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 PRELIMINARY INJUNCTION**

Plaintiffs challenge the State of Tennessee's unreasonable and illegal policies that deny individuals the ability to obtain Medicaid assistance in a timely manner, or obtain a fair hearing to challenge that failing. The State's acts and omissions have deprived 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 65(a), Plaintiffs hereby move for a preliminary injunction enjoining (1) Defendants' unlawful failure to process Medicaid applications in a timely manner; and (2) Defendants' unlawful failure to provide fair hearings to those whose claim is not acted upon with reasonable promptness.

FACTUAL BACKGROUND

A. Medicaid Background

The federal Medicaid program was "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). It was created in 1965 as Title XIX of the Social Security Act. Pub. L. No. 89-97 (codified as amended at 42 U.S.C. § 1396 *et seq.*). State

governments work in partnership with the Centers for Medicare and Medicaid Services (CMS), within the Department of Health and Human Services (HHS), to administer Medicaid.

The state and federal governments share responsibility for funding Medicaid. States administer the program, subject to federal requirements imposed by the Medicaid Act, CMS regulations, and policy directives. Though participation is voluntary, states that 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. If a state opts to participate, the state must create a "State plan for medical assistance," approved by HHS, which identifies the scope of the state's program and assures that it will be administered in conformity with the requirements of federal law. 42 U.S.C. § 1396a; 42 C.F.R. § 430.10.

Tennessee has participated in Medicaid continuously since 1968. *See* 1968 Tenn. Pub. Acts, ch. 551. In 1993, Tennessee obtained from the Secretary of HHS a Medicaid demonstration waiver under Section 1115 of the Social Security Act, 42 U.S.C. § 1315. The waiver permitted the State to replace its conventional Medicaid program with a demonstration program called TennCare. *See* Letter from Bruce Vladeck to H. Russell White (Nov. 18, 1993) (attached as Ex. 1 to Brooke Decl.). The federal waiver exempts the demonstration program from compliance with some Medicaid statutes and rules, but none are applicable to this action.

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. *See* Cong. Research Svc., *Medicaid Checklist: Considerations in Adding a Mandatory Eligibility Group* 1 (Sept. 21, 2010) (attached as Ex. 2 to Brooke Decl.). They must show that their income is below certain limits, which vary depending on the categorical eligibility group to which they

belong. *Id.* Finally, individuals in a few categorical eligibility groups must meet additional limits on the amount of resources, or assets, they own. Income and resource requirements vary by state and, within a state, by category of eligibility.[1]

1. Ability to Apply and Prompt Determination of Eligibility

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 term 'medical assistance' means payment of part or all of the cost of the following care and services or the care and services themselves, or both . . . ." 42 U.S.C. § 1396d(a). 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, § 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).

2. Fair Hearings

The Medicaid statute requires that a State plan "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 . . . not acted upon with reasonable promptness." 42 U.S.C. § 1396a(a)(3); 42 C.F.R. § 431.220(a); *see also* § 435.912(c)(3) (determination of eligibility may not exceed 45 days for most applicants, or 90 days if application is based on a disability).

B. Changes to Medicaid under the Affordable Care Act

In March 2010, Congress enacted the Patient Protection and Affordable Care Act, Pub. L.

[1] For a list of income and asset requirements by category, see TennCare, *Eligibility Categories*, http://www.tn.gov/tenncare/mem-categories.shtml, (attached as Ex. 3 to Brooke Decl.)

No. 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. No. 111-152. The ACA implemented many changes to the Medicaid and Children's Health Insurance Programs (CHIP) programs, including changes to the application process and to the method of calculating income.

1. Application Process

The ACA and its implementing regulations introduced a number of changes to the application process, most of which came into effect on January 1, 2014. First, the ACA requires use of a single, streamlined application for state health insurance and subsidy programs, including Medicaid, CHIP, and insurance plans offered through Exchanges. 42 U.S.C. §§ 18083(b)(1)(A); 1396w-3(b)(3). Second, it established that there is no wrong door to enrollment; States are required to "accept an application from the applicant . . . (1) Via the internet Web site . . . ; (2) by telephone; (3) via mail; (4) in person; and (5) through other commonly available electronic means." 42 C.F.R. § 435.907(a). Third, the state "must provide assistance to any individual seeking help with the application or renewal process in person, over the telephone, and online." 42 C.F.R. § 435.908(a). Fourth, the application process is supposed to maximize an applicant's ability to complete the form properly and minimize the burden on individuals. 42 U.S.C. § 18083(b)(1); 42 C.F.R. § 435.1200(b)(3)(i). Together, these requirements simplify and streamline the process for applicants and expand access to health coverage. *See* Eligibility Changes Under the ACA, 77 Fed. Reg. 17144, 17145 (Mar. 23, 2012).

2. Financial Eligibility Changes

The ACA introduced a new standard methodology to calculate income and financial

eligibility for most categories of Medicaid[2] and for CHIP, 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 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).

C. Modifications to Application and Determination Process in Tennessee

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

[2] 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. 42 U.S.C. § 1396a(e)(14)(D)(i)(I-V).

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. 4 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 Hum. Svcs., *TennCare Medicaid and TennCare Standard Policy Manual* 409–23 (excerpt attached as Ex. 5 to Brooke Decl.).

In December 2012, Defendants executed a $35.7 million contract to develop a new IT system to replace ACCENT, known as the TennCare Eligibility Determination System, or TEDS, in order to meet ACA requirements. *See* 42 U.S.C. § 18083(c); Contract btwn. TennCare and Northrop Grumman Sys. Corp. (Dec. 4, 2012) (excerpt attached as Ex. 6 to Brooke Decl.). CMS required state systems to comply with seven critical standards, including acceptance of applications and ability to make MAGI-based determinations, by October 1, 2013. Letter from Jessica Kahn to Darin Gordon at 1 (Aug. 16, 2013) (attached as Ex. 7 to Brooke Decl.)

When the State notified CMS in 2013 that it would not meet the ACA compliance deadlines, CMS required Defendants to submit a Mitigation Plan to minimize adverse impact on applicants and enrollees. *See Id.* at 1; Tenn.'s Strategy for Oct. 1, 2013, Mitigation Plan 1 (attached as Ex. 8 to Brooke Decl.). While representing that TEDS would be operational and that the State would accept its own applications by January 1, 2014, it proposed interim strategies for the period between October 1 and December 31, 2013. *Id.* at 1. Specifically, the State authorized the federal Marketplace to determine eligibility for MAGI-based categories and promised to accept the federal Marketplace's transfer of accounts containing applicants' applications and related information by November 1, 2013. *Id.* at 2. CMS approved this plan on August 16, 2013. Kahn Aug. 16, 2013, Letter 1 (Ex. 7).

Notwithstanding these representations, and in defiance of the provisions of the ACA designed to simplify the application process, the Defendants methodically set about closing application portals and making it more difficult to apply. In September 2013, approximately one month after CMS's approval of the mitigation plan, Defendant Hatter sent a bulletin to all county DHS offices informing them that, beginning in January 2014, DHS would no longer accept or process TennCare applications. Memo from Marcia Garner 5 (Sep. 30, 2013) (attached as Ex. 9 to Brooke Decl.). Defendants also posted notices on the TennCare website warning potential applicants that DHS's role had changed, and informing them that the only way to apply for most Medicaid programs was through the Health Insurance Marketplace. *See* TennCare, *Do you need help applying for TennCare?*, http://www.tn.gov/tenncare/forms/DoYouNeedHelp.pdf (attached as Ex. 10 to Brooke Decl.); TennCare, *How to Apply*, http://www.tn.gov/tenncare/mem-apply.shtml (attached as Ex. 11 to Brooke Decl.). Defendants created a call center, called the Tennessee Health Connection, which is the sole point of contact for TennCare applicants to seek information from the State of Tennessee, *id.*, though the call center has little ability to directly assist most applicants.

Defendants continue to direct all TennCare applicants, with the exception of those applying to the CHOICES and Medicare Savings Program, to the federal Marketplace (FFM) because of the State's asserted inability to determine eligibility under new MAGI standards. Yet the State's assertion that all TennCare applicants must utilize the FFM is belied by two considerations. First, Child Health Insurance Programs ("CHIP") are also subject to the same MAGI requirements as of January 1, 2014, and Tennessee's CHIP program (CoverKids) continues to accept applications and make its own eligibility determinations, *i.e.*, a MAGI calculation. *See* CoverKids, *Apply Now!*, https://www.coverkids.com/login/register.aspx

(attached as Ex. 12 to Brooke Decl.). Second, there are individuals eligible under non-MAGI categories—such as those eligible because of being aged, blind, or on disability—whose eligibility is not based on a MAGI determination. *See* TennCare, *Eligibility Categories* (Ex. 3). Yet the State insists that these individuals apply through the FFM, even though the FFM cannot assess their eligibility. *See* CMS, *Fed. Facilitated Marketplace Enrollment Op. Policy & Guidance* § 3.1 at 21 (Oct. 3, 2013) (Non-MAGI Scenario) (excerpt attached as Ex. 13 to Brooke Decl.); *see also* 42 C.F.R. § 435.1200(e)(2). This invites unnecessary bureaucratic problems, for the FFM transfers these applications to the State for review of the non-MAGI categories *only if* the applicant checks an appropriate box on the application flagging that she may be non-MAGI eligible. Assuming an application is referred from the FFM, the State must then request any additional information needed to determine eligibility, which adds unnecessary bureaucracy and delay to the process.

On June 27, 2014, CMS wrote to Defendant Gordon, noting that TennCare lacks many of the identified "critical success factors" of ACA implementation. Letter from Cindy Mann, CMS, to Darin Gordon, TennCare (June 27, 2014) (attached as Ex. 14 to Brooke Decl.). CMS noted that it had met with Tennessee to "express concerns" over the past nine months about the continued delays in implementing TEDS, and that the State "has repeatedly expressed reluctance to deploy resources toward adopting mitigation solutions for in-state applications." *Id.* at 2. The letter emphasized that CMS's "approval to leverage the FFM to receive and process applications on the state's behalf was approved as a short-term measure, not a long-term solution." *Id.* at 3. CMS outlined possible solutions, noting that it had already offered Tennessee options such as "manual MAGI processing (with tools that can facilitate this processing that can be readily adapted for Tennessee) and hiring additional staff to assist with application processing (for

which enhanced Medicaid matching funds may be available)." *Id.* at 2.

In the State's response, Defendant Gordon informed CMS that the State would continue attempting to implement TEDS and in the interim would refer all applicants to the FFM. Gordon July 14, 2014, Letter (Ex. 4). He provided no update on when TEDS would be ready. *Id.* at 4.

D. Plaintiffs' Delayed Attempts to Access TennCare Benefits[3]

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 TNHC does not provide those types of hearings. *Id.* ¶ 7.

[3] Declarations from Plaintiffs referenced herein are attached to the Complaint.

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.* The bills and debt collection calls cause Ms. Reynolds an incredible amount of consternation, especially in light of her heart condition. *Id.* ¶¶ 11-12. Ms. Reynolds was told that she would need monthly health checkups following her hospital stay, but has only visited a doctor once since the incident due to her fear of accumulating more 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. It is a struggle to pay for her medication and to support her family of 5. *Id.* ¶ 10.

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 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 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 between $50-$100 per drug. *Id.* Though Mr. Mossa has been able to obtain the most expensive drug, which costs between $2,000 and $3,000, without cost to date, 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 called Tennessee Health Connection 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. ¶ 12. 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 K.P.'s lack of insurance and her 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. The long delay in obtaining a determination of eligibility, and the lack of answers from the State, has been stressful for T.V. as she tries to obtain coverage for her young child. *Id.* ¶ 17.

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 her application could not be found in their system. When she asked for a hearing she was told 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. S.P. was covered as an unborn child under CoverKids, and her mother received health coverage through CoverKids, but CoverKids did not provide S.P. with any medical assistance after her birth.[4] Neither she nor her parents received notification that S.P.'s coverage was being terminated, an explanation of how they could challenge this premature termination, or information about renewing S.P.'s coverage. *Id.* ¶ 2.

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 the family received bills totaling over $17,000. The family cannot afford to pay these bills—almost equivalent to one year's income. *Id.* ¶ 13. Her father worries that she will again become sick and they will not be able to seek medical attention, and he has been incredibly frustrated by the lack of answers as he tries to get his newborn health insurance. *Id.* ¶¶ 11, 15.

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

[4] CoverKids provides coverage for unborn children of pregnant women (of any age) with incomes at or below 250% of the Federal Poverty Level who are not otherwise eligible for TennCare. State Child Health Plan § 4.1.9, *available at* http://www.medicaid.gov/CHIP/Downloads/TN/TN-CSPA-09-FINAL.pdf. Eligibility is redetermined at birth. *Id.* § 4.1.8.

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 not resolved. *Id.* ¶ 11.

Plaintiffs C.A. and D.A. applied for TennCare on February 27, 2014. D.P. Decl. ¶ 2. C.A. is an infant who was born in late February. *Id.* C.A. was covered as an unborn child under CoverKids, and he received health coverage through CoverKids, but CoverKids did not provide C.A. with any medical assistance after his birth. *Id.*

Shortly after his birth, D.A. and his wife, D.P., 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.* Bills from his four day stay in the hospital are now going to debt collectors. *Id.*

D.A. applied for TennCare for himself 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. S.V.'s mother received healthcare coverage through the CoverKids program, but S.V. never received benefits through CoverKids after birth. *Id.* ¶ 2.

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. *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.'s mother received prenatal care through the CoverKids program, but S.G's CoverKids benefits did not continue after his birth. *Id.*

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.* S.G. is a member of a family of 7 that lives on less than $2,000 per month. *Id.* ¶ 9. They are unable to afford the costs of the

shots currently and he is not receiving them; they are scared about what will happen if he continues to go without these shots into the fall season, when the risk of infection is greater. *Id.*

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.)

E. Plaintiffs' Class Allegations

Plaintiffs seek to certify a class of similarly situated individuals. The class, represented by all Plaintiffs and referred to as the "Delayed Adjudication Class," 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.

See Mot. for Class Cert.

ARGUMENT

Plaintiffs are entitled to a preliminary injunction because (1) they are "likely to suffer irreparable harm in the absence of preliminary relief"; (2) they are "likely to succeed on the merits"; (3) the balance of the equities tips in their favor; and (4) an "injunction is in the public interest." *Obama for America v. Husted*, 697 F.3d 423, 428 (6th Cir. 2012) (citation omitted). "The four considerations applicable to preliminary injunction decisions are factors to be balanced, not prerequisites that must be met." *Hamad v. Woodcrest Condo. Ass'n*, 328 F.3d 224, 230 (6th Cir. 2003) (citation omitted). In actions brought under Section 1983 to enforce the Medicaid Act, district courts are invested with broad equitable powers to fashion appropriate remedial relief. *Doe v. Kidd*, 419 Fed. App'x 411, 419 (4th Cir. 2011).

I. PLAINTIFFS ARE SUFFERING AND WILL CONTINUE TO SUFFER IRREPARABLE HARM IN THE ABSENCE OF PRELIMINARY RELIEF.

Plaintiffs and the proposed class are suffering irreparable harm every day Defendants

continue to defy their legal obligations under the federal law. TennCare is an essential source of support intended to help enable Tennessee's most vulnerable families and children to survive at the edge of poverty. TennCare provides Plaintiffs and class members with the means to secure crucial health care, without which they will suffer physical or mental harm—or forgo other necessities of life in an attempt to maintain a healthy level of care. Defendants' systemic failure to process TennCare applications, provide TennCare assistance in a timely manner, and provide TennCare applicants with a fair hearing to quickly resolve delayed applications, seriously threatens the on-going safety and well-being of Plaintiffs and class members.

Showing irreparable harm is often considered the most important aspect of the request for preliminary relief, since the greater "degree of injury the plaintiff will suffer absent an injunction" will "vary inversely" with the likelihood of success that plaintiffs will be required to establish to obtain an injunction. *Friendship Materials, Inc. v. Mich. Brick, Inc.*, 679 F.2d 100, 105 (6th Cir. 1982) (citations omitted). An injury is irreparable "if it is not fully compensable by monetary damages." *Obama for America*, 697 F.3d at 436 (quoting *Certified Restoration Dry Cleaning Network, L.L.C. v. Tenke Corp.*, 511 F.3d 535, 550 (6th. Cir. 2007)). Since Plaintiffs and others are incurring a loss of benefits to which they are entitled under federal law, as a result of Defendants' actions, they are suffering irreparable harm.[5]

Harm caused from delayed or denied medical care is not readily calculable nor fully compensable, and courts routinely recognize that "delay or denial of Medicaid benefits can

[5] Nor does retroactive application of TennCare benefits, when an application is finally processed and granted back to the application date (long after the deadline required by federal law) adequately address this injury. It not possible to receive retroactive health care. Those who had to forego treatment or services when they were needed, because they lacked insurance under the TennCare program and independent resources, and therefore could not get an appointment with a specialist, or surgery to address a painful condition, or a prescription filled to slow the progress of a progressive disease, or routine infant medical care to ensure a healthy future life, cannot be made whole by Defendants' granting of their applications back to the date of application.

amount to irreparable harm." *Markva v. Haveman*, 168 F. Supp. 2d 695, 718 (E.D. Mich. 2001), *aff'd*, 317 F.3d 547 (6th Cir. 2003); *see also M.K.B. v. Eggleston*, 445 F. Supp. 2d 400, 437 (S.D.N.Y. 2006) ("Given the often perilous economic circumstances of the plaintiffs [being denied Medicaid and Food Stamp benefits], and those similarly situated, the denial of public benefits to such individuals unquestionably constitutes irreparable harm."); *Reynolds v. Guiliani*, 35 F. Supp. 2d 331, 339 (S.D.N.Y. 1999) ("To indigent persons, the loss of even a portion of subsistence benefits constitutes irreparable injury." (citation omitted)); *Crawley v. Ahmed*, 08-14040, 2009 WL 1384147 at *28 (E.D. Mich. May 14, 2009) ("it is undeniable that unpaid bills, loss of needed medical assistance, and ultimately poor health suffered by Plaintiffs, cannot be adequately addressed by the promise of future Medicaid coverage"). For example, in *Class v. Norton*, the district court ordered that interim benefits must be granted to applicants of public assistance whose applications were pending beyond the statutorily-mandated timeframe. 376 F. Supp. 496, 502 (D. Conn. 1974), *aff'd in part and rev'd in part*, 505 F.2d 123 (2d Cir. 1974).

Courts have also found actions that force plaintiffs to pay out-of-pocket for care and/or forego other necessary expenditures are non-compensable, irreparable injuries. In *Schalk v. Teledyne*, 751 F. Supp. 1261 (W.D. Mich. 1990), retirees sought to enjoin changes in a collective bargaining agreement that resulted in increased out-of-pocket payments for health insurance ranging from $592 to $1900 annually. The court found these payments would impose a "financial hardship" and place an unacceptable "financial planning burden" on plaintiffs. *Id.* at 1268. The "uncertainty and worry" posed by the "lack of knowing just how much money will be needed to cover medical expenses" under the new plan was also a form of non-compensable injury causing irreparable harm. *Id. See also Mowbray v. Kozlowski*, 725 F. Supp. 888 (W.D. Va. 1989); *Reed v. Lukhard*, 578 F. Supp. 40, 42 (W.D. Va. 1983) (finding irreparable harm

where plaintiffs had other sources of income, noting that while plaintiffs "have not yet starved to death," the public benefits "no doubt, go far toward improving the daily quality of their lives.") *Merkner v. AK Steel Corp.*, 1:09-CV-423, 2010 WL 373998 at *5 (S.D. Ohio Jan. 29, 2010 (finding that increases in out-of-pocket expenses for medical coverage would result in "decrease in medical care, the rationing of other necessities of life, and an increased uncertainty and anxiety . . . ."). In *Becker v. Toia*, the court enjoined Medicaid copayments, finding that "injury to those whose health is maintained on the slenderest chemical balance provided through medication is not merely irreparable, it is ultimate." 439 F. Supp. 324, 336 (S.D.N.Y. 1977).

The high likelihood of irreparable injury is well illustrated by the facts of the Plaintiffs in this case, as explained above. For example, Plaintiffs Melissa Wilson, Mohammed Mossa, Mayan Said, and April Reynolds, have acute needs from ongoing medical conditions, and are unable to afford and are not receiving the treatment that doctors have told them that they need. Parents are forced to postpone regular checkups for their newborns during this critical stage of development; C.A. hasn't regularly seen a pediatrician because his first doctor has refused to see him again absent proof of insurance. D.P. Decl. ¶ 4. S.G. requires particular shots to stave off infection since he was born prematurely, and they cannot afford them. L.G. Decl. ¶¶ 8-9. And the failure of the State to provide a prompt determination has caused Plaintiffs to delay essential medical care. This action could be deadly. Worried about potential bills, D.A. delayed seeking medical attention after obtaining an infection; when he finally went into the emergency room he was diagnosed as infected with MRSA, and was told that if he had waited another four hours he would likely be dead. D.P. Decl. ¶ 5. Each family is attempting to skirt by on the brink of financial ruin, rationing health care and other basic needs.

Plaintiffs thus are suffering irreparable harm, and require preliminary relief to ensure that

this injury does not continue.

II. PLAINTIFFS ARE LIKELY TO SUCCEED ON THE MERITS.

Plaintiffs, on behalf of individuals similarly situated, assert claims under 42 U.S.C. § 1983 based on violations of the federal Medicaid statute and the Due Process Clause of the Fourteenth Amendment to the U.S. Constitution. Specifically, Plaintiffs assert that Defendants have unlawfully failed to process Medicaid applications in a timely manner; and unlawfully failed to provide fair hearings to those whose claim is not acted upon with reasonable promptness, in defiance of state and federal law and the Due Process Clause.

Before turning to the particular legal claims, it is worth acknowledging that TennCare has authorized the FFM to make certain eligibility determinations, specifically, the MAGI determination. Nevertheless, the Medicaid Act makes clear that there is always only one entity in control and ultimately responsible for ensuring that federal law is followed—the State agency. The "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 (DFA)—"may not delegate, to other than its own officials, the authority to supervise the plan . . . ." 42 C.F.R. § 431.10(e). And while the State agency *may* delegate eligibility determinations to, *inter alia*, the FFM, § 431.10(c)(i), it nevertheless retains the obligation to ensure that all federal laws are followed notwithstanding that delegation of eligibility determinations, § 431.10(c)(3); *see also* § 435.1200(b)(3)(iii) and § 435.1200(c)(2) (requiring state agency to comply with timeliness provisions to same extent as if the application had been submitted to the Medicaid agency).

In other words, "[o]ne head chef in the Medicaid kitchen is enough," and the head chef is the DFA—supported by its sous chef the TennCare Bureau. *See K.C. ex rel. Africa H. v.*

Shipman, 716 F.3d 107, 119 (4th Cir. 2013). Thus TennCare's "duties relative to ensuring that the plaintiffs receive medical services with reasonable promptness are non-delegable," as are its other legal obligations under the Medicaid Act. *Carr v. Wilson-Coker*, 203 F.R.D. 66, 75 (D. Conn. 2001) (citing 42 U.S.C. § 1396a(a)(5); 42 C.F.R. § 431.10; *Catanzano v. Dowling*, 60 F.3d 113, 118 (2d Cir. 1995)); *McCartney ex rel. McCartney v. Cansler*, 608 F. Supp. 2d 694, 701 (E.D.N.C. 2009), *aff'd sub nom. D.T.M. ex rel. McCartney v. Cansler*, 382 F. App'x 334 (4th Cir. 2010); *J.K. ex. rel. R.K. v. Dillenberg*, 836 F. Supp. 694, 699 (D. Ariz. 1993).

A. Defendants' Failure to Promptly Determine Plaintiffs' Eligibility for Benefits, and to Promptly Provide Benefits to Plaintiffs, is Illegal and Violates Plaintiffs' Rights Under 42 U.S.C. § 1396a(a)(8).

Plaintiffs are substantially likely to succeed on the merits of their claim that Defendants are denying their rights to a prompt determination of eligibility and receipt of benefits under federal law. This claim is brought by all Plaintiffs and the Delayed Adjudication Class.

The Medicaid Act requires every State plan to provide individuals with the right to apply for Medicaid benefits and to a determination of eligibility and provision of benefits for eligible individuals "with reasonable promptness." 42 U.S.C. § 1396a(a)(8). As stated by the Sixth Circuit, this provision is most reasonably interpreted to both mean that "all eligible individuals should have the opportunity to apply for medical assistance," and that this assistance "shall be provided to the individual with reasonable promptness." *Westside Mothers v. Olszewski*, 454 F.3d 532, 540 (6th Cir. 2006) ("*Westside Mothers II*").

The concept of "reasonable promptness" is further explained through section 1396a(a)(8)'s implementing regulations. The State must "[f]urnish Medicaid promptly to beneficiaries without any delay caused by the agency's administrative procedures." 42 C.F.R. § 435.930(a). It also must set standards for timeliness regarding the maximum period of time in

which every applicant is entitled to a determination of eligibility, which may not exceed 45 days for most categories of eligibility. 42 C.F.R. § 435.912(a)(1), (c)(3). *See Westside Mothers II*, 454 F.3d at 540–41 ("The regulations that implement these provisions also indicate that what is required is a prompt determination of eligibility and a prompt payment to eligible individuals to enable them to obtain the necessary medical services.") (citing 42 C.F.R. §§ 435.911[6]; 435.930); *Ability Ctr. of Greater Toledo v. Lumpkin*, 808 F. Supp. 2d 1003, 1020 (N.D. Ohio 2011) (defining "reasonable promptness" by reference to §§ 435.911; 435.930); *see also Romano v. Greenstein*, 721 F.3d 373, 379 & n.35 (5th Cir. 2013) (same).

Defendants are defying these requirements by erecting barriers that operate to deny TennCare assistance to Plaintiffs and members of the Delayed Adjudication Class. In violation of the ACA—*see* 42 U.S.C. § 18083(b)(1)(A), (c); 42 C.F.R. § 435.907(a)—they have failed to provide a means of applying directly to the State agency, and instead send individuals to the FFM for all determinations. Their call center—which is the only entity available to the public for questions about TennCare—fails to provide any assistance to individuals inquiring about their eligibility or the status of their applications, and instructs people that hearings or appeals are not available even when no prompt determination has been made. Because of these barriers, and Defendants' adamant refusal to create any sort of work-around to address cases that are long delayed in the federal Marketplace (processes every state <u>but</u> Tennessee has created) many individuals like Plaintiffs have applications that have been pending for well more than 45 days permitted by law; for the named Plaintiffs, each has been pending for three to four times the permissible limit. *See* M.M. Decl ¶ 3 (194 days); T.V. Decl. ¶ 2 (180 days); Wilson Decl. ¶ 4

[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).

(163 days); J.P. Decl. ¶ 2 (168 days); Mossa Decl. ¶ 6 (155 days); Reynolds Dec. ¶ 3 (154 days); L.G. Decl. ¶ 4 (147 days); and D.P. Decl. ¶ 3 (146 days). There can be no dispute Plaintiffs have established a violation of section 1396a(a)(8)'s demand for a reasonably prompt determination.

As noted above, Defendants are responsible for ensuring that Plaintiffs and those similarly situated obtain a prompt determination of eligibility on their TennCare applications so that they are able to access the healthcare that they need. Because they have not done so, Plaintiffs are likely to succeed on their claim.

B. Defendants' Denial of a Fair Hearing after Failing to Make a Prompt Determination of Eligibility is Illegal and Violates Plaintiffs' Rights Under 42 U.S.C. § 1396a(a)(3) and the Due Process Clause.

Plaintiffs are substantially likely to succeed on the merits of their claims alleging that the State is denying their statutory and constitutional rights to a fair hearing upon failing to determine eligibility with reasonable promptness. These claims are brought by all Plaintiffs and the Delayed Adjudication Class.

The Medicaid Act requires all state programs to "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). This right to a fair hearing is also guaranteed by the Due Process Clause, which requires notice and opportunity for a hearing. *See Hamby v. Neel*, 368 F.3d 549, 559–60 (6th Cir. 2004).

The statute provides that these rights must be satisfied by a hearing "before the State agency." 42 U.S.C. § 1396a(a)(3). The State thus cannot disregard this provision and deny all responsibility because of its contract with another entity for other services. *See supra* pp. 19–20; *Carr v. Wilson-Coker*, 203 F.R.D. 66, 75 (D. Conn. 2001) (Single State Agency responsible for providing a fair hearing under § 1396a(a)(3)); *see also* Exchanges: Eligibility and Enrollment, 78

Fed. Reg. 42160-01, 42165 (July 15, 2013) ("[B]oth state Medicaid agencies and the Exchange have distinct responsibilities to provide for such hearings, and we do not have authority to eliminate individuals' statutory rights, or a Medicaid agency's or Exchange's statutory responsibility."); *id.* at 42164 ("[T]he statute requires that the option [to have a hearing before the State] be provided.").

Plaintiffs and members of the class were denied their right to a fair hearing before the State agency. Defendants' standard policy is to deny all requests for a fair hearing or appeal requested before a determination of eligibility and based on the State's failure to provide such a determination with reasonable promptness. *See* Wilson Decl. ¶ 7 (no hearing available); Reynolds Decl. ¶ 8 (no hearing available before determination of eligibility); Mossa Decl. ¶ 10 (no hearings on cases like this); M.M. Decl. ¶ 7 (no process for such hearing); T.V. Decl. ¶ 10 (no possibility for a hearing); J.P. Decl. ¶ 11 (no hearing available because no determination of eligibility had been made). As Plaintiffs have a clear federal right to such a hearing that is enforceable under § 1983, their claim is substantially likely to succeed.

III. THE BALANCE OF EQUITIES TIPS IN PLAINTIFFS' FAVOR.

The harm caused to Plaintiffs and the class they represent outweigh any potential harms that would be imposed on the Defendants. Plaintiffs and the members of the class are suffering the loss of medical assistance necessary, in some cases, for their very survival. The relief requested by Plaintiffs is nothing more than to have Defendants comply with the statutory obligations they have voluntarily undertaken through its State Medicaid program. "Once a state has voluntarily elected to participate in the Medicaid program, it must comply with all federal Medicaid standards. Accordingly, 'no state may characterize its duty to comply with the requirements of an elective program such as Medicaid as constituting a hardship to its citizens.'"

Parents League for Effective Autism Servs. v. Jones-Kelley, 565 F. Supp. 2d 905, 917–18 (S.D. Ohio 2008) (citations omitted), *aff'd sub nom. Parents' League for Effective Autism Servs. v. Jones-Kelley*, 339 F. App'x 542 (6th Cir. 2009).

Nor can Defendants argue that budgetary considerations justify their malfeasance. As the Supreme Court has held, a Medicaid agency's claim of economic harm does not outweigh the harm posed to a plaintiff facing the threat of forgoing necessary medical care:

> On the other side of the balance are the life and health of the members of this class: persons who are aged, blind, or disabled and unable to provide for necessary medical care because of lack of resources. The District Court noted that some of the members of the class have already died since this suit was filed, and the denial of necessary medical benefits during the months pending filing and disposition of a petition for writ of certiorari could well result in the death or serious medical injury of members of this class. The balance of equities therefore weighs in favor of the respondents.

Blum v. Caldwell, 446 U.S. 1311, 1316 (1980). Especially where, as here, the State elected to eliminate the roles of DHS workers and others that previously provided this support, "any hardship suffered by the state . . . would be largely self-imposed." *See U.S. Student Ass'n Found. v. Land*, 585 F. Supp. 2d 925, 946 (E.D. Mich. 2008). Moreover, CMS has noted its willingness to facilitate manual eligibility processing, currently used by other states, and noted the availability of enhanced matching funds for Tennessee to hire (or re-hire) additional staff. *See* Letter from Cindy Mann to Darin Gordon at 2 (Ex. 17). Defendants currently have the ability to hold hearings, as evidenced by their ability to provide such hearings for some denials, but simply refuse to provide them for Plaintiffs and others seeking a hearing because of Defendants' failure to determine eligibility promptly.

IV. THE PUBLIC INTEREST WOULD BE SERVED BY GRANTING PRELIMINARY INJUNCTIVE RELIEF.

The issuance of an injunction would also serve the public interest. Plaintiffs seek to have Defendants comply with their legal obligations under the Medicaid statute and the Constitution

on behalf of the Plaintiffs and the class individuals they represent. The public interest is served when laws passed by Congress are enforced, *Glenwood Bridge, Inc. v. City of Minneapolis*, 940 F.2d 367, 372 (8th Cir. 1991), and "it is always in the public interest to prevent the violation of a party's constitutional rights," *G & V Lounge, Inc. v. Mich. Liquor Control Comm'n*, 23 F.3d 1071, 1079 (6th Cir. 1994), especially when the State defiance relates to *de facto* denying the provision of subsistence-level assistance established as an entitlement under both state and federal law to some of the most financially challenged residents of the State. *See Johnson v. U.S. Dep't of Agric.*, 734 F.2d 774, 788 (11th Cir. 1984) (consideration of legislative intent); *see also* 42 U.S.C. §1396-1 (purpose of Medicaid is to, *inter alia*, furnish medical assistance to families whose income and resources are insufficient to meet the costs of necessary medical services).

Finally, a pattern of severe and intentional violations of federal and constitutional law such as this erodes respect for federal law, especially since the State receives federal dollars each year expressly premised on its agreement to comply with all of the basic requirements of federal Medicaid law, including processing times and due process protections.

V. THIS COURT SHOULD WAIVE THE BOND.

Plaintiffs request that they not be required to post a cash bond under Rule 65. This Court has discretion to issue a preliminary injunction without requiring a security. *Roth v. Bank of the Commonwealth*, 583 F.2d 527, 538–39 (6th Cir. 1978). Plaintiffs, as "[p]oor persons . . . are by hypothesis unable to furnish security as contemplated by Rule 65(c)." *Denny v. Health & Soc. Servs. Bd. of State of Wis. Dep't of Health & Soc. Servs.*, 285 F. Supp. 526, 527 (E.D. Wis. 1968). Especially in a suit like this, brought in the public interest to enforce important federal rights, it is appropriate to waive the bond. *See Moltan Co. v. Eagle-Picher Indus., Inc.*, 55 F.3d 1171, 1176 (6th Cir. 1995); *see also Bass v. Richardson*, 338 F. Supp. 478, 491 (S.D.N.Y. 1971).

CONCLUSION

Plaintiffs meet all of the four factors for the issuance of a preliminary injunction. Therefore, Plaintiffs respectfully request this Court grant their Motion for a Preliminary Injunction and enter the attached Proposed Order.

DATED this twenty-third day of July, 2014.

Respectfully submitted,

/s/ Christopher E. Coleman
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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