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

DEFENDANT'S RESPONSE IN OPPOSITION TO PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

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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: no Plaintiff will be affected in any way by the proposed injunction, and so Plaintiffs lack standing to request it. For the same reason, Plaintiffs have shown no irreparable harm; all Plaintiffs are currently receiving TennCare benefits, and the State is not disenrolling anyone for the foreseeable future while the COVID-19 national emergency is ongoing. The only harm Plaintiffs put forward to justify their motion falls entirely on a subset of the proposed class whose interests Plaintiffs cannot assert as their own. 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 them, and the evidence in the record decisively refutes them. What Plaintiffs portray as systemic, chronic failures are in fact a collection of disparate 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 been corrected and Plaintiffs fail to tie them to any individual who could possibly benefit from the proposed injunction. And what Plaintiffs portray as deficient notice and hearing practices are, in fact, lawful policies that have been approved by the Centers for Medicare and Medicaid ("CMS"), the federal agency charged by Congress to oversee the State's program. Plaintiffs' claims must fail because TennCare's notices and policies fully comply with the State's due process obligations under the Medicaid statute and the Fourteenth Amendment.

The public interest and potential harm to third parties also strongly counsel against an injunction. Not only is there *no risk* of harm to Plaintiffs, but also the financial harm an injunction

would impose on the State would be enormous—totaling almost $1 billion in just two years.

Finally, Plaintiffs' requested injunction is vague, overbroad, and unworkable. It is impermissible under Rule 65.

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 LACK STANDING TO SEEK AN INJUNCTION.

As demonstrated in the State's Motion to Dismiss, Doc. 139-1, Plaintiffs cannot succeed on the merits because this Court lacks jurisdiction. All but two of the 34 Plaintiffs lack standing, and the claims of the other two are moot. *Id.* at 2. Even if this Court had jurisdiction, Plaintiffs' motion fails because they plainly lack standing to seek relief that will not in any way impact them. Under Article III, "a plaintiff must demonstrate standing for each claim . . . *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 sought an injunction:

> requiring Defendant to prospectively reinstate coverage for members of the proposed Plaintiff Class whose TennCare coverage was involuntarily terminated between March 19, 2019, and March 18, 2020, and *who are not currently enrolled*, and notify them of the reinstatement; and (2) prohibiting Defendant from involuntarily terminating *any such individual*'s TennCare coverage until the person receives notice and an opportunity for a fair hearing that complies with due process.

Doc. 141 at 1 (emphasis added). By its plain terms, the proposed injunction would only apply to members of the proposed class who are not currently enrolled, meaning it would not apply to a

single Plaintiff in this case. Any doubt on this score is removed by the Plaintiffs' admission that it is "former members [who] are the subject of this motion." *Id.* at 5. Although Plaintiffs seek to demonstrate the alleged defects in TennCare's notices and hearing processes through reference to their own cases, their brief makes clear that they seek to gain relief for an entirely different group of people, not the Plaintiffs who indisputably have coverage.

Plaintiffs "must demonstrate separate standing to seek declaratory or injunctive relief focused on prospective harm." *WCI, Inc. v. Ohio Dep't of Pub. Safety*, 18 F.4th 509, 514–15 (6th Cir. 2021) (quoting *Barber v. Miller*, 809 F.3d 840, 849 (6th Cir. 2015)). Plaintiffs have *no basis* for a prospective theory of harm for themselves. They are enrolled in TennCare and face no "certainly impending" injury because disenrollments have been suspended during the ongoing COVID-19 emergency. *Id.* (quoting *Buchholz v. Meyer Njus Tanick, PA*, 946 F.3d 855, 865 (6th Cir. 2020)). Even after the State resumes eligibility redeterminations, Plaintiffs will not face "certainly impending" injury because the vast majority of redeterminations conclude that the enrollee is still eligible. *See* Decl. of Kimberly Hagan in Opp'n to Pls.' Mots. for Class Cert. and for a Prelim. Inj. ¶ 18 ("Hagan Decl."). These facts render Plaintiffs' claim of harm to themselves entirely speculative. "A plaintiff seeking a preliminary injunction must establish that *he* is likely to succeed on the merits, that *he* is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of the equities tips in *his* favor . . . ." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008) (emphasis added).

Plaintiffs' pending class certification motion does not resolve this problem; quite the opposite, this problem serves to highlight how defective Plaintiffs' class allegations are. The Plaintiffs cannot represent a class seeking relief that will not affect at least *one* named plaintiff. *Cf. O'Shea v. Littleton*, 414 U.S. 488, 494 (1974) ("[I]f none of the named plaintiffs purporting to

represent a class establishes the requisite of a case or controversy with defendants, none may seek relief on behalf of himself or any other member of the class.); *Warth v. Seldin*, 422 U.S. 490, 502 (1975) ("Petitioners must allege and show that they personally have been injured, not that injury has been suffered by other, unidentified members of the class to which they belong and which they purport to represent.").

II. PLAINTIFFS HAVE FAILED TO SHOW A RISK OF IRREPARABLE HARM.

The Sixth Circuit has 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 Cnty. Sch.*, 942 F.3d 324, 326–27 (6th Cir. 2019) (cleaned up). Because "the existence of an irreparable injury is mandatory" to obtain a preliminary injunction, where a plaintiff fails to prove irreparable harm is likely, a court may deny preliminary-injunctive relief without considering the remaining three factors. *Id.* at 327 (emphasis omitted).

It is undisputed that all 34 named Plaintiffs are currently receiving TennCare benefits. Hagan Decl. ¶ 77. Indeed, 32 of them were enrolled in TennCare *before* this lawsuit was filed. *See id.* ¶¶ 77-80. Furthermore, the State has "suspended involuntary disenrollments indefinitely" due to the COVID-19 pandemic. Order, Doc. 34 at 2 (Apr. 14, 2020); *see also* Hagan Decl. ¶ 37.

Thus, *the only basis* for irreparable harm that Plaintiffs can invoke is that allegedly caused to absent members of the proposed class who are currently not enrolled in TennCare. Doc. 141-1 at 21. But this assertion of irreparable harm fails because an injunction must be justified with reference to the harm felt by the party seeking it, not unknown third parties. What is more, Plaintiffs have not shown that any such class exists and in fact have been unable to bring forward a *single* Tennessean who lacks coverage today due to any of the alleged defects with TennCare's administration of the State's Medicaid program.

Harm to some members of a putative class, whose very existence is disputed, cannot form the basis for a finding of irreparable harm to Plaintiffs. *See Adams v. Freedom Forge Corp.*, 204 F.3d 475, 488, 490–91 (3rd Cir. 2000) (holding allegations of harm to putative class members, supported by scant evidence of harm to named Plaintiff harm cannot justify injunctive relief because "[m]erely petitioning for class certification cannot provide plaintiffs the right to be treated collectively," and "plaintiffs only presented evidence from which a court could infer that *some* of them were threatened with harm"). Although courts can infer from evidence of irreparable harm to the existing Plaintiffs that irreparable harm is likely to extend to a broader class of individuals, *see, e.g.*, *Yolton v. El Paso Tenn. Pipeline Co.*, 318 F. Supp. 2d 455, 472 (E.D. Mich. 2003), *aff'd* 435 F.3d 571 (6th Cir. 2006), Plaintiffs here are asking the Court to find irreparable harm despite an undisputed record showing that no named Plaintiff faces such harm. They do not cite a case to support this unusual theory and Defendant is aware of none that would.

Significantly, Plaintiffs offer no evidence that eligible individuals who were terminated between March 2019 and March 2020 remain without any health coverage—a crucial element of the alleged irreparable harm. Rather, they assume that all 108,175 former TennCare enrollees have no other health coverage. A "speculative or theoretical" injury cannot support a preliminary injunction. *D.T.*, 942 F.3d at 327. Certainly, it is very unlikely that any of those 108,175 individuals are currently eligible for, or wish to be enrolled in, TennCare, for they may apply at any time and will be promptly enrolled if eligible. Hagan Decl. ¶ 82(b). With this pathway open and clearly in use, Plaintiffs' assumption that all 108,175 individuals have continued to be eligible and yet remain without coverage is at best speculative.

III. PLAINTIFFS ARE UNLIKELY TO SUCCEED ON THE MERITS.

A. CMS Has Certified the System That Plaintiffs Challenge.

Plaintiffs argue that they are likely to succeed on the merits because (1) TennCare's notices

do not comply with due process and the Medicaid Act, and (2) TennCare's appeals process violates the Medicaid Act. Each argument is fundamentally flawed as detailed below. Also, both these bases for issuing an injunction must fail because the very aspects of the TennCare system that Plaintiffs challenge here were approved by CMS in its recent decision to certify that TEDS meets the extensive statutory and regulatory requirements to receive enhanced Federal Financial Participation ("FFP"). Doc. 139-6 at 2.

The full impact of the certification decision is described in Defendants' motion to dismiss. *See* Doc. 139-1 at 13–19. CMS found that TEDS "[s]upport[s] accurate and timely processing and adjudications/eligibility determinations and effective communications with providers, beneficiaries, and the public." 42 C.F.R. § 433.112(b)(14). In particular, CMS reviewed and approved the notice templates challenged by Plaintiffs and identified no deficiencies. Hagan Decl. ¶¶ 14, 53. CMS's decision is entitled to "substantial deference," and forecloses the relief Plaintiffs seek. *See Rosen v. Goetz*, 410 F.3d 919, 927 (6th Cir. 2005).

B. TennCare's Notices Provide Individuals With Accurate and Adequate Information Regarding Any Adverse Determination.

1. TennCare Considers All Facts and Bases for Eligibility.

First, Plaintiffs argue that TennCare's notices of decision ("NODs") "unlawfully contained false or incomplete information about the basis for Defendant's termination decisions." Doc. 141-1 at 9. Plaintiffs challenge this statement in the NODs: "Remember, when we make our decision, we look at *all* of your facts, *all* of our program rules, and *each* kind of group we have." *Id.* at 10. Plaintiffs suggest, based on a few idiosyncratic and atypical errors in a handful of the named Plaintiffs' cases in which an incorrect eligibility decision was made, that this statement is "false." But Plaintiffs do not deny that it is an accurate statement of TennCare's policy, nor could they. As Plaintiffs acknowledge, this statement "tracks Defendant's duty" under the Medicaid statute to

"consider all bases of eligibility" before "making a determination of ineligibility." *Id.* (quoting 42 C.F.R. § 435.916(f)(1)). Moreover, even if Plaintiffs could point to a pattern of repeated and related failures (they cannot and do not) that would indicate this statement is sometimes inaccurate, Plaintiffs are still 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) (holding that a notice with potentially misleading or false statements was constitutionally adequate because they did not pertain to "the right to request a hearing or to appeal an adverse decision").

More importantly, Plaintiffs have not presented any evidence that any such pattern exists. The isolated instances of past worker error, issues with the conversion of eligibility data into TEDS, or early systems issues (which have all been corrected). *See* Hagan Decl. ¶¶ 77-83; *see also* Doc. 142-2 ¶¶ 80-206. They certainly do not establish a systemic failure to consider all facts pertinent to eligibility for any—let alone every one—of the 108,175 individuals for whom Plaintiffs seek relief. 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. *See* Hagan Decl. ¶¶ 40, 42-58, 63.

TennCare reassesses eligibility through its annual renewal process in accordance with federal Medicaid regulations. *See* 42 C.F.R. § 435.916. TEDS can automatically verify eligibility in many cases by interfacing with multiple databases allowing the auto-renewal of members without asking for any additional information. *See* Hagan Decl. ¶ 40. 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. ¶¶ 43, 45–58.

Plaintiffs complain that nevertheless, TennCare "misidentified members 'as not currently receiving [Supplemental Security Income ("SSI")] . . .' and terminated their coverage," Doc. 141-1 at 10 (quoting Ex. 2 ¶ 35(a)), citing to the cases of Plaintiff Barnes,[1] Caudill, and Walker. They allege that this error flows directly from a TennCare policy of not asking for SSI income in the renewal packets. *Id.* (citing Ex. 11). But Plaintiffs argument misunderstands TennCare's processes. First, renewal packets are not sent to individuals currently receiving SSI or currently in an SSI-related category; they would be auto-renewed if selected for annual redetermination. Members who have lost their SSI benefits are sent a Preterm Notice, which since May 2020 has asked about past receipt of SSI. Hagan Decl. ¶ 65(a). Second, TennCare does not ask about current receipt of SSI in either the renewal packet or Preterm Notice because TEDS interfaces directly with the Social Security Administration ("SSA") database to verify social security income, including but not limited to SSI. It is SSA, not TennCare, that determines who is eligible for SSI (and thus automatically eligible for TennCare). Hagan Decl. ¶ 50 & n.11. Third, TennCare does not ask about current or past receipt of SSI income in the renewal packets because that information is obtained directly from SSA. *Id.* Fourth, TennCare has worked with SSA to identify any other individuals similarly situated to Plaintiffs Barnes, Caudill, and Walker to correct any errors that may have resulted from the receipt of incorrect SSA data at the time of eligibility data conversion into TEDS. *See* Hagan Decl. at ¶¶ 24(a)–(e). In short, there is no reason to believe that any of the

[1] Plaintiffs also complain, in a footnote, about a notice sent to Plaintiff Barnes as part of TennCare's review for eligibility in non-SSI categories. This notice was generated as a result of a "placeholder case" created to facilitate that review and, under an update to TEDS in August 2019, would be suppressed today. In any case, the notice had no practical effect—Plaintiff Barnes remained covered at that time as the notice stated; the notice was simply unnecessary and thus potentially confusing, which is why it would be suppressed today. Hagan Decl. ¶ 83(e).

108,175 individuals for whom Plaintiffs seek relief experienced any of the scattered, idiosyncratic problems that occurred in the cases of three of the 34 named Plaintiffs and lost coverage as a result.

Plaintiffs' arguments also implicate TennCare's reverification process when it 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. ¶ 63. Since March 19, 2019, TEDS has reverified eligibility over 2 million times without requiring any additional information from the member. *Id.* ¶ 16. 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 pre-termination notice and questionnaire ("Preterm Notice"). *Id.* ¶ 65.

Plaintiffs' claims regarding alleged notice deficiencies in this process focus primarily on individuals who were eligible for TennCare because they qualify in another SSI-related category based on past receipt of SSI benefits. *See* Doc. 141-1 at 12. Plaintiffs wrongly assume that TennCare does not screen for the SSI-related categories based on a handful of idiosyncratic problems experienced by a few of the 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. ¶¶ 61–63; *cf. id.* n. 7 (14,968 individuals losing SSI coverage found eligible in another category of Medicaid or CoverKids with no break in coverage).

Plaintiffs' description of the ways that SSI errors allegedly impacted some of the named Plaintiffs only serves to underscore that their claims are not about these processes generally but about isolated errors that have been fixed. For instance, TennCare found 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. Hagan Decl. ¶ 25(e). This of course means none of the 108,175 individuals for whom Plaintiffs seek relief experienced this problem. TennCare also discovered a defect in the TEDS programming logic that caused TEDS to not load the latest Social Security income record. This in turn could cause a member to erroneously appear ineligible in the Widow/Widower Category. This happened to Plaintiff Cleveland. This gap was fixed with the 9.0.1 release of TEDS, following which TEDS loads the most recent Social Security income records for enrollees. Hagan Decl. ¶ 83(i).

Plaintiffs wrongly infer, from these isolated instances, that the 2,773 members disenrolled because they were no longer receiving SSI (out of 213,488 SSI cases converted into TEDS, *i.e.*, 1 percent) received misleading notices because the notices stated that TennCare considered "all of [their] facts." Doc. 141-1 at 11. But TennCare's policy was, and remains, to consider all available information and assess eligibility in all categories. Hagan Decl. ¶¶ 63, 65(a).[2]

Plaintiffs also argue that so-called "case merge issues" belie the notice's statement that TennCare looks at all relevant facts and assesses all possible bases for eligibility. Doc. 141-1 at 12. In several of these cases, the errors Plaintiffs identify were specific to the one-time conversion of eligibility data into TEDS. Hagan Decl. ¶¶ 25, 81. Other errors arose from a different type of "case merge" in which two cases already in TEDS need to be combined into one. For example, in the case of Plaintiff K.A., worker error was responsible for an accidental termination that resulted

[2] Even if the Court were to find that there were errors in the conversion process rendering the notices issued to individuals losing their SSI coverage incorrect, *at most*, this would have impacted only 2,773 individuals out of the 108,175 for whom Plaintiffs seek relief and even that is highly unlikely as TennCare worked with SSA to ensure those individuals were properly disenrolled. Hagan Decl. at ¶ 24(e).

from closing K.A.'s individual case before authorizing eligibility in the family case. This inadvertent error occurred because K.A.'s birth was reported to TennCare through a new member application rather than as an update to the family's existing case. Hagan Decl. ¶ 83(c).

Neither of these categories of "case merge" issues has *anything* to do with the content of TennCare's notices. In each case, worker error or an unforeseen but subsequently fixed issue with the conversion of data into TEDS caused a temporary change in eligibility, and none of these cases resulted in an unfilled gap in coverage.

Plaintiffs attempt to relate these case merge anecdotes to the putative class by pointing out that seventeen named Plaintiffs allegedly have experienced some form of a merge problem and thus, so their argument goes, these are not "one time issues." Doc. 141-1 at 14. As an initial matter, that means half of the named Plaintiffs did not experience these issues and all who did had the error corrected through the normal processes. There is no basis to infer harm justifying a preliminary injunction requiring the reinstatement of 108,175 absent putative class members when just half of the class representatives briefly experienced that harm themselves and it was promptly corrected once discovered. *See Adams*, 204 F.3d at 488.

Plaintiffs argue that 2,907 erroneous terminations identified in discovery that were related to merger issues are "powerful circumstantial evidence" that these are not one-time issues, but these terminations do not demonstrate any such thing. Doc. 141-1 at 14. These merger cases involved errors that can occur when an individual has two or more cases in TEDS that need to be combined. Due to worker error in some instances, the member may lose coverage (often very briefly). TennCare has developed a back-end process that carefully monitors and identifies these cases, reinstates eligibility, and backfills any gap; most of the time, the member is never aware of a change because the issue is resolved before a notice could issue. Hagan Decl. ¶ 83(c)(i).

TennCare has also created a front-end fix that has drastically reduced the number of these types of errors in the first instance. *Id.* ¶ 83(c)(iii). More importantly, TennCare has taken steps to identify any cases impacted by this type of merger error that resulted in loss of eligibility since March 19, 2019, and reinstated eligibility without a gap in coverage for all such individuals. This means there are no individuals among the 108,175 for whom Plaintiffs seek relief who are without coverage due to this type of worker error. *Id.* ¶ 83(c)(v).

Plaintiffs also claim that TennCare has no method for ensuring its eligibility determinations are accurate. This is incorrect as well. Indeed, it strains credulity to think that CMS would approve TEDS (and agree to the expenditure of hundreds of millions of dollars to support its operation) if TennCare's own administrators acknowledged they have no way of determining whether they are appropriately assessing eligibility. Plaintiffs cite a statement in a quarterly report to CMS that, with respect to the program goal of determining accuracy, "No [Key Performance Indicators ("KPIs")] exist at this time for this outcome." Doc. 142-4 at 3; *see* Doc. 141-1 at 14. However, this is merely a statement that there is no *standardized*, *national*, or *CMS-approved and mandated*, way to measure the accuracy of eligibility determinations that CMS could apply to states' Medicaid programs. Hagan Decl. ¶ 15. TennCare *does* measure the quality of its determinations. It conducts a "case read" process to review randomly selected cases from every eligibility case worker each month so that errors can be identified and corrected. *Id.* ¶ 29. Case workers are rated annually based on their performance in the case reads process and common errors are corrected through additional training. Based on the case reads process, TennCare has found that it averages 97.38 percent accuracy in its initial case determinations. *Id.*

2. TennCare's Notices Provide Adequate Information Regarding the Basis of Its Eligibility Determinations.

Plaintiffs next argue that TennCare failed to provide " 'the specific reasons supporting'

ineligibility determinations" based on an enrollee's income level. Doc. 141-1 at 15 (quoting 42 C.F.R. § 431.210(c)). They also argue that Case Change Notices preceding the NODs likewise fail to "disclose the specific change in income" that resulted in ineligibility. Doc. 141-1 at 16. The crux of these claims seems to be that the Case Change Notices do not include a specific income calculation, but instead provides the monthly income limit for the coverage for which the member is otherwise eligible and states that the member's income is over that limit. *See* Doc. 142-8.

But Plaintiffs' argument fails because due process 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, even if they sometimes precede a NOD, which does. *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); Hagan Decl. ¶ 62 (explaining that change notices do not themselves alter any benefits). 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. Cent. Hanover Bank & Tr. Co.*, 339 U.S. 306, 314 (1950). Case Change Notices give members the information relevant to the first step in a *potential* termination process (that TennCare has found a change in income) and direct the Plaintiffs to seek additional information in another form (by phone or online). In other words, members have all the information they need to assess the status of their (at that point, unaffected) benefits and they will receive two additional notices if TennCare determines that the change impacts their eligibility.

Plaintiffs rely on *Barry v. Lyon*, 834 F.3d 706 (6th Cir. 2016), for the proposition that TennCare cannot omit specific income information from its Case Change Notices and require

members to call in or check their online account in order to view the specific change recorded. Doc. 141-1 at 16. But Plaintiffs mischaracterize *Barry*, for it unambiguously stated that due process is satisfied so long as the relevant information is "provided [by the State agency] *in some form*." 834 F.3d at 720 (emphasis added). In *Barry*, the state agency did not provide 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, instead of 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 held that a state agency need not communicate all the facts relevant to a termination in a single notice if it provides the information through other means referenced in the termination notice. *Rosen*, 410 F.3d at 931 (information provided in second notice). The *Barry* Court held *Rosen* did not apply because the agency did not provide the relevant information at all, but TennCare does provide individualized income information "in some [other] form," *Barry*, 834 F.3d at 720, so this case is controlled by *Rosen* not *Barry*.

Plaintiffs' arguments based on the content of the NODs do not fare any better. Every NOD for denial based on income level contains this statement: "The monthly income limit for the kind of <coverage> you could get is <$xxx.xx>. Our records show your monthly income is over this limit." Doc. 141-1 at 15 (quoting Doc. 142-5). This explanation of the termination, accompanied by a notice about the appeals process, gives enrollees everything they need to challenge TennCare's decision. If a member can show her income is less than the limit provided in the NOD,

she will 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). TennCare's notices provide a much clearer explanation for income-based denials with information that is better tailored to informing members of whether they have a claim on appeal.[3] Furthermore, as explained above, CMS reviewed the notices generated by TEDS as part of the certification process and approved the system with the challenged language in place. *See* Hagan Decl. ¶ 14.

3. TennCare's Notices Provide An Adequate Statement Of Appeal Rights.

Plaintiffs next argue that TennCare's NODs do not adequately inform Plaintiffs of their appeal rights because they (1) require members to identify a valid factual dispute to support their appeal, (2) do not inform members of a "good cause" exception to appeals deadlines, and (3) do not inform members of their "right to reconsideration if they submitted requested information within ninety days" (the "90-day reconsideration" provision). Doc. 141-1 at 17–18.

[3] Even if the Court were to accept Plaintiffs' argument about this type of NOD being deficient, at most this would impact only 13,246 of the 108,175 individuals for whom Plaintiffs seek relief as that is the number of individuals who lost coverage for an income related reason. Hagan Decl. ¶ 56.

First, Plaintiffs complain that the valid factual dispute requirement does not allow Plaintiffs to challenge the application of law to the facts. Doc.141-1 at 17. Not so. An allegation that TennCare had erroneously applied the law to the facts—such as the complaint that TennCare found some Plaintiffs ineligible when in fact they met the requirements for certain SSI-related categories, *see* Doc. 1 at ¶ 120—will be deemed a valid factual dispute entitling the member to a fair hearing. *See* Hagan Decl. ¶ 72(g). Indeed, of the 85,439 termination of benefits appeals filed since March 19, 2019, only 3,649 (4 percent) have been closed for lack of a valid factual dispute. Hagan Decl. ¶ 5. Furthermore, 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 . . . if the only issue is one of law or policy." *Grier v. Goetz*, 402 F. Supp. 2d 876, 921 (M.D. Tenn. 2005). Plaintiffs are therefore not likely to succeed on this claim.

The arguments regarding the good cause exception and 90-day reconsideration provision fare no better. Although Plaintiffs fault *all* NODs for failing to mention the 90-day reconsideration provision, that provision only applies in the context of the annual renewal process. *See* 42 C.F.R. § 435.916(a)(3)(iii). All individuals going through that process are notified in the cover letter that accompanies their renewal packet 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 (P-Ex. 12-D). In addition, TennCare sends every individual who files an untimely appeal a letter informing them that they may have an opportunity to extend their appeals deadline if they can demonstrate good cause for the delay. Hagan Decl. ¶ 53; Ex. I; *cf. Rosen*, 410 F.3d at 931 (agency may include relevant information in separate letters). Furthermore, Plaintiffs have offered no evidence to show how many, if any, of the 108,175 individuals at issue in this motion went through the annual renewal process or filed untimely appeals. Without that information, it is impossible to say what, if any, difference either of these policies could have made in their cases.

Plaintiffs have also not pointed to *any* State or federal regulation or case law requiring TennCare to include information about either the good cause or 90-day reconsideration provisions in its NODs. Neither is required by the narrow notice requirements outlined in the federal regulations governing Medicaid appeals. *See* 42 C.F.R. § 431.206(b). Indeed, the 90-day reconsideration provision does not involve the appeals process at all. Nor does *Hamby v. Neel*, 368 F.3d 549 (6th Cir. 2004), provide any support for Plaintiffs' position. In *Hamby*, the Court concluded that TennCare had to inform applicants that failing to pursue an appeal would bar applicants from receiving benefits retroactive to their application date and that filing a new application would cut off eligibility based on the date of a prior application. *Id.* at 560. The Sixth Circuit believed that omitting this information rendered notices insufficient regarding "the consequences of not appealing and filing new applications." *Id.* at 561. Here, unlike in *Hamby*, the 90-day reconsideration and good cause provisions are not hidden pitfalls that threaten to curtail the benefits of unwary applicants but rather are policies that extend additional flexibility that could *benefit* applicants. There is no reason to think that *Hamby*'s requirement that the agency inform applicants of negative consequences of failing to file timely appeals should extend to requiring the

agency to disclose every type of *leniency* it provides to applicants.

Federal regulations do not even require TennCare to *provide* good cause extensions, much less to notify individuals about their availability. Plaintiffs admit these extensions originate from State, rather than federal, regulations. *See* Doc. 141-1 at 18 (citing Tenn. Comp. R. & Regs. § 1200-13-19-.06(3)). Due process does not require TennCare to notify members of a procedural benefit it chooses to provide that is not 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). The 90-day reconsideration provision is also *more* generous than federal law requires. The relevant regulation only requires that States "reconsider" an individual's eligibility if she submits 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 the individual provides the requested information during the 90-day period and is subsequently determined eligible, *see* Tenn. Comp. R. & Regs. § 1200-13-20-.09(1)(d)(11). Due process 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 exceptions 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.* ¶ 58. Plaintiffs object to this rationale as "patronizing," but offer no reason why TennCare's policy determination should not stand. Doc. 141-1 at 19. 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).

C. TennCare Provides Fair Hearings Consistent with the Medicaid Act and Due Process.

Plaintiffs next contend that TennCare failed to provide adequate hearing rights by depriving members of continuation of benefits pending appeal. Doc. 141-1 at 19. Even if Plaintiffs were likely to succeed on this claim (and they are not), it is entirely retrospective and disconnected from the class of individuals on whose behalf they seek this injunction. Although TEDS did suffer from a programming issue that led it to incorrectly deny continuation of benefits in some cases, that defect was corrected in August 2019 and every affected individual received corrected notices and continuation of benefits. Hagan Decl. ¶ 83(f). Plaintiffs have made clear that this preliminary injunction is sought on behalf of *currently unenrolled* individuals, not individuals currently awaiting an appeal. Doc. 141-1 at 1. This claim therefore cannot justify the preliminary injunction Plaintiffs have sought even if it were valid. Plaintiffs' argument that TennCare systemically failed to provide timely hearings, Doc. 141-1 at 20, suffers from the same issue. It is in no way connected to the group of currently unenrolled individuals who are, by Plaintiffs' own definition of that group, not awaiting hearings. Hagan Decl. ¶ 71.

What is more, Plaintiffs have utterly failed to support their sweeping assertion that these failures are systemic. Plaintiffs cite just three instances of delayed appeals. The first, involving Plaintiffs Hill and Vaughn, concerned hearings delayed "over eleven months," but in both cases, the Plaintiffs retained full coverage while their appeal was pending. *See* Doc. 142-2 ¶¶ 156 (Hill); 200 (Vaughn). Although, due to a high volume of appeals at that time, TennCare was forced to

prioritize cases in which a member had lost their coverage over those who maintained coverage, Plaintiffs tellingly cannot provide any evidence that this prioritization practice resulted in any harm since all affected individuals had coverage. *Id.* ¶¶ 157; 200. The third individual, Plaintiff S.F.A., did not have continuation of benefits pending appeal initially but, once the appeal extended beyond 90 days, continuation was added to ensure she also was not harmed by the delay in processing her case. Hagan Decl. ¶ 71.

These isolated instances of delay do not suffice to show a *systemic* problem with TennCare's appeals process that has resulted in systemic harm. As a result, neither Plaintiffs' 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) (emphasis added). This language does not require perfect compliance, i.e., that the State can never fail to provide an opportunity for a hearing (or a timely 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 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 provides a comprehensive appeals process in which members can challenge adverse agency decisions. *See* Hagan Decl. ¶¶ 69–74. These procedures more than adequately meet the statutory and regulatory requirements in the vast majority of cases. Without evidence of a systemic pattern of delaying appeals 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 *three* cases in which an appeal was delayed, without any harm to those individuals, 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.").

D. 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, Zane Seals, Plaintiffs' requested injunction would cost about $435 million, and that number assumes the injunction would only last one year. Decl. of Zane Seals in Opp. to Pls.' Mots. for Class Cert. & for a Prelim. Inj. ¶ 5. In fact, 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 for more than a year, 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 other priorities to pay for Plaintiffs' unjustified injunction. *See id.* ¶ 8.

Plaintiffs attempt to downplay this enormous expense by noting that the regulations "offer[] federal matching funds to underwrite the cost of coverage pending appeal or pursuant to a court order." Doc. 141-1 at 24 (citing 42 C.F.R. § 431.250). But draining the federal fisc is equally important to costs imposed on Tennessee taxpayers in assessing the public interest. In any case, the regulation Plaintiffs cite does not obviously resolve the issue. Although it states that federal

matching is available for "payments made for services provided within the scope of the Federal Medicaid program and made under a court order," 42 C.F.R. § 431.250(b) (cleaned up), that does not necessarily give state Medicaid programs a blank check if they are subject to a preliminary injunction. By its plain text, the regulation requires *both* that the services be "within the scope" of Medicaid *and* made "under a court order." *See State of Georgia v. Heckler*, 768 F.2d 1293, 1298 (11th Cir. 1985) ("[T]he regulation provides for federal funds to be furnished where a court has ordered a state to provide Medicaid benefits that would have been eligible for federal funds had the state in implementing its federally approved program, provided those funds on its own initiative."). Here, it is at least possible, if not likely, that the federal government would refuse to reimburse services provided under a preliminary injunction because the State has previously determined all the affected individuals are not eligible and it has no information suggesting they have become eligible since their terminations. Seals Decl. ¶ 4.

Furthermore, 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 there is a moratorium on most disenrollments from TennCare, Plaintiffs face no risk of irreparable harm. The 108,175 absent potential beneficiaries of a preliminary injunction are free to apply for TennCare benefits at any time if they remain or become eligible. And in fact, the proposed injunction could very well *harm* these individuals, for they could face disenrollment from other state Medicaid programs if they have coverage elsewhere and are put back on TennCare with no warning. Hagan Decl. ¶ 85. Or if they have since acquired coverage through the healthcare exchange, these individuals could be required to pay subsidies back to the federal government as a result of their reenrollment in TennCare. Hagan Decl. ¶ 84. Plaintiffs offer nothing that would justify the crushing cost that their

proposed relief would impose on the public and do not acknowledge the harm it could do to their own putative class members.

IV. PLAINTIFFS' PROPOSED PRELIMINARY INJUNCTION IS IMPERMISSIBLE UNDER RULE 65(d).

A. Plaintiffs' Proposed Preliminary Injunction Is Impermissibly Vague.

Because the Plaintiffs' proposed injunction incorporates the proposed class definition, 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. The proposed class definition purports 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." Doc. 140-1 at 12 (emphasis added). Plaintiffs have not suggested any means for the Court to determine which, if any, of the 108,175 disenrolled individuals on whose behalf Plaintiffs seek relief 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 they are eligible. 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 injunction thus does not "state its terms specifically," nor "describe in reasonable detail" who is and who is not entitled to the relief that it mandates. FED. R. CIV. P. 65(d)(1). It lacks 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 Educ. v.*

Spangler, 427 U.S. 424, 439 (1976).

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 reenroll individuals who have previously been found ineligible and then to redetermine their eligibility (once the COVID-19 moratorium is lifted) would be both impracticable and a recipe for administrative chaos.

B. Plaintiffs' Proposed Preliminary Injunction Is Overbroad.

Because Plaintiffs' proposed injunction is impossible to implement as written, Plaintiffs alternatively appear to be suggesting that the State be ordered to reinstate *everyone* whose coverage was terminated since March 19, 2019, regardless of whether they were impacted by any of the same problems that some named Plaintiffs have alleged, 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 applies to parties not before the court, who have not been shown to be injured. As noted, 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.[4] Providing relief when 98 percent of the recipients are not entitled to it is antithesis of narrow tailoring.

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.

CONCLUSION

The State respectfully submits that the Court should deny Plaintiffs' motion.

[4] 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* FINANCIAL AND COMPLIANCE AUDIT: STATE OF TENNESSEE SINGLE AUDIT FOR THE YEAR ENDED JUNE 30, 2020, 57, https://bit.ly/3eq5eBR. Contrary to Plaintiffs' bald assertions, the Report bases its conclusions on random samples of TennCare enrollees. Hagan Decl. ¶ 35.

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Respectfully submitted,

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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 4th day of January, 2022.

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