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 A PRELIMINARY INJUNCTION

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 ii

INTRODUCTION 1

ARGUMENT 2

I. Plaintiffs' Preliminary-Injunction Motion Should Be Denied Because There Is No Risk Of Irreparable Harm. 2

II. Plaintiffs Are Unlikely To Succeed On The Merits..5

A. TennCare's Procedures Do Not Violate The Due Process Clause Or The Medicaid Act 5

1. TennCare Provides Individuals With Adequate Notice Of Termination And Denial Of Benefits...5

a. Case Change Notices..5

b. Notices of Adverse Action...7

2. TennCare Provides Fair Hearings Consistent With The Medicaid Act And Due Process...17

B. TennCare's Procedures Do Not Violate Title II Of The ADA 21

III. The Remaining Factors Counsel Against An Injunction 30

IV. Plaintiffs' Proposed Preliminary Injunction Is Impermissible Under Rule 65(d) 31

A. Plaintiffs' Proposed Preliminary Injunction Is Impermissibly Vague 32

B. The Proposed Preliminary Injunction Is Overbroad 33

V. In All Events, This Court Should Not Enter A Class-Wide Injunction 35

CONCLUSION 35

TABLE OF AUTHORITIES

Cases **Page**

Ability Ctr. of Greater Toledo v. City of Sandusky, 385 F.3d 901 (6th Cir. 2004)......22, 24, 29, 30

Alexander v. Choate, 469 U.S. 287 (1985)..23, 24, 28

Alexander v. Sandoval, 532 U.S. 275 (2001)..29

Aluminum Workers Int'l Union v. Consolidated Aluminum Corp.,
696 F.2d 437 (6th Cir. 1982) 34

Anderson v. City of Blue Ash, 798 F.3d 338 (6th Cir. 2015) 22, 24

Barry v. Lyon, 834 F.3d 706 (6th Cir. 2016) 7

Bedford v. Michigan, 722 F. App'x 515 (6th Cir. 2018) 28

Bernstein v. City of New York, No. 13-CV-04610 (CM)(SN),
2015 WL 12434370 (S.D.N.Y. Feb. 18, 2015)..30

Caswell v. City of Detroit Hous. Comm'n, 418 F.3d 615 (6th Cir. 2015) 19

Chevron, U.S.A., Inc. v. NRDC, 467 U.S. 837 (1984) 29

City of New York v. Mickalis Pawn Shop, LLC, 645 F.3d 114 (2nd Cir. 2011) 35

Codd v. Velger, 429 U.S. 624 (1977)..21

D.T. v. Sumner Cty. Sch., 942 F.3d 324 (6th Cir. 2019)...2, 5

Doe v. Univ. of Cincinnati, 872 F.3d 393 (6th Cir. 2017) 2

Flatford v. Chater, 93 F.3d 1296 (6th Cir. 1996) 8

Frazar v. Gilbert, 300 F.3d 530 (5th Cir. 2002)...18

Friends of the Earth, Inc. v. Laidlaw Envt'l Servs., 528 U.S. 167 (2000)...............................34

Fritz v. Michigan, 747 F. App'x 402 (6th Cir. 2018) 28

Garrett v. Puett, 557 F. Supp. 9 (M.D. Tenn. 1982)...8

Garrett v. Puett, 707 F.2d 930 (6th Cir. 1983) 8, 9

Goldberg v. Kelly, 397 U.S. 254 (1970) 6, 10

Grier v. Goetz, 402 F. Supp. 2d 876 (M.D. Tenn. 2005)...21

Havens v. Colorado Dep't of Corr., 897 F.3d 1250 (10th Cir. 2018) 24

Herrada v. City of Detroit, 275 F.3d 553 (6th Cir. 2001)...11

Hunsaker v. Contra Costa Cty., 149 F.3d 1041 (9th Cir. 1998).......................................24, 29

Jones v. City of Monroe, 341 F.3d 474 (6th Cir. 2003) 24

Kanuszewski v. Michigan Dep't of Health & Human Servs., 927 F.3d 396 (6th Cir. 2019)...........5

Mathews v. Eldridge, 424 U.S. 319 (1976)...11, 20, 29

McPherson v. Michigan High Sch. Athletic Ass'n, Inc., 119 F.3d 453 (6th Cir. 1997)................23

Michigan v. EPA., 135 S. Ct. 2699 (2015) 29
Mullane v. Central Hanover Bank & Tr. Co., 339 U.S. 306 (1950)....................6, 8
Nken v. Holder, 556 U.S. 418 (2009) 30
Parham v. J.R., 442 U.S. 584 (1979)....................19
Pasadena City Bd. of Ed. v. Spangler, 427 U.S. 424 (1976) 32
Pennhurst State Sch. & Hosp. v. Halderman, 465 U.S. 89 (1984) 19, 20
Rolen v. Barnhart, 273 F.3d 1189 (9th Cir. 2001).................... 10
Rosen v. Goetz, 410 F.3d 919 (6th Cir. 2005)....................7, 13, 17, 21, 27, 28, 29
Ruskai v. Pistole, 775 F.3d 61 (1st Cir. 2014) 28
Sandison v. Michigan High Sch. Athletic Ass'n, Inc., 64 F.3d 1026 (6th Cir. 1995) 30
Schmidt v. Lessard, 414 U.S. 473 (1974) 32
Steimel v. Wernert, 823 F.3d 902, 916 (7th Cir. 2016)....................30
Town of Chester v. Laroe Estates, Inc., 137 S. Ct. 1645 (2017) 5
Tucker v. Tennessee, 539 F.3d 526 (6th Cir. 2008) 22
Unan v. Lyon, 853 F.3d 279 (6th Cir. 2017)....................18
Util. Air Regulatory Grp. v. EPA, 573 U.S. 302 (2014) 29
Walters v. Nat'l Ass'n of Radiation Survivors, 473 U.S. 305 (1985) 19
Williams v. Owens, 937 F.2d 609 (table), 1991 WL 128775 (6th Cir. July 16, 1991) 34
Wright v. New York State Dep't of Corr., 831 F.3d 64 (2d Cir. 2016)....................28

Statutes, Regulations, and Rules

42 U.S.C. §
12131(2)....................22
12132....................21, 23
1396a(a)(3)....................18
1396a(a)(10)(A) 13
18083(c)(3) 25, 26

28 C.F.R. §
35.130(b)(3)(i)–(ii)....................30
35.130(b)(3) 29
35.130(b)(8) 29, 30

42 C.F.R. §
431.201....................6
431.205(a) 18
431.205(b)....................18
431.206(b)....................10
431.206(c) 6
431.210....................9,10

431.221(d) 20
431.230(a) 20
435.911 13
435.916 ....12, 35
435.916(a)(3) 13
435.916(a)(3)(iii) 9, 10
435.948 26

FED. R. CIV. P. 65(d)(1) 32

Pub. L. No. 116-127, 134 Stat. 178 (Mar. 18, 2020) 3, 4

Tenn. Comp. R. & Regs. 1200-13-19-.06(3) 19

Tenn. Comp. R. & Regs. 1200-13-20-.09(1)(d)(11) 10

<u>Other Authorities</u>

Tennessee Comptroller of the Currency, PERFORMANCE AUDIT REPORT: SPECIAL PROJECT; DIVISION OF TENNCARE'S REDETERMINATION PROCESS AND THE IMPACT ON CHILDREN'S ENROLLMENT (Feb. 2020), https://bit.ly/2APHVRz 34, 35

INTRODUCTION

Despite Plaintiffs' voluminous filings and the complex statutory schemes at issue, this Court may deny their Motion for Preliminary Injunction for a simple, dispositive reason: because all Plaintiffs are currently enrolled in TennCare and the State has suspended disenrollments for the foreseeable future while the COVID-19 national emergency is ongoing; neither the named Plaintiffs nor any member of the proposed class faces a current or future risk of irreparable harm. Under Sixth Circuit precedent, that disposes of Plaintiffs' request for preliminary-injunctive relief.

Plaintiffs' argument does not improve even if this Court reaches the likelihood of success on the merits. While Plaintiffs make sweeping factual assertions about TennCare's procedures, they muster almost no evidence to support those broad assertions, and the evidence in the record decisively refutes them. What Plaintiffs portray as systemic, chronic failures are in fact a collection of one-off human mistakes and systems errors that one would expect with the rollout of any new large-scale, complex eligibility-verification system. All such errors have either already been corrected or soon will be. But even on their own terms, Plaintiffs' claims fail as a matter of law: TennCare's procedures fully comply with the State's due process obligations under the Medicaid statute and the Fourteenth Amendment, just as they fully comply with the Americans with Disabilities Act (ADA).

Even apart from the merits, the public interest and potential harm to third parties strongly counsel against an injunction. Not only is there *no risk* of harm to Plaintiffs, the financial harm an injunction would impose on the public fisc would be enormous—totaling almost $1 billion (and potentially more). Granting Plaintiffs' motion would necessarily mean depriving important programs of needed funds in the midst of a pandemic and at a time when the State's financial resources have already been stretched beyond the breaking point.

Finally, even putting to the side the preliminary-injunction factors, Plaintiffs' requested injunction is hopelessly vague, and even if it were not, it would clearly be overbroad and unworkable. It is impermissible under Rule 65.

Regardless of whether Plaintiffs' motion is viewed from the standpoint of irreparable harm, the merits, the equities, or the scope of the remedy, the answer is the same: this Court should deny Plaintiffs' Motion for Preliminary Injunction.

ARGUMENT

In considering a motion for a preliminary injunction, courts evaluate four factors: "(1) whether the movant has demonstrated a strong likelihood of success on the merits; (2) whether [the movant] would suffer irreparable injury without the injunction; (3) whether the injunction would cause substantial harm to others; and (4) whether issuing the injunction would serve the public interest." *Doe v. Univ. of Cincinnati*, 872 F.3d 393, 399 (6th Cir. 2017).

I. Plaintiffs' Preliminary-Injunction Motion Should Be Denied Because There Is No Risk Of Irreparable Harm.

The Sixth Circuit has recently held that "even the strongest showing on the other three factors cannot eliminate the irreparable harm requirement. That factor is indispensable: If the plaintiff isn't facing imminent and irreparable injury, there's no need to grant relief *now* as opposed to at the end of the lawsuit." *D.T. v. Sumner Cty. Sch.*, 942 F.3d 324, 326–27 (6th Cir. 2019) (emphasis in original) (quotation marks and citation omitted). Because "the existence of an irreparable injury is mandatory" to obtain a preliminary injunction, *id.*, where a plaintiff fails to prove that irreparable harm is likely, a court may deny preliminary-injunctive relief without considering the remaining three factors, *id.* at 327 (emphasis omitted).

The irreparable harm asserted here is "[t]he serious threat to Plaintiffs' health in the midst of the current pandemic as a result of Defendant terminating their TennCare coverage." Mem. of

Law in Supp. of Pls.' Mot. For a Prelim. Inj., Doc. 26-1 at 17 (April 10, 2020). But this assertion of irreparable harm fails for two indisputable reasons: (1) no Plaintiff is *currently* being denied TennCare coverage, and (2) no Plaintiff will be disenrolled from TennCare in the foreseeable *future*. Because Plaintiffs face no present or future risk of irreparable harm, their Motion for Preliminary Injunction should be denied.

First, it is undisputed that all 35 named Plaintiffs are currently enrolled in TennCare. *See* Hagan Decl. ¶ 2, Doc. 29-2; Doc. 26-1 at 7, 14. Indeed, 32 out of 35 of them were enrolled in TennCare *before* this lawsuit was filed. *See* Hagan Decl. ¶ 2, Doc. 29-2. Nor is TennCare aware of *anyone* who is eligible for TennCare but is not currently enrolled or in the process of being enrolled, Decl. of Kimberly Hagan in Opp. to Pls.' Mots. for Class Cert. & for a Prelim. Inj. ¶ 82 ("Hagan Decl."), and Plaintiffs offer *no evidence whatsoever* to suggest that such individuals exist. Of course, if any such individual came to TennCare's attention, TennCare would enroll the person once they applied for coverage, as the State is required to do under the Medicaid statute. *Id.* There is thus no *current* threat of harm to any Plaintiff or proposed class member based on a lack of TennCare coverage.

Second, it is undisputed that the State "has suspended involuntary disenrollments indefinitely" due to the COVID pandemic. Order, Doc. 34 at 2 (Apr. 14, 2020).[1] On March 18, 2020, the President signed into law the Families First Coronavirus Response Act. *See* Pub. L. No. 116-127, 134 Stat. 178 (Mar. 18, 2020). In this Act, Congress offered to pay a higher share of the cost of Medicaid coverage in exchange for the States' agreement that they would cease all involuntary disenrollments for as long as the President's declaration of national emergency

[1] The only exception is for those individuals who no longer reside in Tennessee, Hagan Decl. ¶ 4, Doc. 29-2, but Plaintiffs do not and cannot purport to represent non-Tennessee residents, since all named Plaintiffs are Tennessee residents.

remains in effect. *See* Pub. L. No. 116-127, div. F, § 6008(a), (b)(3), 134 Stat. at 208–09. Tennessee has agreed to suspend involuntary disenrollments indefinitely, so "none of the named Plaintiffs have any likelihood, much less an imminent likelihood, that they will be found ineligible for Medicaid in the near future." Hagan Decl. ¶ 4, Doc. 29-2. Thus, just as there is no *current* risk to Plaintiffs based on a *lack* of TennCare coverage, there is no *future* risk based on a *loss* of TennCare coverage. *See* Doc. 34 at 2 ("without ruling on the merits of Plaintiff's motion for injunctive relief, the Court does not find Plaintiffs would face irreparable harm absent expedited briefing, particularly because Defendant has suspended involuntary disenrollments indefinitely").

Indeed, even if the State had *not* suspended disenrollments indefinitely, Plaintiffs would *still* fail to satisfy their burden of proving a likelihood of irreparable harm. As explained in the State's Motion to Dismiss, Plaintiffs have failed to plausibly allege—let alone *prove*—that they face a likelihood of *any* sort of injury in the near future. All of their allegations relate to injuries that they have suffered *in the past*. They offer no evidence that they or any members of the proposed class are likely to suffer a loss of TennCare coverage in violation of due process *in the future*. To the contrary, the vast majority of members who were subject to eligibility reviews prior to the suspension of disenrollments—over 88 percent—remain on the program today, Hagan Decl. ¶ 74, and there is no evidence of any TEDS defects that have not been corrected or that have not been scheduled to be corrected, *id.* ¶ 84. Plaintiffs cannot obtain a preliminary injunction to prevent an injury based on speculation.

Plaintiffs' allegation of irreparable harm comes down to this: *if* the President repeals his national-emergency declaration *while the pandemic is ongoing*; and *if* TennCare restarts disenrollments after repeal of the President's declaration, notwithstanding an ongoing pandemic; and *if* one of the Plaintiffs, specifically, is disenrolled from TennCare *in violation of due process*,

see Doc. 26-1 at 1 (allowing disenrollments that "compl[y] with due process"); and *if* such disenrollment is finalized while the pandemic remains a threat to public health, *but see* Hagan Decl. ¶ 41 (describing lengthy process for disenrollment); and *if* this Court has not yet entered final judgment by that time; *then* the disenrolled Plaintiff *might* face an imminent risk of irreparable harm. "[T]here's a lot of ifs in there. And all those 'ifs' rule out the certain and immediate harm needed for a preliminary injunction." *D.T.*, 942 F.3d at 327 (quotation marks and citation omitted). Plaintiffs' motion should be denied for that reason alone.

II. Plaintiffs Are Unlikely To Succeed On The Merits.[2]

A. TennCare's Procedures Do Not Violate The Due Process Clause Or The Medicaid Act.

1. TennCare Provides Individuals With Adequate Notice Of Termination And Denial Of Benefits.

a. Case Change Notices

Plaintiffs first argue that TennCare's "Case Change" notices related to income changes do not "meet the level of specificity required by 42 C.F.R. § 431.210 or provide the kind of detailed explanation that due process requires" because the notices do not specify TennCare's income calculation, but instead advise individuals to consult their online accounts or call TennCare for more information about the change. Doc. 26-1 at 21. The Case Change notices explain that they do not contain individualized information to protect the member's privacy. *See, e.g.*, Pls.' Exs. 8–12, Doc. 26-5 at 121 (Apr. 10, 2020). Plaintiffs' argument fails at the outset because due process

[2] As demonstrated in the State's Motion to Dismiss, Doc. 59-1, Plaintiffs cannot succeed on the merits for the additional reason that this Court lacks jurisdiction. All but 3 of the 35 Plaintiffs lack standing, and the claims of the other 3 are moot. In addition, Plaintiffs must *separately* demonstrate that they have standing to seek a preliminary injunction. Under Article III, "a plaintiff must demonstrate standing for each claim he seeks to press *and for each form of relief that is sought*." *Town of Chester v. Laroe Estates, Inc.*, 137 S. Ct. 1645, 1650 (2017) (emphasis added). Plaintiffs have not shown that they face a *substantial risk* of irreparable injury, and so they also lacking standing to seek the preliminary injunction. *See Kanuszewski v. Michigan Dep't of Health & Human Servs.*, 927 F.3d 396, 406 (6th Cir. 2019).

does not require that TennCare provide *any* information when it records a change in a member's case file. Case Change notices do *not* pertain to an adverse agency action. *Cf. Goldberg v. Kelly*, 397 U.S. 254, 267–68 (1970) (requiring notice only when the State reduces or terminates a public benefit); 42 C.F.R. §§ 431.201, 431.206(c) (requiring notice when an agency terminates, suspends, reduces, or denies a claim for benefits). Rather, TennCare sends these notices whenever TEDS receives *any* change in income—whether an increase or decrease—and without regard to whether the change affects a member's eligibility. Hagan Decl. ¶ 59(a)–(b). Members are not required to do anything in response to Case Change notices. TennCare only sends a second, pre-termination notice and questionnaire ("Preterm Notice") if, after reviewing the change and the agency's records, it determines the member ineligible for continued coverage in her current category and additional information is needed to determine eligibility in other categories. *Id.* ¶ 59(b)–(e). It is not until *after* the member responds (or fails to respond) to the Preterm Notice and TennCare finds that the member is not eligible under any category that TennCare sends a notice of decision ("NOD") explaining that benefits will be terminated for being over-income. *Id.* at ¶ 59(i)–(k).

Even if Case Change notices *did* trigger due process protections, these notices are "reasonably calculated, under all the circumstances, to apprise interested parties of the pendency of the action," and "convey the required information." *Mullane v. Central Hanover Bank & Tr. Co.*, 339 U.S. 306, 314 (1950). Case Change notices not only give members the information relevant to the first step in a *potential* termination process (that TennCare has found a change in income), but also provide the information Plaintiffs seek in another form (by phone or online). In other words, members have all the information they need to assess the current status of their (at that point, unaffected) benefits and will receive two additional notices if TennCare determines that the change impacts their eligibility.

Plaintiffs mischaracterize *Barry v. Lyon*, 834 F.3d 706 (6th Cir. 2016), asserting that the Sixth Circuit held that due process precludes a State agency from conveying relevant information over the phone or online. *See* Doc. 26-1 at 21. To the contrary, the Court of Appeals unambiguously stated that due process will be satisfied so long as the information is "provided [by the State agency] *in some form*." *Id*. at 720 (emphasis added). The problem in *Barry* was that the state agency was not providing the needed information—the identity of the arrest warrant it was relying upon to terminate benefits—*at all*. Instead, the notice required enrollees to contact local law enforcement—not the agency—to gather information about and challenge the arrest warrant making them ineligible for benefits. *See id*. at 711. The agency also instructed employees to direct inquiring enrollees to local law enforcement rather than disclose fugitive-felon status. *Id.* Thus, the court's reference to "elsewhere" in its exhortation that the agency could not "satisfy due process by requiring notice recipients to call elsewhere" clearly meant outside of the *agency* and not outside of the *mailed notice. See id.* at 720.

The Sixth Circuit has squarely held that a state agency need not communicate all the facts relevant to a termination decision in a single notice so long as the information is provided through other means referenced in the termination notice. *Rosen v. Goetz*, 410 F.3d 919, 931 (6th Cir. 2005) (information provided in second notice). The *Barry* Court held *Rosen* did not apply because the agency did not provide the relevant information at all; TennCare does provide individualized income "in some [other] form," *Barry*, 834 F.3d at 720, so this case is controlled by *Rosen*.

b. Notices of Adverse Action

Plaintiffs do not analyze a single notice of adverse action. Rather, they bury in a footnote a string citation to over two dozen NODs to support the vague assertion that TennCare fails to sufficiently explain the reasons for adverse actions. *See* Doc. 26-1 at 21 n.48. Many of the notices Plaintiffs cite are completely irrelevant. Due process protections do not apply to approval notices,

see Flatford v. Chater, 93 F.3d 1296, 1303–04 (6th Cir. 1996), and denials of TennCare applications are beyond the scope of Plaintiffs' claims. And a review of the termination and denial notices included in Plaintiffs' string cite demonstrates that every single one gives the recipient the necessary information for understanding and appealing adverse decisions, thus satisfying due process and regulatory notice requirements. In particular, each notice states the reason for the decision along with a citation to the applicable TennCare rules governing the decision.

For example, the NOD sent to James and Linda Rebeaud on June 26, 2019 explained that James's coverage for the Qualified Medicare Beneficiary Program (QMB) ended on June 24, 2019 because TennCare, after receiving new information about his income, reevaluated his eligibility and found he no longer qualified. Pls.' Exs. 13–18, Doc. 26-6 at 42 (Apr. 10, 2020). The notice further explained: "[t]he monthly income limit for the kind of Medicare Savings Program (MSP) you could get is $1,041.00. Our records show your monthly income is over this limit." *Id.* This explanation of the termination, as well as notice about the appeals process, gave Mr. Rebeaud the necessary facts needed to challenge TennCare's decision: if he could show that his income was less than $1,041 per month, he would prevail on appeal. *See Mullane*, 339 U.S. at 314; *see also* Doc. 26-5 at 75–76 (P-Ex. 9-D) (providing similar information in a denial notice).

The Sixth Circuit has held that a less specific explanation than that provided by TennCare satisfies due process. In *Garrett v. Puett*, 707 F.2d 930 (6th Cir. 1983), the Court reviewed a number of notices, including one explaining that "[t]he total income which had to be counted for your family is more than 150% of the Department's need standard so your case must be closed." *Garrett v. Puett*, 557 F. Supp. 9, 12 (M.D. Tenn. 1982), *aff'd* 707 F.2d 930 (6th Cir. 1983). The Court of Appeals held that these "notices satisfy due process and statutory requirements." 707 F.2d

at 931; *see also* 42 C.F.R. § 431.210 (prescribing the content of notices, which TennCare's termination and denial notices clearly contain).

Plaintiffs also complain that TennCare's NODs do not provide recipients with adequate notice of their right to appeal. Plaintiffs do not, and could not, contend that the notices do not inform members that they have the right to appeal terminations, denials or effective dates, and the notices likewise provide a clear explanation of how to do so by telephone, mail, or fax. TennCare's NODs also provide information about Legal Aid or Legal Services, which may be able to provide free help in filing an appeal. *See, e.g.*, Pls.' Exs. 1–3, Doc. 26-3 at 158 (denial of benefits notice), 229–31 (termination notice) (Apr. 10, 2020). Thus, the notices accurately and unambiguously inform recipients of their right to appeal, leaving no room for confusion that they will not receive benefits if they fail to appeal the denial or termination of benefits. Nevertheless, Plaintiffs argue that the notices do not satisfy due process because they do not explain (1) that the "regulations authorize the extension of deadlines for good cause" and (2) that "if coverage is terminated for failure to timely submit requested information, the recipient can regain coverage by submitting the missing information within 90 days" (the "90-day reconsideration" provision). Doc. 26-1 at 22. This argument fails for several reasons.

First, Plaintiffs are factually wrong in asserting that TennCare gives recipients *no notice* that they can regain coverage by submitting missing information. The 90-day reconsideration provision is only relevant in the context of the annual renewal process, *see* 42 C.F.R. § 435.916(a)(3)(iii), and the cover letter of TennCare's renewal packet informs recipients that TennCare will consider responsive information and make an eligibility determination even if the information is returned after a termination notice is issued, *see, e.g.*, Doc. 26-5 at 304.

Second, Plaintiffs cannot point to any State or federal regulation or any case law mandating that TennCare include information about either the good cause or 90-day reconsideration provisions in its NODs. Neither of Plaintiffs' demands for further information are required by the narrow notice requirements outlined in the federal regulations governing Medicaid appeals. *See* 42 C.F.R. §§ 431.206(b), 431.210. In fact, the 90-day reconsideration provision does not involve the appeals process at all.

Third, federal regulations do not even require that TennCare *provide* good cause extensions much less notify individuals about their availability. Plaintiffs admit that good cause extensions originate from State, rather than federal, regulations. *See* Doc. 26-1 at 22 n.52 (citing Tenn. Comp. R. & Regs. 1200-13-19-.06(3)). Due process does not require TennCare to notify members of a benefit it chooses to provide that is *not even required* by federal law. *See, e.g.*, *Goldberg*, 397 U.S. at 261–66 (requiring hearing rights when public benefit is terminated, not when it is conferred). TennCare's 90-day reconsideration provision is also *more* generous than federal law requires. The relevant regulation requires only that States "reconsider" an individual's eligibility if they submit the renewal packet within 90 days after the date of termination, 42 C.F.R. § 435.916(a)(3)(iii), whereas TennCare will *reinstate* coverage as of the date of the termination if individuals provide the requested information during the 90-day period and are subsequently determined eligible, *see* Tenn. Comp. R. & Regs. 1200-13-20-.09(1)(d)(11). Due process also does not require TennCare to re-notify members of this benefit in the termination notice. *See Rolen v. Barnhart*, 273 F.3d 1189, 1191–92 (9th Cir. 2001) (rejecting plaintiff's argument that he was denied due process when a notice advised him of his right to appeal the dismissal of his benefits application but not that "he could have his claim considered on the merits by filing a new application").

Finally, while Plaintiffs contend that including information about these provisions would aid recipients in pursuing appeals, doing so would likely have a *detrimental* effect instead. Language about good cause extensions in NODs might lead recipients to mistakenly believe that they can wait to appeal after the deadline when they lack good cause to do so. *See* Hagan Decl. ¶ 53. And specific information about the 90-day reconsideration period in termination notices could motivate recipients to send in the packet after their termination date rather than filing an appeal, which could lead to a break in coverage. *See id.* ¶ 57. It is settled that "substantial weight" must be given to TennCare's "good-faith judgments" to not include language on either. *See Mathews v. Eldridge*, 424 U.S. 319, 349 (1976); *see also* Hagan Decl. ¶¶ 53, 57.

Next, Plaintiffs argue that TennCare's NODs are inadequate because they "incorrectly state" that TennCare has checked the information it had about the member to consider whether she qualifies in another category. Doc. 26-1 at 22. They contend this statement is inaccurate because TennCare: (1) "routinely fails to check all of the information in its files"; (2) "does not collect all information needed to evaluate eligibility"; and (3) "does not screen for all eligibility categories." *Id.* at 22–23. Even if these claims were true—and they are not—Plaintiffs are unlikely to succeed on the merits of their due process claim because TennCare's NODs are reasonably calculated to inform recipients of its decision and their right to appeal. *Cf. Herrada v. City of Detroit*, 275 F.3d 553, 557–59 (6th Cir. 2001) (finding constitutionally adequate a notice with potentially misleading or false statements because they did not pertain to "the right to request a hearing or to appeal an adverse decision").

In any case, as demonstrated in great detail in the Declaration of Director Hagan, these allegations are simply not true. Other than scattered anecdotal accounts from the named Plaintiffs that generally reflect worker error, isolated issues with the conversion of eligibility data into

TEDS, or early TEDS systems issues that have all been corrected or are scheduled to be corrected soon, Plaintiffs have submitted no evidence to support these claims. An overview of TennCare's processes demonstrates that, in fact, it reviews the relevant information available to it under its CMS-approved verification plan, and it screens individuals for all Medicaid categories in determining eligibility during the annual renewal process and the reverification process following a reported change.

First, TennCare reassesses eligibility for all non-SSI categories[3] through the annual renewal process in accordance with federal Medicaid regulations. *See* 42 C.F.R. § 435.916. TEDS is a major improvement on past processes because in many instances it can automatically verify eligibility by interfacing with multiple databases allowing the auto-renewal of members without having to ask for any additional information. *See* Hagan Decl. ¶ 43. In conducting this auto-renewal process, TennCare follows a verification plan approved by CMS. *Id.* ¶¶ 43–44; *see* Hagan Decl. Ex. A (Verification Plan). Anyone who cannot be automatically renewed receives a pre-populated renewal packet asking members to confirm information and answer questions necessary to assess eligibility in other TennCare categories. Hagan Decl. ¶¶ 45, 48–52.

Plaintiffs' main complaint appears to be their allegation that TennCare does not ask for relevant information or consult its records to assess eligibility for SSI-related categories. *See* Doc. 26-1 at 22–23 & nn.55–56. But Plaintiffs are factually wrong in both instances. The renewal packet always asks members to list all income they have received in the last 30 days and explicitly lists "Social Security" as a relevant source. *See, e.g.*, Doc. 26-5 at 313. And if TEDS has information about Social Security income, it will populate that information for the member to confirm in the

[3] Member eligible in SSI and SSI-related categories, pursuant to CMS guidance, are not required to go through an annual eligibility renewal process. Hagan Decl. ¶ 42(a).

"Current Job and Income Information" section of the renewal packet. *See id.* TennCare does not ask for more information relevant to SSI-related categories because, once a member returns the packet, TEDS interfaces with SSA databases to verify Social Security income. Hagan Decl. ¶ 52 & n.15. At that point, a TennCare worker uses the information available in TEDS and from SSA to screen for those categories. *Id.* ¶ 52. The financial information provided by the renewal packet is crucial for this process because TennCare cannot assess eligibility under these SSI-related categories without confirming the individual's current resources. *Id.* ¶ 52 & n.15; *see* 42 U.S.C. § 1396a(a)(10)(A) (establishing categories of eligibility); 42 C.F.R. § 435.911 (determination of eligibility); *see also Rosen*, 410 F.3d at 929 (explaining that if the State does not have the relevant information it has no other choice but to ask members to provide it); 42 C.F.R. § 435.916(a)(3) (same). Thus, Plaintiffs' notice arguments regarding TennCare's renewal process are meritless.

Likewise meritless are Plaintiffs arguments about TennCare's reverification process ("change mode" in TEDS), which is triggered by a reported change that may affect a member's eligibility. Whenever a change is reported, TEDS assesses a member's eligibility to determine whether it can reverify the member in her current eligibility category or find her eligible in another category. Hagan Decl. ¶ 59(a), (c). Since March 19, 2019, TEDS has reverified eligibility over 2 million times without requiring any additional information from the member. *Id.* ¶ 12. If such *ex parte* reverification is not possible, then TennCare is required to evaluate whether the member is eligible in another category by sending the member a Preterm Notice. *Id.* ¶ 59(e).

Plaintiffs' claims regarding this process again focus primarily on individuals who were sent Preterm Notices even though they were eligible for TennCare because they receive SSI benefits or they qualify in another SSI-related category based on past receipt of SSI benefits. *See* Doc. 26-1 at 23 n.55. Plaintiffs wrongly assume that TennCare does not screen for the SSI-related

categories in change mode based on a handful of idiosyncratic problems experienced by nine of the thirty-five Plaintiffs. But TennCare *does* evaluate eligibility for the SSI-related categories, both when members lose their SSI-cash benefits (and thus their entitlement to SSI Medicaid) and when TennCare receives a reported change making a member ineligible in her current category (such as a caretaker adult no longer caring for a child). Hagan Decl. ¶ 59(a), (c). There is no need to screen for eligibility in the SSI Medicaid category because TennCare automatically provides Medicaid to any individual for whom the SSA provides data to TennCare indicating that the individual is receiving SSI-cash benefits. This is not an eligiblity category for which an individual may apply directly with TennCare or for which TennCare determines eligibility. *Id.* ¶¶ 120, 126. The issues experienced by Plaintiffs Barnes, Caudill, and Walker were due to incorrect data from the SSA, not a failure to recognize this category of eligibility by TennCare. *Id.* ¶ 35(a). TennCare is working with SSA officials to identify any other indivduals for whom TennCare may not have correct SSI-cash benefit information who have lost coverage. *Id.* Currently, there are over 200,000 individuals receiving SSI Medicaid based on SSA information indicating they are receiving SSI-cash benefits in Tennessee. *Id.* ¶ 2.

What is more, TennCare has found over 17,000 individuals eligible under an SSI-related category through TEDS, either on initial application or reverification, in the last year. *Id.* ¶ 35(g). That said, TennCare did discover a handful of issues with its review for eligibility in the SSI-related categories that it has corrected or is in the process of correcting. First, TennCare found that a small number of individuals' eligibility data was converted into TEDS in the wrong SSI-related category causing TEDS to find them over-income. This happened to Plaintiffs Hill and Vaughn. They, and all similarly situated individuals, have had their eligibility restored. *Id.* ¶ 25(e). Second, TennCare discovered a defect in TEDS programming logic that was causing TEDS to not load the

latest Social Security income record. This in turn could cause a member to erroneously appear ineligibile in the Widow/Widower category. This happened to Plaintiff Cleveland. This gap was fixed with the 9.0.1 release of TEDS. *Id.* ¶ 35(i). Third, TennCare discovered that in instances in which the change mode *ex parte* reverification process triggered by the conversion of eligibility data into TEDS ran before Social Security income data was received from SSA, TEDS would designate that individual as "not Pickle" and would not create a task for a worker to review that indivdual for eligiblity in the Pickle category even when Social Security income was received later. This occurred with Plaintiff Fultz. TennCare is updating TEDS in July 2020 to require the creation of a Pickle review task whenever Social Security income is received and to reset the "not Pickle" designation so that a member will not be terminated from the program before a Pickle eligibility review occurs. *Id.* ¶ 35(j). The other issues experienced by Plaintiffs with one of the SSI-related categories are attributable to worker error. *Id.* ¶¶ 133 (S.L.C.); 169 (Monroe).

Contrary to Plaintiffs' allegation that TennCare does not screen for SSI-related categories of eligibility, TennCare has taken several steps to ensure such screening occurs and to prevent similar errors to what happened to these Plaintiffs from occurring. TennCare designed TEDS to create a "Pickle task" for eligibility workers to alert them whenever an individual *may* be eligible in the Pickle category. This task requires workers to screen for such eligibility, and TEDS was further updated after initial implementation so that a worker cannot approve or deny eligibility on a case until this task is resolved. *Id.* ¶ 14. In addition, in response to Plaintiffs' concerns, TennCare has added a question to its Preterm Notice targeted at these categories to prompt members to inform TennCare about their status. *Id.* ¶ 59(h). TennCare is also working on several improvements to TEDS to facilitate review for the SSI-related categories, such as loading Disabled Adult Child and Widow/Widower indicators into TEDS even in instances where an member is not currently

receiving SSI-cash benefits and re-setting the "Pickle task" so that a prior determination that an member was not Pickle eligible will not prevent a new review in the future. *Id.* ¶ 35(h)–(l). Thus, contrary to Plaintiffs' assertions, there is no evidence of a systemic problem with TEDS review for eligibility in the SSI-related categories. And TennCare has taken steps to mitigate the potential for future mistakes.

Plaintiffs also argue that TennCare does not screen for all eligibility categories "even when members or their advocates bring information establishing eligibility to TennCare's attention." Doc. 26-1 at 23. But this claim is belied by the undisputed fact that TennCare has reinstated benefits for every case that Plaintiffs' advocates brought to its attention before the lawsuit was filed. *See* Compl., Doc. 1 at ¶¶ 232 (Caudill), 245 (Cleveland), 260 (S.L.C.), 320; Hagan Decl. ¶¶ 94–95 (A.M.C.), 102–03 (K.A.), 107–08 (S.F.A.), 165 (E.I.L.), 185–87 (D.R. family), 197 (A.L.T. and J.L.T.), 205 (Walker). And when TennCare learned of the issues in Plaintiffs Barnes, Fultz, and Monroe's cases, it acted swiftly to reinstate their benefits as well. Hagan Decl. ¶¶ 119, 148, 174. This proves the opposite of Plaintiffs' point—TennCare has routinely acted to remedy the eligibility issues Plaintiffs and their advocates have brought to its attention.

Lastly, Plaintiffs argue that TennCare's notices[4] discourage appeals by "incorrectly stating[] that individuals only have a right to a hearing if they can show that TennCare made a mistake of fact." Doc. 26-1 at 24. They contend that TennCare's valid factual dispute process, which functions like summary judgment does in civil litigation, "denies the crucial right to challenge terminations based on an inaccurate application of law or policy." *See id.* But an allegation that TennCare had erroneously applied a policy—such as the complaint that TennCare

[4] Strangely, Plaintiffs cite several approval notices in making this argument. *See, e.g.*, Doc. 26-3 at 5–6 (P-Ex. 1-B), 133–34 (P-Ex. 1-J), 214 (P-Ex. 2-B). But only denial or termination notices implicate the adequacy of TennCare's notices regarding *appeal* rights.

found some Plaintiffs ineligible when in fact they met the requirements for certain SSI-related categories, *see* Doc. 1 at ¶ 120—would be deemed a valid factual dispute entitling the member to a fair hearing, *see* Hagan Decl. ¶ 71(g). Indeed, of the 80,855 appeals related to a termination of benefits that have been filed since March 19, 2019, only 776 (or less than 1 percent) have been closed for lack of a valid factual dispute. *Id* ¶ 71(i). In any case, as we show below, the valid factual dispute process for appealing an adverse decision is supported by federal regulation and was approved by the Sixth Circuit in *Rosen v. Goetz*, 410 F.3d 919 (6th Cir. 2005). Thus, Plaintiffs' contention that TennCare's notices misstate the law is not likely to succeed on the merits.

2. TennCare Provides Fair Hearings Consistent With The Medicaid Act And Due Process.

Plaintiffs contend that TennCare systemically fails to grant timely hearing requests in violation of the Medicaid Act and the Due Process Clause. *See* Doc. 26-1 at 2, 24. But Plaintiffs have utterly failed to support this sweeping assertion. In fact, some of the Plaintiffs cited *did not* file a timely appeal, *see* Doc. 1 at ¶¶ 336–37 (E.I.L); 426 (Walker), or had their appeals closed for failing to respond to a notice asking for more information about TennCare's mistake, *see* Doc. 1 at ¶¶ 403–05 (Turner family); Hagan Decl. ¶ 125 (Caudill). Likewise, TennCare discovered that, contrary to their assertions, others did not file an appeal, *see* Hagan Decl. ¶¶ 91–94 (A.M.C.), 99 (K.A.), 112–18 (Barnes). And some Plaintiffs admit that they *did* receive a hearing, *see* Doc. 1 at ¶ 375 (J.Z.), or they were not denied a hearing, but rather continuation of benefits, based on timeliness*, see id.* at ¶¶ 387–88 (D.R. family); Hagan Decl. ¶ 106 (S.F.A). Likewise, other Plaintiffs' appeals were closed because TennCare resolved their appeal by *reinstating* or backdating coverage without a hearing. *See* Hagan Decl. ¶¶ 102 (K.A.), 107–08 (S.F.A), 127 (Caudill), 135 (S.L.C.), 156 (Hill); 162 (J.S.K., M.N.S., and D.C.S.), 179 (Rebeaud), 186–87 (D.R., J.Z., M.X.C., and J.C.); 200 (Vaughn); 139 (D.D.).

The only Plaintiff who did not receive a timely, requested appeal was Plaintiff Fultz. That failure arose from a combination of one-off idiosyncratic worker errors rather than a systemic issue or TennCare policy. When Mr. Fultz requested an appeal on August 9, 2019, it was mislabeled as proof of insurance and, as a result, was not sent to the appeals unit to create an appeal under the normal procedure. *Id.* ¶ 145. And when a second appeal was filed on August 27, 2019, the appeals unit marked it as untimely because the worker thought Mr. Fultz was appealing an earlier termination decision with a past-due filing deadline and failed to recognize that it was the second appeal attempt. *Id.* ¶ 147. Neither instance highlights a systemic issue.

Because Plaintiffs have failed to demonstrate a systemic problem with TennCare's appeals process, neither their Medicaid Act nor their due process claims are likely to succeed. The Medicaid Act requires that the State's "plan" must "*provide for* granting an opportunity for a fair hearing . . . ." 42 U.S.C. § 1396a(a)(3). This language does not require perfect compliance, i.e., that the State can never mistakenly fail to provide an opportunity for a hearing. *See Frazar v. Gilbert*, 300 F.3d 530, 544 (5th Cir. 2002), *rev'd on other grounds*, *Frew v. Hawkins*, 540 U.S. 431, 436 (2004). In other words, "[t]he law does not require that a state Medicaid agency implement a flawless program." *Unan v. Lyon*, 853 F.3d 279, 288 (6th Cir. 2017) (citing *Frazar*, 300 F.3d at 544 ("Perfect compliance with such a complex set of requirements is practically impossible, and we will not infer congressional intent that a state achieve the impossible.")).

Likewise, the Medicaid regulation that Plaintiffs cite requires that a state "maintain[] a hearing system that meets the requirements of [Subpart E]" and identifies what the State's "hearing system must provide for." 42 C.F.R. § 431.205(a), (b). TennCare's plan provides a thorough appeals process by which members can challenge adverse agency decisions. *See* Hagan Decl. ¶¶ 70–73. These procedures more than adequately meet the statutory and regulatory requirements

in the vast majority of cases. In fact, since March 19, 2019, TennCare has processed 147,897 eligibility-related appeals and only 6,910 (4.7 percent) have been closed as untimely. *See id.* ¶ 71(c). Without evidence of systemic denial of timely appeal requests, Plaintiffs' claim must fail. It is settled that a "process which is sufficient for the large majority of a group of claims is by constitutional definition sufficient for all of them." *Walters v. Nat'l Ass'n of Radiation Survivors*, 473 U.S. 305, 330 (1985). Pointing to *two* worker errors in closing an appeal for *one individual* does not come close to establishing a due process violation. *See id.*; *see also Parham v. J.R.*, 442 U.S. 584, 612–13 (1979) ("That there may be risks of error in the process affords no rational predicate for holding unconstitutional an entire statutory and administrative scheme that is generally followed in more than 30 states."). Finally, Plaintiffs' due process claim fails because they do not—and cannot—point to additional procedural safeguards that would add substantial value in mitigating errors in TennCare's appeals process. *See Caswell v. City of Detroit Hous. Comm'n*, 418 F.3d 615, 621 (6th Cir. 2015).

Next, Plaintiffs contend that TennCare "denies some appeals, or continuation of coverage pending the appeals, on the grounds that the request was not timely, even where an member asserts the good cause that she never received a notice and attempted to appeal as soon as she learned of her termination." Doc. 26-1 at 24–25. But Plaintiffs cite no authority for the proposition that either the Medicaid Act or the Due Process Clause requires that TennCare give good cause extensions for appeal and continuation-of-benefits request deadlines whenever an member alleges they did not receive a termination notice. To the contrary, as explained above, neither the Medicaid Act nor federal regulations require that state agencies grant good cause extensions for appeals—it is purely the creation of *state* regulation. *See* Tenn. Comp. R. & Regs. 1200-13-19-.06(3). Federal courts may not remedy alleged violations of State law because "a claim that state officials violated state

law in carrying out their official responsibilities is a claim against the State that is protected by the Eleventh Amendment." *Pennhurst State Sch. & Hosp. v. Halderman*, 465 U.S. 89, 121 (1984). Rather, the only relevant federal regulations require that an "agency must allow the applicant or beneficiary a reasonable time, not to exceed 90 days from the date that notice of action is mailed, to request a hearing," 42 C.F.R. § 431.221(d), and that, if it sends a 10-day or 5-day notice, it cannot terminate benefits until a decision is rendered if an member requests a hearing (not based solely on an issue of federal or state law or policy) before the date of the action, *id.* § 431.230(a).

In any case, contrary to Plaintiffs' assertions, TennCare *does* grant a good cause extension if an member alleges, and TennCare confirms, that the notice was sent to the wrong address. Hagan Decl. ¶ 71(c). To the extent Plaintiffs argue that TennCare must provide extensions *every time* an member merely *alleges* that she did not receive a notice, their argument fails because "the risk of an erroneous deprivation of [the member's] interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards" are both extremely low. *Mathews*, 424 U.S. at 335. TennCare has shown that it goes to great lengths to ensure it has accurate addresses and that notices are mailed to the correct address, and it has detected no evidence of systemic mailing errors, a conclusion confirmed by an audit conducted by Tennessee's Comptroller. Hagan Decl. ¶¶ 36–39, 75–79. And the value of providing good cause extensions to all members who allege they did not receive a notice is negligible, because they are all free to immediately reapply for TennCare and will be reinstated if they are in fact eligible. *See id.* ¶ 71(c).

"[T]he Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail," *Mathews*, 424 U.S. at 335, weighs strongly in favor of TennCare as well. Deadlines are necessary for the efficient and effective functioning of a system that processes hundreds of thousands of

applications, changes, and renewals, in addition to thousands of appeals every month. Hagan Decl. ¶ 71(c). Requiring TennCare to automatically grant good cause extensions to individuals who, without more, simply allege they did not receive a notice would significantly disrupt the appeals process by imposing additional fiscal and administrative burdens.

Finally, Plaintiffs argue that TennCare fails to give fair hearings in violation of federal regulations and procedural due process because it "subjects every appeal to an unlawful vetting process" by requiring that claimants demonstrate a "valid factual dispute" before receiving a hearing. Doc. 26-1 at 25. But the Sixth Circuit has already upheld this process. In *Rosen*, the Court of Appeals held that neither the Medicaid regulations nor due process required TennCare to provide hearings to individuals who have not raised a "valid factual dispute" about their Medicaid eligibility. 410 F.3d at 926–29. The Court observed that the Supreme Court has "explained that the due process requirement that the government provide a hearing before the termination of benefits turns on the sensible fact/law dichotomy" drawn by TennCare. *Id.* at 928 (citing *Codd v. Velger*, 429 U.S. 624, 627 (1977)). This Court has also upheld Tennessee's valid factual dispute requirement for benefits appeals, explaining that "the Sixth Circuit definitively rejected Plaintiffs' argument that the State must hold a hearing to determine if the only issue is one of law or policy." *See Grier v. Goetz*, 402 F. Supp. 2d 876, 921 (M.D. Tenn. 2005).

B. TennCare's Procedures Do Not Violate Title II Of The ADA.

Title II of the ADA provides: "Subject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. The statute defines a "qualified individual with a disability" as

Case 3:20-cv-00240 Document 62 Filed 05/29/20 Page 26 of 42 PageID #: 2268

> an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.

Id. § 12131(2). Thus, "a plaintiff must show that: (1) she has a disability; (2) she is otherwise qualified; and (3) she was being excluded from participation in, denied the benefits of, or subjected to discrimination under the program because of her disability." *Anderson v. City of Blue Ash*, 798 F.3d 338, 357 (6th Cir. 2015) (footnote omitted).

For purposes of adjudicating Plaintiffs' preliminary-injunction motion, the State does not dispute that the named Plaintiffs who purport to represent a disability subclass are disabled within the meaning of Title II and are otherwise qualified because, even "without reasonable modifications to [TennCare's] rules, policies, or practices," they "meet[ ] the essential eligibility requirements for" TennCare coverage. 42 U.S.C. § 12131(2).[5] Indeed, all of them *are*, in fact, enrolled in TennCare. The question, then, is whether Plaintiffs are being or will be "excluded from participation in, denied the benefits of, or subjected to discrimination under [TennCare] because of [their] disabilit[ies]." *Anderson*, 798 F.3d at 357. Because Plaintiffs are not alleging intentional discrimination, which is required for a discrimination claim under Title II, *see Tucker v. Tennessee*, 539 F.3d 526, 532–38 (6th Cir. 2008) *abrogated on other grounds by Anderson*, 798 F.3d at 357 n.1, Plaintiffs must show that they are or will be "excluded from participation in, [or] denied the benefits of" TennCare, *Anderson*, 798 F.3d at 357; *Ability Ctr. of Greater Toledo v. City of Sandusky*, 385 F.3d 901, 909–10 (6th Cir. 2004).

[5] Those Plaintiffs are S.F.A., Vivian Barnes, S.L.C., Carlissa Caudill, Charles E. Fultz, Michael S. Hill, William C. Monroe, Linda Rebeaud, Kerry Vaughn, and Johnny Walker. *See* Doc. 1 at ¶ 434; Doc. 26-1 at 8 n.13.

Plaintiffs assert that the State denies disabled individuals the benefits of TennCare in two ways: (1) by ostensibly not "reliably screen[ing] for categories of eligibility related to disability status," and (2) by allegedly failing to assist the disabled sufficiently in completing TennCare's eligibility-determination processes. Doc. 26-1 at 29, 32. Of course, Plaintiffs cannot credibly maintain that they are *currently* being "excluded from participation in or be denied the benefits of" TennCare, 42 U.S.C. § 12132, since all of them are currently enrolled in TennCare.[6] Rather, their claim must be that they *will be* denied the benefits of TennCare in the future "by reason of" their disability. But regardless of whether their claim is for present or future denial of TennCare benefits, the standard for assessing their claim is the same: have Plaintiffs demonstrated that the State fails to provide meaningful access to TennCare for those who are eligible due to a disability-related reason? The answer is clearly "no."

In *Alexander v. Choate*, 469 U.S. 287 (1985), the Supreme Court addressed the legal standard for assessing whether a state has denied a benefit to disabled individuals in violation of the Rehabilitation Act.[7] The plaintiffs brought a class action challenging the reduction of inpatient hospital coverage from 20 days to 14 days, arguing that the change in policy would have a disparate impact on the disabled when it went into effect in the future. *Choate*, 469 U.S. at 289–90. The Supreme Court assumed without deciding that a disparate-impact claim was cognizable under the Rehabilitation Act and held that, even under a disparate-impact theory, the Rehabilitation Act only

---

[6] For the same reason, named Plaintiffs cannot represent any purported subclass of disabled individuals who are *currently* being denied TennCare coverage. *See* Def's Opp. to Pls.' Mot. for Class Cert. at Part II.C.

[7] The prohibition of disability discrimination in the Rehabilitation Act is nearly identical to Title II's prohibition. *See McPherson v. Michigan High Sch. Athletic Ass'n, Inc.*, 119 F.3d 453, 459–60 (6th Cir. 1997) (Title II and Rehabilitation Act are construed together because they are "quite similar in purpose and scope").

"requires that an otherwise qualified handicapped individual must be provided with *meaningful access* to the benefit that the grantee offers." *Id.* at 301 (emphasis added). The mere fact that the state law might have disproportionately affected the disabled did not necessarily give rise to a violation of the Rehabilitation Act because the Act does not guarantee that all laws would have equivalent effects on the disabled and non-disabled. *See id.* at 298, 302; *see also Hunsaker v. Contra Costa Cty.*, 149 F.3d 1041, 1044 (9th Cir. 1998) ("disparate impact discrimination is actionable only if it involved a denial of 'meaningful access' to public benefits").

Applying that standard, the Court held that the 14-day limit did not deny disabled individuals the state-provided benefit of inpatient hospital coverage. *Choate*, 469 F.3d at 302–06. The Sixth Circuit has subsequently made clear that *Choate*'s "meaningful access" test is the appropriate standard for assessing denial-of-benefit claims under Title II, *see Ability Ctr. of Greater Toledo*, 385 F.3d at 907–13; *Jones v. City of Monroe*, 341 F.3d 474, 478–80 (6th Cir. 2003), including specifically *Choate*'s caveat that "equal results from the provision of the benefit, even assuming equal results could be achieved, are not guaranteed," *id.* at 479. And because Plaintiffs bear the burden of proving that they have been "denied the benefits of" TennCare, *see Anderson*, 798 F.3d at 357, they bear the burden of proving a *lack of meaningful access* to that benefit, *see Choate*, 469 U.S. at 302 & n.22; *Havens v. Colorado Dep't of Corr.*, 897 F.3d 1250, 1263 (10th Cir. 2018).

The disabled Plaintiffs do not come close to demonstrating a lack of meaningful access to TennCare. Most obviously, the fact that all Plaintiffs are currently enrolled in TennCare (and that 70 percent of the disabled Plaintiffs were enrolled in TennCare *before* this lawsuit was filed) shows that they, themselves, are not being denied meaningful access to TennCare. *See* Hagan Decl. ¶ 81 (Barnes, Fultz, and Monroe gained coverage later); *see also supra* note 5. Nor have Plaintiffs

submitted *any evidence* that other disabled individuals are being denied meaningful access to TennCare, let alone that they are being denied meaningful access based on the specific grounds Plaintiffs allege (i.e., lack of reliable eligibility screening and lack of assistance in completing the application/redetermination process). This Court's analysis of Plaintiffs' ADA claims may end here: there is simply no evidence in the record to support Plaintiffs' claims.

Indeed, the evidence *affirmatively refutes* disabled Plaintiffs' allegations of systemic errors that would deny them or other disabled individuals TennCare benefits in the future. Consider, first, Plaintiffs' allegation that TennCare fails to adequately consider individuals for disability-related eligibility. But TEDS evaluates the individual for eligibility across *all* TennCare categories whether an individual enrolled in TennCare is going through the annual redetermination process or is being evaluated for eligibility due to a change in circumstance. *See supra* Part II.A.1.b; Hagan Decl. ¶¶ 52 & n.15, 59. If an individual is not found eligible automatically for an SSI-related category, a TennCare worker reviews for eligibility once the individual returns a questionnaire or renewal packet. Hagan Decl. ¶ 52 & n.15, 59. That is why, from March 19, 2019 through April 11, 2020, more than *17,000* individuals were determined eligible for TennCare in the disability-related categories identified by the Plaintiffs, *see id.* ¶ 35(g), a figure that flatly contradicts Plaintiffs' allegation that the State denies disabled individuals meaningful access to TennCare.

The disabled Plaintiffs emphasize the alleged errors made in their cases, *see* Doc. 26-1 at 29–31, but as discussed in Director Hagan's declaration, each of their cases presented either idiosyncratic, one-off mistakes (such as human error) or were the result of start-up glitches for TEDS that have since been remedied, *see* Hagan Decl. ¶ 84. For example, Vivian Barnes—whose situation Plaintiffs highlight—lost coverage because of an error in her file sent to TEDS *from the Social Security Administration* (SSA). *Id.* ¶ 35(a). The State has no control over errors made by

the Federal Government and, in accordance with federal law, relies on receiving accurate information from the SSA for the proper functioning of TEDS. *See* 42 U.S.C. § 18083(c)(3); 42 C.F.R. § 435.948. Nothing about Plaintiff Barnes's case or those of any of the other nine disabled Plaintiffs suggests the denial of meaningful access to TennCare benefits for the disabled.

The same is true of the alleged deficiencies in helping disabled individuals navigate TennCare's eligibility-determination processes. Director Hagan's declaration describes in detail the numerous resources available to disabled individuals. *See generally* Hagan Decl. ¶¶ 60–69. Any member whose eligibility is being reassessed due to a change in circumstance or through annual redetermination is provided with the phone number for TennCare Connect and told to call the number if they need help because of a health problem, learning problem or a disability. *Id.* ¶ 47. A trained TennCare Connect representative, in turn, will determine what kind of assistance the member needs and, if necessary, refer the member to a contracted service. *Id.* ¶¶ 61–65. For instance, TennCare contracts with the Department of Human Services (DHS) to maintain trained staff in *every county* who provide in-person assistance to disabled individuals with filling out and submitting TennCare applications, renewal packets, or other verification documents. *Id.* ¶¶ 12, 64. TennCare also contracts with each of nine Tennessee Area Agencies on Aging and Disability (AAAD) to assist members going through redetermination. *Id.* ¶ 65. The AAAD representative must meet face-to-face with a member within five business days of an initial phone contact, and during that meeting, the representative must assist the member with completing a renewal packet and gathering all necessary documentation. *Id.* The AAAD representative must also assist in submitting the completed renewal packet within the timeframe specified by TennCare. *Id.* And TennCare also contracts with the Tennessee Community Services Agency to maintain a toll-free hotline providing information and assistance regarding TennCare eligibility to those with mental

illness and other disabilities, including information relating to renewal, and every member whose eligibility is being reassessed due to a change in circumstance or through annual redetermination is provided with the phone number for this hotline and told to call if they have a mental illness and need help. *Id.* ¶¶ 47, 62–63. Finally, because the annual renewal packet is much longer and more complicated than the short change-of-circumstances questionnaire, TennCare's Managed Care Organizations contact members to whom a renewal packet is mailed (as well as members who fail to respond to a renewal packet) to determine whether the member requires assistance with completing the renewal packet due to disability. *Id.* ¶¶ 45, 50, 58. In light of all the resources that TennCare provides to disabled individuals going through eligibility-determination processes—none of which Plaintiffs mention in their brief—Plaintiffs cannot credibly argue that TennCare denies meaningful access to individuals with disabilities.

Plaintiffs make sweeping assertions about alleged deficiencies in TennCare's assistance to disabled individuals navigating eligibility-determination processes, but provide only two specific examples of accommodations that they believe TennCare is required to provide under the ADA and is not currently providing. First, the "identification of community mental-health centers where each member had most recently received treatment, and notification of those centers to conduct outreach and proactively assist with the reverification of their eligibility." Doc. 26-1 at 32. Second, they seek "notification to all enrollees of the availability of a good cause extension of deadlines for responding to state requests and for submitting appeals." *Id.* Both sets of accommodations were previously offered to a subset of severely mentally disabled individuals who were eligible for TennCare through an eligibility category that no longer exists. *See Rosen*, 410 F.3d at 921.

Plaintiffs cite no authority and make no argument for why these specific forms of assistance are required for disabled individuals to have meaningful access to TennCare benefits, which is

what they must show for these accommodations to be required by the ADA. *See Bedford v. Michigan*, 722 F. App'x 515, 519 (6th Cir. 2018) ("The Disabilities Act . . . does not require that disabled persons . . . necessarily be given the accommodation of their choice."); *Wright v. New York State Dep't of Corr.*, 831 F.3d 64, 72 (2d Cir. 2016).[8] Indeed, if TennCare were required to extend deadlines any time an individual requested an extension based on disability, that would effectively mean that the ADA prohibits the State from imposing a neutral deadline on the disabled and non-disabled alike simply because the deadline had a greater impact on the disabled. But that is precisely the kind of argument the Supreme Court *rejected* in *Choate* in the related Rehabilitation Act context. *See Choate*, 469 U.S. at 302–06; *Ruskai v. Pistole*, 775 F.3d 61, 79 (1st Cir. 2014) ("A facially neutral government restriction does not deny 'meaningful access' to the disabled simply because disabled persons are more likely to be affected by it."); *see also Fritz v. Michigan*, 747 F. App'x 402, 405 (6th Cir. 2018) (refusal to extend court deadlines did not violate Title II). And if the State has no obligation to extend its neutral deadlines for all disabled individuals, it necessarily follows that it has no obligation to *affirmatively notify* all disabled individuals of the discretionary *possibility* of such an extension.

Plaintiffs rely on the Sixth Circuit's decision in *Rosen*, but that was a decision about "compliance with certain federal Medicaid regulations and the Due Process Clause," 410 F.3d at 921, *not* about compliance with the ADA, and while *Rosen* concluded that the accommodations for severely mentally disabled individuals *satisfied* due process, it did not hold that those

---

[8] Plaintiffs assert that TennCare sometimes fails to apply the good-cause exception for disabled individuals who request it. Doc. 26-1 at 33. But even if that allegation were true, it would be irrelevant, since the issue is not whether having a disability should qualify as "good cause" (which is a question of state law); the issue is whether TennCare is required under Title II to affirmatively notify disabled individuals of the good-cause exception in order for those individuals to have meaningful access to TennCare benefits.

accommodations were *required* by due process, *see id.* at 931–32. And even if *Rosen* had been an ADA decision, and even if it had held that the accommodations for severely mentally disabled individuals were required by the ADA, such a holding would only be relevant to *today's* TennCare system if Plaintiffs were correct in asserting that "[t]he current redetermination process is at least as challenging for members to successfully complete as it was when TennCare implemented" the *Rosen* accommodations. Doc. 26-1 at 32. But Plaintiffs offer *no evidence at all* for that assertion,[9] and it is manifestly untrue. Rather, the current redetermination process is *far easier* to complete than it was when *Rosen* was decided in 2005, for TEDS has dramatically reduced the amount and complexity of paperwork that members must complete. *See* Hagan Decl. ¶ 69.

Finally, Plaintiffs cite two regulations to support their argument, *see* 28 C.F.R. § 35.130(b)(3), (b)(8), but because they make no effort to explain how those regulations apply to this case, the nature of Plaintiffs' argument is unclear. Insofar as Plaintiffs argue that these regulations require *more* than Title II requires (e.g., requires the State to do more than provide the disabled with meaningful access to TennCare), the State reserves the right to argue that the regulations exceed the agency's statutory authority and are invalid. *See Util. Air Regulatory Grp. v. EPA*, 573 U.S. 302, 321–22 (2014); *Hunsaker*, 149 F.3d at 1043.[10] And even if the regulations are valid, Plaintiffs lack a cause of action to enforce them insofar as they impose a requirement that Title II does not. *See Alexander v. Sandoval*, 532 U.S. 275, 285–86 (2001); *Ability Ctr. of*

[9] Plaintiffs cite alleged difficulties that they had completing the eligibility-determination process after TEDS was implemented, *see* Doc. 26-1 at 32 n.73, but since "the risk of error" is "inherent" in any eligibility-determination system, *see Mathews*, 424 U.S. at 344, this anecdotal evidence does not show that the current process and the process in place in 2005 are equally difficult to navigate. In any event, as described above, many of Plaintiffs allegations are simply untrue. *See supra* Part II.A.1.b.

[10] The State reserves the right to argue, in subsequent proceedings, that *Chevron, U.S.A., Inc. v. NRDC*, 467 U.S. 837 (1984), was wrongly decided and should be overruled, *see Michigan v. EPA*., 135 S. Ct. 2699, 2712–14 (2015) (Thomas, J., concurring).

Greater Toledo, 385 F.3d at 913–15; *Bernstein v. City of New York*, No. 13-CV-04610 (CM)(SN), 2015 WL 12434370, at *5 n.4 (S.D.N.Y. Feb. 18, 2015), *vacated on other grounds*, 621 F. App'x 56 (2d Cir. 2015).

If instead Plaintiffs concede that these regulations merely implement Title II's requirement that the State provide meaningful access to TennCare, then the State has not violated the regulations for the reasons described above. The State "does not prevent the plaintiffs from 'fully and equally' " accessing TennCare's benefits, *see Sandison v. Michigan High Sch. Athletic Ass'n, Inc.*, 64 F.3d 1026, 1037 (6th Cir. 1995) (rejecting challenge under 28 C.F.R. § 35.130(b)(8)),[11] and its "methods of administration" do not "have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability" or "have the purpose or effect of defeating or substantially impairing accomplishment of the objectives" of TennCare "with respect to individuals with disabilities," 28 C.F.R. § 35.130(b)(3)(i)–(ii).

III. The Remaining Factors Counsel Against An Injunction.

The public interest and balance of equities also favor the State. *See Nken v. Holder*, 556 U.S. 418, 435 (2009) (these factors "merge" where the defendant is a governmental entity). Granting Plaintiffs' motion would impose an enormous cost on the public. As demonstrated in the Declaration of TennCare's Chief Financial Officer, William Aaron, Plaintiffs' requested injunction would cost about *$1 billion*,[12] and that number assumes the injunction would only last

---

[11] Section 35.130(b)(8) is clearly inapplicable to this case. That regulation only applies to a public entity's "eligibility criteria." 28 C.F.R. § 35.130(b)(8); *see also Sandison*, 64 F.3d at 1037; *Steimel v. Wernert*, 823 F.3d 902, 916 (7th Cir. 2016). Plaintiffs do not challenge the State's eligibility criteria for TennCare coverage; they argue that the State does not reliably screen for eligibility *under its current criteria* and that the State must do more to assist the disabled complete the TennCare application or redetermination processes *governed by those criteria*.

[12] As indicated in Mr. Aaron's declaration, his estimate of $788 million for reinstating coverage for 178,951 individuals is less than the $1.182 billion figure provided in the State's motion to stay briefing, *see* Def.'s Combined Mem. of Law Doc. 29-1 at 6–7 (April 13, 2020),

through June 2021. Decl. of William Aaron in Opp. to Pls.' Mots. for Class Cert. & for a Prelim. Inj. ¶ 4. In truth, Plaintiffs have not requested a sunset date on their requested injunction, and given how long it might take this Court to fully adjudicate this complicated case, it is entirely possible that a preliminary injunction would remain in effect past June 2021, leading to an even larger price tag for the public. This enormous cost would necessarily require the State to make trade-offs, foregoing the funding of healthcare and other priorities to pay for Plaintiffs' unjustified injunction. *See id.* ¶ 9. And this comes at a time when the State is seeking ways to *reduce* its budget due to the economic consequences of the COVID-19 pandemic. *Id.* And as demonstrated above, there is nothing to weigh on Plaintiffs' side of the balance of equities. Because every eligible individual is currently covered by TennCare (including all the named Plaintiffs), and because it is undisputed that no one currently enrolled in TennCare will be involuntarily disenrolled for the foreseeable future, Plaintiffs face no risk of irreparable harm. Plaintiffs offer nothing that would justify the crushing cost that their proposed relief would impose on the public, so the balance of equities and public interest strongly counsel against granting a preliminary injunction.

IV. Plaintiffs' Proposed Preliminary Injunction Is Impermissible Under Rule 65(d).

Plaintiffs' injunction is not "appropriately tailored." It is vague on its face and would quickly prove either unworkable or overbroad should an attempt ever be made to put it into effect. Thus, even if Plaintiffs could satisfy the four equitable factors for an injunction to issue—and they cannot—their proposed injunction fails under Rule 65(d)(1).

---

because it became clearer to the State that Plaintiffs' requested injunction only seeks *prospective* reinstatement of TennCare benefits, not *retroactive* reinstatement back to March 19, 2019, Aaron Decl. ¶ 4 & n.2. The $1.182 billion estimate had assumed a retroactive reinstatement of coverage for the proposed class. However, the cost of prospective reinstatement *plus* the cost of stopping future disenrollments from the program are estimated at a little over $1 billion for *just one year. Id.* ¶ 4. The cost goes up substantially the longer the injunction remains in place. *Id.* ¶¶ 4, 7.

A. Plaintiffs' Proposed Preliminary Injunction Is Impermissibly Vague.

Because the Plaintiffs' proposed injunction incorporates the proposed class and subclass definitions, it shares the same fundamental defect: it does not permit the Court or the State to determine who is and who is not entitled to relief. Both definitions purport to limit relief to "individuals who *meet the eligibility criteria for TennCare coverage* and who, since March 19, 2019 have been, or will be, disenrolled." Mem. of Law in Supp. of Pls.' Mot. For Class Cert., Doc. 12-1 at 3 (March 27, 2020) (emphasis added). Plaintiffs have not suggested any means for the Court to determine which, if any, of the approximately 179,000 individuals who were disenrolled, *see* Hagan Decl. ¶ 74, actually "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.

The proposed injunctions thus do not "state [their] terms specifically," nor "describe in reasonable detail" who is and who is not entitled to the relief that they mandate. FED. R. CIV. P. 65(d)(1). They lack the specificity that is necessary "to prevent uncertainty and confusion on the part of those faced with injunctive orders, and to avoid the possible founding of a contempt citation on a decree too vague to be understood." *Schmidt v. Lessard*, 414 U.S. 473, 476 (1974). "Because of the rightly serious view courts have traditionally taken of violations of injunctive orders, and because of the severity of punishment which may be imposed for such violation, such orders must in compliance with Rule 65 be specific and reasonably detailed." *Pasadena City Bd. of Ed. v. Spangler*, 427 U.S. 424, 439 (1976).

Even if the Court awarded only forward-looking relief, requiring the State not to terminate any TennCare members without notice and an opportunity for a hearing, Plaintiffs' proposed

injunctions still lack any of the reasonably-detailed standards and procedures to measure compliance and would as a result be practicably unworkable. Even the best systems of administrative adjudication will never achieve perfection and infallibility. Mistakes will be made. Yet the evidence before this Court establishes that, whenever such a mistake has been brought to the State's attention—whether by a covered individual, or by a family member's caretaker, or by an advocate—Defendant has fixed that mistake and restored coverage. *See* Hagan Decl. ¶¶ 82–83; Staniewski Decl. ¶¶ 2–5, Doc. 59-2. Indeed, the State is unaware of anyone whose coverage was incorrectly terminated and has not now been restored. Hagan Decl. ¶ 82. And the State remains committed to fixing mistakes if, when, and as soon as they are brought to its attention.

All of which raises the question: what would TennCare be expected—indeed, required under penalty of contempt—to do in order to comply with Plaintiffs' proposed injunction that TennCare is not already doing? Here, the injunction is silent, offering neither guidance nor instruction. If the State is required to use the systems and procedures that have been approved by the federal government for redetermining eligibility, the fact is that TennCare is not aware of anyone who is entitled to receive relief to whom relief has not already been provided under that very system. If TennCare is expected to devise and put into practice some other process, the injunction does not say what that process would entail. Requiring TennCare to implement this unknown and untested process to redetermine the eligibility of hundreds of thousands of members annually (once the COVID-19 moratorium is lifted) would be both impracticable and a recipe for administrative chaos.

B. The Proposed Preliminary Injunction Is Overbroad.

Because Plaintiffs' proposed injunction is impossible to implement as written, Plaintiffs alternatively may be suggesting that the State be ordered to reinstate *everyone* whose coverage was terminated since March 19, 2019, regardless of whether they received notice, regardless of

whether they had an opportunity to be heard, and most importantly, regardless of whether they are actually eligible for coverage today. Such relief is impermissible because it is not narrowly tailored to the scope of the alleged injury.

"Precisely because equitable relief is an extraordinary remedy to be cautiously granted, it follows that the scope of relief should be strictly tailored to accomplish only that which the situation specifically requires and which cannot be attained through legal remedy." *Aluminum Workers Int'l Union v. Consol. Aluminum Corp.*, 696 F.2d 437, 446 (6th Cir. 1982). Thus, the "[f]ederal courts should aim to ensure the framing of relief no broader than required by the precise facts," *Friends of the Earth, Inc. v. Laidlaw Envt'l Servs.*, 528 U.S. 167, 193 (2000) (quotation marks omitted), and tailor their injunctions "to give only the relief to which the plaintiff is entitled," *Williams v. Owens*, 937 F.2d 609 (table), 1991 WL 128775, at *3 (6th Cir. July 16, 1991).

The injunction requested by Plaintiffs does neither. The relief Plaintiffs seek is far broader than necessary to redress the injury that Plaintiffs allege. As just noted above, the State is not aware of a single TennCare-eligible person who is not currently on the program. We are thus unaware of *anyone* who is both entitled to and in need of the requested relief, and Plaintiffs have not identified any such person either. Plaintiffs have conceded that as few as 2 percent of those whose coverage was terminated are actually eligible for TennCare. Doc. 12-1 at 14–15.[13] Providing relief when 98 percent of the recipients are not entitled to it is antithesis of narrow tailoring.

---

[13] A recent performance audit performed by the Tennessee Comptroller of the Treasury suggests that the size of the class—if any class exists at all—is likely minuscule. *See* Tennessee Comptroller of the Currency, PERFORMANCE AUDIT REPORT: SPECIAL PROJECT; DIVISION OF TENNCARE'S REDETERMINATION PROCESS AND THE IMPACT ON CHILDREN'S ENROLLMENT (Feb. 2020), https://bit.ly/2APHVRz. Contrary to Plaintiffs' bald assertions, the Report bases its conclusions on random samples of TennCare enrollees. It found that problems with the program were not systematic and widespread, but random and small in number. For example, examining a sample of 289 members who had not returned their redetermination packets revealed that packets had, in fact, been mailed to all 289. *Id.* at 12. This suggests that individuals who fail to return their

Moreover, federal law requires TennCare to annually redetermine eligibility and terminate those who are found to be ineligible. *See* 42 C.F.R. § 435.916. Thus, the injunction would also "restrain the defendants from engaging in legal conduct," *City of New York v. Mickalis Pawn Shop, LLC*, 645 F.3d 114, 145 (2nd Cir. 2011), and require TennCare to act contrary to federal law or be held in contempt.

V. In All Events, This Court Should Not Enter A Class-Wide Injunction.

Finally, even if this Court decides (wrongly, we respectfully submit) to issue a preliminary injunction, such an injunction should be limited to the named Plaintiffs. Plaintiffs are unlikely to prevail in their effort to obtain class-wide relief because neither their proposed class nor their subclass meet the requirements of Rule 23. As we explain in the opposition to Plaintiffs' motion for class certification,[14] both definitions are invalid under Rule 23 because they would require the court to engage in extensive individualized fact-finding to determine whether an individual is a member of the class. The proposed classes also fail to meet the general requirements of commonality and typicality under Rule 23(a) and the specific requirements of Rule (23)(b)(2).

CONCLUSION

The State respectfully submits that the Court should dismiss Plaintiffs' Motion for Preliminary Injunction for lack of jurisdiction. Alternatively, the Court should deny Plaintiffs' motion.

---

redetermination packets are not doing so because they did not receive those packets. Likewise, a sample of 85 appeals revealed "that the division appropriately processed appeals and documented its final administrative action for each member tested." *Id.* at 23. This suggests that the problems with the appellate process that Plaintiffs allege are systematic are, in fact, outliers.

[14] As explained in the State's briefing on the motion to stay, this Court must resolve Plaintiffs' Motion for Class Certification before granting class-wide relief. *See* Doc. 29-1 at 3–5; Def.'s Reply in Supp. of Mot. to Stay, Doc. 32 at 1–3 (Apr. 14, 2020).

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
Faith E. Gay
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