Court. The very possibility of subjecting

Defendants to such a dilemma indicates that the presence of the United States is required pursuant to Rule 19(a)(1)(B)(ii). *Cf. Weeks v. Housing Auth of Opp*, 292 F.R.D. 689, 693 (M.D. Ala. 2013) (finding HUD an indispensable party where "[i]t is . . . clear that if the Court orders the relief [Plaintiff] requests . . . there is a substantial risk that [Defendant] will face multiple inconsistent obligations," since it "could be forced to choose between complying with the Court's order . . . or complying with HUD's express directive"); *Idaho Aids Found., Inc. v. Idaho Hous. & Fin. Ass'n*, 422 F. Supp. 2d 1193, 1208 (D. Idaho 2006) (concluding, where HUD had ordered the defendant to take the actions challenged by plaintiffs, that "[w]ithout a binding judgment against HUD, [Defendant] will be forced to either comply with the Court's order or ignore HUD's orders. [Defendant] would have to choose between being held in contempt of the Court's order or losing Idaho's . . . grants from HUD").

The District Court of the District of Columbia's decision in *Bridges v. Blue Cross & Blue Shield Association*, 889 F. Supp. 502 (D.D.C. 1995), is instructive. Federal employees sued Blue Cross and Blue Shield for allegedly overcharging them for coinsurance provided under an arrangement between Blue Cross and the Office of Personnel Management ("OPM"). The court held that the OPM was a required party under Rule 19(a)(B)(ii) because "BCBSA and the OPM are currently working to implement an agreement which would provide rebates to some federal employees" for the alleged overcharges, and "[i]f this Court were to award plaintiffs all or some of the remedies they currently seek, BCBSA would be obligated not only to fulfill its duties under the OPM agreement, but also its duties as imposed by this Court, and those obligations might well come into conflict." *Id.* at 504.

Likewise here, the State has been working for months with CMS to mitigate the delays in TennCare eligibility determination caused by the rollout of the Affordable Care Act and the

FFM's deficiencies in processing Medicaid applications. *See* Letter from Darin Gordon, Deputy Comm'r for Health Care Fin. & Admin., to Cindy Mann, Dir. of the Ctr. for Medicaid and CHIP Servs. at 3 (July 14, 2014) (attached to Ex. 5 of the Brooke Decl., D.E. 2-2). As in *Bridges*, Plaintiffs now ask this Court to interfere with the State's ongoing attempt to work with CMS to develop solutions to these problems, and "[i]f this Court were to award plaintiffs all or some of the remedies they currently seek," the State "would be obligated not only to fulfill its duties" under agreements reached with CMS, "but also its duties as imposed by this Court, and those obligations might well come into conflict." *Bridges*, 889 F. Supp. at 504. As in *Bridges*, this Court should conclude that Rule 19(a)(1)(B)(ii) requires joinder of the United States or dismissal of the case.

CONCLUSION

For the foregoing reasons, Defendants submit that the Court should dismiss this case with prejudice.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

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

s/ Michael W. Kirk