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

A.M.C., by her next friend, C.D.C., *et al.*,

Plaintiffs,

v.

STEPHEN SMITH, in his official capacity as Deputy Commissioner of Finance and Administration and Director of the Division of TennCare,

Defendant.

Civil Action No. 3:20-cv-00240
Chief District Judge Crenshaw
Magistrate Judge Newbern

BRIEF IN OPPOSITION TO PLAINTIFF'S MOTION FOR CLASS CERTIFICATION

May 29, 2020

Herbert H. Slatery III
Attorney General and Reporter

Sue A. Sheldon TN BPR #15295
Senior Assistant Attorney General
Jeffrey L. Wilson TN BPR #36259
Assistant Attorney General
OFFICE OF THE ATTORNEY GENERAL
P.O. Box 20207
Nashville, TN 37202
(615) 770-1903
logan.wilson@ag.tn.gov

Michael W. Kirk*
Nicole J. Moss*
Harold S. Reeves*
J. Joel Alicea*
Shelby L. Baird*

COOPER & KIRK, PLLC
1523 New Hampshire Avenue, NW
Washington, D.C. 20036
(202) 220-9600
mkirk@cooperkirk.com
nmoss@cooperkirk.com

*Appearing *pro hac vice*

Counsel for the Defendant

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Regulations and Rules

Other Authorities

INTRODUCTION

Plaintiffs have asked the Court to certify a class consisting of:

> All individuals who meet the eligibility criteria for TennCare coverage and who, since March 19, 2019, have been or will be disenrolled from TennCare. The class excludes individuals, and the parents and legal guardians of individuals, whose termination is due to a requested withdrawal from the TennCare program.

Mem. of Law in Supp. of Pls.' Mot. for Class Cert., Doc. 12-1 at 3 (Mar. 27, 2020). Plaintiffs have further asked the Court to certify a subclass consisting of:

> Plaintiff Class members who are "qualified individuals with a disability" as defined in 42 U.S.C. § 12131(2).

Id. The motion must be denied because Plaintiffs have failed to propose a valid, administratively feasible class definition and have not carried their burden of proving that each of the demanding prerequisites of Federal Rules of Civil Procedure 23(a) and (b)(2) has been satisfied.

First, by making membership in the class and subclass dependent on whether an individual is eligible for Medicaid, Plaintiffs have proposed a class definition that would require the Court and Defendant to determine, at the outset, the very relief the class is seeking—an accurate determination of whether an individual is eligible for Medicaid. Plaintiffs have not suggested any means for the Court to determine which, if any, of the 179,037 individuals who were disenrolled (excluding those who died, moved out state, or voluntarily withdrew), *see* Decl. of Kimberly Hagan in Opp. to Pls.' Mots. for Class Cert. & for a Prelim. Inj. ¶ 74 ("Hagan Decl."), currently "meet the eligibility criteria for TennCare coverage." Indeed, the only way to make this determination would be to permit these individuals to reapply for TennCare and have the State determine whether or not they are eligible. Of course, there is no need for a Court order to implement that solution because these individuals already have the right to apply at any time. Simply put, the class Plaintiffs ask the Court to certify is not "sufficiently definite so that it is

administratively feasible for the court to determine whether a particular individual is a member of the proposed class." *Young v. Nationwide Mut. Ins. Co.*, 693 F.3d 532, 537–38 (6th Cir. 2012) (quotation marks omitted) (quoting 5 JAMES W. MOORE ET AL., MOORE'S FEDERAL PRACTICE § 23.21[1] (Matthew Bender 3d ed. 1997)). Such a class cannot be certified.

Second, the proposed class does not satisfy the requirements of Rules 23(a) and 23(b)(2). Specifically, Plaintiffs have not established that proposed class members suffered a common injury, either legally or in fact, that was the result of a systemic policy or practice that Defendant applied or refused to apply on a classwide basis. Instead, the Plaintiffs' allegations and the Defendant's evidence both establish that the named Plaintiffs were affected by random and varied start-up errors during the first year of operations of the new Tennessee Eligibility Determination System ("TEDS") along with some instances of human error, none of which affected the proposed class as a whole. The class thus fails to satisfy both Rule 23(a)'s requirements of commonality, typicality, and adequacy of representation, and the corresponding specific requirements of Rule 23(b)(2).

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). TennCare administers the Tennessee Medicaid program, and, with its annual budget of approximately $12.7 billion, provides coverage to approximately 1.5 million Tennesseans. Hagan Decl. ¶ 2.

TennCare has approximately 1,280 employees, 724 of whom work in eligibility. *Id.* Of those 724 employees, 228 work specifically in eligibility appeals. *Id.* TennCare contractors also operate two call centers, collectively known as TennCare Connect, that employ approximately 400

workers. These call centers enable Tennesseans to apply for coverage, renew coverage, file eligibility appeals, and update their address or other information by phone. *Id.*

In 2013, the State began the transition from a decades-old legacy mainframe eligibility determination system that was paper-driven and mostly manual. Over the next several years, with CMS oversight and approval, TennCare designed and implemented the largely automated system known as TEDS. *Id.* ¶¶ 3–4, 9–13. In addition to allowing automated, no-touch eligibility renewals and real-time eligibility decisions, TEDS has substantially reduced worker error by reducing the need for manual data entry, manual eligibility analysis, manual case authorization, and manual issuance of notices. *Id.* ¶ 13. But as Director Hagan attests:

> In my nearly twenty (20) years of experience with TennCare, I have learned that it is inevitable that some mistakes will be made in processing the enormous volume of cases that TennCare handles each year. Despite best efforts to reduce worker error through training, oversight, and the automation of processes, human errors will always be a factor as long as humans are involved.

Id. ¶ 83. No computer system or program will be free from defects, particularly when it is first put into operation. And no system can ever eliminate the risk of human error entirely.

1. During the class period, which largely corresponds with the first year that TEDS was fully operational, TennCare converted eligibility data for over 1.9 million individuals in over 970,000 cases from existing databases that housed this information into TEDS. *Id.* ¶ 25. In this same period, TennCare has used TEDS to process over 2 million eligibility reverifications—either through annual eligibility renewals or reverifications of eligibility prompted by a reported change in information that could impact a TennCare member's eligibility—without requiring the member to submit any information in order to keep their TennCare coverage. *Id.* ¶ 12. TEDS has also processed or is in the midst of processing over 80,000 appeals related to a termination of benefits. *Id.* ¶ 2. The vast majority of these eligibility verifications confirmed the member's continued

eligibility for TennCare. As of April 17, 2020, not including individuals who voluntarily withdrew from the program, have died, or moved out of state, there are 179,037 individuals who received TennCare or CoverKids coverage on or after March 19, 2019, but are not on the program today. *Id.* ¶ 74. Thus, only 11.2 percent of the total number of individuals who were the subject of an eligibility review conducted by TennCare since March 19, 2019 are not currently on the program. *Id*. Due to the COVID-19 moratorium on terminations, other than voluntary terminations, TennCare has ceased all disenrollments from the program until the national emergency is over. Hagan Decl. ¶ 4, Doc. 29-2.

With the volume of cases converted into TEDS, the volume of eligibility redeterminations and reverifications, and the volume of appeals processed, particularly during the first year of operation of a brand-new, operationally complex, eligibility-determination system, one would expect to find that some errors were made or gaps in design discovered. And the named Plaintiffs have alleged precisely the type of random and varied defects, gaps, and isolated human errors that one would expect in these circumstances.

Specifically, Plaintiffs allege that:

- 7 of 35 of the named Plaintiffs had to provide information that was duplicative of information that TennCare should have had on file or been able to obtain from another government agency. Compl., Doc. 1 at ¶ 83 (Mar. 19, 2020).
- 6 of 35 lost coverage when they became ineligible in one Medicaid category even though they remained eligible in a different eligibility category. *Id.* ¶ 92.
- 7 of 35 were denied their appeal rights although they timely submitted requests. *Id.* ¶ 113.
- 10 of 35 did not receive their redetermination packets in the mail or, in a subset of these cases, their termination notices. *Id.* ¶ 97.
- 4 of 35 were terminated for failing to provide requested information, even when they had provided that information. *Id.* ¶ 101.

While these errors, to the extent they occurred, are regrettable, they are nonetheless unavoidable in a system that has to verify periodically the eligibility of 1.5 million individuals using categories and criteria that are as manifold and variegated as those contained in the Medicaid statute. *See* Hagan Decl. ¶ 83.

Since the filing of this action, TennCare has reviewed the records and the case files of the 35 named Plaintiffs and confirmed that none of the errors identified were the product of any policy or practice, or even of several distinct policies and practices. Instead, they arose from isolated and idiosyncratic issues related to the conversion of hundreds of thousands of cases into TEDS, varied inadvertent defects or unforeseen gaps in TEDS's complex design and programming that only impacted small groups of individuals in different Medicaid categories of eligibility, and random human errors. *See id.* ¶¶ 19–26, 35, 84. For example:

- A.M.C., D.D., T.E.W., S.D.W., Y.A.D., Z.M.D., X.M.D., Michael Hill, D.R., J.Z., M.X.C., J.C., S.L.C., Charles Fultz, Linda Rebeaud, and Kerry Vaughn all experienced problems that can be traced back to the one-time process of converting eligibility data into TEDS. *Id.* ¶¶ 25(a)–(e), 141, 149, 177, 180.

- Vivian Barnes, Carlissa Caudill, and Johnny Walker's problems, in turn, were the result of information that was received from the Social Security Administration indicating they were not actively receiving SSI payments. *Id.* ¶ 35(a).

- K.A. and E.I.L. were affected by a gap in the programming logic of TEDS that produced erroneous effective dates of coverage of some newborns. *Id.* ¶ 35(b).

- S.F.A. and A.L.T. were affected by a TEDS programming defect that blocked transitional Medicaid coverage for some children. *Id.* ¶ 35(f).

- Rhonda Cleveland was affected by a TEDS defect that failed to load the most recent Social Security income information from the SSA. *Id.* ¶ 35(i).

- Charles Fultz was affected by an unforeseen gap in TEDS programming that did not identify him as potentially "Pickle" eligible because TEDS had not received Social Security income information at the time it sent him through an *ex parte* eligibility review. *Id.* ¶ 35(j).

All these discrete defects have been, or are scheduled to be, corrected through updates to TEDS. *See id.* ¶¶ 26, 35(a)–(l).

Human error also contributed to problems experienced by some of the named Plaintiffs. For example, K.A.'s coverage was briefly terminated when his case was merged with his mother's case. *Id.* ¶ 101. A worker failed to recognize that Linda Rebeaud's coverage should have been reinstated sooner leaving her with a gap in coverage for a month longer than otherwise would have occurred. *Id.* ¶ 119. Workers failed to properly screen Michael Hill, William Monroe, and Kerry Vaughn for eligibility in an SSI-related category. *Id.* ¶¶ 152, 174–75, 199. A worker wrongly updated S.L.C.'s residence, which resulted in TEDS determining her ineligible for Institutional Medicaid coverage. *Id.* ¶ 133. A worker erroneously misclassified an appeal filed by Charles Fultz and the appeals unit later marked as untimely a second appeal attempt because the worker thought Mr. Fultz was appealing an earlier termination decision with a past-due filing deadline. *Id.* ¶¶ 145, 147. And a worker failed to timely process the renewal packet for J.S.K., M.N.S., and D.C.S. *Id.* ¶ 161.

Further demonstrating the non-uniform, non-systemic nature of the issues Plaintiffs have alleged, six of the thirty-five named Plaintiffs never received a termination notice and never lost coverage, and five additional Plaintiffs received a termination notice but never lost coverage. *See* Hagan Decl. ¶ 81. Taken together, these eleven named Plaintiffs fall into many of the same eligibility categories as the other named Plaintiffs who did have issues—deemed newborns, children, SSI-recipients, and individuals eligible in an SSI-related category.

TennCare does not pretend that its processes or its determinations are infallible. Indeed, this is why the Medicaid statute mandates an appeal process—and far from denying enrollees of their right to appeal, TennCare has processed 80,855 appeals related to terminations of eligibility

during the class period. *Id.* ¶ 2. TennCare also corrects errors on its own outside the appeals process when those errors are brought to its attention. These practices and processes had already remedied the errors in the cases of 32 of 35 of the named Plaintiffs *before Plaintiffs had filed their complaint*, all of whom either had their coverage restored or never had it interrupted in the first place. *Id.* ¶ 83. And coverage has since been restored (or, in the case of Mr. Monroe, granted) in the ordinary course to the remaining three. *Id.* ¶ 82; *see also id.* ¶ 174. Furthermore, TennCare is currently in the process of gathering data from 2020 eligibility redeterminations to undergo robust auditing and monitoring. *Id.* ¶ 29. In subsequent years, TennCare will continue, as part of its overall compliance processes, to audit and monitor TEDS in order to identify and self-correct any errors that may arise. *Id.* ¶¶ 28–30.

ARGUMENT

Class actions are "an exception to the usual rule that litigation is conducted by and on behalf of the individual named parties only." *Califano v. Yamaski*, 442 U.S. 682, 700–01 (1979). In order to invoke this exception, Plaintiffs must first propose a class definition "sufficiently definite so that it is administratively feasible for the court to determine whether a particular individual is a member of the proposed class." *Young*, 693 F.3d at 537–38. Plaintiffs also bear the burden of proving that

> (1) the class is so numerous that joinder of all members is impracticable; (2) there are questions of law or fact common to the class; (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class; and (4) the representative parties will fairly and adequately protect the interests of the class.

FED. R. CIV. P. 23(a). Finally, Plaintiffs must prove that the proposed class satisfies one of the requirements of Rule 23(b)—here, that "the party opposing the class has acted or refused to act on grounds that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole." *Id*. at (b)(2).

The burden is on the moving party to "affirmatively demonstrate his compliance with [Rule 23]—that is, he must be prepared to prove that there are *in fact* sufficiently numerous parties, common questions of law or fact, etc." *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 350 (2011) (emphasis in original). "Given the huge amount of judicial resources expended by class actions, particular care in their issuance is required." *Pipefitters Local 636 Ins. Fund v. Blue Cross Blue Shield of Mich.*, 654 F.3d 618, 630 (6th Cir. 2011). Accordingly, a class action "may only be certified if the trial court is satisfied, after a rigorous analysis, that the prerequisites of Rule 23(a) have been satisfied." *Gen. Tel. Co. of Sw. v. Falcon*, 457 U.S. 147, 161 (1982).

Plaintiffs' arguments cannot withstand such rigorous analysis. They have not defined a class that meets the threshold requirements of Rule 23, nor have they satisfied the four demanding prerequisites of Rule 23(a), or demonstrated that TennCare "acted or refused to act on grounds that apply generally to the class" as required by Rule 23(b)(2).

I. Plaintiffs Have Not Defined An Administratively Feasible Class.

"Before a court may certify a class pursuant to Rule 23, the class definition must be sufficiently definite so that it is administratively feasible for the court to determine whether a particular individual is a member of the proposed class." *Young*, 693 F.3d at 537–38 (quotation marks omitted). To meet this standard, a class definition must not require a court to engage in "extensive individualized fact-finding" to determine whether an individual is a member of the class. *Lumpkin v. Farmers Grp., Inc.*, No. 05-2868, 2009 WL 10698662, at *4 (W.D. Tenn. Mar. 24, 2009).

Both of Plaintiffs' proposed classes are limited to "individuals who meet the eligibility criteria for TennCare coverage." Doc. 12-1 at 3. In addition, the disability subclass is limited to "Class Members who are 'qualified individuals with a disability' as defined in 42 U.S.C. § 12131(2)." *Id*. Accordingly, both would require the Court to resolve whether an individual is

"eligible" for TennCare in order to determine whether that individual is a member of the class or subclass. Determining whether an individual is a member of either the class or subclass would thus require the sort of extensive individualized fact-finding that renders a class administratively infeasible and thus uncertifiable.

Any class definition that requires a court to determine an individual's statutory eligibility for a public benefit, multiplied over thousands of potential plaintiffs, will raise significant difficulties "related to fulfilling the requirement that a class description must be sufficiently definite so that it is administratively feasible for the court to determine whether a particular individual is a member." *Young*, 693 F.3d at 538 (citing *Crosby v. Soc. Sec. Admin.*, 796 F.2d 576, 580 (1st Cir. 1986)). The Court in *Young* held that "a [class] definition requiring legal determinations of whether each class member was 'disabled' under the Americans with Disabilities Act" is a paradigmatic example of such an administratively unworkable class. *Young*, 693 F.3d at 538 (citing *Davoll v. Webb*, 194 F.3d 1116, 1146 (10th Cir. 1999)). This is, of course, the very criteria that Plaintiffs use to define their subclass. Doc. 12-1 at 3.

This problem also afflicts both the class and subclass definitions because membership in both turns on an individual's eligibility for Medicaid. Indeed, in a case Plaintiffs themselves relied upon, the court rejected a definition based on eligibility for Medicaid. The court explained that "whether an individual is eligible for a particular Medicaid category turns on the category's criteria and the individual's personal circumstances (e.g., the individual's Modified Adjusted Gross Income)." *Dozier v. Haveman*, No. 2:14-cv-12455, 2014 WL 5483008, at *15 (E.D. Mich. Oct. 29, 2014). The court held that, because "the membership inquiry should not involve significant individualized factfinding," a definition that uses Medicaid eligibility as one of its criteria for membership is invalid under Rule 23. *Id.* (citing *Hayes v. Wal–Mart Stores, Inc.*, 725 F.3d 349,

355 (3rd Cir. 2013) ("[I]f class members are impossible to identify without extensive and individualized fact-finding or 'minitrials,' then a class action is inappropriate.") (quotation marks omitted)).

Plaintiffs' unsupported assurance that it "will be simple to identify members of" the class blinks reality. Doc. 12-1 at 24 n.7. The Medicaid statute is "among the most intricate ever drafted by Congress. Its Byzantine construction, as Judge Friendly has observed, makes the Act 'almost unintelligible to the uninitiated.' " *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981) (quoting *Friedman v. Berger*, 547 F.2d 724, 727 n.7 (2nd Cir. 1976)). Even after the passage of the Affordable Care Act, "Medicaid eligibility remains a highly complex program determination with numerous rules and requirements. There are still many different eligibility categories, and each involves different eligibility criteria that in turn give rise to different potential obstacles to eligibility." Hagan Decl. ¶ 8.

Even a court having full knowledge of the underlying facts of each individual case would be hard-pressed to determine whether certain individuals fall into one of the numerous eligibility categories established by the applicable statutes and regulations. At the very least, it would be necessary for the Court to examine the TennCare file of each of the over 179,000 individuals who were terminated on or after March 19, 2019, and are not on the program today, in order to determine whether that person had, in fact, been eligible for TennCare at the time coverage was terminated. A class that requires the Court to make case-by-case eligibility determinations—determinations that are currently performed by 724 full-time employees—is not merely administratively infeasible, but practically impossible.

Moreover, in most instances, determining eligibility would be impossible based solely on the information contained in that person's file. And examining information from a past file will

not necessarily tell the Court anything about whether that individual "meet[s] the eligibility criteria for TennCare coverage" today, as Plaintiffs' class definition requires. This is particularly true in the case of individuals who have lost eligibility in one category (for example, those who were eligible as children, but who have now reached the age of maturity; those who were eligible as caregivers, but who are no longer caring for their charge; and those women who were eligible as pregnant, but who have now given birth). In order to determine eligibility for Medicaid today, and thus eligibility in the class, in virtually every case financial, medical, disability, and/or other personal information would have to be obtained and reviewed. "Where extensive factual inquires [sic] are required to determine whether individuals are members of a proposed class, class certification is likely improper." *Brashear v. Perry Cty., Ky.,* No. 6:06-143-DCR, 2007 WL 1434876, at *2 (E.D. Ky. May 14, 2007). It is certainly improper here.

II. Plaintiffs Have Failed To Carry Their Burden of Proving Each Of The Demanding Prerequisites Of FED. R. CIV. P. 23(a).

To warrant certification, Plaintiffs must "satisfy all four of the Rule 23(a) prerequisites—numerosity, commonality, typicality, and adequate representation—and fall within one of the three types of class actions listed in Rule 23(b)." *Young*, 693 F.3d at 537 (citing *Sprague v. Gen. Motors Corp.*, 133 F.3d 388, 397 (6th Cir. 1998) (en banc)). The party seeking class certification has the burden of proof. *Id*. (citing *In re Am. Med. Sys., Inc.*, 75 F.3d 1069, 1079 (6th Cir. 1996)).

A. Plaintiffs Have Not Proven Commonality.

Plaintiffs bear the burden of proving that "there are questions of law or fact common to the class." FED. R. CIV. P. 23(a)(2). "Commonality requires the plaintiff to demonstrate that the class members 'have suffered the same injury.' " *Wal-Mart*, 564 U.S. at 349–50 (citation omitted). And the common question "must be of such a nature that it is capable of classwide resolution—which means that determination of its truth or falsity will resolve an issue that is central to the validity of

each one of the claims in one stroke." *Id*. at 350. In this context, "commonality requires a showing that the particular injury suffered by each member of the putative class was caused by a policy or practice common to all of them." *Singletery v. Equifax Info. Servs., LLC*, No. 2:09-cv-489-TMP, 2011 WL 9133115, at *19 (N.D. Ala. Sept. 22, 2011), *aff'd in part as modified sub nom.*, 540 Fed. App'x 939 (11th Cir. 2013); *see also Walmart*, 564 U.S. at 352–54 (requiring a common practice or policy applicable to all class members to satisfy commonality). There must be "some glue hold[ing] the alleged reasons for all those decisions together." *In re Countrywide Fin. Corp. Mortg. Lending Practices Litig.*, 708 F.3d 704, 707 (6th Cir. 2013) (quoting *Walmart*, 564 U.S. at 352). Finally, commonality requires questions at a reasonable level of specificity: "at a sufficiently abstract level of generalization, almost any set of claims can be said to display commonality. What we are looking for is a common issue the resolution of which will advance the litigation." *Sprague*, 133 F.3d at 397.

The specific claims and injuries alleged by each of the named Plaintiffs are certainly not common, not even to all of the named Plaintiffs. As set forth above, *see supra* at pp. 4–6, the named Plaintiffs instead allege that they each suffered a different, unrelated, and random mistake or a unique series of mistakes during the eligibility redetermination and reverification processes.[1]

[1] The lack of commonality afflicts Plaintiffs' subclass for an additional reason. By defining the subclass to include all " 'qualified individuals with a disability' as defined" under the ADA, Plaintiffs purport to assert claims on behalf not only of those with disabling cognitive impairments, Doc. 1 ¶¶ 247, 286, 305, autism, *id.* ¶ 305, impaired hearing, *id.* ¶ 348, impaired mobility, *id.* ¶ 348, depression and anxiety disorders, *id.* ¶ 363, and short-term memory loss, *id.* ¶ 420, but also on behalf of the blind, the paralyzed, the diabetic, the paraplegic, and the asthmatic, as well as those suffering complications during pregnancy or from cancer, cerebral palsy, epilepsy, multiple sclerosis, muscular dystrophy, HIV, major depressive disorder, bipolar disorder, post-traumatic stress disorder, obsessive compulsive disorder, or schizophrenia, *see* 29 C.F.R. § 1630.2(g)(1) & (j)(3)(iii), as well as by those who are perceived as suffering from one or more of these disabilities, *see id.* § 1630.2(g)(1)(iii). A finding that TennCare either has adopted procedures and made arrangements that adequately accommodate the needs of the blind, would not resolve the question whether TennCare has adequately accommodated the needs of the deaf, or of the autistic, or of the

The fundamental flaw in Plaintiffs' submission is their failure to trace these uncommon claims and injuries to a common policy or practice. Plaintiffs claim, in the first sentence of their complaint, that they are challenging "policies and practices that unlawfully deprive eligible children and adults of vitally necessary medical care under the Medicaid program," Doc. 1 ¶ 1, but they never identify what those policies and practices are. The monthly enrollment data upon which Plaintiffs themselves selectively rely, *see* Doc. 12-1 at 14 & n.1, actually refutes Plaintiffs' claim that any policy or practice is systematically denying TennCare coverage to eligible individuals. The complete data show that, between March 30, 2019 and March 30, 2020, TennCare enrollment went from 1,390,023 to 1,421,442, a net *increase* during the class period of 31,419. *See* TENNCARE ENROLLMENT REPORT FOR MARCH 2019 1, https://bit.ly/2XVdPUD; TENNCARE ENROLLMENT REPORT FOR MAR 2020 1, https://bit.ly/3dfW6NR. TennCare clearly was not systemically "screening out," *see* Doc. 1 ¶ 2(a), children, adults, the disabled, or any subclass or permutation thereof, and denying them healthcare coverage.

No single policy or practice could explain (and Plaintiffs offer no attempt at a coherent explanation) the varied experiences of those who allegedly did not receive their renewal packets or pre-termination notices at the start of the process, of those whose timely-filed appeals were not heard at the end of the process, and of those who experienced one or another of the errors that flowed from human fallibility in the midst of that process. As one court has explained, commonality is lacking where, as here, Plaintiffs allege different problems during different segments of a single bureaucratic process:

> Some consumers went online and requested their disclosures through a website, while others wrote letters to Equifax and Central Source, and yet others made a

diabetic. The needs of the disabled vary from disability to disability, from person to person. There is no common contention the truth or falsity of which will resolve an issue that is central to the validity of each one of the claims in one stroke. *See Wal-Mart*, 564 U.S. at 350.

> telephone request. Some of those who used the internet experienced computer problems ranging from being timed out to printer conflicts to lost connection with the server. Telephone and letter requesters misdirected their calls and correspondence, or failed to provide sufficient identification information. The only common issue among these class members is the fact that they did not receive the requested disclosure on some occasions. They made requests in different ways and experienced different difficulties, which may or may not have been the product of any recklessness on the part of Equifax.

Singletery, 2011 WL 9133115, at *10. Plaintiffs have not asserted a common claim arising from a common policy or practice. Rather, their varied claims of injury reveal "just the opposite of a uniform [redetermination] practice that would provide the commonality needed for a class action." *Wal-Mart*, 564 U.S. at 355.

Plaintiffs argue that all of the members of the proposed class suffered the same injury—disenrollment even though they were actually eligible, *see* Doc. 12-1 at 17—but that does not satisfy Rule 23(a)(2) because they have not demonstrated, nor could they, that the injuries flowed from a common practice or procedure. They have not even demonstrated that all the *named Plaintiffs* suffered this specific injury, since eleven of them never lost coverage. As result, a determination that some of the named Plaintiffs were disenrolled even though they were eligible will not answer the question of whether anyone else was improperly disenrolled. This "common contention" is not "of such a nature that it is capable of classwide resolution—which means that determination of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke." *Wal-Mart*, 564 U.S. at 350.

Indeed, as the Ninth Circuit has recently held, it would be "legal error" to certify a class based on common questions of the sort Plaintiffs raise here without both identifying the specific policies or practices that caused these failures and finding that "these failures caused the same deprivations of services or risks of such deprivations across the whole subclass, or whether some categories of children were deprived services while others were not." *B.K. by next friend Tinsley*

v. Snyder, 922 F.3d 957, 976 (9th Cir. 2019) (alterations in original). For commonality to be satisfied, it is not enough that everyone be subject to the risk that a system will not work in any given individual case; there must be a practice or policy that subjects every class member "to an identical 'significant risk' of a future Medicaid violation that would support injunctive relief." *Id.* at 977.

Here, Plaintiffs do not point to any "identical 'significant risk' of a future Medicaid violation." Instead, Plaintiffs have collected an assortment of defects, gaps, and oversights affecting small groups of enrollees that have since been corrected and idiosyncratic human errors that do not reflect any policy or practice.[2] No policy or practice lurks behind what plainly are nothing more than a collection of random errors.

This case is thus readily distinguishable from those upon which Plaintiffs rely, all of which involved injuries arising from a common process, procedure, or practice. In *Dozier v. Haveman*, for example, the named Plaintiffs were enrollees in an expiring Michigan Medicaid program, each of whom had each received the same form notice announcing the end of that program, and each of whom was asserting the same claim that this common form of notice was legally inadequate. 2014 WL 5483008, at *22. Certification was proper in *Dozier* because, unlike here, the determination of whether the notice was inadequate would "resolve an issue that is central to the validity of each one of the [class members'] claims in one stroke." *Id*. (quoting *Wal-Mart*, 564 U.S. at 350 (alteration in original)). "Moreover, in having pursued their claims that their June 7 Notices were inadequate, Plaintiffs necessarily 'advance[d] the interests of the class members,' each of whom, by definition, received a comparable June 7 Notice." *Id.* (quoting *Young,* 693 F.3d at 542

[2] There is, to be sure, one policy that does emerge from the fact that TennCare had fixed these errors in the case of 32 of 35 of the named plaintiffs, even *before the complaint was filed*, and fixed the remain three shortly thereafter: TennCare identifies and fixes its mistakes.

(alteration in original)); *see also Barry v. Corrigan*, 79 F. Supp. 3d 712, 751 (E.D. Mich. 2015), *aff'd sub nom.*, 834 F.3d 706, 731 (6th Cir. 2016) (finding commonality where plaintiffs challenged the "alleged inadequacy of the disqualification notices" they had each received). Here, there is no one notice common to all Plaintiffs; there is no one TEDS defect; there is no one type of human error; Plaintiffs cannot even allege that all 35 named Plaintiffs were subject to a single eligibility-redetermination process that caused them all to lose their eligibility. Eleven Plaintiffs never lost their eligibility and two are not even complaining about redetermination but rather the deemed newborn process. Hagan Decl. ¶¶ 35(b), 81.

In sum, Plaintiffs make precisely the sort of legal and factual claims that the Supreme Court has held are inadequate to support class certification. All but eleven of the 35 Plaintiffs allege that they lost their TennCare coverage, even though they were eligible for that coverage, in violation of Due Process, the Medicaid statute, and, in the case of the subclass, the ADA. But like the putative class of employees in *Wal-Mart,* the mere claim that they were enrolled in the same Medicaid program and have suffered an injury under the Due Process Clause, the Medicaid statute, or the ADA is insufficient. As the Court in *Wal-Mart* explained:

> Quite obviously, the mere claim by employees of the same company that they have suffered a Title VII injury, or even a disparate-impact Title VII injury, gives no cause to believe that all their claims can productively be litigated at once. Their claims must depend upon a common contention—for example, the assertion of discriminatory bias on the part of the same supervisor. That common contention, moreover, must be of such a nature that it is capable of classwide resolution—which means that determination of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke.

Wal-Mart, 564 U.S. at 350. Here, as in *Wal-Mart,* there is simply no common contention the resolution of which would resolve an issue that is central to the validity of each of the claims in one stroke.

B. Plaintiffs Have Not Proven Typicality.

Plaintiffs' proposed class also cannot be certified because none of the named plaintiffs asserts a claim that is "typical of the claims . . . of the class." FED. R. CIV. P. 23(a)(3). Typicality is closely related to commonality, but whereas commonality refers to a characteristic of the class as a whole, typicality refers to the characteristics of each of the named plaintiffs in relation to the class. *Vega v. T-Mobile USA, Inc.,* 564 F.3d 1256, 1275 (11th Cir. 2009). It thus ensures that "a sufficient relationship exists between the injury to the named plaintiff and the conduct affecting the class, so that the court may properly attribute a collective nature to the challenged conduct." *Beattie v. CenturyTel, Inc.*, 511 F.3d 554, 561 (6th Cir. 2007) (quotation marks omitted) (quoting *Sprague*, 133 F.3d at 399). "The premise of the typicality requirement is simply stated: as goes the claim of the named plaintiff, so go the claims of the class." *Sprague*, 133 F.3d at 399.

As an initial matter, eleven of the named plaintiffs—six of whom never received a termination notice and never lost coverage, and five of whom received a termination notice but never lost coverage—do not satisfy the proposed criteria for membership in the class because, since March 19, 2019, they have never been disenrolled from TennCare. As such they cannot be members of the class, so their claims could not possibly be typical of those of class members.

Nor do the claims of the other 24 named Plaintiffs stand or fall together, much less with the claims of the class as a whole. Evidence establishing that TennCare did not mail redetermination packets to those Plaintiffs alleging that claim, for example, simply would not tend to prove the claim of other class members. Conversely, were it proven that TennCare had mailed those redetermination packets, that would not tend to disprove the claims of the other class members. With respect to some claims, the allegations of some Plaintiffs actually disprove the claims of others; while ten named Plaintiffs allege that TennCare maintains a systemic practice of not mailing redetermination materials, for example, the others who acknowledge receiving those

packets bear witness to the fact that the "practice" is not actually systemic, but isolated and random. A class divided against itself to this degree cannot be litigated for lack of commonality, and it cannot be represented for want of typicality.

Plaintiffs have also not proven typicality because 32 of the named Plaintiffs lack standing, and the claims of the other three are moot. *See generally* Br. in Supp. of Def.'s Mot. to Dismiss, Doc. 59-1 (May 22, 2020). Named Plaintiffs whose injuries have already been redressed present fundamentally different characteristics from proposed class members who have allegedly not had their injuries redressed. "Typicality also encompasses the question of the named plaintiff's standing, for without individual standing to raise a legal claim, a named representative does not have the requisite typicality to raise the same claim on behalf of a class." *Piazza v. Ebsco Indus., Inc.*, 273 F.3d 1341, 1346 (11th Cir. 2001). For the reasons set forth in Defendant's Motion to Dismiss, Plaintiffs' proposed class action thus cannot be certified because the class representatives have failed to allege the ongoing individual, concrete, and particularized injury that is essential to establishing jurisdiction under Article III of the Constitution.

C. Plaintiffs Have Not Proven That They Will Be Adequate Representatives Of The Class.

A class may not be certified unless "the representative parties will fairly and adequately protect the interests of the class." FED. R. CIV. P. 23(a)(4). This "requirement overlaps with the typicality requirement because in the absence of typical claims, the class representative has no incentives to pursue the claims of the other class members." *In re Am. Med. Sys., Inc.*, 75 F.3d at 1083. Adequate representation "is essential to due process, because a final judgment in a class action is binding on all class members." *Id*. (citing *Hansberry v. Lee*, 311 U.S. 32 (1940)).

The named Plaintiffs here clearly have no incentive to pursue the claims of other class members because their claims have already been redressed.

> Individual standing requirements must be met by anyone attempting to represent his own interest or those of a class. If the named plaintiff seeking to represent a class fails to establish the requisite case or controversy, he may not seek relief on his behalf or on that of the class.

Lynch v. Baxley, 744 F.2d 1452, 1456 (11th Cir. 1984). Likewise, "[a] plaintiff whose claims are moot can no longer claim to be a class member and cannot be deemed an adequate representative of the class." *Mathis v. Bess*, 692 F. Supp. 248, 259 (S.D.N.Y. 1988). Without valid incentive, the named Plaintiffs cannot stand in the shoes of other class members. Adequate representation is unsubstantiated here and due process cannot be served

III. Plaintiffs Have Not Proven That TennCare Has Acted Or Refused To Act On Grounds That Apply Generally To The Class.

Plaintiffs must also prove that TennCare has "acted or refused to act on grounds that apply generally to the class, so that . . . injunctive . . . or corresponding declaratory relief is appropriate respecting the class as a whole." FED. R. CIV. P. 23(b)(2). Plaintiffs claim that they meet this requirement because the alleged violations are consistent across the class and subclass on account of their "systemic nature." Doc. 12-1 at 24.

Once more, the evidence says otherwise. The enrollment data discussed above affirmatively disprove that allegedly "systemic" violations have deprived children and the disabled of their vitally necessary Medicaid coverage. *See* Doc. 12-1 at 1. Again, since March 19, 2019, TennCare has conducted 1,597,891 eligibility reverifications—541,679 annual eligibility reviews and 1,056,212 eligibility reverifications following a reported change of information. Hagan Decl. ¶ 74. As of April 20, 2020, only 11.2 percent of the total number of individuals who were the subject of an eligibility review conducted by TennCare since March 19, 2019 were not on the program. And Plaintiffs have not identified *anyone* who was erroneously terminated and is not currently on the program. Only one conclusion can be drawn: *there is no systemic violation of*

TennCare members' rights. The errors Plaintiffs have identified reflect discrete exceptions to the rule, not the rule itself.

Indeed, these errors can appear systemic only because Plaintiffs effectively defined their class to exclude the overwhelming majority of the 1.5 million eligible individuals who are part of that system but who did not experience these purportedly "systemic" errors. Such a tactic does not satisfy the Rule 23(b)(2) standard. Indeed, as demonstrated above, such a rigged definition does not satisfy even the minimum threshold requirements of Rule 23. *See supra* Part II. But a fail-safe class, defined by reference to the merits of each individual's claim, necessarily fails to satisfy the requirements of Rule 23(b)(2) as well. The Sixth Circuit rejected just such a tactic and just such a class in *Romberio v. Unumprovident Corp.*, 385 F. App'x 423 (6th Cir. 2009), when it reversed the certification of a class challenging an insurance company's allegedly "uniform policies and practices" for reviewing and deciding disability insurance claims. *Id*. at 430. The Sixth Circuit there held that class certification under Rule 23(b)(2) was inappropriate because an individualized review would be required "to distinguish between the set of individuals whose claims were properly denied for valid medical reasons and the set of individuals whose claims were improperly denied." *Id*. at 431.

Like Plaintiffs here, the plaintiffs in *Romberio* also sought an injunction that would require individualized determinations of who was entitled to relief. In *Romberio*, the plaintiffs sought an injunction that would have required the defendant "to provide a full and fair review . . . of all claims for benefits under the plan that have been denied." *Id*. at 433 (alteration in original). The Court of Appeals held that where the defendant must "provide the very relief requested (i.e., re-review) in order to determine whether any individual was, in the first instance, a class member, and, in the second instance, entitled to relief for an *improper* denial or termination of benefits[,]

[c]lass certification . . . was an abuse of discretion." *Id*. (emphasis in original). Here too, Plaintiffs ask this Court to require Defendant "to prospectively reinstate [the] TennCare coverage of the Plaintiff Class members until such time as the state determines that enrollees are in fact no longer eligible, based on a redetermination process that reliably complies" with the law. Doc. 1 at 116. But to determine whether an individual is a member of the class, it would be necessary to determine at the outset whether that individual is, in fact, "eligible" for TennCare. In other words, the State would have to "provide the very relief requested (i.e., [re-redetermination of eligibility]) in order to determine whether any individual was, in the first instance, a class member, and, in the second instance, entitled to relief for an *improper* denial or termination of benefits." *Romberio*, 385 F. App'x at 433. The Sixth Circuit has held that, in this *precise* situation, class certification would be an abuse of discretion. Class certification should be denied here, therefore, as inconsistent with the requirements of Rule 23(b)(2).

CONCLUSION

For the reasons stated herein, the State respectfully submits that this Court should deny Plaintiffs' Motion for Class Certification.

May 29, 2020

Respectfully submitted,

Herbert H. Slatery III
Attorney General and Reporter

Sue A. Sheldon TN BPR #15295
Senior Assistant Attorney General
Jeffrey L. Wilson TN BPR #36259
Assistant Attorney General
OFFICE OF THE ATTORNEY GENERAL
P.O. Box 20207
Nashville, TN 37202
(615) 770-1903
logan.wilson@ag.tn.gov

/s/ Michael W. Kirk
Michael W. Kirk*
Nicole J. Moss*
Harold S. Reeves*
J. Joel Alicea*
Shelby L. Baird*

COOPER & KIRK, PLLC
1523 New Hampshire Avenue, NW
Washington, D.C. 20036
(202) 220-9600
mkirk@cooperkirk.com
nmoss@cooperkirk.com

*Appearing *pro hac vice*

Counsel for the Defendant

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing document has been served via the Court's electronic filing system on this 29th day of May, 2020.

Gordon Bonnyman, Jr.
Michele M. Johnson
Catherine M. Kaiman
Laura E. Revolinski
Vanessa Zapata
TENNESSEE JUSTICE CENTER
211 7th Avenue N., Ste. 100
Nashville, TN 37219

Elizabeth Edwards
Sarah Grusin
Jane Perkins
NATIONAL HEALTH LAW PROGRAM
200 N. Greensboro St., Ste. D-13
Carrboro, NC 27510

Jennifer M. Selendy
(pro hac vice pending)
Faith E. Gay
(pro hac vice pending)
Andrew R. Dunlap
Babak Ghafarzade
Amy Nemetz
SELENDY & GAY PLLC
1290 Avenue of the Americas
New York, NY 10104

Gregory Lee Bass
NATIONAL CENTER FOR LAW AND ECONOMIC JUSTICE
275 Seventh Avenue, Suite 1506
New York, NY 10001

s/Michael W. Kirk