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 MEMORANDUM IN SUPPORT OF HIS MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

This case involves claims that the Division of TennCare, the single state agency that partners with the Centers for Medicare and Medicaid Services ("CMS") and oversees the Tennessee state Medicaid program known as TennCare, violates the Due Process Clause of the Fourteenth Amendment, the Medicaid Act, and the Americans with Disabilities Act ("ADA") in operating that program's eligibility redetermination process. *See* Defs.' Statement of Undisputed Material Facts in Supp. of Summ. J., ¶ 1 (July 10, 2023) ("SUMF"). Plaintiffs represent a class of "all individuals who, since March 19, 2019, have been or will be disenrolled from TennCare, excluding individuals, and the parents and legal guardians of individuals, who requested withdrawal from TennCare." Mem. Op. & Order, Doc. 234 at 40 (Aug. 9, 2022). The "Disability Subclass" includes members of the plaintiff class who are "qualified individuals with a disability' as defined in 42 U.S.C. § 12131(2)." Doc. 234 at 40. Though Plaintiffs raised many issues with TennCare's processes in their complaint, the Court recognized that not all of them were susceptible to class-wide consideration, Doc. 234 at 1, 19, 21, and limited this case to the litigation of 15 specific issues related to TennCare's redetermination processes, *see* Proposed Am. Case Mgmt. Order, Doc. 249 at 4–5 (Nov. 1, 2022); *see also* SUMF ¶ 154. TennCare is entitled to summary judgment on all 15 issues.

As an initial matter, Plaintiffs have failed to show any violation of the Medicaid Act. Plaintiffs' claims have been brought under 42 U.S.C. § 1983, which provides a right of action for plaintiffs seeking to vindicate rights created by federal statute or the Constitution. But the basis of all of Plaintiffs' Medicaid Act claims is federal *regulation*, which the Supreme Court has repeatedly held is insufficient to create a Section 1983 enforceable right. Plaintiffs' due process and ADA claims fare no better. Due process is a flexible standard that permits reasonable

judgments by TennCare regarding how best to serve its members. On the issues certified by the Court for class-wide resolution—broadly pertaining to the contents of TennCare's notices, its provision of hearings, and its consideration of all the ways an enrollee could be eligible for Medicaid—Plaintiffs have failed to demonstrate any policy or practice employed by TennCare that has denied them their rights under the Fourteenth Amendment. As for Plaintiffs' ADA claims, the Court correctly recognized in its decision granting class certification that many ADA issues are highly individualized and not susceptible to class-wide resolution. On the three issues the Court determined could be resolved on a class-wide basis, the undisputed record demonstrates that TennCare provides reasonable accommodations and in-person assistance, and it always screens for every category of disability-related eligibility. Finally, the fact that CMS has reviewed and approved TennCare's processes and notices for determining eligibility as part of CMS's certification of the Tennessee Eligibility Determination System ("TEDS") provides an additional reason why this Court should grant judgment in TennCare's favor on each issue.

ARGUMENT

I. Defendant is entitled to summary judgment on each of the certified class issues.

Eight of the issues certified by the Court are purely legal—*e.g.*, "[whether] the NOD's uniform omission of information about the 90-day reconsideration period" violates the Medicaid Act or due process. Doc. 234 at 13, 18 n.10; *see Cabrera-Ramos v. Gonzales*, 233 F. App'x 449, 453 (6th Cir. 2007). The evidence on the remaining issues is undisputed—*e.g.*, "whether the State systematically fails to provide fair hearings at any time." Doc. 234 at 18 n.10 (internal quotation omitted). Summary judgment is appropriate.

A. Plaintiffs cannot show a single Medicaid Act violation.

At this stage in the litigation, Plaintiffs must substantiate their claims both legally and factually. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 256 (1986). For all but three of the

certified issues that implicate the disability subclass, the Court asked whether TennCare's policy or practice violated Plaintiffs' rights under the Medicaid Act or the Due Process Clause, thus giving rise to liability under 42 U.S.C. § 1983. As an initial matter, Plaintiffs' claims under the Medicaid Act must be rejected across the board. On each certified issue, Plaintiffs' argument that TennCare violates the Medicaid Act rests on a single provision of that statute, which requires that TennCare "provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness." 42 U.S.C. § 1396a(a)(3); *see also generally*, Pls.' Resps. and Objs. to Defs.' First Set of Interrogs. and Requests for Produc. to All Pls.' ("Pls.' R&Os") (Dec. 22, 2022) attached as SUMF Exhibit F. This general provision of the statute, however, speaks to almost none of the certified issues and Plaintiffs really base these claims on the regulations promulgated under that statute. *Id.*

The regulations cannot create rights enforceable through Section 1983 and so they are irrelevant. *Johnson v. City of Detroit*, 446 F.3d 614, 628–29 (6th Cir. 2006). Such rights must be found in a statute, and that statute must confer the right "in 'clear and unambiguous terms.' " *Caswell v. City of Detroit Housing Comm'n*, 418 F.3d 615, 619 (6th Cir. 2005) (quoting *Gonzaga Univ. v. Doe*, 536 U.S. 273, 290 (2002)). Accordingly, Plaintiffs must show that, on each of the certified issues, the fair hearing provision of 42 U.S.C. § 1396a(a)(3) "unambiguously" creates a right that TennCare is violating. *See Gonzaga*, 536 U.S. at 284. They cannot do so.

Caswell is instructive. In that case, the Sixth Circuit addressed a claim that an individual's rights had been violated by his allegedly improper termination from a housing voucher program while in the process of being (unsuccessfully) evicted. 418 F.3d at 617. A federal regulation unambiguously entitled the plaintiff to continued assistance payments while the eviction

proceedings were pending. *See* 24 C.F.R. § 982.311(b); *see also Caswell*, 418 F.3d at 619. But a regulation cannot create a right enforceable under Section 1983, so the Sixth Circuit held that Caswell could only rely on a much more general statutory provision to support his claim. *Caswell*, 418 F.3d at 620 (citing 42 U.S.C. § 1437f(o)(2)). The statute, unlike the regulation, said nothing about *when* an individual should be eligible for benefits and, despite the clear regulation, the Sixth Circuit held that the claim failed as a matter of law. *Id.*

As in *Caswell,* Plaintiffs cannot find the rights they claim in federal statute. Even assuming Section 1396a(a)(3) creates an enforceable right, that right is limited to an opportunity for the granting of a fair hearing when claims are denied "or not acted upon with reasonable promptness." The statutory provision says nothing, for instance, about what information must be included in TennCare's notices of determination ("NODs") or TennCare's obligation to screen for all categories of eligibility. Section 1396a(a)(3) is directly relevant only to the issue of "whether TennCare systematically fails to provide fair hearings at any time." Doc. 234 at 18 n.10 (internal quotations omitted), but as discussed below, the undisputed evidence in the record establishes that TennCare does provide fair hearings. The statute is no more than tangentially related to whether TennCare's "valid factual dispute" policy is lawful (since that policy denies individuals hearings when they have only a legal dispute with TennCare's decision), and to the issue of whether TennCare is required to provide hearings within 90 days of appeal. But there is nothing in the statute that "unambiguously" speaks to either of those issues. As to the valid factual dispute policy, the statute does not say TennCare must always provide a hearing when one is requested; it says TennCare must "provide for granting an opportunity for a fair hearing"—recognizing there are circumstances where a hearing is unnecessary. Likewise, the statute says nothing about a 90-day

deadline for holding a hearing. The Medicaid Act is, therefore, with the exception of whether TennCare fails to provide fair hearings at any time, irrelevant to the certified issues.

B. The legal citations in the notices of determination are and were lawful.

The first certified issue is whether a stock citation to the full set of TennCare's eligibility rules previously included in all NODs violates TennCare's obligations under the Medicaid Act or the Due Process Clause of the Fourteenth Amendment. Doc. 234 at 13. When Plaintiffs filed this case, a NOD terminating or denying coverage stated, *inter alia*: "We looked at the facts we have for you. We use those facts to review you for our coverage groups to decide if you qualify. But you don't qualify. [Tenn.Comp.R&Reg. 1200-13-20]." *See* SUMF ¶ 40. The bracketed citation references the set of regulations that prescribe the technical and financial eligibility criteria for coverage in all categories. Just after the quoted language, every NOD included a short explanation of precisely why an individual was ineligible. SUMF ¶ 41. For instance, in the case of an individual who is over an income limit, the notice went on to state: "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." *See* SUMF ¶ 42.

Including the same generic citation in every NOD followed by a more specific plain English explanation of the denial or termination reason was necessary at the time because the eligibility rules were undergoing significant changes and including more specific citations could have led to errors. *See* SUMF ¶¶ 43–44. The citation to the full set of eligibility rules was never intended to be permanent, and TennCare has, since December 2022, provided citations tailored to an individual's specific termination reason. *See* SUMF ¶¶ 45–51. For instance, an NOD to an individual who is over the income threshold for QMB coverage includes citations to 42 C.F.R. § 400.200, Tenn. Comp. R&R 1200-13-20-.02(110) (both defining "QMB"), and Tenn. Compl. R&R 1200-13-20-.08(7)(a)(5) (explaining that QMB eligibility requires income "[a]t or below one

hundred percent (100%) of the [federal poverty level]"). SUMF ¶ 52. The notice still includes a specific statement of what the income limit for that individual is (in dollars) and that TennCare's records show that the individual makes more than that limit. SUMF ¶¶ 41–42.

Plaintiffs cannot challenge TennCare's former use of this stock citation. First, Plaintiffs lack standing because they have not identified *anyone* who was harmed by the citations at issue. *See Lewis v. Casey*, 518 U.S. 343, 358 n.6 (1996); *see also Rosen v. Tenn. Comm'r of Fin. and Admin.*, 288 F.3d 918, 931 (6th Cir. 2002). Second, this claim is moot. Plaintiffs may only seek prospective injunctive relief, *see Edelman v. Jordan*, 415 U.S. 651, 677 (1974), and Plaintiffs cannot show they face a "real or immediate threat that the state will repeat the alleged violation." *Kanuszewski v. Mich. Dep't of Health & Human Servs.*, 927 F.3d 396, 408 (6th Cir. 2019).

The Sixth Circuit has held that:

> a case is considered moot by the defendant's voluntary cessation of the conduct at issue where the defendant can show: (1) there is no reasonable expectation that the alleged violation will recur; and (2) interim relief or events have completely and irrevocably eradicated the effects of the alleged violation.

Thomas v. City of Memphis, 996 F.3d 318, 324 (6th Cir. 2021). Showing mootness is ordinarily a "heavy burden," but that burden is lessened "when it is the government that has voluntarily ceased its conduct," thus "provid[ing] a secure foundation for a dismissal based on mootness so long as the change appears genuine." *Id.* (cleaned up). Here, TennCare's prior citation was a temporary measure designed to avoid the risk of issuing incorrect and misleading notices while changes to eligibility rules were being finalized. SUMF ¶¶ 43–44. It was always TennCare's intention to update the legal citations in the NOD, and TennCare has now done so. SUMF ¶ 45. Moreover, TennCare has no intention of reinstating the old citation, which would require TennCare to go through the same formal, months-long process (involving multiple units within TennCare and a

TennCare contractor) that was initially required to improve the NODs to include more specific legal citations. SUMF ¶¶ 47–51.

In *Thomas*, the Sixth Circuit explained that when a policy change has been "formally promulgated and approved by [a senior official] who provided a sworn declaration that [it] would remain in place going forward," and the agency would have to go through the same process again if it wished to change the policy further, the change in policy is treated more seriously by the court. 996 F.3d at 325–26. In particular, the *Thomas* court placed significant importance on the sworn testimony from a government official. *Id.* at 326–27 ("Our sister circuits have mooted claims based on government policy that was changed through sworn testimony provided by government officials."). We have such sworn testimony here. *See* SUMF ¶ 49. As "[t]here is nothing in the record that would suggest [TennCare] is likely to return to its old ways," the possibility of reversion "is merely theoretical, and the theoretical possibility of reversion to an allegedly unconstitutional policy is simply not sufficient to warrant an exception to mootness in this case." 996 F.3d at 327–28. Indeed, this Court employed similar reasoning when it denied Plaintiffs' motion for a preliminary injunction, noting that TennCare's changes to its practices and policies designed to identify and correct errors made reversion to those prior practices unlikely. *See* Doc. 234 at 24.

Mootness aside, TennCare is also entitled to summary judgment on this issue on the merits. Section 1396a(a)(3) does not address the contents of Medicaid notices, so Plaintiffs' claim rests exclusively on the Due Process Clause. To satisfy due process, "notice [must be] reasonably calculated, under all circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections." *Mullane v. Cent. Hanover Bank & Tr. Co.*, 339 U.S. 306, 314 (1950). "[A] recipient [must] have timely and adequate notice detailing the reasons for a proposed termination, and an effective opportunity to defend." *Goldberg v. Kelly*,

397 U.S. 254, 267–68 (1970). A notice is adequate if it accurately informs a person of the basis for their termination permits them to adequately prepare for an appeal hearing. *Hamby v. Neel*, 368 F.3d 549, 562 (6th Cir. 2004). The notices containing the "stock citation" meet this standard. Though Plaintiffs focus on the citation, the notices all also contained (and still do contain) a plain English explanation of what TennCare's eligibility rules required, and how TennCare believed the individual being terminated failed to satisfy that requirement. That is all that is required to give an individual the opportunity to "adequately prepare for an appeal hearing." *Id.* at 562; *see also Cahoo v. SAS Inst., Inc.*, 2023 WL 4014172, at *5 (6th Cir. June 15, 2023).

In certifying this issue for class resolution, the Court cited *Rodriguez By & Through Corella v. Chen*, 985 F. Supp. 1189 (D. Ariz. 1996), which raised a similar challenge to the contents, including legal citations, of Arizona's Medicaid notices. *Rodriguez* is distinguishable. The Arizona court held the notices did not provide "meaningful" notice as required by due process because they did not "detail the reasons for the proposed action. The reason given for [plaintiff's] termination was '[Plaintiff] is now in a new category for his age and no longer is eligible due to household excess income,' " and for another notice the reason given was simply "net income exceeds maximum allowable." 985 F. Supp. at 1194. The Court found both formulations "vague in as much as they fail to provide any basis upon which to test the accuracy of the decision." *Id.* TennCare NODs, by contrast, when denying an individual based on income, *always* contain a statement of what the maximum allowable monthly income is for a given category, and the assertion that the applicant's income exceeds that limit. *See, e.g.*, SUMF ¶ 52. This difference means that not only do TennCare notices give enrollees more information than the notices in *Rodriguez,* they provide everything an enrollee would need to challenge TennCare's decision.

To the extent *Rodriguez* required *more* detail, like an individualized income calculation, it is inconsistent with binding precedent. The Sixth Circuit has held that notices stating 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), "satisfy due process and statutory requirements." 707 F.2d at 931. The *Garrett* formulation is much less clear than TennCare's (it does not state what the agency thinks the individual's income is, or what the threshold is, in dollar terms). If the *Garrett* notices are adequate, then so are TennCare's.

Nor does *Rodriguez* support the claim that the citation violates the Medicaid Act. As discussed above, the Medicaid Act says nothing about the types of citations that must be included in the NODs. *Rodriguez* found that the citations in Arizona failed to comply with 42 C.F.R. § 210, which requires, *inter alia*, a notice to "contain . . . the specific regulations that support . . . the action." *See Rodriguez*, 985 F. Supp. at 1191, 1195; *see also* Pls.' R&Os at 9. But *Rodriguez* predates the binding Supreme Court and Sixth Circuit precedent, discussed above, that makes clear that Section 1983—the basis for Plaintiffs' suit—cannot be used to enforce a federal regulation. *Johnson*, 446 F.3d at 628–29 (discussing impact of *Alexander v. Sandoval*, 532 U.S. 275 (2001) and *Gonzaga*, 536 U.S. 273). There is no provision of the Medicaid Act that, "in clear and unambiguous terms, confers a particular right" to receive an NOD with a specific legal citation, so Plaintiffs' claim based on the citations in earlier NODs must fail. *Caswell*, 418 F.3d at 620.

C. TennCare's good cause policies are lawful.

The Court certified four issues regarding the "good cause exception" and "good cause hearings": (1) whether the NOD's uniform omission of information concerning good cause violates the Medicaid Act or due process, (2) whether the State is required to offer the exception or hearings at all, (3) whether the State, in fact, provides such hearings, and (4) whether TennCare's

policy of denying good cause exceptions or hearings based on "allegations of non-receipt" of a notice is lawful. *See* Doc. 234 at 13 n.5 & 18 n.10. As with the stock-citations issue, Plaintiffs lack standing to challenge these policies because they "have not identified anyone who should have received a good cause exception and lacks coverage." Doc. 234 at 29; *see also DaimlerChrysler Corp. v. Cuno*, 547 U.S. 332, 352 (2006) ("[A] plaintiff must demonstrate standing for each claim he seeks to press."). Summary judgment is also justified on Plaintiffs' Medicaid Act challenge with respect to these issues because "good cause" is a creation of TennCare rules. Neither the Medicaid Act nor the Medicaid regulations mention it, so Plaintiffs have no right to it that is enforceable under Section 1983.

The "good cause" in question is a reprieve TennCare provides from ordinary deadlines for filing an appeal if "good cause can be shown as to why the appeal or request for a hearing could not be filed within the required time limit." TENN. COMP. R. & REGS. 1200-13-19-.06(3); SUMF ¶¶ 73–74. "Good cause" is defined as "a legally sufficient reason," meaning "a reason based on circumstances outside the party's control and despite the party's reasonable efforts." TENN. COMP. R. & REGS. 1200-13-19-.02(20). It is undisputed that TennCare does not include information about good cause in its NODs, does not grant good cause hearings, and does not automatically provide a good cause exception to individuals who allege (without further support) that they did not receive a notice. *See* SUMF ¶¶ 76, 81, 84. All untimely appeals are reviewed for good cause before they are closed. SUMF ¶ 73. In this review, a legal review team that has been trained to err on the side of the appellant looks for any evidence of returned mail, any attempt to update an address, or any allegations of circumstances justifying a missed deadline (e.g., car wreck, hospitalization, illness). SUMF ¶¶ 78–79. If an appeal is closed as untimely, the appellant is told in a closure notice that they can still submit information about potential good cause and TennCare will then consider that

appeal for good cause a second time. SUMF ¶ 80. If an appellant disagrees with the decision to close an appeal as untimely, she may petition for review in the Chancery Court. SUMF ¶ 85.

1. NOD language and good cause hearings.

Plaintiffs allege that TennCare violates due process by failing to include an explanation of the good cause exception in NODs and failing to provide good cause hearings. "[D]ue process requires the government to provide notice reasonably calculated, under all the circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections." *Jones v. Flowers*, 547 U.S. 220, 226 (2006). It is "flexible and calls for such procedural protections as the particular situation demands." *Mathews v. Eldridge*, 424 U.S. 319, 334 (1976). The NODs, which contain an explanation of the deadlines to file an appeal, satisfy that standard. As a practical matter, TennCare does not inform individuals of the potential exception unless and until their appeal has been deemed untimely because informing enrollees in their NOD of the existence of the possible exception could be detrimental to those members who might then fail to file a timely appeal on the assumption that tardiness will be overlooked. SUMF ¶ 77.

Due process likewise does not require TennCare to provide a hearing on whether "good cause" exists. "[D]ue process generally does not entitle parties to an evidentiary hearing where the [agency] has properly determined that a default summary judgment is appropriate due to a party's failure to file a timely response." *Arch of Ky., Inc. v. Dir., Office Workers' Compensation Programs*, 556 F.3d 472, 478 (6th Cir. 2009) (cleaned up). Courts have repeatedly rejected the contention that due process requires an agency to provide a hearing on whether good cause exists to reopen a case or appeal following a missed deadline. For example, in *Cunningham v. Railroad Retirement Board*, 392 F.3d 567 (3d Cir. 2004), the Court rejected a petitioner's claim that due process required good cause hearings for "*pro se* claimants [who] are otherwise unable to argue

persuasively and present evidence in favor of their good cause explanations." 392 F.3d at 576. The Court noted the petitioner had "cited [no] authority to this Court under which an oral hearing in connection with the evaluation of a motion to reopen a claim for benefits was found to be constitutionally required as a matter of due process," and it was,

> troubled by the implication of [petitioner's] position, which would require the Board to provide an oral hearing each time a *pro se* claimant sought to show good cause to reopen an untimely appeal. Such hearings would be a significant strain on the agency's resources, yet it is not entirely clear . . . what additional value would be gained.

Id. at 577 (citing *Mathews*, 424 U.S. at 347, for the proposition that " . . . the administrative burden" must be considered when "striking the appropriate due process balance").

The same is true here. The uncontradicted testimony of TennCare's witnesses demonstrates that the agency is open to good cause requests and places a thumb on the scale in favor of granting good cause to an appellant. The Sixth Circuit has held that individuals seeking good cause exceptions to an appeals deadline with an agency have no due process claim when they are afforded an "ample opportunity to present [their] reasons for filing the hearing request . . . late" in writing. *Hilmes v. Sec'y of Health & Human Servs.*, 983 F.2d 67, 70 (6th Cir. 1993). That opportunity is afforded to all appellants as part of TennCare's appeal process; thus, Plaintiffs have no due process right to a hearing on good cause.

2. Allegations of nonreceipt are insufficient to establish good cause.

Plaintiffs claim that TennCare violates due process by not automatically applying the good cause exception (or granting a good cause hearing) in every case where an enrollee alleges that she did not receive a notice or request for additional information. Doc. 234 at 18 n.10. Notice is "constitutionally sufficient if it was reasonably calculated to reach the intended recipient when sent." *Jones*, 547 U.S. at 226. Unless it receives returned mail, TennCare has every reason to believe that its mailed notices are received. And it is very common for enrollees, realizing they

have missed a deadline, to falsely claim that they never received a notice which they are told they are now too late to appeal. SUMF ¶ 82. Due process does not require TennCare to take an enrollee's word for it that mail was undelivered with no other corroborating evidence. Such a rule would defy "the commonsensical proposition that a bare, uncorroborated, self-serving denial of receipt, even if sworn, is weak evidence." *Joshi v. Ashcroft*, 389 F.3d 732, 735 (7th Cir. 2004). Indeed, the Sixth Circuit has already rejected the proposition that an individual could overcome the presumption that mail was delivered with this sort of self-serving allegation. *Singh v. Garland*, 2022 WL 4283249, at *5 (6th Cir. Sept. 16, 2022) (citing *Ba v. Holder*, 561 F.3d 604, 607 (6th Cir. 2009)) ("Most mail reaches its destination …. Indeed, we have already suggested that an immigrant generally cannot rebut the presumption of receipt merely by testifying, 'I never received any notice of the hearing.' "); *see also Citizens Ins. Co. v. Harris*, 2016 WL 3743133, at *3 (E.D. Mich. July 13, 2016) ("If a party were permitted to defeat the presumption of receipt of [a] notice resulting from the certificate of mailing by a simple affidavit to the contrary, the scheme of deadlines and bar dates under the Bankruptcy Code would become unraveled.").

Nevertheless, Plaintiffs argue that *unsworn* statements alleging nonreceipt are enough to rebut the presumption that notice was effective, or at least require a hearing. Such a rule would violate Sixth Circuit precedent (as well as unraveling the system of deadlines on which the program relies). Appellants who have additional evidence of nonreceipt can provide that evidence without a hearing, SUMF ¶ 80; *see Mathews*, 424 U.S. at 343 (taking into account "the probable value, if any, of additional procedural safeguards"), and as already mentioned, most enrollees who make such allegations do not have any corroborating evidence.

Indeed, Plaintiffs' allegations in this case, made under oath, demonstrate the ubiquity of incorrect claims of nonreceipt. Plaintiffs' initial verified complaint and their verified amended

complaint alleged that Plaintiff Barnes never received the NOD terminating her Medicaid benefits. Doc. 1, ¶ 205 (Mar. 19, 2020); Doc. 202 ¶ 209 (May 5, 2022). They further alleged that Ms. Barnes' daughter, Glenda Surrett, informed TennCare that her mother had not received the NOD, and TennCare still refused to accept her appeal. *Id*. This was incorrect. Ms. Surrett acknowledged on a recorded call that she *had* received the NOD, but had misunderstood it. SUMF ¶¶ 168, 170. Furthermore, Ms. Surrett never sought to appeal, and TennCare never denied such a request. SUMF ¶¶ 171–72. Due process does not require TennCare to accept these sort of unsworn post hac excuses for missed filing deadlines.

D. TennCare's 90-day reconsideration policies are lawful.

The Court certified the issue of whether the NOD's uniform omission of information concerning the 90-day reconsideration period is lawful. Doc. 234 at 13. The 90-day reconsideration period refers to TennCare's practice of providing enrollees going through annual renewal with a 90-day grace period, following the date of termination, to return their Renewal Packets or additional information needed to determine eligibility. SUMF ¶ 57. It is undisputed that NODs do not reference the 90-day reconsideration period, but they do inform enrollees that if they return their Renewal Packets or additional information prior to termination they will keep their coverage pending review of the late submitted information. SUMF ¶ 57. Further, it is TennCare's policy, consistent with federal regulations, that if the missing information is received within 90 days, that information will be reviewed, and if it shows that an individual is eligible for coverage, coverage will be reinstated and backdated to fill in the gap. SUMF ¶ 57.

TennCare is required to provide a 90-day reconsideration period only as part of the annual renewal process, not when eligibility is being reviewed due to a reported change. *See* 42 C.F.R. §§ 435.916(a)(3)(iii); 457.340(g); 457.343. TennCare does not include information regarding the 90-day reconsideration period in its NODs for the same reason it does not include information about

the "good cause" exception. SUMF ¶¶ 60–61 . When an NOD goes out, the enrollee has not yet lost coverage and can still abide by ordinary deadlines. TennCare believes that disclosing the existence of the 90-day reconsideration period at that point will deter individuals from providing information in a timely manner and potentially cause a temporary loss of coverage. SUMF ¶ 61. TennCare does, however, inform all individuals in the cover letter accompanying their Renewal Packet that it will consider responsive information and make an eligibility determination even if the information is returned after a termination notice is issued. SUMF ¶ 62.

For the same reasons that TennCare's practice of not initially informing individuals of the "good cause" exception is constitutionally adequate, *see supra* at 11, TennCare's notice of the deadlines surrounding reconsideration of termination during renewal are constitutionally adequate. *See Cabrera-Ramos*, 233 F. App'x at 455; *see also 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").

E. TennCare's valid factual dispute policy is lawful.

The Court certified the issue of "whether TennCare's valid factual dispute policy is lawful." Doc. 234 at 13 n.6. This policy, as set forth in TENN. COMP. R. & REGS. 1200-13-19-.05(2) and (3), complies with the Due Process Clause, the Medicaid Act, and all applicable regulations. The valid factual dispute policy provides that an appellant will not receive a fair hearing unless she alleges a factual mistake in determining eligibility (including a mistake in applying the law to Plaintiffs' facts) that, if resolved in favor of the appellant, would entitle the appellant to relief. SUMF ¶¶ 91–92. TennCare's policy is a valid expression of the applicable Medicaid regulation, 42 C.F.R. § 431.220, and the Sixth Circuit has upheld TennCare's policy of denying hearings "to beneficiaries who have failed to raise a 'valid factual dispute' about their eligibility for coverage."

Rosen v. Goetz, 410 F.3d 919, 926 (6th Cir. 2005); *see also id.* (holding that "this approach plausibly interprets the language of the regulations"). In so holding, the Sixth Circuit explained that TennCare's interpretation of the regulations in question is plausible and adheres to precedent holding that hearings are not required for challenges to "matters of law and policy" but only to *factual disputes*. *Id.*; *see also Benton v. Rhodes*, 586 F.2d 1, 3 (6th Cir. 1978).

The Sixth Circuit also found it persuasive that "CMS, the agency that authored and promulgated the regulations, has approved the State's policies as fully compliant with its regulations, a determination to which [courts] owe 'substantial deference.'" *Rosen*, 410 F.3d at 927 (citation omitted). The "valid factual dispute" policy in place today is the same one that was in place in *Rosen* and approved by CMS. In the CMS State Medicaid Manual, § 2901.3, *available at* https://go.cms.gov/3Mhci5K, CMS has confirmed that States "do not have to grant a hearing if the sole issue being appealed is a State or Federal law or policy." Elsewhere, CMS explained that state Medicaid programs should, when a hearing is requested "[d]etermine whether the appeal involves issues of law or policy, or issues of fact or judgment. The decision will affect whether a hearing is granted . . . . The distinction between issues of fact or judgment and issues of State law or agency policy will not usually be difficult to make." *Id.* § 2902.4. The reason that no hearing need be provided in these situations is straightforward—it would do no good. In these cases, "the agency is not in a position to rule in favor of the appellant without a change in agency policy or, in some instances, in State law." *Id.*

Like the Sixth Circuit, this Court has upheld TennCare's valid factual dispute policy, noting 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). And Plaintiffs are bound by *Grier* because all members of the class in this

case were members of the *Grier* class. *See id.* at 881; *see also Parklane Hosiery Co., Inc. v. Shore*, 439 U.S. 322, 326 (1979) ("Collateral estoppel, like the related doctrine of res judicata, has the dual purpose of protecting litigants from the burden of relitigating an identical issue with the same party or his privy and of promoting judicial [efficiency] by preventing needless litigation.").

Furthermore, the requirement of a valid factual dispute is by no means a unique feature of TennCare procedures. The Sixth Circuit's decisions in *Rosen* and *Benton* were in line with other decisions that make clear that due process does not require the provision of an appeal hearing if the hearing could not help the appellant. *See, e.g.*, *Flaim v. Med. Coll. of Ohio*, 418 F.3d 629, 642–43 (6th Cir. 2005). As the Supreme Court has explained in another context, "if [a] hearing mandated by the Due Process Clause is to serve any useful purpose, there must be some factual dispute between an employer and a discharged employee which has some significant bearing [on the case]." *Codd v. Velger*, 429 U.S. 624, 627 (1977). Indeed, under Plaintiffs' theory, this Court violates due process every time it refuses to provide a litigant with a trial after concluding that there is no "genuine" dispute over a "material" issue of fact. *But see* FED. R. CIV. P. 56. Ultimately, "[d]ue process is flexible and calls for such procedural protections as the particular situation demands." *Mathews*, 424 U.S. at 334 (quotation omitted). Individuals who have no factual disagreement with TennCare's eligibility decision could gain nothing from a hearing, so due process does not require one to be provided.

F. Language included in notices of decision regarding the valid factual dispute policy is lawful.

The Court certified closely related issues regarding the way TennCare informs individuals about the valid factual dispute process. Specifically, the Court certified the issues whether (1) "TennCare's prior use of language, in some NODs, telling recipients they could only get a hearing if they thought TennCare made a 'mistake about a fact,' " Doc. 234 at 18 n.10, and (2) TennCare's

uniform statement in all NODs requiring individuals who wish to appeal "to describe the reasons they want to appeal and the facts supporting the appeal," Doc. 234 at 13, violate the Medicaid Act or due process.

TennCare does not dispute that some of its NODs denying new coverage used to say: "If you still think we made a mistake about a fact, you can have a fair hearing. If you don't think we made a mistake about a fact, you can't have a fair hearing." SUMF ¶ 95. Less than five percent of NODs, sent to only 5,238 class members, contained this language. SUMF ¶ 96. This language was intended to inform individuals who were denied new coverage of the valid factual dispute policy. In light of concerns expressed by the Court, *see* Tr. of Proceedings, Doc. 179 at 20:11–15 (Mar. 6, 2022), TennCare voluntarily changed these notices. They now state: "You can have a fair hearing if you still think we made a mistake and, if you're right, you would qualify for our program." SUMF ¶ 97.

Regardless of whether the former language was insufficient, Plaintiffs lack standing to challenge it and their claim is moot. "The only claimants who could have been injured by the inadequacy are those who detrimentally relied on the inadequate denial notice." *Day v. Shalala*, 23 F.3d 1052, 1066 (6th Cir. 1994). Thus, only individuals who would have appealed but were deterred from doing so by the now discarded language, and either remained without coverage or filed a new application and were left with a gap in their coverage history, have standing. At most, some unidentified subset of the 5,238 class members who ever received a notice with this language *could* have been injured by it, but (unlike in *Day*) there is not *one* identified class member who was so injured. And the new language used to describe the valid factual dispute policy moots Plaintiffs' claims for prospective injunctive relief. The change was made formally and TennCare has no intention to revert to the previous language. SUMF ¶ 98; *see Thomas*, 996 F.3d at 325–26.

In any event, the former language did not violate due process. Plaintiffs' argument to the contrary is founded upon their belief that TennCare's duty to provide a hearing "is not limited to those instances in which the individual can identify a 'mistake about a fact.'" SUMF Ex. C at 15. But this amounts to a challenge to the valid factual dispute process itself which, as discussed above, is foreclosed and without merit. An enrollee must have a factual dispute (including a dispute regarding the application of the law to facts) to maintain an appeal; it is not a violation of the Medicaid Act to inform enrollees of that requirement. Nor does it violate due process, which requires that "notice [be] reasonably calculated, under all circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections." *Hamby*, 368 F.3d at 560 (quoting *Mullane*, 339 U.S. at 314) (brackets in original). Notice must provide enrollees with an "[effective] opportunity to be heard," *Goldberg*, 397 U.S. at 268. TennCare's notice language does this by informing appellants about the standard against which their request for an appeal hearing will be judged.

For the same reason, TennCare's uniform language in its NODs informing individuals who wish to appeal that they should describe the reasons *why* they want to appeal and lay out the facts supporting their appeal does not violate due process. SUMF ¶ 93. Just as a litigant in federal appeals court must file a brief explaining *why* she thinks the district court's decision is flawed, appealing enrollees must tell TennCare the reason for their appeal. This requirement is necessary to permit TennCare to adequately assess an individual's appeal. It does not violate due process, which "is flexible and calls for such procedural protections as the particular situation demands." *Mathews*, 424 U.S. at 334.

It should be noted that Plaintiffs' underlying theory for all of these valid-factual-dispute-related claims, that TennCare should *never* be permitted to disenroll anyone consistent with due

process without first affording them a hearing, is impossible to square with the Supreme Court's treatment of due process. The Sixth Circuit has emphasized that in *Mathews* itself, the Supreme Court "upheld 'carefully structured procedures' that permitted the [agency] to disenroll individuals from Social Security's disability benefits program without a hearing." *Rosen*, 410 F.3d at 928–29. Those procedures included instructions, similar to those challenged by plaintiffs, that appealing beneficiaries must submit additional evidence and complete a "detailed questionnaire" that would enable the agency to understand the basis for the appeal. *Id.* at 929.

G. TennCare provides timely appeal hearings.

The Court also certified the issue of whether TennCare is required to provide fair hearings within 90 days of appeal and, if so, whether it fails to do so. As to the factual component of this question, TennCare ordinarily resolves all appeals within 90 days, and has not had a hearing more than 90 days after a termination appeal was filed (without a request for continuance by the appellant) since August 2022. SUMF ¶¶ 64–65. And recently, as part of the restarted renewal process, TennCare has received a waiver from CMS that explicitly permits it to allow appeals to go beyond 90 days as long as it provides continuation of benefits. SUMF ¶¶ 66, 146.

In any event, neither the Medicaid Act nor due process requires hearings to be held within 90 days, given that an individual whose appeal is delayed is given continuation of benefits and therefore has not suffered an adverse action. The Medicaid Act does not specify how quickly hearings must be held, stating only that they must be provided "with reasonable promptness." 42 U.S.C. § 1396a(a)(3). As for due process, in *Mathews*, the Supreme Court explained that it "consistently has held that some form of hearing is required before an individual is finally deprived of a property interest." 424 U.S. at 333. Here, any individual whose right to a hearing is delayed has the assurance that they will not be deprived of their Medicaid benefits until they are afforded a hearing. *Cf. Cotten v. Davis*, 215 F. App'x 464, 467 (6th Cir. 2007) (prisoner did not have a due

process right to a parole revocation hearing when the warrant related to his violation had not yet been executed).

H. TennCare provides fair hearings and considers all categories of eligibility.

The Court certified two purely factual issues: "whether TennCare systematically fails to provide fair hearings at any time," Doc. 234 at 18 n.10, and "whether Defendant considers all categories of eligibility before terminating enrollees' coverage," *id.* at 14.[1] The undisputed evidence in the record demonstrates that TennCare does not systematically fail to provide fair hearings at any time. *See* SUMF ¶ 68. There are only four situations in which a filed appeal will not go to hearing: when the appeal is (1) withdrawn, (2) found to be untimely or otherwise procedurally improper, (3) lacking a valid factual dispute, or (4) resolved in favor of the appellant prior to hearing. SUMF ¶ 69. These four permissible exceptions aside, TennCare regularly sends appeals to hearings. *See* SUMF ¶ 71. Plaintiffs can point to no evidence to the contrary.

Likewise, the undisputed evidence in the record demonstrates that TennCare considers all categories of eligibility. TEDS is programmed, and TennCare workers are trained, to review for eligibility in all categories under a "category of eligibility hierarchy" that seeks to determine eligibility for the "richest" level of benefits first and works its way down the list until the list is exhausted or an individual is found to be eligible in a category. SUMF ¶¶ 21–27. Again, Plaintiffs can point to no evidence to the contrary. Indeed, they concede that TennCare functions this way, suggesting instead that TennCare "fails to *reliably* consider all categories of eligibility." SUMF Ex. C at 17–19. But that is not the issue certified by the Court and it is not a common issue

[1] The Court also certified this question: if TennCare fails to consider all categories of eligibility, do their notices unlawfully mislead recipients on that score? Doc. 234 at 14 n.7. If TennCare systematically fails to consider all categories of eligibility, the State agrees that its notices—which state that it checks for eligibility in "*each kind* of group we have," Doc. 141-1 at 10, would be misleading. But as will be explained, TennCare's notices are accurate because TennCare does consider all categories of eligibility.

susceptible to class-wide resolution. *See* Doc. 234 at 1 (noting the Court was exercising its power "to trim and refine [this] collective action[] such that dysfunctional elements do not contaminate [an] otherwise functional class[]").

In fact, as the Court recognized when it denied a preliminary injunction in this case, the idiosyncratic errors related to accurately determining eligibility in a relatively small number of cases—not one of which involved a systematic failure to screen for eligibility in a certain category—do not show that TennCare fails to consider all categories of eligibility; those cases merely show that TennCare, like any agency processing millions of cases, sometimes makes mistakes and, when it discovers mistakes, it promptly rectifies them and ensures they do not recur. *See, e.g.*, Doc. 234 at 27 ("That Defendant found the 400 individuals and reinstated their coverage indicates Defendant has a process for identifying and remedying income miscalculations."). Even if such an issue could be considered appropriate for class-wide relief (and it cannot), at present, TennCare is not aware of any outstanding systematic issue negatively affecting TennCare's ability to accurately determine eligibility in any category of coverage, and Plaintiffs have not identified any such issues.

I. TennCare's notices adequately explain why an individual is found ineligible.

The Court certified the issue of whether "the NODs' omission of an explanation as to why its recipients do not qualify for other Medicaid categories" is unlawful. Doc. 234 at 14 (quotations omitted). Although TennCare screens for every category of eligibility, NODs terminating or denying coverage do not explain why, for each of the dozens of categories of eligibility, an individual failed to qualify. SUMF ¶¶ 54. For example, someone who was never in foster care will not receive a specific explanation for why they do not qualify for foster care categories of coverage. SUMF ¶ 55. Instead, when an individual is ineligible for TennCare coverage because they do not belong to any group for which some type of coverage is available, they receive a general statement

of denial, along with a description of some of the most common groups that *do* qualify for coverage. SUMF ¶ 54. If an individual *is* part of a covered group but still not eligible, their NOD will explain why they do not qualify for benefits in each group for which they otherwise may appear qualified, with the reasons they were found ineligible—for example, their income is too high for a given category or they failed to satisfy a procedural requirement (like getting a Pre Admission Evaluation for institutional coverage). SUMF ¶¶ 53.

Due process requires only that a notice inform a person of the basis for their termination in a way that permits them to prepare for an appeal hearing. *Hamby*, 368 F.3d at 562. TennCare's existing notices provide enough detail about why an individual was found ineligible to permit them to appeal, without providing them "a potentially confusing laundry list more likely to confuse than to clarify." *Reigh v. Schleigh*, 784 F.2d 1191, 1195 (4th Cir. 1986) (quotation marks omitted).

J. The Disability Subclass questions.

The Court certified two issues specific to the disability subclass. First, does TennCare have a system for granting reasonable accommodations, and if not, does the ADA require such a system? Second, does TennCare provide adequate "in-person assistance" to disabled persons, and if not, does that violate the ADA? *See* Doc. 234 at 20 & n.12.[2]

1. TennCare has a system for granting reasonable accommodations.

Title II of the ADA requires that "no [otherwise] 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. In implementing this statute, programs like TennCare are required to

[2] The Court also certified the question of whether TennCare evaluates all categories of disability-related eligibility pre-termination. *Id.* Because this is a subset of the broader question of whether TennCare evaluates enrollees and applicants for all categories of eligibility, it is fully addressed above.

afford disabled individuals "reasonable accommodations" (also referred to as "reasonable modifications" of the program), or changes to its "policies, practices, [and] procedures, . . . necessary to avoid discrimination on the basis of disability" and permit them to access the program. 28 C.F.R. § 35.130(b)(7)(i); *see Hindel v. Husted*, 875 F.3d 344, 347 (6th Cir. 2017). In contrast, "fundamental alterations"—disability accommodations that "would result in a fundamental alteration in the nature of a service, program, or activity or in undue financial and administrative burdens" —need not be provided. *Hindel*, 875 F.3d at 347.

There is no dispute that TennCare has a system for granting reasonable accommodations. *See* SUMF ¶¶ 127–140. Indeed, Plaintiffs' expert testified affirmatively that he "agreed that there are systems in TennCare for providing assistance and offering reasonable accommodations," and that evaluating TennCare's system and processes for granting reasonable accommodations "was the main focus of [his] report." SUMF ¶ 128.

Because they do not dispute that a system exists, Plaintiffs have shifted to argue that TennCare's system for granting reasonable accommodations is inadequate. *See* SUMF Ex. C at 19–21. That is a different issue than the one certified by the Court, *see* Doc. 234 at 21 ("Defendant has allegedly 'refused to act on grounds that apply generally to the class' by failing to implement a system to grant reasonable accommodation requests."). "Few disabilities are amenable to one-size-fits-all accommodations." *Ward v. McDonald*, 762 F.3d 24, 31 (D.C. Cir. 2014). Rather, reasonable accommodation questions are individual-specific and rarely appropriate for class-wide resolution. *See Hindel*, 875 F.3d at 347 ("It is a factual issue whether a plaintiff's proposed modifications amount to 'reasonable modifications' which should be implemented, or 'fundamental alterations,' which a state may reject." (quoting *Mary Jo C. v. N.Y. State & Local Ret. Sys.*, 707 F.3d 144, 153 (2d Cir. 2013)); *see also Anderson v. City of Blue Ash*, 798 F.3d 338,

356 (6th Cir. 2015) (noting the "highly fact-specific' balancing of the [government's] interests against the plaintiffs'" that the reasonable accommodation inquiry requires).

This is not the rare case. Courts will only find reasonable accommodation questions amenable to class-wide resolution when all class members all have the same disability *and* that disability would permit some uniform type of relief. *See Hindel*, 875 F.3d at 345 (considering a class-wide request for an accommodation for blind voters to allow them to vote without assistance). Here, the disability subclass includes "all individuals who, since March 19, 2019, have been or will be disenrolled from TennCare" (excluding those who request to be disenrolled) and "'are qualified individuals with a disability' as defined in 42 U.S.C. § 12131(2)." Doc. 234 at 40. It would be plainly inappropriate to litigate the adequacy of TennCare's reasonable accommodations for *all* types of disabilities on a class-wide basis. In fact, responding to such a claim recreates the very problems that caused this Court to limit the plaintiff class to certain discrete issues. "TennCare has not acted 'on a ground that is applicable to the entire class'" regarding their specific reasonable accommodations, and thus there is no ground to resolve this issue as to the entire disability subclass. Doc. 234 at 19 (quoting *Gooch*, 672 F.3d at 428).

If the Court does consider this modified claim, and to be clear, it should not, TennCare is still entitled to summary judgment. It is a necessary element of an ADA violation that the plaintiff "is being excluded from participation in, being denied the benefits of, or being subjected to discrimination under the program solely because of her disability." *Jones v. City of Monroe, Mich.*, 341 F.3d 474, 477 (6th Cir. 2003), *abrogated in part on other grounds*, *Lewis v. Humboldt Acquisition Corp., Inc.*, 681 F.3d 312 (6th Cir. 2012) (en banc); *see also Henrietta D. v. Bloomberg*, 331 F.3d 261, 272 (2d Cir. 2003). In other words, a system for granting reasonable accommodations is adequate under the ADA if disabled individuals have "meaningful access to

state-provided services." *Mark H. v. Lemahieu*, 513 F.3d 922, 937 (9th Cir. 2008) (citation omitted) (discussing reasonable accommodations under the Rehabilitation Act of 1973); *see Henrietta D.*, 331 F.3d at 272 (standards governing reasonable accommodations under the Rehabilitation Act and the ADA are generally the same).

Furthermore, before TennCare can be required to grant a reasonable accommodation, a disabled enrollee (or applicant) must request it. *See Jovanovic v. In-Sink-Erator Div. of Emerson Elec. Co.*, 201 F.3d 894, 899 (7th Cir. 2000); *see also Mole v. Buckhorn Rubber Prods., Inc.*, 165 F.3d 1212, 1218 (8th Cir. 1999) ("Only [the employee] could accurately identify the need for accommodations specific to her job and workplace."). "[T]here is no statutory requirement to impose nonmandatory services on disabled individuals who do not desire them." *Dunlap v. City of Sandy*, 846 F. App'x 511, 512 (9th Cir. 2021) (Mem.) (citing *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 602 (1999)); *see also* 28 C.F.R. § 35.130(e)(1) ("Nothing in this part shall be construed to require an individual with a disability to accept an accommodation . . . provided under the ADA or this part which such individual chooses not to accept."). Indeed, the purpose of the ADA is "to protect the dignity of disabled individuals," a purpose that would be contravened by a rule requiring TennCare to *presume* that disabled individuals are incapable of navigating TennCare without accommodations they have not requested. *Dunlap*, 846 F. App'x at 512 (9th Cir. 2021).

Plaintiffs have failed to identify *any* TennCare enrollee who requested an accommodation, was denied, and lacked meaningful access to state provided services as a result. SUMF ¶ 141. Plaintiffs insist their disabilities (and hence, their required accommodations) "should be evident to TennCare" based on the limited information TennCare has on its enrollees, including their "category of eligibility, claims information, or other communication with TennCare." SUMF Ex. C at 6–8. Even accepting, for the sake of argument, that this sort of claim could possibly be

resolved on a class-wide basis, Plaintiffs have failed to show an actionable ADA violation because they have not identified anyone who was injured by TennCare's reasonable accommodation policies in a manner that prevented them from accessing the benefits of the program.

But that predicate should not be accepted. The Plaintiffs unintentionally demonstrate why it would be inappropriate for TennCare to provide un-asked-for accommodations by admitting that there are only *two* disability sub-class representatives who are not currently assisted by family or friends and who claim to currently need accommodations: Linda Rebeaud and Johnny Walker. *See* SUMF Ex. C at 3–5. Ms. Rebeaud's case illustrates well the problems with the theory that TennCare should divine the need for accommodations from an enrollee's medical history. She is eligible for TennCare through the Breast or Cervical Cancer category of eligibility, which is only available to individuals who are being actively treated for breast or cervical cancer. SUMF ¶¶ 182–83. She has never made an accommodation request to TennCare, SUMF ¶ 186, but Plaintiffs suggest that her "disability should be evident to TennCare based on her category of eligibility, claims information and other [unspecified] communication with TennCare," SUMF Ex. C at 8. From the fact that she has either breast or cervical cancer, Plaintiffs expect TennCare to divine that Ms. Rebeaud requires accommodations that "include *but are not limited to*: in-person assistance from an agency employee, simpler explanations, letters that are easier to read, simplified instructions, and follow-up in writing, by telephone, or in person." *Id.* at 5 (emphasis added); *see also* SUMF ¶¶ 184–85. Of course, if she will not identify her needed accommodations, it is difficult to imagine how TennCare could do so adequately based on the fact that it knows she is being treated for cancer. In any event, it is impossible for Ms. Rebeaud to show that the absence of these unrequested accommodations has denied her access to TennCare given that she remains covered.

Plaintiffs have failed to show a violation of the ADA based on TennCare's reasonable accommodation policies.

2. TennCare has a system for providing in-person assistance.

Plaintiffs also argue that TennCare violates the ADA by not providing adequate "in-person assistance" for disabled persons who request it. There is no special requirement to provide in-person assistance, only the general rule that a state must provide reasonable accommodations. *See* SUMF Ex. C at 21. In any case, as with reasonable accommodations generally, the undisputed evidence in the record demonstrates that TennCare provides in-person assistance to anyone—regardless of disability—who requests it and the availability of in-person assistance is disclosed in every renewal packet TennCare sends. *See* SUMF ¶¶ 110–14.

The system TennCare has is adequate. As with reasonable accommodations generally, Plaintiffs have not identified a single case in which the failure to provide in-person assistance denied a disabled individual meaningful access to TennCare. To the contrary, the record shows that TennCare provides such assistance when necessary. Plaintiff Monroe requested and received at-home in-person assistance from the AAAD, which interviewed him and provided a functional assessment related to his request for in-home services. SUMF ¶ 115. And of course, it would be both completely infeasible and utterly inappropriate for TennCare to presume to provide in-person assistance to an enrollee who has not requested it.

II. CMS has certified that TennCare's policies and systems comply with all relevant statutory authority.

Summary judgment is appropriate on each of the Plaintiffs' claims for the independent reason that CMS has reviewed and certified TennCare's processes for determining eligibility and has found, among other things, that it is consistent with the requirements of the federal disability rights and civil rights laws, as well as providing for "prompt eligibility verification and for

processing claims" for individuals who are eligible for Medicare and Medicaid. *See* 42 C.F.R. § 433.112(b)(1), (3), (12), (14), (16), (17), (18).

CMS certified TEDS through a robust review process that took place over several years. SUMF ¶ 13. In its cover letter to the Certification Report, CMS noted that its evaluations covered compliance with the Social Security Act, Affordable Care Act, 42 CFR Part 433, Subpart C (regarding "mechanized claims processing and information retrieval systems"); 42 CFR Part 435 (regarding Medicaid eligibility); the Health Insurance Portability and Accountability Act; and "[c]urrent legislation and CMS policies." SUMF ¶ 13. The Certification Report states that CMS "performed a comprehensive review of functionality [of TEDS] for both Modified Adjusted Gross Income (MAGI)-based and non-MAGI based eligibility supported by [TEDS]." SUMF ¶ 14. CMS also confirmed that TEDS complies with relevant federal regulations and statutory requirements for making eligibility determinations, including annual redeterminations. CMS certified TEDS, concluding that "there were no critical findings." SUMF ¶ 15. In other words, as to the Medicaid Act and ADA claims raised by Plaintiffs, CMS has already investigated and found that TennCare's processes for determining eligibility, ensuring the provision of fair hearings on appeal, and accommodating disabilities comport with all relevant statutory and regulatory requirements.

The Sixth Circuit affords "substantial deference" to decisions made by CMS when administering the Medicaid statute. *See Rosen*, 410 F.3d at 927; *cf. Harris v. Olszewski*, 442 F.3d 456, 465–68 (6th Cir. 2006). In particular, the Court has afforded this deference to agency determinations that a state plan or procedure complies with a relevant Medicaid statutory requirement or regulation. For example, the Sixth Circuit has afforded *Chevron* deference to the Department of Health and Human Service ("HHS") determination that a state Medicaid program lawfully offered eligible enrollees the freedom to choose a medical

provider. *See Harris*, 442 F.3d at 460, 466–68. The Court has also given CMS substantial deference in approving a state's proposed disenrollment process. *See Rosen*, 410 F.3d at 927. CMS's decision that TEDS is functioning in compliance with the applicable federal regulations and TennCare is entitled to enhanced FFP is likewise entitled to substantial deference due to the role that the Congress has assigned to the federal agency to supervise state Medicaid programs.

Finally, CMS has effectively reiterated its findings that TennCare's processes for determining eligibility are consistent with the requirements of the Medicaid Act and other federal disability rights and civil rights laws, by making Tennessee one of only 16 states that CMS did *not* place under a mitigation plan as a result of deficiencies in the state's eligibility processes. SUMF ¶ 148.

CONCLUSION

For the foregoing reasons, Defendant is entitled to summary judgment in his favor on all issues certified by the Court.

July 10, 2023

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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 10th day of July, 2023.

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