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

DEFENDANTS' STATEMENT OF UNDISPUTED MATERIAL FACTS IN SUPPORT OF SUMMARY JUDGMENT

Pursuant to Local Rule 56.01(b), Defendant Stephen Smith, in his official capacity as Deputy Commissioner of Finance and Administration and Director of the Division of TennCare submits the following statements of undisputed material fact in support of his motion for summary judgment.

1. The Division of TennCare is the single state Medicaid agency that, in partnership with the Centers for Medicare and Medicaid Services ("CMS") oversees the Tennessee state Medicaid program known as TennCare. Hagan Decl., Doc. 63 ¶ 2 (May 29, 2020).

Response:

2. Defendant Stephen Smith is the Director of the Division of TennCare. *Information & Statistics, Stephen Smith*, DIV. OF TENNCARE, https://bit.ly/3XD9d3T (last visited July 7, 2023).

Response:

3. TennCare currently serves more than 1.7 million Tennesseans including low-income individuals such as pregnant women, children, caretaker relatives of young children and older adults and adults with disabilities. *This is TennCare*, DIV. OF TENNCARE, https://bit.ly/446f9Vn (last visited July 7, 2023).

Response:

4. TennCare contractors operate two call centers, collectively known as TennCare Connect, that employ approximately 400 workers and that enable Tennesseans to apply for coverage, renew coverage, file eligibility appeals, and update their address and other information over the phone. Doc. 63 ¶ 2.

Response:

5. Prior to the public health emergency discussed below, TennCare processed approximately 400,000 applications per year, 100,000 annual eligibility renewals per month, 200,000 eligibility reverifications per month as required by receipt of new information. Doc. 63 ¶ 2.

Response:

6. In 2012, the State of Tennessee began the procurement process for designing and building a new eligibility determination system for use by TennCare, the Tennessee Eligibility Determination System, or "TEDS". Doc. 63 ¶ 3.

Response:

7. TEDS was designed and built for TennCare by Deloitte. Doc. 63 ¶ 9.

Response:

8. Deloitte still contracts with TennCare to maintain TEDS and to perform regular updates to the system. Decl. of Kimberly Hagan in Supp. of Pls.' Mot. for Summ. J. ("New Hagan Decl.") at ¶ 27, attached hereto as Exhibit A.

Response:

9. TEDS became operational statewide with full functionality, including the ability to track and process appeals, on May 30, 2019. Doc. 63 ¶ 9.

Response:

10. TEDS provides members with access to an online portal which they can access through an internet browser or through a smartphone application. Doc. 63 ¶ 9.

Response:

11. TEDS was designed following guidance from CMS. Doc. 63 ¶ 10.

Response:

12. Through TEDS, TennCare evaluates individuals for eligibility in every category of eligibility available in Tennessee. Doc. 63 ¶ 12; New Hagan Decl. ¶¶ 15–16.

Response:

13. CMS has reviewed and certified that TennCare's systems for determining eligibility comply with the Social Security Act, the 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." Letter from CMS to Stephen Smith, Div. of TennCare, re CMS Review and Assessment (Nov. 2, 2020), Doc. 139-6 at 2 (Nov. 12, 2021).

Response:

14. In approving TEDS, 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]." CMS, DIV. OF STATE SYS., ELIGIBILITY & ENROLLMENT SYS. CERTIFICATION REV. REP.; TENN. ELIGIBILITY DETERMINATION SYS. (TEDS) 3 (Nov. 2, 2020) ("Certification Report"), Doc. 139-5 at 3 (Nov. 12, 2021).

Response:

15. CMS had no critical findings in its review of TEDS. Certification Report at 7.

Response:

16. CMS assigned eleven professionals to perform the certification review of TEDS, devoting six months to review preparation, during which time it had regular meetings with TennCare to devise the criteria and formalize the review process. Certification Report at 4, 7.

Response:

17. TennCare is required to re-evaluate the eligibility of all enrollees annually or whenever a change of circumstances that could impact eligibility is reported. 42 C.F.R. § 435.916.

Response:

18. As the first step of the renewal process, TennCare tries to renew as many members as it can with no input on their part through an *ex parte* review process. New Hagan Decl. ¶¶ 13–14.

Response:

19. As part of the *ex parte* review process, TEDS examines all information that TennCare has about a member, as well as certain information TennCare is authorized to look at from verified third-party sources, and if that information shows a member is eligible, whether in

their current category or in another category, TEDS will automatically renew that member's coverage. New Hagan Decl. ¶ 14.

Response:

20. TEDS has "business rules" that allow it to assess eligibility for Medicaid, TennCare Standard, CoverKids, and Medicare Savings Program ("MSP") coverage all at once. New Hagan Decl. ¶ 15.

Response:

21. In assessing eligibility, TEDS is designed to screen for every category of eligibility. New Hagan Decl. ¶ 13.

Response:

22. TEDS does so reliably. New Hagan Decl. ¶ 18.

Response:

23. TennCare has enrollees in every category of eligibility available in Tennessee. New Hagan Decl. ¶ 15; Hagan Decl. Ex. 7 (renewal statistics).

Response:

24. When TennCare discovers issues with its systems for determining eligibility, it diligently works to identify the source of any errors, to correct errors for those who have already been affected and to prevent the errors from recurring in the future. New Hagan Decl. ¶¶ 17–25.

Response:

25. In applying the business rules, TEDS analyzes a person for eligibility in every category of TennCare coverage through what is called the "COE [category of eligibility] Hierarchy." New Hagan Decl. ¶ 15.

Response:

26. TEDS starts at the top of the hierarchy and works its way down through each category until it finds one that an individual could qualify for, or "group" into. New Hagan Decl. ¶ 15.

Response:

27. The hierarchy is structured such that TEDS begins by assessing whether an individual qualifies for the categories with the highest level of benefits first and progresses to categories with lower levels of benefits until it finds a category for which the individual "groups." New Hagan Decl. ¶ 15.

Response:

28. An individual "groups" into a category if they meet the basic criteria for inclusion in that category before assessing income and resources (if a category includes income and resource limits). New Hagan Decl. ¶ 15.

Response:

29. If TEDS has all the information it needs to approve an individual for coverage without their input, it does so. New Hagan Decl. ¶ 14.

Response:

30. If TEDS cannot automatically renew a member's coverage, it issues a pre-renewal letter to the member, followed by a Renewal Packet containing questions necessary to gather information to see if the individual qualifies for health coverage. New Hagan Decl. ¶¶ 5(f), 14; Hagan Decl. Exs. 1 (Pre-Renewal Letter) and 4 (Renewal Packet).

Response:

31. The Renewal Packet is pre-populated with the information TennCare has for the member. New Hagan Decl. ¶ 7(j).

Response:

32. The Renewal Packet (along with a cover letter) explains to an individual how to fill out the form, what to do if any pre-populated information is incorrect, and describes the types of coverage that are available. Doc. 63 ¶ 47.

Response:

33. Renewal packets differ according to the specific circumstances of the member, but, among other things, they always (1) tell members where and how to provide the information being requested, (2) tell members that if they do not have all the information being requested when it is time to send in the renewal packet, to send it anyway and that TennCare will determine what facts it still needs and send a follow-up letter, and (3) tell members ways to get help with the packet by calling TennCare Connect, going online to TennCare's website, or going in person to their local DHS County office. Doc. 63 ¶ 49.

Response:

34. Members have 40 days to respond to a Renewal Packet. Doc. 63 ¶ 51.

Response:

35. If the member returns the Renewal Packet, the information from the member is entered into TEDS. New Hagan Decl. ¶ 15.

Response:

36. If TEDS is able to determine an individual is eligible after they return their Renewal Packet, they will be renewed. Doc. 63 ¶ 51.

Response:

37. If a member returns a Renewal Packet, but more information, such as proof of income, is required to complete the renewal process, TennCare will send the member a request for Additional Information. Doc. 63 ¶ 54; Ex. G to May 29, 2020 Hagan Decl., Doc. 63-7 (AI Notice).

Response:

38. If a member fails to return a Renewal Packet or any additional requested information, or if they return the Renewal Packet and any requested additional information and they are nevertheless found ineligible, they will receive a Notice of Decision ("NOD"). Doc. 63 ¶ 57.

Response:

39. The NOD tells the member the reason their coverage is ending and the specific date their coverage will end along with a legal citation supporting the decision. Doc. 63 ¶ 52.

Response:

40. When this suit was filed, all TennCare NODs terminating or denying coverage included the statement and citation: "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]." Ex. C to Jan. 4, 2022 Hagan Decl., Doc. 166-3 at 49.

Response:

41. After this citation to the TennCare eligibility rules, every NOD included a brief, plain English explanation of precisely why an individual was considered ineligible. Doc. 166-3 at 49; *see also* New Hagan Decl. Ex. 13 (Business Reference Table listing termination explanations).

Response:

42. For example, if an individual was denied or terminated because they were determined to be over the income limit for the category of eligibility into which they would

otherwise group, the notice would state: "The monthly income limit for the kind of coverage you could get is <$xxx.xx>. Our records show your monthly income is over that limit." New Hagan Decl. Ex. 13 at 3 (Business Reference Table listing termination explanations).

Response:

43. When TEDS was first implemented, the eligibility rules were undergoing changes. New Hagan Decl. ¶ 25

Response:

44. TennCare was concerned that specific citations in the NODs' explanation of a termination or denial could lead to errors as a result of rules changes and, if implemented at that time, cause confusion among NOD recipients. New Hagan Decl. ¶ 26

Response:

45. It was always TennCare's intention to update the citations to include more specific citations tailored to an individual's specific termination reason. New Hagan Decl. ¶ 26.

Response:

46. When the Court certified the issue of whether the 95-page citation was adequate, TennCare prioritized implementing these changes. New Hagan Decl. ¶ 26.

Response:

47. Changing the citations used in NODs was a formal, months-long process that required senior TennCare officials to work with Deloitte and multiple units within TennCare itself. New Hagan Decl. ¶ 27.

Response:

48. In addition to legal review and readability review, changing the citations in the NODs involved significant testing of the new notices to ensure that no errors were occurring and the notices that would be issued were accurate. New Hagan Decl. ¶ 27.

Response:

49. TennCare views the updated legal citations as an improvement and has no intention to revert to the former citation format. New Hagan Decl. ¶ 27.

Response:

50. The only changes TennCare anticipates making to the citations in the NODs going forward are changes necessitated by changes in the eligibility rules or in federal statutes and regulations. New Hagan Decl. ¶ 27.

Response:

51. If TennCare were to change the citations in the NODs in the future, it would have to go through the same formal, lengthy process it went through to change them to the present citations. New Hagan Decl. ¶ 27.

Response:

52. To give an example of how the current NODs read, if an individual is found to be ineligible for QMB coverage because they are over the income threshold for that category, the NOD would now cite 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]"). New Hagan Decl. Ex. 13 (Business Reference Table).

Response:

53. If an individual groups into multiple categories for which they are not ultimately eligible, the NOD will provide a specific reason why that individual is not eligible for each of the categories for which they group. New Hagan Decl. ¶ 32.

Response:

54. An NOD will not provide a specific denial reason for any category into which an individual does not group, unless the individual does not group into *any* category, in which case they will receive special non-grouping language explaining their denial. New Hagan Decl. ¶¶ 29–31.

Response:

55. For example, someone who is not and has never been in foster care will not receive a specific explanation for why they do not qualify for foster care coverage. New Hagan Decl. ¶ 31.

Response:

56. If an individual is not eligible for Medicaid because of an overarching non-financial reason, like failing the SSN requirement or failing the state residency requirement, those reasons will also be included in the NOD. New Hagan Decl. ¶ 33.

Response:

57. If an individual fails to respond to a Renewal Packet or any requests for additional information after a Renewal Packet is received by the required deadlines but returns their renewal packet or missing requested information within 90 days following the date of termination, TennCare will review the completed Renewal Packet or additional information and, if the information demonstrates the member is eligible, TennCare will backdate their coverage to fill the gap created by their termination. Doc. 63 ¶ 57.

Response:

58. If an individual returns their renewal packet or supplies requested missing information within 20 days of termination, they are automatically re-enrolled for the period during which TennCare determines their eligibility. Doc. 63 ¶ 57; New Hagan Decl. Ex. 3 at TC-AMC-000662867.

Response:

59. Renewal packets do not include information regarding the 90-day reconsideration period. Doc. 63 ¶ 57.

Response:

60. The NOD also does not include an explanation of the 90-day reconsideration period. Doc. 63 ¶ 57.

Response:

61. In TennCare's experienced judgment, disclosing the existence of the 90-day reconsideration period before an individual has been terminated, and when they still have ordinary appeals rights, would be detrimental to enrollees by potentially deterring them from providing information in a timely manner (and thereby creating at least a temporary loss in coverage). Doc. 63 ¶ 57.

Response:

62. The cover letter accompanying the renewal packet informs individuals that TennCare will consider responsive information and make an eligibility determination even if the information is returned after a termination notice is issued. Pls.' Ex. 8, Doc. 26-5 at 304 (Apr. 10, 2020).

Response:

63. The NOD tells the member they have appeal rights, explains how to file an appeal, as well as the deadline to file an appeal in order to keep benefits pending its resolution (a 20-day deadline), and the deadline for appealing on time (a 40-day deadline). Doc. 63 ¶ 52.

Response:

64. TennCare ordinarily resolves all appeals within 90 days. New Hagan Decl. ¶ 39.

Response:

65. TennCare has not had a coverage ending or termination appeal take over 90 days to resolve (excluding cases in which the appellant requests a continuance) since August 2022 and has not had such an appeal in which the appellant did not have continuation of benefits ("COB") go over 90 days since January 2022. New Hagan Decl. ¶ 39.

Response:

66. During the ongoing restarted Annual Renewal Process, if an appeal does take more than 90 days to resolve, TennCare will automatically grant the appellant continuation of benefits pending resolution of the appeal. May 29, 2020 Hagan Decl., Doc. 142-2 ¶ 71; New Hagan Decl. ¶ 38.

Response:

67. CMS has waived the regulatory imposed 90-day deadline for taking final administrative action in an appeal provided TennCare provides the appellant COB pending resolution of the appeal. New Hagan Decl. ¶ 38.

Response:

68. TennCare does not systematically fail to provide fair hearings at any time. New Hagan Decl. ¶¶ 40–42

Response:

69. Appeals always go to hearing, unless they are (1) withdrawn, (2) found to be untimely or otherwise procedurally improper, (3) lack a valid factual dispute, or (4) can be resolved in favor of the appellant prior to hearing. New Hagan Decl. ¶ 40.

Response:

70. In the last six months (January 1, 2023 to June 27, 2023), TennCare has received 8089 termination or change of benefit appeals, and out of those, 3019 appeals have been resolved in favor of the appellant, 75 appeals have been closed as untimely and 629 appeals have been closed for no Valid Factual Dispute. New Hagan Decl. ¶ 42.

Response:

71. In the last six months (January 1, 2023 to June 27, 2023), TennCare had 95 termination appeals go to hearing and receive an order. New Hagan Decl. ¶ 42.

Response:

72. When an appeal is filed, it is reviewed for timeliness and, if found to be untimely, it is dismissed. Doc. 63 ¶ 71(c).

Response:

73. As part of this review, every appeal is reviewed to see whether it qualifies for the "good cause exception." Doc. 63 ¶ 71(c).

Response:

74. The "good cause exception" is an exception to ordinary appeals deadlines that TennCare provides to individuals who fail to appeal in a timely fashion but have a good reason for failing to do so. Hagan Dep. 205:7–22 (Apr. 14, 2023), attached hereto as Exhibit B.

Response:

75. TennCare accepts good cause requests in any format. Hagan Dep. 206:9–14.

Response:

76. TennCare does not provide information about the "good cause exception" in NODs. Doc. 63 at ¶ 53.

Response:

77. In TennCare's judgment, providing information about the "good cause exception" in NODs would potentially induce individuals to miss a deadline to their detriment, believing (wrongly) that there would always be an opportunity to have their lateness excused. Doc. 63 at ¶ 53.

Response:

78. Based on the information in its possession—including any evidence of returned mail, an attempt to update an address—as well as any information submitted by the appellant or allegation of circumstances justifying a missed deadline, TennCare legal review staff decides whether an individual has "good cause" for filing a late appeal. Leffard Dep. ¶ 84:21–85:2 (Apr. 27, 2023), attached hereto as Exhibit C.

Response:

79. TennCare staff is instructed and trained to err on the side of the appellant when assessing good cause. Leffard Dep. 48:1–49:2.

Response:

80. If the appeal is closed as untimely, the appellant is informed that they can submit any information about a potential good cause and TennCare will then consider that appeal for good cause a second time. New Hagan Decl. ¶ 35; Hagan Decl. Ex. 14 (Appeal Resolution Notice).

Response:

81. TennCare does not automatically grant good cause to appellants who allege that they did not receive a notice or request for additional information. New Hagan Decl. ¶ 36.

Response:

82. It is extremely common for individuals to allege that they did not receive a notice when they learn they have been disenrolled or have missed a deadline, even when there is no other evidence of a missed deadline. New Hagan Decl. ¶ 36.

Response:

83. TennCare does not consider an individual's allegation of nonreceipt, without further explanation for why an individual did not receive a notice or some corroborating evidence of nonreceipt, to be evidence justifying the "good cause" exception. New Hagan Decl. ¶ 36.

Response:

84. TennCare does not provide a hearing to appellants to assess whether good cause exists. Leffard Dep. 55:8–18.

Response:

85. If an appellant disagrees with the decision to close an appeal as untimely, she may petition for review in Chancery Court. Leffard Dep. 63:15–18.

Response:

86. Historically, less than 5% of appeals are closed as untimely. Doc. 63 ¶ 71(c).

Response:

87. If an individual's appeal is found to be timely, it is next reviewed by the "resolution unit" within the appeals group at TennCare. Leffard Dep. 21:14–24:25; Doc. 63 ¶ 71(e).

Response:

88. The resolution unit investigates the appeal and, if it is able to do so with the information available to TennCare, including any information submitted by the appellant as part of the appeal, it will approve the member for coverage and terminate the appeal. Doc. 63 ¶ 71(e), (j).

Response:

89. If an appeal cannot be resolved in this way, it is next sent to legal review. Doc. 63 ¶ 71(f).

Response:

90. The legal review unit looks to see if there were any legal errors made in terminating the enrollee and also assesses appeals to ensure that there is a "valid factual dispute" which could be resolved through the appeal. Doc. 63 ¶ 71(f).

Response:

91. A valid factual dispute arises when the appellant alleges a factual mistake in determining eligibility that, if resolved in favor of the appellant, would entitle the appellant to relief. Doc. 63 ¶ 71(f).

Response:

92. TennCare considers allegations that errors were made in applying the law to an appellant's facts to be valid factual disputes entitling that appellant to a hearing. New Hagan Decl. ¶ 43.

Response:

93. In every NOD, TennCare informs individuals that if they are going to appeal, they should describe the reasons they want to appeal and all the facts supporting the appeal. New Hagan Decl. Ex. 3 at TC-AMC-0000662871 (NOD Template).

Response:

94. TennCare provides individuals with examples of reasons they may have a fair hearing in the NOD. New Hagan Decl. ¶ 30.

Response:

95. Additionally, when this case was filed, TennCare included language in NODs denying new coverage that said: "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." Def's. Not. of Filing, Doc. 213 at 1–2 (June 9, 2022).

Response:

96. Less than 5% of NODs contained this language, and only 5,238 class members ever received it. Doc. 213 at 4; Suppl. Hagan Decl., Doc. 222 at ¶ 6 (July 1, 2022).

Response:

97. TennCare has since changed those notices which now say: "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." Doc. 213 at 2.

Response:

98. TennCare has no intention to revert to the earlier language describing this policy in some NODs. New Hagan Decl. ¶ 34.

Response:

99. If TennCare does not believe, based on the appellant's filed appeal, that there is a valid factual dispute, TennCare sends the appellant a valid factual dispute additional information notice, requesting more information to clarify the factual mistake being alleged. Doc. 63 at ¶ 71(f); Doc. 63-7 (VFD AI Notice).

Response:

100. If there is still no identifiable valid factual dispute, the appeal will be closed for lack of a valid factual dispute. Doc. 63 at ¶ 71(g) & (h).

Response:

101. The notice closing an appeal for no valid factual dispute informs appellants how they can petition for review in Chancery Court if they disagree with TennCare's decision. Doc. 63 ¶ 71(h); Ex. L to May 29, 2020 Hagan Decl., Doc. 63-12 (VFD Closure Notice).

Response:

102. In a case where there is no valid factual dispute, there is no relief that an administrative judge could order that would resolve the appeal favorably for the appellant. New Hagan Decl. ¶ 45.

Response:

103. A very small number of appeals are closed for lack of a valid factual dispute. Doc. 63 at ¶ 73(i); New Hagan Decl. ¶ 42.

Response:

104. If an appeal presents a valid factual dispute and has not otherwise been able to be resolved, it proceeds to a hearing before an administrative judge. Doc. 63 at ¶ 72.

Response:

105. Before a hearing is held, the individual is sent a Notice of Hearing, explaining what happens at a fair hearing, informing them of the date and time, and explaining how to request an in-person hearing or contact TennCare with questions. Doc. 63 at ¶ 72.

Response:

106. TennCare has a number of policies and procedures in place to ensure that its renewal process—and the entire program more generally—is accessible to individuals with disabilities. New Hagan Decl. ¶ 7.

Response:

107. TennCare has designed its program to make the renewal process as easy and accessible as possible for all individuals, regardless of whether they are disabled or not. New Hagan Decl. ¶ 7(a)–(n).

Response:

108. TennCare does not require enrollees going through renewal to visit DHS County offices in person. New Hagan Decl. ¶ 7(a).

Response:

109. Renewal Packets can be submitted over the phone, online, by mail, fax, or in person. New Hagan Decl. ¶ 7(a).

Response:

110. Individuals who require in-person assistance still have the option of visiting a DHS County office for help. New Hagan Decl. ¶ 7(b).

Response:

111. Enrollees who need in-person assistance at home can get such assistance from one of the State's Area Agencies on Aging and Disability ("AAAD"). New Hagan Decl. ¶ 7(c).

Response:

112. TennCare can make referrals to the AAAD on behalf of enrollees and enrollees are also given contact information for AAADs to request such assistance directly. New Hagan Decl. ¶ 7(d).

Response:

113. Under its contract with TennCare, AAAD representatives must meet face-to-face with TennCare enrollees requesting in-person assistance within five business days of receiving such a request. Doc. 63 at ¶ 65.

Response:

114. The availability of in-person assistance is disclosed in every renewal packet TennCare sends. Doc. 63 at ¶¶ 170–72.

Response:

115. Plaintiff William 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. Doc. 63 at ¶¶ 170–72.

Response:

116. For certain groups of disabled enrollees, providers, MCOs, AAADs, or advocates can submit renewal packets for them. New Hagan Decl. ¶ 7(d).

Response:

117. For TennCare's Long Term Services and Supports ("LTSS") population, all of whom are part of the Disability Subclass, if an enrollee is going through renewal, they will receive assistance with the process from either a care coordinator, an Independent Support Coordinator, the Department of Intellectual and Development Disabilities ("DIDD"), or through the nursing homes or intermediate care facilities in which they reside. New Hagan Decl. ¶ 7(e).

Response:

118. Enrollees can upload documents, such as requested verifications, directly to TennCare via the online member portal or through a mobile application on a smartphone in

addition to the traditional methods of mailing, faxing, or submitting documents in person at a DHS County office. New Hagan Decl. ¶ 7(f).

Response:

119. Enrollees can view the eligibility notices TennCare has sent to them through the member portal on TennCare Connect and through the TennCare Connect mobile app. New Hagan Decl. ¶ 7(g).

Response:

120. With the implementation of TEDS, TennCare is now able to conduct much more extensive verifications of necessary information such as income and resources by leveraging third-party databases. *See* CMS Approved Eligibility Verification Plan, Ex. A to Jan. 4, 2022 Hagan Decl., Doc. 166-1; *see also* Doc. 166 at ¶40; New Hagan Decl. ¶ 7(h).

Response:

121. The ability to access and utilize these third-party databases alleviates the need for many enrollees to provide this information as part of the Annual Renewal Process and enables TennCare to automatically renew the eligibility for significantly more enrollees without ever having to issue a Renewal Packet. New Hagan Decl. ¶ 7(h).

Response:

122. Disabled individuals receiving SSI, something that makes them automatically eligible for TennCare, are auto-renewed through an *ex parte* process without having to submit any information. New Hagan Decl. ¶ 7(i).

Response:

123. The current Renewal Packet is pre-populated with information already known about an enrollee and does not include questions about information already verified or known to TennCare that is not subject to change. New Hagan Decl. ¶ 7(j).

Response:

124. Enrollees have 40 days (inclusive of mail time) to return their Renewal Packets (which as noted above can be returned orally over the phone or online in addition to by mail or fax). New Hagan Decl. ¶ 7(k).

Response:

125. TennCare maintains a contract with the Tennessee Community Services Agency ("TNCSA") to provide advocacy services particularly to individuals with cognitive or mental disabilities to include helping them navigate the renewal process and to provide outreach to at-risk populations. New Hagan Decl. ¶ 7(l).

Response:

126. TennCare has a contract with Rural Health Association of Tennessee to provide outreach and assistance to some enrollees going through renewal. Rural Health has the capacity to provide assistance to approximately 10,000 individuals a year and is conducting in-person events across Tennessee and enrollees can also schedule appointments to receive in-person assistance. New Hagan Decl. ¶ 8(c).

Response:

127. TennCare has a system for granting reasonable accommodations to disabled enrollees to enable them to access the program. New Hagan Decl. ¶¶ 9–10.

Response:

128. Indeed, Plaintiffs' own expert testified 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." Blanck Dep. 52:13–14; 56:7–9; 327:24–328:3 (June 16, 2023), attached hereto as Exhibit D.

Response:

129. Talley Olson, the director of TennCare's Office of Civil Rights Compliance, administers TennCare's program for granting reasonable accommodations. Olson Dep. 17:14–15 (Apr. 12, 2023), attached hereto as Exhibit E.

Response:

130. TennCare staff and contractors are instructed, when they are able to provide the sort of assistance being requested, to provide such assistance promptly themselves. New Hagan Decl. ¶ 9.

Response:

131. In many cases, the aids and assistances provided to all enrollees, regardless of disability, are sufficient to provide the assistance the enrollee needs. Olson Dep. 66:9–12.

Response:

132. For instance, if an individual calls TennCare Connect and explains that they are having difficulty reading a notice issued by TennCare, the call center worker can read the notice to the individual themselves, accommodating their request without need for further approval. Olson Dep. 66:9–22.

Response:

133. When requests do require escalation, they still can be granted without granting a special "reasonable accommodation," for example, when TennCare provides notices in large print. Olson Dep. 67:2–10.

Response:

134. These "accommodations" are already part of TennCare's procedures and are available to *all* TennCare enrollees, regardless of whether they are disabled or not. Olson Dep. 68:1–11.

Response:

135. The types of accommodations that a disabled person might need are context and individual specific. *See* Blanck Dep. at 55:3–56:8 (discussing the circumstances under which certain accommodations may be appropriate).

136. TennCare employees and contractors are instructed, when they get a request for relief that they cannot grant themselves, to escalate that request to Ms. Olson, who reviews the requests, seeks additional information from both the requesting party and from TennCare as necessary, and makes a decision. New Hagan Decl. ¶ 9.

Response:

137. Disabled enrollees who wish to request assistance generally or a reasonable accommodation specifically have multiple avenues for doing so. New Hagan Decl. ¶ 9.

Response:

138. "There's no wrong door" through which to submit a request for a reasonable accommodation. Olson Dep. 127:10; New Hagan Decl. ¶ 10.

Response:

139. Enrollees may request assistance through TennCare Connect, communications through an MCO, by email, or by individuals filling out a form provided expressly for that purpose. Olson Dep. 71:15–72:9.

Response:

140. Because TennCare's program already includes avenues for so many types of additional assistance or relief from its rules, Ms. Olson has never had a request for a "true reasonable accommodation" that would involve an alteration to TennCare's program or policies that would be necessary to permit a disabled individual to access the program. Olson Dep. 74:1–10.

Response:

141. Plaintiffs have not identified any TennCare enrollee who requested an accommodation, was denied, and lacked meaningful access to state provided services as a result. Blanck Dep. 81:22–82:8.

Response:

142. In March 2020, TennCare suspended its annual renewal processes and halted disenrollments except for a small set of acceptable reasons and halted the renewal process as a result of a declared public health emergency. Doc. 63 ¶ 41.

Response:

143. On April 1, 2023, as a result of President Biden declaring an end to the disenrollment moratorium, TennCare restarted its renewal and reverification processes. New Hagan Decl. ¶ 2.

Response:

144. As part of restarting renewals, TennCare has worked closely with CMS to ensure that TennCare's processes complied with all applicable federal statutes and regulations, and that TennCare would be operating its renewal processes in a manner that reduced the number of individuals terminated from TennCare for procedural reasons. New Hagan Dec ¶ 2.

Response:

145. TennCare has sought and obtained approval for nine Section 1902(e)(14)(A) waivers from CMS. New Hagan Decl. ¶ 3.

Response:

146. These waivers permit TennCare to automatically renew certain categories of eligibility by using data that TennCare ordinarily cannot use, work with MCOs and USPS to update member contact information, and extend past 90 days the timeframe to resolve appeals for enrollees who are provided continuation of benefits. New Hagan Decl. ¶ 3.

Response:

147. TennCare is considering additional waivers from CMS that were just recently, in June of 2023, made available to states. New Hagan Decl. ¶ 4.

Response:

148. TennCare is just one of 16 state Medicaid programs that was not placed under a mitigation plan by CMS related to deficiencies in the state's eligibility processes that required the adoption of mitigation strategies to address deficiencies with the restarting of the annual renewals. New Hagan Decl. ¶ 6.

Response:

149. As part of starting renewals, TennCare is engaging in an extensive outreach campaign related to the renewal process with a specific emphasis on identified groups of disabled enrollees. New Hagan Decl. ¶ 8.

Response:

150. Prior to the restart of the Annual Renewal Process, TennCare engaged in an extensive community outreach campaign with providers and professional associations to make them aware that renewals were restarting and to provide tools they could use to inform the populations they serve about the Renewal Process. New Hagan Decl. ¶ 8(d).

Response:

151. TennCare is providing MCOs with data on all their enrollees who will be receiving a renewal packet each month and who were terminated for not returning their renewal packet, so that the MCOs may conduct outreach. New Hagan Decl. ¶ 8(a).

Response:

152. The information the MCOs receive includes an identification of those enrollees actively receiving services through a Community Mental Health Center ("CMHC") so that the CMHCs can provide outreach and assistance to those individuals who likely have a cognitive or mental impairment and are going through renewal. New Hagan Decl. ¶ 8(a).

Response:

153. CMHCs are highly incentivized to make sure that the individuals they are treating maintain their TennCare coverage because the CMHCs provide services whether paid for by TennCare or not, so maintaining the TennCare insurance payments is extremely important to the CMHCs. New Hagan Decl. ¶ 8(a).

Response:

154. In its August 9, 2022 memorandum opinion and order certifying the class, Doc. 234, the Court limited class-wide litigation to fifteen issues:

a. whether the State considers all categories and bases of eligibility before terminating enrollees' coverage, Doc. 234 at 14, 18 n.10;

b. whether the notices of decision (NODs) mislead recipients to think that TennCare considers all bases of eligibility, all program rules, and all facts in determining eligibility, *id.* at 14 n.7, 18 n.10;

c. whether the NODs' citation to a 95-page compendium of TennCare regulations, Chapter 1200-13-20, satisfies the notice requirement of 42 U.S.C. § 1396a(a)(3) or the Due Process Clause, *id.* at 12–13, 18 n.10;

d. whether the NODs' omission of an explanation why recipients do not qualify for every other Medicaid category violates 42 U.S.C. § 1396a(a)(3) or the Due Process Clause, *id.* at 13–14, 18 n.10;

e. whether Defendant lacks any system to grant requests for reasonable accommodations for disabled persons navigating TennCare, *id.* at 18 n.10, 20;

f. whether the NODs' omission of information concerning the good cause exception and good cause hearings violates the Medicaid Act or the Due Process Clause, *id.* at 13, 18 n.10;

g. whether the NODs' omission of information about the 90-day reconsideration period violates the Medicaid Act or the Due Process Clause, *id.* at 13, 18 n.10;

h. whether the NODs' language instructing class members to describe the reasons they want to appeal and facts supporting their appeal violates the Medicaid Act or Due Process Clause, *id.* at 13, 18 n.10;

i. whether the State's valid factual dispute policy violates the Medicaid Act or the Due Process Clause, *id.* at 13 n.6, 18 n.10;

j. whether the 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" violated the Medicaid Act or the Due Process clause, *id.* at 18 n.10;

k. whether the State's policy of denying good cause exceptions or hearings based on "allegations of non-receipt" of a notice violates the Medicaid Act or the Due Process Clause, *id.*;

l. whether the State systematically fails to provide fair hearings at any time, *id.*;

m. whether the State is required to provide fair hearings within 90 days of an appeal and, if so, whether it fails to do so, *id.*;

n. whether the State provides adequate "in-person assistance" for disabled persons and, if not, whether that violates the ADA, *id.* at 18 n.10, 20 n.12;

o. whether the State fails to evaluate disability related eligibility categories in making termination decisions and, if so, whether that violates the ADA, *id.*

Response:

155. The Court also certified the past-tense version of each of these questions, and noted the possibility that answering these questions may raise others, including "whether injunctive or declaratory relief is appropriate and, if so, what type." Doc. 234 at 14.

Response:

156. The Court certified a disability subclass with the following named Plaintiffs: S.F.A., Vivian Barnes, Carlissa Caudill, S.L.C., Charles E. Fultz, Michael S. Hill, William C. Monroe, Linda Rebeaud, Kerry A. Vaughn, and Johnny Walker. *Id*. at 40.

Response:

157. The disability subclass representatives have a wide variety of different disabilities. *See* Pls.' Resps. & Objs. to Def.'s First Set of Interrogs. and Requests for Produc. to All Pls.' ("Pls.' R&Os"), 3–5 (Dec. 22, 2022), attached hereto as Exhibit F.

Response:

158. Of these subclass representatives, four (S.F.A., Barnes, Caudill, and Walker) receive SSI and have been or will be auto-renewed for TennCare coverage this year with no need to submit anything to TennCare. New Hagan Decl. ¶ 7(i).

Response:

159. Plaintiff Fultz is deceased. Pls.' Suggestion of Death Upon the Record, Doc. 78 (July 8, 2020).

Response:

160. One subclass representative has already been successfully renewed as part of the Annual Renewal Process, and four subclass representatives who are in the SSI category have had or will have their benefits automatically renewed without having to go through the Annual Renewal Process. New Hagan Decl. ¶ 11.

Response:

161. No subclass representative has ever been denied meaningful access to TennCare for failure to get a reasonable accommodation. *See* Blanck Dep. 81:22–82:8.

Response:

162. Disability subclass representative S.F.A. is a child and, like non-disabled children enrolled in TennCare coverage, their parents are responsible for navigating the enrollment and renewal processes for them. *See* Pls.' R&Os at 3–4.

Response:

163. Plaintiff S.F.A. does not claim to need any form of reasonable accommodation to navigate the program. Pls.' R&Os at 3.

Response:

164. To navigate the program, Plaintiff Barnes claims that she requires in-person assistance, transportation as necessary to access in-person help, additional time to respond to requests, an indicator of a mailed notice through a phone call or some other means, additional time to gather documents, follow-up in person from a case worker familiar with her and the eligibility process she must navigate, and help of an individual at TennCare or her MCO to assist, case manage, and/or coordinate assistance for her in responding to requests for information and documentation from TennCare. Pls.' R&Os at 3–4.

Response:

165. Plaintiff Barnes claims that there are other, undisclosed accommodations which she may also require. Pls.' R&Os at 4.

Response:

166. Plaintiff Barnes has never requested a reasonable accommodation from TennCare. Pls.' R&Os at 6.

Response:

167. Plaintiff Barnes' daughter, Glenda Surrett, acts as her authorized representative and navigates the program for her. Pls.' R&Os at 4.

Response:

168. Glenda Surrett, acknowledged on a recorded call to TennCare that she had received an NOD prior to her mother's termination from TennCare. Doc. 63 ¶ 113

Response:

169. TennCare produced a recording of Ms. Surrett's call to TennCare Connect on July 1, 2020. New Hagan Decl. ¶ 37.

Response:

170. Ms. Surrett claimed she had misunderstood the NOD. Doc. 63 ¶ 113.

Response:

171. Ms. Surrett never sought to appeal her mother's termination decision. Doc. 63 ¶ 113.

Response:

172. As it was never requested, TennCare never denied Ms. Surrett or her mother the opportunity to appeal her NOD. Doc. 63 ¶ 113.

Response:

173. Plaintiff Caudill does not require any reasonable accommodations to navigate the program. Pls.' R&Os at 4.

Response:

174. To navigate the program on her own, Plaintiff S.L.C. claims she requires in-person assistance, transportation as necessary to access in-person help, additional time to respond to requests, additional time to gather documents, simpler or alternative explanations of questions, written follow-ups from a case worker to in-person or telephone conversations, or help from an individual at TennCare or her McO to assist, case manage, and/or coordinate assistance for her in responding to requests for information and documentation. Pls.' R&Os at 4.

Response:

175. Plaintiff S.L.C. claims that there are other, undisclosed accommodations which she may also require. Pls.' R&Os at 4.

Response:

176. Plaintiff S.L.C. has never requested a reasonable accommodation from TennCare. Pls.' R&Os at 6.

Response:

177. To navigate the program on his own, Plaintiff Hill claims he requires in-person assistance, transportation as necessary to access in-person help, additional time to respond to requests, additional time to gather documents, simpler explanations, letters that are easier to read, simplified instructions, and the help of an individual at TennCare or his MCO to assist, case manage, and/or coordinate assistance for him in responding to requests for information and documentation. Pls.' R&Os at 4.

Response:

178. Plaintiff Hill claims that there are other, undisclosed accommodations which he may also require. Pls.' R&Os at 4.

Response:

179. Plaintiff Hill has never requested a reasonable accommodation from TennCare. Pls.' R&Os at 7.

Response:

180. To navigate the program on his own, Plaintiff Monroe claims he requires in-person assistance, transportation as necessary to access in-person help, additional time to respond to requests, an indicator of a mailed notice through a phone call or some other means, additional time to gather documents, in person follow-up from a TennCare representative, the ability to verify or

sign documents verbally, and the help of an individual at TennCare or his MCO to assist, case manage, and/or coordinate assistance for him in responding to requests for information and documentation. Pls.' R&Os at 4–5.

Response:

181. Plaintiff Monroe claims that there are other, undisclosed accommodations which he may also require. Pls.' R&Os at 4.

Response:

182. Plaintiff Rebeaud is eligible for TennCare through the Breast or Cervical Cancer ("BCC") category of eligibility. Doc. 63 ¶ 176.

Response:

183. BCC coverage is only available to individuals who are actively undergoing treatment for breast or cervical cancer. Doc. 63 ¶ 176.

Response:

184. To navigate the program on her own, Plaintiff Rebeaud claims she requires in-person assistance from an agency employee, simpler explanations, letters that are easier to read, simplified instructions, a follow-up in writing, by telephone, or in person, and she notes she would benefit from additional time to respond to requests and gather documents. Pls.' R&Os at 5.

Response:

185. Plaintiff Rebeaud claims that there are other, undisclosed accommodations which she also may require. Pls.' R&Os at 5.

Response:

186. Plaintiff Rebeaud has never requested an accommodation. Pls.' R&Os at 8.

Response:

187. Plaintiff Vaughn does not claim to require any reasonable accommodations. Pls.' R&Os at 5.

Response:

188. Plaintiff Vaughn has never requested an accommodation. Pls.' R&Os at 8.

Response:

189. Plaintiff Vaughn just had her eligibility renewed through TennCare's Annual Renewal Process without requiring any reasonable accommodation. New Hagan Decl. ¶ 11.

Response:

190. To navigate the program on his own, Plaintiff Walker claims he requires in-person assistance, additional time to respond to requests, additional time to gather documents, simpler explanations, letters that are easier to read, simplified instructions, and the help of an individual at TennCare or his MCO to assist, case manage, and/or coordinate assistance for him in responding to requests for information and documentation. Pls.' R&Os at 5.

Response:

191. Plaintiff walker claims that there are other, undisclosed accommodations which he also may require. Pls.' R&Os. At 5.

Response:

July 10, 2023

Respectfully submitted,

Jonathan Skrmetti
Attorney General and Reporter

Meredith Bowen TN BPR #34044
Assistant Attorney General
Matthew Dykstra TN BPR #38237
OFFICE OF THE ATTORNEY GENERAL
P.O. Box 20207
Nashville, TN 37202
(615) 741-1366

/s/ Michael W. Kirk
Michael W. Kirk*
Nicole J. Moss*
William V. Bergstrom*
COOPER & KIRK, PLLC
1523 New Hampshire Avenue, NW
Washington, D.C. 20036
(202) 220-9600
mkirk@cooperkirk.com
nmoss@cooperkirk.com

meredith.bowen@ag.tn.gov *Appearing *pro hac vice*

Counsel for the Defendant

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing document has been served via the Court's electronic filing system on this 10th day of July, 2023.

Brant Harrell
Gordon Bonnyman, Jr.
Michele M. Johnson
Laura E. Revolinski
Madeline D. Wiseman
Vanessa Zapata
TENNESSEE JUSTICE CENTER
211 7th Avenue N., Ste. 100
Nashville, TN 37219

Jennifer M. Selendy
Faith E. Gay
Andrew R. Dunlap
Babak Ghafarzade
Amy Nemetz
Bret Matera
David Coon
SELENDY & GAY PLLC
1290 Avenue of the Americas
New York, NY 10104

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

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

/s/ Michael W. Kirk
Michael W. Kirk

EXHIBIT B

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,

vs. Civil Action No. 3:20-cv-00240

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

Defendant.

Deposition of:

KIM HAGAN

Taken on behalf of Plaintiffs
April 14, 2023

Commencing at 8:29 a.m.

Elite-Brentwood Reporting Services
www.elitereportingservices.com
Lindsey R. Perry, LCR, RPR, CRR, CSR
Post Office Box 292382
Nashville, Tennessee 37229
(615)595-0073

in TEDS when it's a single member case?
A. Correct.
Q. And is that still the case?
A. I don't know. I'd have to verify that, but I assume. I mean, that follows guidance that we've gotten as recently as in the last month or so from CMS.
Q. Okay. If an individual is tied to a household, submits a more accurate change of address, the old address TennCare had on file would remain; is that correct?
A. Were you reading that or is that a question?
Q. Not from the document. Sorry.
A. Oh, okay. Okay.
Q. I can restate if --
A. Yeah. That would be great.
Q. Sure.
If an individual is tied to a household and submits a more accurate change of address, the old address TennCare had on file would remain; is that right?
A. So we don't know that it's accurate for the whole household, and that's the issue. So for example, family of four, the 20-year-old child moves out and -- and goes to the USPS website and submits

an individual change of address. You don't want to update the entire rest of the family with that 20-year-old's address.

Q. Do you -- as part of your roles, do you deal with the good cause exception? Sorry. Let me back up.

Does TennCare have a good cause exception?

A. Exception to what?

Q. To a deadline or -- an eligibility deadline in the renewal process?

MS. MOSS: Objection.

BY MR. HARRELL:

Q. Or an appeals deadline.

A. We definitely have the concept of good cause on filing appeals.

Q. Does the good cause exception apply outside of appeals?

A. We wouldn't refer it -- refer to anything else as good cause. For example, someone could come -- could call and ask for more time, more time to submit, you know, pay stubs. We don't call that good cause.

Q. What would you call it?

A. Just request for additional time.

Q. Okay. Is that tracked in any way?

A. I mean, I guess, yes, in the system, because a worker has to go in and give more time on the due date.
Q. When you say "in the system," are you referring to a specific case file?
A. Yes, in the individual's TEDS record.
Q. Is it tracked in an aggregate way?
A. No.
Q. Okay. What are all the ways that members can allege good cause or request a good cause exception for appeals?
A. They could call. They could write. They could fax. I guess they could drop off a note at a -- at a DHS office.
Q. Does TennCare provide training as to the good cause exception to DHS or call center employees or a contractor?
A. No. I mean, they're not taking any action other than giving the information to the appeals team.
Q. Would DHS or a contractor or call center know what to do with that information?
A. Yes.
Q. So are they trained on that piece?
A. I mean, DHS is trained to get anything

TennCare related to TennCare, so I guess, yes. And then the call center is trained to take in an appeal, write down all the information that they're given, make case notes.

Q. So is it fair to say that DHS and call centers would have general training to transmit information to TennCare but no specific training on the good cause exception?

A. Right.

Q. Okay. Does TennCare sometimes collect more than one address for a given enrollee?

A. For a given enrollee. Yeah. We collect a mailing and a residential address.

Q. Does TennCare only send a renewal packet, an NOD, or other notice to one address on file for an enrollee?

A. We send it to the address that the member has designated as their mailing address, yes.

Q. So if there are different addresses for mailing addresses and the residence, then it would just go to the mailing address?

A. Right. The instructions are "What's your mailing address? What's your residence address if different from the mailing address?" And I believe there's a description of, you know, "This is where

EXHIBIT C

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,

vs.

Civil Action No. 3:20-cv-00240

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

Defendant.

Deposition of:

CAITLYN LEFFARD

Taken on behalf of Plaintiffs
April 27, 2023

Commencing at 8:31 a.m.

Elite-Brentwood Reporting Services
www.elitereportingservices.com
Jeannie Chaffin, LCR
Post Office Box 292382
Nashville, Tennessee 37229
(615)595-0073

Does AOG's work involve creating trainings for TennCare or TennCare contractors that address members' due process rights?

A. We have internal training within AOG that does involve training on due process, but that doesn't relate to member services as a whole.

Q. Okay. And do you -- does AOG have any role in training of contractors?

A. We do, yes.

Q. Okay. And on what topics?

A. As contractors are employed in AOG, we train them on the area in which they are going to be working. They, of course, go through the training that we require of all of our staff. You know, the policy training, TEDS training. I'm sure you've heard about all of the -- all of that training. But then we send them through area-specific training.

Q. So AOG employs contractors?

A. We do, yes.

Q. And so not all of AOG's employees are full-time TennCare employees?

A. Yes.

Q. How many are contractors?

A. Currently?

Q. Yes.
A. Oh, I'm not sure I could -- I don't have that information.
Q. How big is AOG? How many employees work in AOG?
A. Over 200 employees, approximately.
Q. Do you have a guess as to what percentage of that over 200 would be contractors?
A. I don't have a guess. I'm sorry.
Q. What -- do contractors have a role that's different from full-time employees'? Can you tell me a little bit about how AOG is -- let me just back up. Strike whatever I just said.

Tell me about how AOG is structured.

A. So we have several different groups within AOG. We have a clerk's office, a resolution unit, a valid factual dispute unit or a legal review unit, a litigation unit, a litigation specialists unit, and an order implementation unit.
Q. And what does the clerk's office do?
A. So the clerk's office handles the intake of appeals. They handle the registration process. So as appeals come in, kind of checking to see that the appeal has all the

information we need. They also have a call center that handles calls from appellants.

Q. What about the resolution unit?

A. The resolution unit reviews appeals before they reach legal review to ensure that the issue can't be resolved.

Q. What do you mean by "the issue can't be resolved"?

A. So if an appellant files an appeal and they allege an issue, such as a termination, if we see that there is additional information now that we can rerun their eligibility and approve them, resolution will look to see that there's not been any additional action that would reverse their adverse action.

Q. So is it fair to say that they take an initial look at the appeal to see if anything has changed since the action that the enrollee has appealed?

A. Yes.

Q. And you mentioned the VFD unit, which I know you previously oversaw. And I think you also said a legal review unit. Are those the same thing?

A. They are the same, yes.

Q. So VFD unit and legal review unit are sort of used interchangeably?
A. They are, yes.
Q. And I believe you mentioned that there are ten legal review attorneys and 12 leads?
A. So there are ten legal review attorneys and two leads over those.
Q. Two leads?
A. So 12 in total.
Q. And tell me what that group does.
A. That group will review for a valid factual dispute.
Q. Does every appeal first go through the resolution unit?
A. Yes, that is our process.
Q. And from the resolution unit, would it go to legal review?
A. That's our process, yes.
Q. Unless there's something that can be rerun to reverse the adverse action?
A. Yes.
Q. And what about the litigation unit?
A. So the litigation unit actually handles the litigation of appeals. So that's a group of attorneys that would send notices of

hearing.
Q. How big is that group?
A. That group has 24 attorneys, four leads, and one director.
Q. Is there any overlap between the VFD unit and the litigation unit?
A. There is not, no.
Q. Does there -- do they work together at all?
MS. MOSS: Objection.
BY MS. WISEMAN:
Q. You can still answer if you understand.
A. Okay. In that we collaborate with changes in policy, you know, there's -- there's free exchange of information, but the actual work that they do does not overlap.
Q. And do different people oversee the attorneys in each group?
A. Yes.
Q. And what is the order implementation unit?
A. That group, we also refer to it as OIU. They implement the initial order as its issued by administrative judge or commissioner's designee unit.

A. I think there are a whole host of reasons. If the appellant alleges that they've been in the hospital. If they -- if there's been a natural disaster, a tornado, a fire. I feel like there's probably a very exhaustive list on when they might send it on for additional review and determination by VFD.

Q. How many facts would the appeal have to include to trigger that decision that it should be reviewed for good cause?

MS. MOSS: Objection.

BY MS. WISEMAN:

Q. How detailed would a member's story need to be?

A. I think we would need the initial details of, you know, whether they were hospitalized. We don't need to know the details of the hospitalization; but I was in the hospital and unable to respond timely.

Q. You said that AOG doesn't need the details. How long would a member need to be hospitalized for that to constitute good cause?

A. Well, we would need to know that the hospitalization interfered with, you know, the 40-day time period.

Q. If the -- sorry. Did you have more to say?
A. However, we do infer -- we always try to err on the side of the appellant. So if we don't have a lot of details, we do try to err on the appellant's side.
Q. And how is that policy communicated to people who work in AOG, the policy of erring on the side of the appellant?
A. I know that's verbally spoken to everyone through our training, through our, you know, on-the-job training for appeals staff.
Q. So the clerk's office would be given that instruction?
A. They would, yes.
Q. And the registration unit would be given that instruction?
A. It's my understanding that they -- they likely would since they would be reviewing the appeal as it's coming in.
Q. And does the VFD or legal review team also review for good cause?
A. Yes. The ultimate decision is with legal review.
Q. And are they given that instruction?

A. It's my understanding that, yes, they are.
Q. When an AHS call center employee is interacting with an individual who wants to file an appeal, do they offer information about the good cause exception?
A. I'm unsure. That would be something to ask Johnny Gonzalez about.
Q. Do you think they should offer that information?
MS. MOSS: I'm going to object to the extent that this is -- as it relates -- she's designated as it relates to the appeals unit. I don't think her opinion on what AHS should or shouldn't do is relevant.
But you can offer an opinion in your personal capacity.
THE WITNESS: In my personal capacity, I would have concerns about the AHS unit discussing good cause with our appellants just based on -- you know, I would have concerns about that.
BY MS. WISEMAN:
Q. Why would you have concerns? Or what -- I'll rephrase that.

good cause, but two attorneys primarily handle that.

Q. And does AOG seek to ensure that those individuals are exercising the discretion consistently?

A. Yes, in that the director does review -- I know a lot of our good cause inquiries are discussed among the two legal review attorneys, as well as with their lead and the director. It's my understanding that with the -- we're now able to track that a little bit more closely.

So did that answer your question?

Q. Yes.

You mentioned that you're now able to track more closely. What do you mean by that?

A. We've recently had an enhancement in TEDS that allows us to really track when good cause is granted more closely.

Q. And what does that enhancement involve?

A. I believe it involved an update to a screen, but that's -- I don't have many more details besides that.

Q. And it allows AOG to track application of good cause more consistently?

A. Yes.
Q. To understand how it's being applied?
A. Yes.
Q. To real cases?
A. (Nods head affirmatively.)
Q. Yes?
A. Yes.
Q. If a person believes that they've established good cause but TennCare disagrees and decides not to apply the good cause exception, can an individual appeal that determination -- or the individual's denied an appeal, correct?
A. They would be sent an untimely letter, yes.
Q. Their appeal would be closed because it was untimely and there was no good cause?
A. Yes.
Q. If they -- can they appeal the denial of good cause?
A. It's my understanding they can appeal to Chancery Court. And I believe on our untimely notice, we have the clerk's office phone number. If they have a question or concern, they can, of course, call back in.

Q. That's the AOG's clerk's office?
A. Yes.
Q. You mentioned this a little bit earlier. But you are -- are you aware of good cause applying outside of the context of untimely appeals?
A. As it relates to AOG and granting COB, I'm not aware of good cause being applied anywhere else.
Q. If an individual missed the 20-day deadline to appeal and to have continuation of benefits but they had good cause for missing that deadline, might good cause apply there?
A. Yes.
Q. And are appeals automatically reviewed -- appeals that come in from day 21 to 40, are they automatically reviewed for the potential that there's good cause for missing the 20-day deadline?
A. It's my understanding that the clerk's office does review the appeal, and if there is an issue alleged that prevented from appellant from filing within that 20 days, they would then escalate it to legal review.
Q. And is that policy documented somewhere?

A. Yes.
Q. Approximately how many untimely appeals does TennCare receive, as a percentage of overall appeals?
A. I'm not --
MS. MOSS: Are you -- specific to redetermination, or are you asking more broadly?
BY MS. WISEMAN:
Q. Let's do redetermination.
A. I'm not -- and can you clarify, are you asking how many appeals that we receive are untimely or that we resolve as untimely?
Q. That are untimely.
A. I'm not certain of that number.
Q. Do you have a sense of what percentage out of the overall number of appeals with respect to redetermination are untimely?
A. Between 4 and 5 percent are resolved as untimely.
Q. Are resolved as untimely?
A. Yes.
Q. Does TennCare conduct hearings to determine whether circumstances meet the good cause standard?

A. No.
Q. In resolving an appeal as untimely, because the good cause exception was not met, does TennCare explain to the appellant why their circumstances did not meet the good cause standard?
A. No. We do state on the untimely that they were untimely for filing an appeal.
Q. So the same notice would go out whether an individual said nothing that related to good cause exception -- the good cause exception or whether an individual alleged circumstances that didn't meet the good cause exception?
A. Yes.
Q. Is there any way for a TennCare enrollee to challenge TennCare's determination of good cause?
A. An appeal could be filed with Chancery Court.
Q. That's the only way?
A. Yes.
MS. MOSS: We've been going an hour and 15. Can we take a break?
MS. WISEMAN: Sure. That's fine.
(Short break.)

for additional information are never sent related to good cause?

A. They are not, no.

Q. Is there any other way that TennCare would ask a member for proof that they didn't receive a notice?

A. Not that I'm aware of.

Q. If an appeal came in on day 41 and the holiday weekend exception didn't apply, and in the appeal the appellant described not receiving the notice, would that be enough to constitute good cause?

MS. MOSS: Objection to incomplete hypothetical.

But you can respond.

THE WITNESS: In that scenario, we would, of course, look at the entire case, entire scenario. Likely, it would -- we would find good cause.

BY MS. WISEMAN:

Q. You mentioned earlier that the primary focus of good cause review is the appeal itself, correct?

A. Yes.

Q. So what do you mean when you say you

would look at the entire case?
A. We -- so we have -- the appeal is set up through kind of a separate area of TEDS, our eligibility system. And so there's the case and the appeal. And we would look at all the information related to the appeal, but we would also look at the eligibility case and if there was any important information or relevant information in making our determination.
Q. And if there's no additional relevant information and the information that TennCare has is that the member, who appeals on day 41, says they didn't receive the notice, would that be enough to constitute good cause?
A. Likely, yes.
Q. And there wouldn't be additional verification or proof required?
A. No. We don't send an AI for good cause.
Q. Would the AOG consult the unit in TennCare that deals with undeliverable mail?
A. When making the determination of whether we're granting good cause or not, we do look at the case notes. And if -- as well as the notice history documents. If there is something within the case that indicates we do

have returned mail, that is taken into consideration.

Q. Would returned mail always be noted in a person's TEDS file?

A. I'm uncertain because that does relate to an area outside of AOG.

Q. Would the absence of information in the case file indicating that mail was returned as undeliverable mean that good cause wouldn't apply?

MS. MOSS: Objection. Incomplete hypothetical.

THE WITNESS: Can you restate your question?

BY MS. WISEMAN:

Q. You mentioned that you're not sure whether this is always the case. But sounds like you're familiar with circumstances -- okay. Strike that. We're going to move on.

Are individuals in the registration unit instructed to review case notes on undeliverable mail in reviewing an untimely appeal?

A. Yes, I believe so.

Q. What's your belief based on?

A. That registration typically does look to ensure that they have the most accurate address. So I believe that they do check the case just to ensure that we have the most -- most accurate address.
Q. Something that's not on this list is being homeless and not having a fixed address. Might that constitute good cause?
A. Yes.
Q. And would additional proof beyond the allegation of homelessness be required?
A. No.
Q. Another reason that's not on this list is an individual saying they were blind and, therefore, unaware of the contents of the TennCare notice. Might that constitute good cause?
A. Yes.
Q. And no additional proof would be required?
A. No.
Q. And earlier you mentioned there's an unlimited number of possibilities that might constitute good cause; is that right?
A. Yes.

EXHIBIT D

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,	)	
vs.	)	CASE NO. 3:20-CV-00240
STEPHEN SMITH, in his official capacity as Deputy Commissioner of Finance and Administration and Director of the Division of TennCare,	)	
Defendant.	)	

DEPOSITION of PETER BLANCK taken by Defendant, held at 500 Charlotte Avenue, Nashville, Tennessee, commencing at 8:33 A.M., on June 16, 2023, before Gary Schneider, RPR, CRR, RMR, TLCR and Notary Public within and for the State of Tennessee.

time as well, I didn't keep track to the tenth of an hour, it would roughly be in the neighborhood of a hundred hours.

Q. I'm not sure I entirely followed that. You -- setting aside what your compensation is, my question was how much time did you spend preparing for and drafting your report. Is your answer approximately a hundred hours?

A. I think that's a fair estimate.

Q. Okay. Do you know how much money you have made providing expert reports in civil litigation over the course of your career?

A. Over the course of my 35-year career? I don't know that number.

Q. Okay. How about for last year, 2022?

A. Last year, I think it was in the neighborhood of 65 to $80,000, if I recall --

Q. Okay.

A. -- based on tax returns.

Q. Okay. Is $75,000 a typical amount that you charge for an expert report?

A. It's a little higher than I've been paid in the past.

Q. Have you ever authored an expert

report for defendants in civil litigation?

A. Yes.

Q. In which case have you done that?

A. In the largest accommodation case I believe that was ever brought, I was represented -- I was retained by the United States government, the United States Postal Service --

Q. Okay.

A. -- to talk about the nature of reasonable accommodations.

Q. And do you recall the name of that case?

A. I don't.

Q. Do you recall when that took place?

A. It was likely over ten years ago or within the last ten years.

Q. And you authored a report defending the adequacy of the reasonable accommodations that the Postal Service provided?

A. Generally, yes.

Q. Okay. Where in your report do you describe the research methodology used to reach your conclusions?

A. In several places, but primarily on page 7 talking about triangulation.

Q. So are you referring to the sentence that "My evaluation of TennCare systems for providing access to TennCare for the disability class as manifested in its policies, practices, and institutional structure uses well-recognized social science research methods to 'triangulate' sources using a disability policy framework"?

A. Yes, triangulation is a method that's often used in these type of in-depth case analysis and qualitative research.

Q. Okay. Do you describe your triangulation method in any detail in your report?

A. Well, the triangulation method is the comparing and the contrasting of sources from different perspectives so it is described.

Q. Where would you point me to as in terms of -- is that the description that I just read?

A. That is a description, and then the application of that is made throughout the report, for example, different perspectives by different players in the system.

Q. Okay. Have you ever analyzed a state Medicaid program using this triangulation method apart from this case?

A. Apart from this case, no.

Q. And how would one replicate the research methodology used in your report?

A. That's a very good question that goes back to the history of qualitative research in general. Qualitative research versus quantitative research, which is more numerical based, often relies on developing themes and various sources, resources, that you look at from different perspectives, i.e., triangulation to try to come up with basic themes that are both reliable and valid in terms of the research question that you're typically asked.

And in this case I was asked a very straightforward research question, pretty much developed by the court, and that was whether or not TennCare had a valid and reliable reasonable accommodation process for individuals with disabilities seeking renewal.

Q. Okay. And you indicate that that was developed by the court. What are you referring to?

A. In the court's memorandum and order, as I read that, the court had a sentence which I couldn't quote, but basically said -- one question was the extent to which TennCare provided reasonable accommodations in a systemic way or not.

Q. Okay. And so you evaluated TennCare's system?

A. Yes.

Q. Okay. And specifically, you evaluated TennCare's system and processes for granting reasonable accommodations or providing reasonable accommodations?

A. That was the main focus of the report.

Q. Okay. And what were your conclusions upon evaluating TennCare's system for granting and -- for granting reasonable accommodations or providing reasonable accommodations?

A. Well, taking a step back, as I reference in the report, systems theory is a theory that looks at the extent to which an organization is reliable and valid for achieving its purposes. And the null hypothesis in this

case related to the question would be that TennCare did have a system that was reliable and valid. And so starting with that research question, that's how I went about developing the research methodology.

Q. Okay. And so going back to the question, what were your conclusions having evaluated TennCare's system?

A. My conclusions were that it's in many ways a siloed system, that many of the key players are not consistently understanding each other's roles, that there was a lack of monitoring and tracking, that the training was generally inadequate with regard to the provision of reasonable accommodations.

Q. I'm going to delve into that in a minute. But before we go any further down that path, can you first describe what you mean by the term "reasonable accommodations" used throughout your report?

A. "Reasonable accommodation" is a term derived from the Americans with Disabilities Act, even prior to it, which focuses on adjustments in a structure or a system to enable an otherwise qualified individual with a

A. Yes.

Q. And those individuals, I think you've recognized, do not have to do anything to have their eligibility renewed year to year as long as they're eligible for SSI; isn't that right?

A. Typically, unless it's -- there's some change in their status.

Q. Okay. So as part of the annual renewal process in your attempt to determine what the potential impact is of individuals that would need reasonable accommodations, the approximately 230-some-thousand that are on SSI can just be taken out of that equation, correct?

MR. HARRELL: Misstates the report.

THE WITNESS: I didn't follow your question. I'm sorry.

BY MS. MOSS:

Q. So if I'm understanding what you're saying correctly, you estimated the potential size of the disability subclass to determine how many individuals may potentially need reasonable accommodations. And if we're in agreement that individuals receiving SSI do not

need to go through the annual renewal process, they would be taken out of that calculation, correct?

A. They could be, yes.

Q. Okay. And so what does that do in terms of your analysis for the number of disabled individuals that may need reasonable accommodations?

A. Well, that was just to get a general prevalence rate to get a sense of the types of magnitude of accommodations that might be possible and be needed.

Q. Okay. And those individuals would not need to be considered in the magnitude, correct, because they don't have to go through the annual renewal process?

A. Potentially.

Q. When you say "potentially," if somebody is receiving SSI, do they or do they not need to go through annual renewal?

A. Yes. But, for example, as I mentioned Mr. Walker earlier, he was on SSI and there was a problem. He was not getting the services, not -- and so he had to go through it again. So there's an example of a person who

might be in that category but, nonetheless, resulted in an issue.

Q. Okay. So first of all, what is your understanding as to whether Mr. Walker went through annual renewal versus a reverification of his eligibility based on a purported change, such as the loss of SSI?

A. My understanding was he went through an annual renewal.

Q. Okay. And if you were wrong about that, would that affect your analysis?

A. Any change could potentially affect my analysis.

Q. Okay. Did you do anything to attempt to determine how many disabled enrollees will have their eligibility renewed without having to require -- without having to submit any additional information to the state?

A. I did not.

Q. Okay. Did you do any analysis of how likely it is for an enrollee who is eligible in an SSI-related category to have to submit a renewal packet as opposed to having their eligibility automatically renewed through the ex parte process?

A. No. Only through the named plaintiffs' cases.

Q. Okay. Do you know what reasons there would be for an individual in an SSI-related category to have to submit additional information as opposed to having their eligibility automatically renewed? Like what would cause them to have to go through the renewal process?

A. Well, perhaps if there was an income change or some sort of additional information.

Q. And you did nothing to -- I take it your analysis did nothing to try to estimate how likely it is that individuals in an SSI-related category will have changes or income or resources that might necessitate them going through the paper renewal process?

A. I didn't do an analysis of those individuals.

Q. Okay. Did you do anything to determine the number of individuals with disabilities that had their eligibility renewed successfully since March of 2019?

A. I didn't have access to that information.

in which a person was terminated on the basis of that training.

Q. You indicate on page 24, your words is "Among other components a program needs to," "needs to," and then you list these four attributes. And number 4 is "Needs to use available data and systems to proactively identify accommodation and access issues and monitor for ongoing compliance."

When you contend that a program needs to do that, what do you mean?

A. I mean that for a program to be most effective from a systems point of view, that that's a necessary element.

Q. Okay. For it to be effective?

A. You could say that, effective or reliable and valid.

Q. But you're not offering an opinion on whether it needs to do that to be in compliance with the ADA?

MR. HARRELL: Calls for legal conclusion.

THE WITNESS: I think in not doing that, there's a high chance it might not be in compliance with the

ADA.

BY MS. MOSS:

Q. But that's not what you're offering an opinion on here, correct? You're not opining on whether or not TennCare's system is complying with the ADA?

A. Well, that would be a legal conclusion, so I wouldn't answer that.

Q. So you're not -- so when you say a system needs to do that, you're not -- you're not offering that as a legal conclusion that it needs to do that to comply with Title II?

A. Yes, I'm not offering that as a legal conclusion. I'm offering it as a systems effectiveness issue.

Q. Okay. So you're evaluating effectiveness, not compliance with the ADA?

A. I'm not sure I understand the question because.

Q. Your -- because?

A. Because it's kind of mixing apples and oranges.

Q. Okay. You're evaluating whether systems that exist, and you agree that there are systems in TennCare for providing assistance and

offering reasonable accommodations, right?

A. Yes. That was the main focus of my report.

Q. So you acknowledge that there are systems or you agree that there are systems and you're evaluating whether in your view and agree they're effective, reliable, and valid; is that right?

A. Yes.

Q. But what you're not offering because that would be a legal conclusion is whether those systems comply with the ADA?

A. Yeah, I wouldn't make that opinion because it would be a legal conclusion.

Q. Okay. And in determining whether they're effective, reliable, or valid, you don't cite to any -- anywhere in your report, you don't cite to any specific statutes or regulations or case law that mandates the various -- the various attributes of the system that you contend should be put in place?

A. Yes, because I'm not offering up legal conclusions.

Q. On page 26 of your report, at line 18, you indicate -- you talk about "a system

should." And in this particular instance, are you referring to the -- so the system -- are you referring specifically to the computer system as opposed to the eligibility determination process --

A. Yes.

Q. -- system?

A. Yes.

Q. Okay.

A. The frontline workers should have this capability through TEDS.

Q. Through TEDS. Okay.

So you contend they should have this through TEDS. Did you do anything to evaluate the feasibility of putting these features in place in TEDS?

A. Well, they seem pretty simple and straightforward to me, so I don't know what you mean by "evaluate."

Q. Well, are you a computer programmer?

A. No.

Q. Do you have any idea what it would entail to include a drop-down list such as you reference here in the TEDS?

EXHIBIT E

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,

vs.

Civil Action No.
3:20-cv-00240

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

Defendant.

Deposition of:

TALLEY OLSON

Taken on behalf of Plaintiffs
April 12, 2023

Commencing at 8:29 a.m.

Elite-Brentwood Reporting Services
www.elitereportingservices.com
Jeannie Chaffin, LCR
Post Office Box 292382
Nashville, Tennessee 37229
(615)595-0073

you kind of examples to help the person realize that they can call for help. And then there's a statement, like, if you feel like you did not get help or you need help under any of the applicable federal state laws, you can call my office. And then I also have you can call me. You can call the Office of Civil Rights for the Department of Health and Human Services. Some of the taglines have a statement about fraud and abuse as well.

Q. The disability statement document you mentioned, would that be the "Do You Need Special Help" page?

A. There is a "Do You Need Special Help" page. But that goes, like, with materials. But that's not, per se, like, my taglines. That's part of the notice documents. Yeah.

Q. So the disability statement you mentioned, that is not the "Do You Need Special Help" page? What document is that, if you recall?

A. That's a document that Member Services created for a lot of our materials that come out of TennCare. That's part of, you know, the letter packet that a person would get. But my

taglines, in general, I create not only for the agency but for, like, our MCOs, which are a little bit different than that.

Q. Would these be statements typically that would appear at the bottom of documents, such as notices?

A. Yes. Yeah.

Q. Did you talk to anyone else at TennCare to prepare for this case, other than counsel?

A. No.

Q. And I believe you've already stated this, but could you tell us what your position and job title is at TennCare?

A. I'm the director of the Office of Civil Rights Compliance.

Q. How long have you held this position?

A. Since approximately August of 2015.

Q. Who was previously in the position before you?

A. Helen Moore.

Q. And where is Helen Moore now? Do you know?

A. I don't know. I don't know.

Q. Do you work in a physical office?

A. I work at home.

situation we did conduct a home visit?
A. They would just pass on what happened, yeah, like a little summary.
Q. Now, to clarify, with respect to AHS staff, is it fair to say that they do not make what you would consider contacts with you regarding reasonable accommodation requests of enrollees? Is that fair to say?
A. They have never sent me what would be considered a true request for reasonable accommodation. They are just mitigating measures that are already in place.
Q. And how did you make that determination that these are not concerning reasonable accommodation requests?
A. Because it's the nature of, what was the person, member, applicant asked for help. There were already things that were in place, like in-person assistance or more time in general or to read a letter. Like, you can -- anyone can get a letter read to them over the phone.
Q. Have you ever received contacts from AHS staff regarding an enrollee who's requesting an American Sign Language interpreter?

A. Not from AHS.
Q. Have you ever received a request from AHS regarding an enrollee who wishes a written document to be converted into an alternate format?
A. Yes.
Q. Do you recall any examples of that?
A. Yes. I've had people ask for large print, which is not a reasonable accommodation. That's a necessary aid or service.
Q. Have you received any contacts from the AHS nondiscrimination compliance coordinator regarding what you would consider to be an accommodation request?
A. No.
Q. Have you received any contacts from Department of Human Services staff regarding what you would consider to be an accommodation request?
A. No.
Q. Any contacts from the DHS nondiscrimination compliance coordinator regarding what you would consider to be an accommodation request?
A. No.

Q. Is it fair to say that you do not regard these typically as accommodation requests because these involve assistance that is available to every enrollee regardless of whether or not they are disabled? Is that a fair statement?
A. It depends on what you're talking about. Mitigating measures and auxiliary aid services are available to people, depending on their needs. But not all members would need, like, an auxiliary aid or service.
Q. Is it possible that someone has contacted AHS and that has relayed to you and the contact involves an enrollee with a disability who's making an accommodation request because of his or her disability?
MS. MOSS: Objection.
BY MR. BASS:
Q. You can answer.
A. Could you restate that?
MR. BASS: Can you read that back, please?
THE REPORTER: Sure.
(WHEREUPON, the pending question was read back by the reporter.)

THE WITNESS: I would say yes. But just because someone is saying it's an accommodation or that they have a disability, it doesn't necessarily mean that's accurate.

BY MR. BASS:

Q. But it's possible that that would be accurate; is that correct?

A. There's always a possibility.

Q. So are you saying -- and correct me if I'm wrong -- that reasonable accommodation requests that would typically come to your attention are to be subsumed within requests for mitigating measures?

MS. MOSS: Objection.

BY MR. BASS:

Q. You can answer.

MS. MOSS: You can answer.

THE WITNESS: I don't -- could you read that back again?

(WHEREUPON, the pending question was read back by the reporter.)

THE WITNESS: I would say it's kind of like the members -- many mitigating measures are coming to me as reasonable accommodation requests.

BY MR. BASS:
Q. How so?
A. Because, like, someone will call in and say, like, I need more time. And then the call center person is blocking that as a reasonable accommodation request and sending it to me. But it's not a request for a reasonable accommodation. It's a mitigating measure that people can already get, and there's a process in place to do that.
Q. Let me ask you a hypothetical.
A. Okay.
Q. If an enrollee is cognitively impaired, they have a cognitive disability and they don't understand a form that they received from TennCare and they need help having that form explained to them, would you consider that to be a reasonable accommodation request?
A. That's a mitigating measure.
Q. How so?
A. Because there's already a process in place for the call center person to explain to them that form. And if they are not -- if that person isn't feeling that's enough help, there's also a process in place, too. There's

an advocacy group that can further work with the person to help them understand the form.

Q. What is that advocacy group?

A. I don't know their official name. We just call them the advocacy group.

Q. Is this a group within TennCare?

A. My understanding is that they are contractors, but...

Q. Have you ever been involved in situations where this group has rendered the assistance you're describing?

A. I've not actively been involved.

Q. Does TennCare use a form for reasonable accommodation requests?

A. A person does not have to complete the form for a reasonable accommodation request. They can just call and ask for one or tell their MCO or send an e-mail to me. But if they want to complete the form, that would be wonderful.

Q. So a form does exist?

A. There's a discrimination complaint form, and they can fill that out even with -- for reasonable accommodation requests.

Q. So are you saying that the requests for

reasonable accommodation form is the same as the TennCare discrimination complaint form; is that correct?

A. I'm saying that if a person wanted to submit a reasonable accommodation on the TennCare complaint form, they are welcome to do that. But there are many different ways that they can ask for accommodation requests. They do not necessarily have to fill out a form.

Q. Is there a separate form that's specifically for the purpose of requesting a reasonable accommodation, apart from filing a complaint?

A. No.

MS. MOSS: We've been going about an hour and a half. Why don't we take a short break.

MR. BASS: Ten minutes?

MS. MOSS: That's fine.

(Short break.)

BY MR. BASS:

Q. So prior to the corrective action plan process with AHS, did your duties include reviewing TennCare or AHS responses to reasonable accommodation requests from TennCare

enrollees?

MS. MOSS: I'm -- can you read that back to me? I missed it. I'm sorry.

THE REPORTER: Yes.

(WHEREUPON, the pending question was read back by the reporter.)

THE WITNESS: So neither TennCare nor AHS would respond to reasonable accommodation requests -- true reasonable accommodation requests. As we covered before, I'm the sole decisionmaker in that area.

Did you hear me?

THE REPORTER: I didn't hear the last couple of words. I'm the sole decisionmaker?

THE WITNESS: In that area.

THE REPORTER: Thank you.

BY MR. BASS:

Q. So is it fair to say that AHS staff or their nondiscrimination compliance coordinator would not have anything to do with acknowledging or treating reasonable accommodation requests in TennCare enrollees?

MS. MOSS: Objection.

BY MR. BASS:

Q. You can answer.

A. A true reasonable accommodation request, they would just log in the person's name, contact information, what they need -- like, the help that they've asked for, and send it to me. And then I would start the process, if it was a true reasonable accommodation request.

However, I do like to clarify that as of to date, I have never had a true reasonable accommodation request come to me; that they are all mitigating measures from AHS.

Q. And mitigating measures are available to anyone who is a TennCare enrollee, regardless of whether they are disabled; is that correct?

A. Yes.

Q. The decisions that you make regarding discrimination complaints, if you make a decision that finds that there was no discrimination, is that decision forwarded to any of the federal agencies that you work with?

A. Okay. So I'm sorry, I was thinking about something else.

THE REPORTER: I'll read it to you.

(WHEREUPON, the pending question was read back by the reporter.)

THE WITNESS: No.

BY MR. BASS:
Q. So you are making what, in effect, is a final decision in those circumstances, correct?
A. Yes. But they can ask for a review of that decision. Or they could just go themselves to HHS, Office of Civil Rights. They are given that option as well.
Q. Who makes a review of that decision?
A. I do.
Q. So an enrollee can ask for a review by you personally of your prior decision?
A. Yes. Uh-huh. Or they could ask HHS, Office of Civil Rights. I mean, they are welcome to do that.
Q. Are you able to say since 2020 how many reasonable accommodation requests you have personally granted?
A. I cannot give you an accurate number. Are you just talking about the whole program or redetermination?
Q. The whole program.
A. For the whole program I cannot give you an accurate number, no.
Q. Can you give an accurate number for redeterminations?

the complaint process?
A. Yes. I include those types of things in here, yes.
Q. Where do these entries come from?
A. I input them myself.
Q. Are these -- how do these come to your attention? From what source or sources?
A. So again, complaints, they can come -- or requests for reasonable accommodations, whatever, there's no wrong door. They come to me from all different types of sources. People can e-mail them to me. They can do the online forms, either the realtime or the PDF version. There's forms in member handbooks. The MCOs can help people complete forms or send them forms for them to complete. AHS can help them with forms.

All the providers and our network contractors, they are all taught to help people complete forms or how to get forms to me.

I feel like I'm leaving out a couple things. But again -- oh, sometimes other agencies, they'll get things accidentally, and they send them to me.

Yeah. There's just not a limit to

how things can get to me.
Q. Is it fair to say that the complaint log records only events related to formal complaints of discrimination?
A. No.
Q. Why is that?
A. Because again, not all of these are, like, complete complaints. Some of them aren't valid complaints. Some of them are just when things -- let me be -- it's not -- they didn't officially file an allegation, but maybe I talked to the person about their concerns and then wrote them a letter or something. I'll put that in here as well.

Some things are not even complaints at all. Like, maybe a person had a question, but it kind of came through me, like on the complaint form, even though it's not, like, a complaint. And I wrote them a letter explaining a question about the program. That will be on here.

Sometimes I'll put my compliance reviews on here. Something that maybe involves, like, a considerable amount of time with me helping the member might go on here,

EXHIBIT F

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.	**Civil Action No. 3:20-cv-00240**
STEPHEN SMITH, in his official capacity as Deputy Commissioner of Finance and Administration and Director of the Division of TennCare,	**Class Action**
Defendant.	**Chief Judge Crenshaw** **Magistrate Newbern**

PLAINTIFFS' RESPONSES AND OBJECTIONS TO DEFENDANTS' FIRST SET OF INTERROGATORIES AND REQUESTS FOR PRODUCTION TO ALL PLAINTIFFS

Pursuant to Federal Rules of Civil Procedure 26, 33, and 34, Plaintiffs hereby serve on the Defendant the following responses and objections to Defendant's First Set of Interrogatories and Requests for Production to All Plaintiffs.

Interrogatories

Objection: Plaintiffs object to the definition of "Valid Factual Dispute Policy" as defined in the Interrogatory because it includes "mistaken application of fact to law," which is not referenced in TennCare's Valid Factual Dispute rule. *See* TennCare Rule 1200-13-13-.11.

1. For each Class Representative for the Disability Subclass, identify with particularity every disability he or she has.

RESPONSE:

Plaintiffs submit that TennCare has notice of an individual's disability(ies) based on eligibility categories that involve a disability (e.g. Disabled Adult Child), based on internal documentation or information provided by Plaintiffs during the application, renewal, termination, or redetermination processes, or from claims or other information showing the person's diagnoses, treatment, and/or services being received. Every prescription, medical evaluation, therapy, or other clinical encounter for the Subclass is documented in a uniform billing form submitted to the managed care organization (MCO) identifying the enrollee, their diagnoses, and treatments. This billing information is submitted to TennCare within weeks of the encounter and must meet rigorous

standards of completeness. TennCare could, if it chose to do so, run a search, or direct its MCOs to run a search, to find enrollees with certain diagnoses, or who are receiving medications, for example, that are for mental conditions that are typically associated with impaired cognition. TennCare also has access to information about services for the blind, deaf, hard of hearing, other state services, or accommodations granted by the MCO that it could draw upon. Specifically, and subject to the above, the Class Representatives for the Disability Subclass submit the following:

Plaintiff S.F.A.: Plaintiff S.F.A., who is four years old, has spina bifida, a neurogenic bladder, and hydrocephalus.

Plaintiff Vivian Barnes: Plaintiff Vivian Barnes has osteoarthritis, is bed-ridden due to an ankle/leg injury, and suffers from vertigo. Plaintiff Barnes also has macular degeneration, limited hearing loss, diabetes, hypertension, heart disease, neuropathy, and sleep apnea. Plaintiff Barnes is able to read hard copy documents if the print is big enough. Plaintiff Barnes's impairments prevent her from responding to or gathering requests for documentation or information quickly, accessing or seeing online information, physically signing documents, regularly checking her mailbox, or clearly hearing and responding to questions asked over the telephone, at all or without great effort.

Plaintiff Carlissa Caudill: Plaintiff Carlissa Caudill has serious neurological and orthopedic injuries sustained from a childhood accident and again in a 1996 car accident. She has chronic pain and impaired mobility from the accident. Plaintiff Caudill also has chronic obstructive pulmonary disease (COPD) and recurrent pneumonia. Plaintiff Caudill's physicians have also identified skin cancer and multiple nodules and a mass on her lung that is growing.

Plaintiff S.L.C.: Plaintiff S.L.C. suffers from brain damage and a seizure disorder that she developed after she contracted viral encephalitis when she was five years old. She has intellectual and developmental disabilities, low stamina, and poor memory. S.L.C. meets the Special Eligibility requirement for TennCare coverage as a Disabled Adult Child and through enrollment in ECF CHOICES.

Plaintiff Charles Fultz: Plaintiff Charles Fultz died on June 17, 2020. Plaintiffs have filed a suggestion of death on the record. (ECF 78.)

Plaintiff Michael Hill: Plaintiff Michael Hill has autism and is unable to understand the significance of paperwork, respond to requests for documentation, or keep track of dates and deadlines. In addition, Plaintiff Hill has scoliosis and sleep apnea.

Plaintiff William Monroe: Plaintiff William Monroe has heart disease, spinal stenosis, limited-to-no use of his fingers and hands, one functioning leg, and he is hard of hearing. Plaintiff Monroe's impairments prevent him from responding to or gathering requests for documentation or information quickly, accessing online information, physically signing documents, regularly checking his mailbox, or clearly hearing and responding to questions asked over the telephone, at all or without great effort.

Plaintiff Linda Rebeaud: Plaintiff Linda Rebeaud has a history of breast cancer and has received treatment since 2013. Plaintiff Rebeaud has also been diagnosed with and receives treatment for depression and an anxiety disorder, which make it difficult for her to make decisions and act under pressure.

Plaintiff Kerry Vaughn: Plaintiff Kerry Vaughn has Cerebral Palsy, a leaking heart valve, asthma, and anemia, and she is on oxygen and is wheelchair bound.

Plaintiff Johnny Walker: Plaintiff Johnny Walker has a traumatic brain injury that impairs his ability to process questions and formulate responses, respond to requests for documentation quickly, or keep track of calendar dates and deadlines. In addition, Plaintiff Walker has a seizure disorder.

2. For each Class Representative for the Disability Subclass, identify with particularity every reasonable accommodation he or she requires to apply for or maintain through redetermination, their TennCare coverage.

RESPONSE:

Plaintiffs submit that TennCare has notice of an individual's disability(ies) based on eligibility categories that involve a disability (e.g. Disabled Adult Child), based on internal documentation or information provided by Plaintiffs during the application, renewal, termination, or redetermination processes, or from claims or other information showing the person's diagnoses, treatment, and/or services being received. Every prescription, medical evaluation, therapy, or other clinical encounter for the Subclass is documented in a uniform billing form submitted to the MCO identifying the enrollee, their diagnoses, and treatments. This billing information is submitted to TennCare within weeks of the encounter and must meet rigorous standards of completeness. TennCare could, if it chose to do so, run a search, or direct its MCOs to run a search, to find enrollees with certain diagnoses, or who are receiving medications, for example, that are for mental conditions that are typically associated with impaired cognition. TennCare also has access to information about services for the blind, deaf, hard of hearing, other state services, or accommodations granted by the MCO that it could draw upon. Additionally, Plaintiffs contend that because of TennCare's deficient notices, most Subclass members did not know that they had a right to a reasonable accommodation under the ADA. Specifically, and subject to the above, the Class Representatives for the Disability Subclass submit the following:

Plaintiff S.F.A.: Plaintiff S.F.A. is four years old. Her mother and next friend C.M.H. temporarily navigates the TennCare process of accessing and maintaining TennCare Coverage on her behalf.

Plaintiff Vivian Barnes: To navigate the TennCare process of accessing and maintaining TennCare Coverage on her own, Plaintiff Barnes's accommodations include but are not limited to: in-person assistance, transportation as necessary to access in-person help,

additional time to respond to requests, an indicator of a mailed notice through a phone call or some other means, additional time to gather documents, follow-up in person from a case worker familiar with the person's needs and the eligibility process the person must navigate, and help of an individual at TennCare or the MCO to assist, case manage, and/or coordinate assistance for her in responding to requests for information and documentation from TennCare. Without an accommodation, Plaintiff Barnes's daughter Glenda Surrett temporarily navigates the process for her.

Plaintiff Carlissa Caudill: Plaintiff Caudill currently navigates the process of accessing and maintaining TennCare Coverage on her own and, while her circumstances may change, does not presently require an accommodation to navigate TennCare's process. Plaintiff Caudill receives SSI and related TennCare coverage based on her disabilities, which include chronic pain. Reasonable accommodations such as additional time to gather documents, simplified, more specific, or alternative explanations or requests, or other accommodations, would support access to the program.

Plaintiff S.L.C.: To navigate the TennCare process of accessing and maintaining TennCare Coverage on her own, the accommodations that Plaintiff S.LC. requires include but are not limited to: in-person assistance, transportation as necessary to access in-person help, additional time to respond to requests, additional time to gather documents, simpler explanations or explaining a question in different ways, written follow ups from a case worker to in-person or telephone conversation, or help of an individual at TennCare or an MCO to assist, case manage, and/or coordinate assistance for her in responding to requests for information and documentation from TennCare. Without an accommodation, S.L.C.'s mother and father temporarily navigate the process for her.

Plaintiff Charles Fultz: Plaintiff Charles Fultz died on June 17, 2020. Plaintiffs have filed a suggestion of death on the record. (ECF 78.)

Plaintiff Michael Hill: To navigate the TennCare process of accessing and maintaining TennCare Coverage on his own, the accommodations that Plaintiff Hill requires include but are not limited to: in-person assistance, transportation as necessary to access in-person help, additional time to respond to requests, additional time to gather documents, simpler explanations, letters that are easier to read, simplified instructions, and the help of an individual at TennCare or an MCO to assist, case manage, and/or coordinate assistance for him in responding to requests for information and documentation from TennCare. Without an accommodation, Plaintiff Hill's sister and next friend Kimberly Noe temporarily navigates the process for him.

Plaintiff William Monroe: To navigate the TennCare process of accessing and maintaining TennCare Coverage on his own, the accommodations that Plaintiff Monroe requires include but are not limited to: in-person assistance, transportation as necessary to access in-person help, additional time to respond to requests, an indicator of a mailed notice through a phone call or some other means, additional time to gather documents, in person follow-up from a TennCare representative, the ability to verify or sign documents verbally (where appropriate), and the help of an individual at TennCare or an MCO to assist, case

manage, and/or coordinate assistance for him in responding to requests for information and documentation from TennCare.

Plaintiff Linda Rebeaud: To navigate the TennCare process of accessing and maintaining TennCare Coverage, the accommodations that Plaintiff Rebeaud requires 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. She would also benefit from additional time to respond to requests and gather documents.

Plaintiff Kerry Vaughn: Plaintiff Vaughn currently navigates the process of accessing and maintaining TennCare Coverage on her own and, while her circumstances may change, does not presently require an accommodation to navigate TennCare's process. Plaintiff Vaughn, who requires a wheelchair and is on oxygen, receives SSDI and related TennCare coverage based on her disabilities, which include Cerebral Palsy, a leaking heart valve, asthma, and anemia. Reasonable accommodations such as additional time to gather documents, simplified, more specific, or alternative explanations or requests, the ability to verify or sign documents verbally (as allowed), or other accommodations, would support access to the program.

Plaintiff Johnny Walker: To navigate the TennCare process of accessing and maintaining TennCare Coverage on his own, the accommodations that Plaintiff Walker requires include but are not limited to: in-person assistance, additional time to respond to requests, additional time to gather documents, simpler explanations, letters that are easier to read, simplified instructions, and the help of an individual at TennCare or an MCO to assist, case manage, and/or coordinate assistance for him in responding to requests for information and documentation from TennCare.

3. For each Class Representative for the Disability Subclass, identify with particularity (including but not limited to identifying the date, time, and manner a request was made, the nature of the request, to whom the request was made, and who made the request on the individual's behalf) every time he or she requested a reasonable accommodation from TennCare and state what accommodation(s) they ultimately received.

RESPONSE:

Plaintiffs submit that TennCare has notice of an individual's disability(ies) based on eligibility categories that involve a disability (e.g. Disabled Adult Child), based on internal documentation or information provided by Plaintiffs during the application, renewal, termination, or redetermination processes, or from claims or other information showing the person's diagnoses, treatment, and/or services being received. Every prescription, medical evaluation, therapy, or other clinical encounter for the Subclass is documented in a uniform billing form submitted to the MCO identifying the enrollee, their diagnoses, and treatments. This billing information is submitted to TennCare within weeks of the encounter and must meet rigorous standards of completeness. TennCare could, if it chose to do so, run a search, or direct its MCOs to run a search, to find

enrollees with certain diagnoses, or who are receiving medications, for example, that are for mental conditions that are typically associated with impaired cognition. TennCare also has access to information about services for the blind, deaf, hard of hearing, other state services, or accommodations granted by the MCO that it could draw upon. Additionally, Plaintiffs contend that because of TennCare's deficient notices, most Subclass members did not know that they had a right to a reasonable accommodation under the ADA. Specifically, and subject to the above, the Class Representatives for the Disability Subclass submit the following:

Plaintiff S.F.A.: Plaintiff S.F.A.'s disability should be evident to TennCare based on S.F.A.'s category of eligibility, claims information, or other communication with TennCare. Plaintiff S.F.A. has not formally stated to a TennCare representative that they request reasonable accommodation (or an equivalent phrase) and is not known to have received any reasonable accommodation from TennCare. Plaintiff S.F.A.'s next friends and other helpers have had difficulty accessing, understanding, or navigating the program and have had to make at least 15 calls to TennCare for assistance. C.M.H. cannot recollect specific dates, exact contents of letters, or number of times she was on calls with TennCare, but the above is generally consistent with her memory.

Plaintiff Vivian Barnes: Plaintiff Barnes's disability should be evident to TennCare based on her category of eligibility, claims information, or other communication with TennCare. Plaintiff Barnes has not formally stated to a TennCare representative that they request reasonable accommodation (or an equivalent phrase) and is not known to have received any reasonable accommodation from TennCare. Plaintiff Barnes's next friends and other helpers have had difficulty accessing, understanding, or navigating the program and have had to make numerous calls to TennCare for assistance.

Plaintiff Carlissa Caudill: Plaintiff Caudill's disability should be evident to TennCare based on her category of eligibility, claims information, or other communication with TennCare. Plaintiff Caudill has not formally stated to a TennCare representative that she requests reasonable accommodation (or an equivalent phrase) and is not known to have received any reasonable accommodation from TennCare. Plaintiff Caudill or others have had difficulty accessing, understanding, or navigating the program and have had to make at least 10 calls to TennCare for assistance. Ms. Caudill cannot recollect specific dates, exact contents of letters, or number of times she was on calls with TennCare, but the above is generally consistent with her memory.

Plaintiff S.L.C.: Plaintiff S.L.C.'s disability should be evident to TennCare based on S.L.C.'s category of eligibility, claims information, or other communication with TennCare. Plaintiff S.L.C. has not formally stated to a TennCare representative that she requests reasonable accommodation (or an equivalent phrase) and is not known to have received any reasonable accommodation from TennCare. In a call with TennCare dated June 19, 2019, S.L.C.'s father attempted to call and update S.L.C.'s residence address on her behalf and the TennCare representative refused because S.L.C. is an adult and the TennCare representative refused to see her parents as authorized to speak on her behalf though TennCare should have S.L.C.'s Power of Attorney on file and TennCare should

have records that S.L.C. is enrolled in ECF CHOICES, which is a program for individuals with intellectual and developmental disabilities. *See* TC-AMC-0000002061. In a call dated October 10, 2019, S.L.C.'s father also attempts to request a sit-down meeting after being unable to understand or be understood by the TennCare representative, but this request is rejected. *See* TC-AMC-0000002066. Plaintiff S.L.C's next friends or others have had difficulty accessing, understanding, or navigating the program and have had to make at least 6 calls to TennCare for assistance. S.L.C.'s father cannot recollect specific dates, exact contents of letters, or number of times he was on calls with TennCare, but the above is generally consistent with his memory.

Plaintiff Charles Fultz: Plaintiff Charles Fultz died on June 17, 2020. Plaintiffs have filed a suggestion of death on the record. (ECF 78.)

Plaintiff Michael Hill: Plaintiff Hill's disability should be evident to TennCare based on his category of eligibility, claims information, or other communication with TennCare. Plaintiff Hill has not formally stated to a TennCare representative that he requests reasonable accommodation (or an equivalent phrase) and is not known to have received any reasonable accommodations from TennCare. Plaintiff Hill's next friends or others have had difficulty accessing, understanding, or navigating the program and have had to make at least 12 calls to TennCare for assistance.

Plaintiff William Monroe: Plaintiff Monroe's disability should be evident to TennCare based on his category of eligibility, claims information, or other communication with TennCare. A review of records involving Mr. Monroe shows the following:

In a TennCare call with a TJC Client Advocate Nora Hendricks on September 16, 2019, Plaintiff Monroe stated that: he lives alone (21:02), cannot drive (24:53), is hard of hearing (3:12, 16:03), the woman who was assisting with his mail died (8:10, 10:39), has spinal stenosis (13:08), lost use of his hands (13:08), lost use of one of his legs (13:08), had been hospitalized for approximately a four month period, and needed someone to get his mail because he could not do so himself (14:04). TC-AMC-0000003721. Plaintiff Monroe made a reasonable accommodation request to TennCare on September 30, 2019 through a letter from TJC Client Advocate Nora Hendricks. This correspondence is included in the State's production at TC-AMC-000042571 and is in response to a TennCare demand (template TN 303.2) for 12 categories of documents from Plaintiff Monroe with due dates between 6 days to 20 days. TC-AMC-000003641. Among other things, the September 30, 2019 letter from TJC states that Plaintiff Monroe has minimal use of his hands due to a spinal cord injury, has extreme difficulty signing or returning correspondence but can give verbal authorization over the phone, and is hard of hearing. The request asked for in-person assistance, verbal authorizations, slow and clear speaking from the TennCare representative on explanatory calls, and additional resources to help Plaintiff Monroe submit the requested information. On October 9, 2019, Plaintiff Monroe had a three-way call with TennCare and TJC Client Advocate Nora Hendricks that referenced Plaintiff Monroe's difficulty signing documents and hearing and requested the ability to verify or sign documents verbally. TC-AMC-0000003724. On October 18, 2019, Plaintiff Monroe made another similar request to TennCare through TJC Client Advocate Nora Hendricks.

This request also states that Plaintiff Monroe has minimal use of his hands due to a spinal cord injury, has extreme difficulty signing or returning correspondence but can give verbal authorization over the phone, is hard of hearing, and cannot drive. *See* TC-AMC-000004257. TennCare gave Plaintiff Monroe until October 29, 2019 to return the requested verifications. *See* TC-AMC-000003713, -3715. Plaintiff Monroe submitted applications for TennCare coverage with verbal authorizations on or around September 9, 2019 and September 16, 2019. *See* TC-AMC-0000003721, TC-AMC-0000003726. On July 2, 2020, after the filing of the lawsuit, TennCare's MCO provided Mr. Monroe with some care coordination services. *See* AMC-DS-WM-00005. Overall, Plaintiff Monroe has had difficulty accessing, understanding, or navigating the program and he or someone on his behalf has had to call TennCare at least 7 times. Mr. Monroe cannot specific recollect the dates, exact contents of letters, or number of times he was on calls with TennCare, but the above is generally consistent with his memory.

Plaintiff Linda Rebeaud: Plaintiff Rebeaud's disability should be evident to TennCare based on her category of eligibility, claims information, or other communication with TennCare. Plaintiff Rebeaud has not formally stated to a TennCare representative that they request reasonable accommodation (or an equivalent phrase) and is not known to have received any reasonable accommodations from TennCare.

Plaintiff Kerry Vaughn: Plaintiff Vaughn's disability should be evident to TennCare based on her category of eligibility, claims information, or other communication with TennCare Plaintiff Vaughn has not formally stated to a TennCare representative that she requests reasonable accommodation (or an equivalent phrase) and is not known to have received any reasonable accommodations from TennCare. Plaintiff Vaughn or others have had difficulty accessing, understanding, or navigating the program and have had to make at least 7 calls to TennCare for assistance. Ms, Vaughn cannot recollect specific dates, exact contents of letters, or number of times she was on calls with TennCare, but the above is generally consistent with her memory.

Plaintiff Johnny Walker: Plaintiff Walker's disability should be evident to TennCare based on his eligibility category, claims information, or other communication with TennCare. Plaintiff Walker is on SSI and has a limited fixed income. Plaintiff Walker has a traumatic brain injury that impairs his memory. Based on a review of Plaintiff Walker's records and not Plaintiff Walker's memory, the following occurred:

In calls with TennCare on Plaintiff Walker's behalf in August and September 2019, a TennCare representative was told, among other things, that Plaintiff Walker has a disability and limited abilities in a lot of areas because of an accident with a train. TC-AMC-0000008234, -8235. In a letter to TennCare on October 10, 2019, TJC Legal Fellow Vanessa Zapata stated that:

- Plaintiff Walker "is cognitively impaired and began receiving SSI benefits at 17 years old after he was hit by a train,"

- he needs medications that treat seizures,

- asked why TennCare requested that Plaintiff Walker verify financial information from the Social Security Administration to which it already had access,

- "[e]ven if he received this notice, due to his cognitive impairment he didn't understand the necessity of responding," and

- "[TJC] was concerned that given TennCare's awareness of his disability it did not offer him accommodation to navigate the redetermination process." TC-AMC-0000008222.

Essentially, in the October 10, 2019 letter, TJC was requesting the help of an individual at TennCare or an MCO to assist, case manage, and/or coordinate assistance for him in understanding and responding to requests for information and documentation from TennCare. While his coverage was eventually reinstated (see TC-AMC-000008232), Plaintiff Walker is not known to have received any reasonable accommodations from TennCare.

4. If you contend that the Defendant violates the Medicaid Act by citing to a 95-page compendium of TennCare regulations to support its decision in NODs, describe with particularity the specific provisions of the Medicaid Act that this practice violates.

RESPONSE:

Plaintiffs respond that Defendant's general citation to a 95-page compendium of TennCare regulations to support its decisions in NODs, without citing any specific TennCare regulation, violates 42 U.S.C. § 1396a(a)(3). Specifically, Defendant violates § 1396a(a)(3) by violating the requirement in 42 C.F.R. § 431.210(c) that any notice required under 42 C.F.R. § 431.206(c)(2)–(4) must contain "the specific regulations that support, or the change in Federal or State law that requires, the action [taken in the NOD]." Defendant further violates 42 U.S.C. § 1396a(a)(3) by violating the requirement in 42 C.F.R. § 431.210(b) that any notice required under 42 C.F.R. § 431.206(c)(2)-(4) must contain "[a] clear statement of the specific reasons supporting the intended action." Defendant further violates U.S.C. § 1396a(a)(3) by violating the requirement of 42 C.F.R. § 435.905 that the agency must furnish information, electronically, on paper and orally as appropriate, to all applicants and other individuals who request it regarding the eligibility requirements and the rights and responsibilities of applicants and beneficiaries, and such information must be provided in plain language and in a manner that is accessible and timely to individuals living with disabilities. Defendant further violates § 1396a(a)(3) by violating the requirement in 42 C.F.R. § 431.231(c) that Defendant continue services where action is taken without adequate notice.

5. If you contend that the Defendant violates the Medicaid Act by omitting information about the Good Cause Exception and Good Cause Hearings from NODs, describe with particularity the specific provisions of the Medicaid Act that this practice violates.

RESPONSE:

Plaintiffs respond that Defendant's omission of information about the Good Cause Exception and Good Cause Hearings from its NODs violates 42 U.S.C. § 1396a(a)(3). Specifically, Defendant violates § 1396a(a)(3) by violating the requirement in 42 C.F.R. § 431.210(d)(1) that any notice required under 42 C.F.R. § 431.206(c)(2)–(4) must contain "[a]n explanation of . . . [t]he individual's right to request a local evidentiary hearing if one is available, or a State agency hearing." Defendant further violates § 1396a(a)(3) by violating the requirement in 42 C.F.R. § 431.206(b)(1)–(2) that Defendant inform every beneficiary, in writing, "[o]f his or her right to a fair hearing and right to request an expedited fair hearing" and "[o]f the method by which he may obtain a hearing." Defendant further violates § 1396a(a)(3) by violating the requirement in 42 C.F.R. § 431.231(c) that Defendant continue services where action is taken without adequate notice. Defendant further violates U.S.C. § 1396a(a)(3) by violating the requirement of 42 C.F.R. § 435.905 that the agency must furnish information, electronically, on paper and orally as appropriate, to all applicants and other individuals who request it regarding the eligibility requirements and the rights and responsibilities of applicants and beneficiaries, and such information must be provided in plain language and in a manner that is accessible and timely to individuals living with disabilities. Defendant further violates § 1396a(a)(3) by violating the requirement in 42 C.F.R. § 431.231(c) that Defendant continue services where action is taken without adequate notice.

6. If you contend that Defendant violates the Medicaid Act by omitting information concerning the 90-Day Reconsideration Period from the NODs, describe with particularity the specific provisions of the Medicaid Act that this practice violates.

RESPONSE:

Plaintiffs respond that Defendant's omission of information concerning the 90-Day Reconsideration Period from its NODs violates 42 U.S.C. § 1396a(a)(3). Specifically, Defendant violates § 1396a(a)(3) by violating the requirement in 42 C.F.R. § 431.210(d)(1) that any notice required under 42 C.F.R. § 431.206(c)(2)–(4) must contain "[a]n explanation of . . . [t]he individual's right to request a local evidentiary hearing if one is available, or a State agency hearing." Defendant further violates U.S.C. § 1396a(a)(3) by violating the requirement of 42 C.F.R. § 435.905 that the agency must furnish information, electronically, on paper and orally as appropriate, to all applicants and other individuals who request it regarding the eligibility requirements and the rights and responsibilities of applicants and

beneficiaries, and such information must be provided in plain language and in a manner that is accessible and timely to individuals living with disabilities. Defendant further violates U.S.C. § 1396a(a)(3) by violating the requirement in 42 C.F.R. § 435.912(d) that "[t]he agency must inform applicants of the timeliness standards adopted in accordance with [§ 435.912(a)–(c)]." Defendant further violates § 1396a(a)(3) by failing to notify NOD recipients of the requirement in 42 C.F.R. § 435.916(a)(3)(iii) and section 1200-13-20-.09(1)(d)(11) of TennCare's rules that Defendant must reconsider in a timely manner the eligibility of an individual who is terminated for failure to submit the renewal form or necessary information, if the individual subsequently submits the renewal form within 90 days after the date of termination, or a longer period elected by the State, without requiring a new application. Defendant further violates § 1396a(a)(3) by violating the requirement in 42 C.F.R. § 431.231(c) that Defendant continue services where action is taken without adequate notice.

7. If you contend that Defendant violates the Medicaid Act by failing to explain why recipients do not qualify for each Medicaid category in the NODs, describe with particularity the specific provisions of the Medicaid Act that this practice violates.

RESPONSE:

Plaintiffs respond that Defendant's failure to explain why recipients do not qualify for each Medicaid category in its NODs violates 42 U.S.C. § 1396a(a)(3). Specifically, Defendant violates § 1396a(a)(3) by violating the requirement in 42 C.F.R. § 431.210(b) that any notice required under 42 C.F.R. § 431.206(c)(2)–(4) must contain "[a] clear statement of the specific reasons supporting the intended action." Defendant violates § 1396a(a)(3) by violating the requirement in 42 C.F.R. § 431.210(c) that any notice required under 42 C.F.R. § 431.206(c)(2)-(4) must contain "[t]he specific regulations that support, or the change in Federal or State law that requires, the action." Defendant further violates § 1396a(a)(3) by violating the requirement in 42 C.F.R. § 431.231(c) that Defendant continue services where action is taken without adequate notice. Defendant further violates U.S.C. § 1396a(a)(3) by violating the requirement of 42 C.F.R. § 435.905 that the agency must furnish information, electronically, on paper and orally as appropriate, to all applicants and other individuals who request it regarding the eligibility requirements and the rights and responsibilities of applicants and beneficiaries, and such information must be provided in plain language and in a manner that is accessible and timely to individuals living with disabilities. Defendant further violates § 1396a(a)(3) by violating the requirement in 42 C.F.R. § 431.231(c) that Defendant continue services where action is taken without adequate notice.

8. If you contend that Defendant violates the Medicaid Act by requiring members to describe the reasons they want to appeal and the facts supporting their appeal, describe with particularity the specific provisions of the Medicaid Act this practice violates.

RESPONSE:

The State violates the Medicaid Act, including 42 U.S.C. § 1396a(a)(3), by requiring members to describe the reasons they want to appeal and the facts supporting their appeal because the Medicaid Act and its implementing regulations do not require such information in order to receive a hearing. Under 42 U.S.C. § 1396a(a)(3), the State is required to provide for "granting an opportunity for a fair hearing before the State agency *to any individual* whose claim for medical assistance under the plan is denied or not acted upon with reasonable promptness." (emphasis added). Under the Medicaid Act, individuals are entitled to a hearing whether or not they provide reasons and facts supporting their appeal.

The Medicaid Act authorizes the Secretary of Health and Human Services to make and publish rules and regulations not inconsistent with the Medicaid Act "as may be necessary to the efficient administration" with his or her job duties. 42 U.S.C. § 1302(a). Under this authority, the Secretary of Health and Human Services has promulgated a rule stating that absent an automatic change to Federal or State law that adversely affects some or all members,

> [t]he State agency *must grant* an opportunity for a hearing to the following: *Any individual* who requests it because he or she believes the agency has taken an action erroneously, *denied his or her claim for eligibility or for covered benefits or services*, or issued a determination of an individual's liability, or has not acted upon the claim with reasonable promptness including, if applicable--- an initial or subsequent decision regarding eligibility[.]

42 C.F.R. § 431.220(a)(1) (emphasis added).

Absent an automatic change to federal or state law adversely affecting some or all members, TennCare is required to grant hearings to any individual who has his or her claim for eligibility or for covered benefits or services regardless of whether they have provided facts supporting their appeal or provided reasons for the appeal. Under 42 C.F.R. § 431.220(b), "[t]he agency need not grant a hearing if the sole issue is a Federal or State law requiring an automatic change adversely affecting some or all beneficiaries." Aside from this, the agency may deny or dismiss a request for a hearing only if "the applicant or beneficiary withdraws the request …(b) the applicant or beneficiary fails to appear at a scheduled hearing without good cause[,]" 42 C.F.R. § 431.223, and "may not limit or interfere with the applicant's or beneficiary's freedom to make a request for a hearing." 42 C.F.R. § 431.221(b). TennCare's requirement that members describe the reasons they want to appeal and the facts supporting their appeal violates 42 U.S.C. § 1396a(a)(3), including 42 C.F.R. §§ 431.220(a)(1) and 431.221(b).

Notices to enrollees that implement TennCare Rule 1200-13-13-.11 violate 42 U.S.C. § 1396a(a)(3) and its implementing regulations in 42 C.F.R. 42 C.F.R. § 431.206(c)(2)–(4) by misrepresenting enrollees' right to a hearing. By stating that hearings are only available to those who meet the Valid Factual Dispute Rule requirements, the notices also violate the requirement of 42 C.F.R. § 435.905 that the agency must furnish information, electronically, on paper and orally as appropriate, to all applicants and other individuals who request it regarding the rights and responsibilities of applicants and beneficiaries, and such information must be provided in plain language and in a manner that is accessible and timely to individuals living with disabilities.

Defendant further violates § 1396a(a)(3) by violating the requirement in 42 C.F.R. § 431.231(c) that Defendant continue services where action is taken without adequate notice.

9. If you contend that the State's Valid Factual Dispute Policy violates the Medicaid Act, describe with particularity the specific provisions of the Medicaid Act this policy violates.

RESPONSE:

Objection: Plaintiffs object to the definition of "Valid Factual Dispute Policy" as defined in the Interrogatory because it includes "mistaken application of fact to law," which is not referenced in TennCare's Valid Factual Dispute rule. *See* TennCare Rule 1200-13-13-.11. Without waiving this objection, the Plaintiffs submit as follows:

Under 42 U.S.C. § 1396a(a)(3), the State is required to provide for "granting an opportunity for a fair hearing before the State agency *to any individual* whose claim for medical assistance under the plan is denied or not acted upon with reasonable promptness." (emphasis added). The State violates 42 U.S.C. § 1396a(a)(3) by not providing a hearing to individuals whose claim for medical assistance under TennCare is denied or not acted upon with reasonable promptness and who have not been adversely affected by an automatic change adversely affecting some or all beneficiaries.

The Medicaid Act authorizes the Secretary of Health and Human Services to make and publish rules and regulations not inconsistent with the Medicaid Act "as may be necessary to the efficient administration" with his or her job duties. 42 U.S.C. § 1302(a). In implementing regulations for the Medicaid Act's fair hearing provision, 42 U.S.C. § 1396a(a)(3), the Secretary of Health and Human Services has promulgated regulations stating that:

> [t]he State agency must grant an opportunity for a hearing to the following: *Any individual who requests* it because he or she believes the agency has taken an action erroneously, *denied his or her claim*

> *for eligibility or for covered benefits or services*, or issued a determination of an individual's liability, or has not acted upon the claim with reasonable promptness including, if applicable--- an initial or subsequent decision regarding eligibility[.]

42 C.F.R. § 431.220(a)(1) (internal lettering omitted).

Under 42 C.F.R. § 431.220(b), "[t]he agency need not grant a hearing if the sole issue is a Federal or State law requiring an automatic change adversely affecting some or all beneficiaries." Aside from this exception, the agency may deny or dismiss a request for a hearing only if "the applicant or beneficiary withdraws the request …(b) the applicant or beneficiary fails to appear at a scheduled hearing without good cause[,]" 42 C.F.R. § 431.223, and "may not limit or interfere with the applicant's or beneficiary's freedom to make a request for a hearing," 42 C.F.R. § 431.221(b). TennCare's Valid Factual Dispute policy denies hearings outside of an automatic change based on Federal or State law and in cases where the individual has not withdrawn a request or failed to appear.

In addition, the State's Valid Factual Dispute Policy, as set forth in TennCare Rule 1200-13-13-.11, violates the Medicaid Act, including 42 U.S.C. § 1396a(a)(3) and its implementing regulations because it does not allow an individual a hearing to challenge an application of the individual's facts to law. Absent a circumstance described in 42 C.F.R. § 431.220(b), the Medicaid Act, 42 U.S.C. § 1302(a), and 42 C.F.R. § 431.220, require a hearing to challenge an application of the individual's facts to law. *See Rosen v. Goetz*, 410 F.3d 919, 926 (6th Cir. 2005).

Notices to enrollees that implement TennCare Rule 1200-13-13-.11 violate 42 U.S.C. § 1396a(a)(3) and its implementing regulations in 42 C.F.R. 42 C.F.R. § 431.206(c)(2)–(4) by misrepresenting enrollees' right to a hearing. By stating that hearings are only available to those who meet the Valid Factual Dispute Rule requirements, the notices also violate the requirement of 42 C.F.R. § 435.905 that the agency must furnish information, electronically, on paper and orally as appropriate, to all applicants and other individuals who request it regarding the rights and responsibilities of applicants and beneficiaries, and such information must be provided in plain language and in a manner that is accessible and timely to individuals living with disabilities.

Defendant further violates § 1396a(a)(3) by violating the requirement in 42 C.F.R. § 431.231(c) that Defendant continue services where action is taken without adequate notice.

10. If you contend that Defendant's prior use of language, in some NODs, telling recipients that they could only get a hearing if they thought TennCare made a "mistake about a fact" violated the Medicaid Act, describe with particularity the specific provisions of the Medicaid Act that language violated.

RESPONSE:

Defendant's use of language in NODs telling recipients that they could only get a hearing if they thought TennCare made a "mistake about a fact" violates 42 U.S.C. § 1396a(a)(3). Defendant is required to provide for "granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or not acted upon with reasonable promptness." 42 U.S.C. § 1396a(a)(3). The Medicaid Act authorizes the Secretary of Health and Human Services to make and publish rules and regulations not inconsistent with the Medicaid Act "as may be necessary to the efficient administration" with his or her job duties. 42 U.S.C. § 1302(a).

Implementing regulations for the Medicaid Act's fair hearing provision, 42 U.S.C. § 1396a(a)(3), require the state to provide procedural safeguards that "meet the due process standards set forth in *Goldberg v. Kelly*, 397 U.S. 254 (1970), and any additional standards specified in [the Medicaid regulations.]" 42 C.F.R. § 431.205(d). Constitutional due process requires that "that notice be reasonably calculated to inform the recipient of the action to be taken and an 'effective opportunity to be heard.'" *Hamby v. Neel*, 368 F.3d 549, 560 (6th Cir. 2004) (quoting *Goldberg*, 397 U.S. at 268). Notice under section 1396a(a)(3) "must include: (1) a statement of the actions being taken, (2) reasons for the intended actions, (3) specific regulations that support or require the intended action, and (4) an explanation of the right to a hearing, and under what circumstances Medicaid benefits will continue during the pendency of the requested hearing." *Crawley*, 2009 WL 1384147, at *26; *accord Boatman v. Hammons*, 164 F.3d 286, 288 (6th Cir. 1998); *Ability Ctr. of Greater Toledo v. Lumpkin*, 808 F. Supp. 2d 1003, 1027 (N.D. Ohio 2011); 42 C.F.R. §§ 431.210, 435.917(b)(2). Additionally, NODs must provide "adequate written notice of any decision." 42 C.F.R. § 435.917(a). Other implementing regulations provide that "[t]he agency may not limit or interfere with the applicant's or beneficiary's freedom to make a request for a hearing." 42 C.F.R. § 431.221(b).

For the reasons set forth in the Answer to Interrogatory 9, which is incorporated by reference, an individual's right to a hearing is not limited to those instances in which the individual can identify a "mistake about a fact." Saying otherwise in NODs violates 42 U.S.C. § 1396a(a)(3) and its implementing regulations including 42 C.F.R. §§ 431.205; 431.210, 431.221(b), 435.905, 435.917(a), and 435.917(b)(2). Defendant further violates § 1396a(a)(3) by violating the requirement in 42 C.F.R. § 431.231(c) that Defendant continue services where action is taken without adequate notice.

11. If you contend that Defendant's policy of declining to apply the Good Cause Exception or grant Good Cause Hearings based on allegations of non-receipt of a notice violates the Medicaid Act, describe with particularity the specific provisions of the Medicaid Act that policy violates.

RESPONSE:

Defendant's policy of declining to apply the Good Cause Exception or grant Good Cause Hearings based on allegations of non-receipt of a notice violates 42 U.S.C. § 1396a(a)(3). Defendant is required to provide for "granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or not acted upon with reasonable promptness." 42 U.S.C. § 1396a(a)(3). The Medicaid Act authorizes the Secretary of Health and Human Services to make and publish rules and regulations not inconsistent with the Medicaid Act "as may be necessary to the efficient administration" with his or her job duties. 42 U.S.C. § 1302(a).

Implementing regulations for the Medicaid Act's fair hearing provision, 42 U.S.C. § 1396a(a)(3), require the state to provide procedural safeguards that "meet the due process standards set forth in *Goldberg v. Kelly*, 397 U.S. 254 (1970), and any additional standards specified in [the Medicaid regulations.]" 42 C.F.R. § 431.205(d). Constitutional due process requires that "that notice be reasonably calculated to inform the recipient of the action to be taken and an 'effective opportunity to be heard.'" *Hamby v. Neel*, 368 F.3d 549, 560 (6th Cir. 2004) (quoting *Goldberg*, 397 U.S. at 268). Implementing regulations require the agency to provide "all applicants and beneficiaries with timely and adequate written notice of any decision affecting their eligibility," 42 C.F.R. § 435.917(a) along with their right to a fair hearing, 42 C.F.R. § 431.206(b)(1)–(4). Further, implementing regulations provide that "[t]he agency may not limit or interfere with the applicant's or beneficiary's freedom to make a request for a hearing." 42 C.F.R. § 431.221(b).

By declining to apply the Good Cause Exception or grant Good Cause Hearings based on allegations of non-receipt of a notice, Defendant interferes with an individual's right to a fair hearing in violation of 42 U.S.C. § 1396a(a)(3) and implementing regulations 42 C.F.R. §§ 431.205, 435.917(a), 431.206(b)(1)–(4), and 431.221(b). Defendant further violates § 1396a(a)(3) by violating the requirement in 42 C.F.R. § 431.231(c) that Defendant continue services where action is taken without adequate notice.

The Defendant's failure to inform enrollees of their right to request a hearing to establish that they meet the Good Cause Exception in TennCare Rule 1200-13-13-.11 based on allegations of non-receipt of a notice violates violate 42 U.S.C. § 1396a(a)(3) and its implementing regulations in 42 C.F.R. 42 C.F.R. § 431.206(c)(2)–(4) by omitting material and relevant information regarding enrollees' right to a hearing. The failure to inform enrollees also violates the requirement of 42 C.F.R. § 435.905 that the agency must furnish information, electronically, on paper and orally as appropriate, to all applicants and other individuals who request it regarding the rights and responsibilities of applicants and

beneficiaries, and such information must be provided in plain language and in a manner that is accessible and timely to individuals living with disabilities.

12. If you contend that Defendant does not consider all categories of eligibility before terminating enrollees' coverage, describe with particularity the specific enrollment categories that Defendant fails to consider and under what circumstances Defendant fails to consider those categories.

RESPONSE:

As detailed below, Plaintiffs contend that Defendant fails to reliably consider all categories of eligibility before terminating enrollees' coverage. Because terminations of individuals who would be eligible in these categories have largely been suspended during the public health emergency moratorium, Plaintiffs have been unable to confirm the current extent of these problems. Discovery is ongoing.

A. Plaintiffs contend that the Defendant fails to reliably consider all categories of eligibility before terminating TennCare coverage:

1) in circumstances where individuals fail to respond to TennCare's requests for information; or
2) in circumstances where TennCare fails to consider information or materials submitted by or on behalf of individuals to support their eligibility

In either set of circumstances, coverage is terminated without considering any category of potential eligibility. In these cases, all enrollment categories are implicated.

B. Plaintiffs contend that the Defendant fails to reliably consider eligibility in the Disabled Adult Child (DAC) eligibility category. The failure occurs:

1) when individuals first meet the eligibility criteria for that category; or
2) when individuals who have been DAC-eligible for Medicaid in other states move to Tennessee and apply for TennCare; or
3) when TennCare receives information that an individual has received an increase in income or has otherwise experienced a change in circumstances that requires a reverification of their eligibility for TennCare; or
4) when an individual comes up for periodic redetermination of eligibility.

C. Plaintiffs contend that the Defendant fails to reliably consider eligibility in the Disabled Widow/Widower eligibility category. The failure occurs:

1) when individuals first meet the eligibility criteria for that category; or

2) when individuals who have been eligible for Medicaid in other states as Disabled Widows or Widowers move to Tennessee and apply for TennCare; or
3) when TennCare receives information that an individual has received an increase in income or has otherwise experienced a change in circumstances that requires a reverification of their eligibility for TennCare; or
4) when an individual comes up for periodic redetermination of eligibility.

D. Plaintiffs contend that the Defendant fails to reliably consider eligibility in the Pickle Amendment category. The failure occurs:

1) when individuals first meet the eligibility criteria for that category; or
2) when individuals who have been eligible for Medicaid in other states under the Pickle Amendment move to Tennessee and apply for TennCare; or
3) when TennCare receives information that an individual has received an increase in income or has otherwise experienced a change in circumstances that requires a reverification of their eligibility for TennCare; or
4) when an individual comes up for periodic redetermination of eligibility.

E. Plaintiffs contend that the Defendant fails to reliably consider eligibility based on current receipt of Supplemental Security Income (SSI). This occurs if there is a miscommunication between the Social Security Administration and TennCare that results in a failure to register in a person's TEDS record that the person is currently eligible for SSI. In that circumstance, neither the Pre-term Questionnaire nor the scripts used by the TennCare Connect call center elicit from individuals the information that they are SSI eligible.

F. Plaintiffs contend that the Defendant fails to reliably consider eligibility based on current enrollment in the CHOICES program. This occurs:

1) when TennCare receives information that an individual has received an increase in income or has otherwise experienced a change in circumstances that requires a reverification of their eligibility for TennCare; OR
2) when an individual comes up for periodic redetermination of eligibility; AND
3) TennCare fails to cross match against its CHOICES enrollment files;
4) the Pre-term Questionnaire and TennCare Connect call center scripts do not elicit information from the individual regarding their current enrollment in the CHOICES program.

G. Plaintiffs contend that the Defendant fails to reliably consider eligibility based on current enrollment in the Employment and Community First (ECF) CHOICES program. This occurs:

1) when TennCare receives information that an individual has received an increase in income or has otherwise experienced a change in circumstances that requires a reverification of their eligibility for TennCare; OR
2) when an individual comes up for periodic redetermination of eligibility; AND
3) TennCare fails to cross match against its ECF CHOICES enrollment files;
4) the Pre-term Questionnaire and TennCare Connect call center scripts do not elicit information from the individual regarding their current enrollment in the ECF CHOICES program.

H. The Plaintiffs contend that the Defendant has failed to consider eligibility for the Transitional Medicaid category as acknowledged by Kim Hagan in her second declaration, ECF 63, p. 27, ¶ 35(f).

13. If you contend that Defendant violates the Medicaid Act by not providing hearings within 90 days of an appeal, describe with particularity the specific provisions of the Medicaid Act that policy violates.

RESPONSE:

Defendant's failure to provide hearings within 90 days of an appeal violates 42 U.S.C. § 1396a(a)(3). The Medicaid Act authorizes the Secretary of Health and Human Services to make and publish rules and regulations not inconsistent with the Medicaid Act "as may be necessary to the efficient administration" with his or her job duties. 42 U.S.C. § 1302(a). In implementing regulations for the Medicaid Act's fair hearing provision, 42 U.S.C. § 1396a(a)(3), the Secretary of Health and Human Services has promulgated regulations requiring the state agency "take final administrative action . . . within 90 days" from an appeal or a request for a fair hearing. 42 C.F.R. § 431.244(f)(1). The 90-day deadline applies "except in unusual circumstances," when the appellant "requests a delay or fails to take a required action" or "[t]here is an administrative or other emergency beyond the agency's control." 42 C.F.R. § 431.244(f)(4)(i). The reasons for "any delay" must be documented in the appellant's record. 42 C.F.R. § 431.244(f)(4)(ii).

Defendant violates § 1393a(a)(3), § 431.244(f)(1), and § 431.244(f)(4) by failing to provide hearings and take final administrative action within 90 days when the reasons for the delay are not documented or do not fall into one of two "unusual circumstances."

14. If you contend that Defendant lacks any system to grant requests for reasonable accommodations for disabled persons navigating TennCare, describe with particularity the specific requirements of an Americans with Disabilities Act compliant system you contend Defendant is lacking.

RESPONSE:

TennCare must have a system of effectively implementing its statements of compliance with the ADA. This system must include, but not be limited to the following factors, which Plaintiffs contend TennCare fails to provide:

a. Provision of reasonable notice to applicants and recipients with disabilities of their rights under the ADA to reasonable accommodations to assist with accessing and maintaining TennCare coverage.

b. A process to determine if an applicant and a recipient with a disability is in need of a reasonable accommodation to assist with accessing or maintaining TennCare coverage.

c. An accessible process through which applicants and recipients with disabilities may request reasonable accommodations, with assistance as necessary from TennCare, to help with accessing or maintaining TennCare coverage.

d. Uniform, consistent standards for granting or denying reasonable accommodation requests, including timelines for decisions and authority of staff to grant or deny.

e. A process for implementation of reasonable accommodation requests that are granted.

f. A process for implementation of reasonable accommodation requests that are granted and are identified as an ongoing needed accommodation.

g. Uniform, consistent standards for ending reasonable accommodations granted, including any procedures for notifying applicants and recipients with disabilities on the decision to discontinue a previously granted accommodation including the right to dispute that decision.

h. Uniform, consistent standards for ensuring the continuation of reasonable accommodations granted as warranted.

i. Provision of appropriate auxiliary aids and services to applicants and recipients with disabilities giving primary consideration to the applicant or beneficiary as to their preference, including but not limited to interpreters for people who are deaf or hard of hearing, and conversion of documents

into alternate formats for applicants and recipients who are blind or seriously visually impaired.

j. Uniform, consistent standards for resolving conflicts about requested accommodations, including but not limited to auxiliary aids and services, and the role of primary consideration or deference to applicant or beneficiary preference in such standards.

k. Provision of opportunities for applicants and recipients with disabilities to appeal alleged acts or omissions of TennCare that deny reasonable accommodations or otherwise subject individuals to discrimination based on disability.

l. Identification of an ADA coordinator to effectively, comprehensively, and with the resources to oversee and monitor TennCare's compliance with the ADA, including but not limited to monitoring of TennCare's capacity and implementation to meet the need for reasonable accommodations or to otherwise prevent discrimination against individuals on the basis of disability.

15. If you contend that Defendant violates the Americans with Disabilities Act by failing to provide adequate in person assistance, describe with particularity the specific provisions of the Americans with Disabilities Act Defendant has violated.

RESPONSE:

Plaintiffs incorporate their response to Interrogatory No. 14. In addition, TennCare staff must make an individualized assessment, interactively with each applicant or recipient with a disability, of the need for a reasonable accommodation, giving consideration to the requester's accommodation preference, if it is reasonable and available.

For the Responses to Interrogatories 1-3, the undersigned declare under penalty of perjury that the foregoing is true and correct.

Executed in LaFollette, Tennessee
Dated: December 21, 2022

/s/ C.M.H.
C.M.H. on behalf of S.F.A.

Executed in Cosby, Tennessee
Dated: December 19, 2022

/s/ Glenda Surrett
Glenda Surrett on behalf of Vivian Barnes

Executed in Russellville, Tennessee
Dated: December 14, 2022

/s/ Carlissa Caudill
Carlissa Caudill

Executed in Nashville, Tennessee Dated: December 16, 2022	*/s/ C.B.C.* C.B.C. on behalf of S.L.C.
Executed in Morristown, Tennessee Dated: December 15 2022	*/s/ Kimberly Noe* Kimberly Noe on behalf of Michael Hill
Executed in Dyersburg, Tennessee Dated: December 18, 2022	*/s/ William Monroe* William Monroe
Executed in Waynesboro, Tennessee Dated: December 16, 2022	*/s/ James Rebeaud* James Rebeaud on behalf of Linda Rebeaud
Executed in Old Hickory, Tennessee Dated: December 19, 2022	*/s/ Kerry Vaughn* Kerry Vaughn
Executed in Cowan, Tennessee Dated: December 15, 2022	*/s/ Johnny Walker* Johnny Walker

For Interrogatories 4-15, the undersigned declares under penalty of perjury that foregoing is true and correct.

Executed in Nashville, Tennessee Dated: December 22, 2022	*/s/ Brant Harrell* Brant Harrell
Signed as to Objections: Dated: December 22, 2022	*/s/ Brant Harrell* Brant Harrell

Requests for Production

1. For each Class Representative of the Disability Subclass, produce documents sufficient to show each disability they allege that they have.

RESPONSE:

Plaintiffs object to the extent that the request suggests that each Disability Subclass Class Representative has to affirmatively prove each disability in order to be subject to the protections of the Americans with Disabilities Act, which is to be broadly construed and should not demand extensive analysis into the question of whether an individual's impairment is a disability. *See* 28 C.F.R. § 35.108(a)(2)(i), (d)(1)(ii), (e)(2).

Plaintiffs object to the extent that the request seeks documents that only it, its contractors, or third parties possess. Plaintiffs submit that TennCare has notice of an individual's disability(ies) based on eligibility categories that involve a disability (e.g. Disabled Adult Child), based on internal documentation or information

provided by Plaintiffs during the application, renewal, termination, or redetermination processes, or from claims or other information showing the person's diagnoses, treatment, and/or services being received. Every prescription, medical evaluation, therapy, or other clinical encounter for the Subclass is documented in a uniform billing form submitted to the managed care organization (MCO) identifying the enrollee, their diagnoses, and treatments. This billing information is submitted to TennCare within weeks of the encounter and must meet rigorous standards of completeness. TennCare could, if it chose to do so, run a search, or direct its MCOs to run a search, to find enrollees with certain diagnoses, or who are receiving medications, for example, that are for mental conditions that are typically associated with impaired cognition. TennCare also has access to information about services for the blind, deaf, hard of hearing, other state services, or accommodations granted by the MCO that it could draw upon.

Plaintiffs have not withheld any documents based on these objections.

Plaintiffs intend to produce any records in searchable Adobe PDF format with bates stamps that identify the specific Disability Subclass member.

Plaintiffs have not produced responsive records contained in Defendant's production that are identified using a bates stamp prefix: "TC-AMC."

Subject to the above, Plaintiffs submit the following:

Plaintiff Skai Anders: Plaintiffs are seeking medical and other records that are responsive to this request from health care providers, clinics, or third parties. If and when Plaintiffs receive responsive documents from these efforts, they will supplement production sufficiently in advance of any court deadline or deposition of the Subclass Representative or next friend.

In addition, Plaintiff Anders contends that Defendant already has in its possession documents that are responsive to this request. For example, Defendant has produced the following documents: TC-AMC-0000000626, TC-AMC-0000000627, TC-AMC-0000000631, TC-AMC-0000000637, and TC-AMC-0000000635.

Plaintiff Vivian Barnes: Plaintiffs are seeking medical and other records that are responsive to this request from health care providers, clinics, or third parties. If and when Plaintiffs receive responsive documents from these efforts, they will supplement production sufficiently in advance of any court deadline or deposition of the Subclass Representative or next friend.

In addition, Plaintiff Barnes contends that Defendant already has in its possession documents that are responsive to this request. For example, Defendant has produced the following documents: TC-AMC-000000971, TC-AMC-0000000641, TC-AMC-00000972, TC-AMC-00000970, TC-AMC-00000977, TC-AMC-00000975, TC-AMC-000000660 through 61.

Plaintiff Carlissa Caudill: Plaintiffs are seeking medical and other records that are responsive to this request from health care providers, clinics, or third parties. If and when Plaintiffs receive responsive documents from these efforts, they will supplement production sufficiently in advance of any court deadline or deposition of the Subclass Representative or next friend.

Plaintiff Caudill submits the following responsive documents: AMC-DS-CC-00001 through 00048.

In addition, Plaintiff Caudill contends that Defendant already has in its possession documents that are responsive to this request. For example, Defendant has produced the following documents: TC-AMC-0000001616, TC-AMC-0000001615, TC-AMC-0000001610, TC-AMC-0000001613, TC-AMC-0000001474, TC-AMC-0000001602 through 0000001607, TC-AMC-0000001608, TC-AMC-0000042084, TC-AMC-0000170913.

Plaintiff S.L.C.: Plaintiffs are seeking medical and other records that are responsive to this request from health care providers, clinics, or third parties. If and when Plaintiffs receive responsive documents from these efforts, they will supplement production sufficiently in advance of any court deadline or deposition of the Subclass Representative or next friend.

Plaintiff S.L.C. submits the following responsive documents:
AMC-DS-SLC-00001 through 00037.

In addition, Plaintiff S.L.C. contends that Defendant already has in its possession documents that are responsive to this request. For example, Defendant has produced the following documents: TC-AMC-0000001886 through 0000001898, TC-AMC-0000001920 through 0000001921, TC-AMC-0000001899 through 0000001916, TC-AMC-0000002031, TC-AMC-0000002008, TC-AMC-0000001984, TC-AMC-0000002060, TC-AMC-0000002065, TC-AMC-0000002064, TC-AMC-0000002063, TC-AMC-0000002066, TC-AMC-0000042186, TC-AMC-0000046038, TC-AMC-0000046041, TC-AMC-0000046043, TC-AMC-0000170916, TC-AMC-0000170917, TC-AMC-0000170918, TC-AMC-0000046110.

Plaintiff Charles Fultz: Plaintiff Charles Fultz died on June 17, 2020. Plaintiffs have filed a suggestion of death on the record. (ECF 78.)

Plaintiff Michael Hill: Plaintiffs are seeking medical and other records that are responsive to this request from health care providers, clinics, or third parties. If and when Plaintiffs receive responsive documents from these efforts, they will supplement production sufficiently in advance of any court deadline or deposition of the Subclass Representative or next friend.

Plaintiff Hill submits the following responsive documents: AMC-DS-MH-00001 through -00008.

In addition, Plaintiff Hill contends that Defendant already has in its possession documents that are responsive to this request. For example, Defendant has produced the following documents: TC-AMC-0000002784, TC-AMC-0000002785, TC-AMC-0000002792, and TC-AMC-0000002794.

Plaintiff William Monroe: Plaintiffs are seeking medical and other records that are responsive to this request from health care providers, clinics, or third parties. If and when Plaintiffs receive responsive documents from these efforts, they will supplement production sufficiently in advance of any court deadline or deposition of the Subclass Representative or next friend.

Plaintiff Monroe produces the following documents responsive to this request: AMC-DS-WM-00002, AMC-DS-WM-00007 through -28.

In addition, Plaintiff Monroe contends that Defendant has in its possession documents that are responsive to this request. For example, Defendant has produced the following documents: TC-AMC-0000003721, TC-AMC-0000042571, TC-AMC-000003724, TC-AMC-0000004257, TC-AMC-000003456.

Plaintiff Linda Rebeaud: Plaintiffs are seeking medical and other records that are responsive to this request from health care providers, clinics, or third parties. If and when Plaintiffs receive responsive documents from these efforts, they will supplement production sufficiently in advance of any court deadline or deposition of the Subclass Representative or next friend.

Plaintiff Rebeaud submits the following responsive documents: AMC-DS-LR-00001 through -34.

In addition, Plaintiff Rebeaud contends that Defendant already has in its possession documents that are responsive to this request. For example, Defendant has produced the following document: TC-AMC-0000003801.

Plaintiff Kerry Vaughn: Plaintiffs are seeking medical and other records that are responsive to this request from health care providers, clinics, or third parties. If and when Plaintiffs receive responsive documents from these efforts, they will supplement production sufficiently in advance of any court deadline or deposition of the Subclass Representative or next friend.

In addition, Plaintiff Vaughn contends that Defendant already has in its possession documents that are responsive to this request. For example, Defendant has produced the following documents: TC-AMC-0000008027, TC-AMC-0000008028, TC-AMC-0000007800 through TC-AMC-0000007803, TC-AMC-0000007814, TC-

AMC-0000007815, TC-AMC-0000007811, TC-AMC-0000007844, TC-AMC-0000007889, TC-AMC-0000007747, TC-AMC-0000042934, TC-AMC-0000042949.

Plaintiff Johnny Walker: Plaintiffs are seeking medical and other records that are responsive to this request from health care providers, clinics, or third parties. If and when Plaintiffs receive responsive documents from these efforts, they will supplement production sufficiently in advance of any court deadline or deposition of the Subclass Representative or next friend.

Plaintiff Walker submits the following responsive documents: AMC-DS-JW-00001 through -02.

In addition, Plaintiff Walker contends that Defendant already has in its possession documents that are responsive to this request. For example, Defendant has produced the following documents: TC-AMC-0000008234 through -35, TC-AMC-000008222.

2. For each Class Representative of the Disability Subclass, produce all documents relating to any request they have made for a reasonable accommodation from TennCare.

RESPONSE:

Plaintiffs do not interpret this request for production as seeking documents protected by the attorney-client privilege, work product doctrine, or common interest doctrine. To the extent that Defendant interprets this request as seeking such documents, Plaintiffs object on the basis of the attorney-client privilege, work product doctrine, or common interest doctrine.

Plaintiffs intend to produce any records in searchable Adobe PDF format with bates stamps that identify the specific Disability Subclass member.

Plaintiffs have not produced responsive records contained in Defendant's production that are identified using a bates stamp prefix: "TC-AMC."

Plaintiffs submit that TennCare has notice of an individual's disability(ies) based on eligibility categories that involve a disability (e.g. Disabled Adult Child), based on internal documentation or information provided by Plaintiffs during the application, renewal, termination, or redetermination processes, or from claims or other information showing the person's diagnoses, treatment, and/or services being received. Every prescription, medical evaluation, therapy, or other clinical encounter for the Subclass is documented in a uniform billing form submitted to the MCO identifying the enrollee, their diagnoses, and treatments. This billing information is submitted to TennCare within weeks of the encounter and must meet rigorous standards of completeness. TennCare could, if it chose to do so, run a search, or direct its MCOs to run a search, to find enrollees with certain diagnoses,

or who are receiving medications, for example, that are for mental conditions that are typically associated with impaired cognition. TennCare also has access to information about services for the blind, deaf, hard of hearing, other state services, or accommodations granted by the MCO that it could draw upon. Additionally, Plaintiffs contend that because of TennCare's deficient notices, most Subclass members did not know that they had a right to a reasonable accommodation under the ADA. Specifically, and subject to the above, the Class Representatives for the Disability Subclass submit the following:

Plaintiff S.F.A.: Plaintiff S.F.A. does not have additional documents to produce that are responsive to this request. Plaintiff S.F.A.'s disability should be evident to TennCare based on S.F.A.'s category of eligibility, claims information, or other communication with TennCare. Plaintiff S.F.A. has not formally stated to a TennCare representative that they request reasonable accommodation (or an equivalent phrase) and is not known to have received any reasonable accommodation from TennCare. Plaintiff S.F.A.'s next friends and other helpers have had difficulty accessing, understanding, or navigating the program and have had to make at least 15 calls to TennCare for assistance.

Plaintiff Vivian Barnes: Plaintiff Barnes does not have additional documents to produce that are responsive to this request. Plaintiff Barnes's disability should be evident to TennCare based on her category of eligibility, claims information, or other communication with TennCare. Plaintiff Barnes has not formally stated to a TennCare representative that they request reasonable accommodation (or an equivalent phrase) and is not known to have received any reasonable accommodation from TennCare. Plaintiff Barnes's next friends and other helpers have had difficulty accessing, understanding, or navigating the program and have had to make numerous calls to TennCare for assistance.

Plaintiff Carlissa Caudill: Plaintiff Caudill does not have additional documents to produce that are responsive to this request. Plaintiff Caudill's disability should be evident to TennCare based on her category of eligibility, claims information, or other communication with TennCare. Plaintiff Caudill has not formally stated to a TennCare representative that she requests reasonable accommodation (or an equivalent phrase) and is not known to have received any reasonable accommodation from TennCare. Plaintiff Caudill or others have had difficulty accessing, understanding, or navigating the program and have had to make at least 10 calls to TennCare for assistance.

Plaintiff S.L.C.: Plaintiff S.L.C. does not have additional documents to produce. Plaintiff S.L.C.'s disability should be evident to TennCare based on S.L.C.'s category of eligibility, claims information, or other communication with TennCare. Plaintiff S.L.C. has not formally stated to a TennCare representative that she requests reasonable accommodation (or an equivalent phrase) and is not known to have received any reasonable accommodation from TennCare. Plaintiff S.L.C's

next friends or others have had difficulty accessing, understanding, or navigating the program and have had to make at least 6 calls to TennCare for assistance.

Plaintiff S.L.C. submits that Defendant possesses responsive documents to this request. For example, these documents include:TC-AMC-000002061; TC-AMC-000002066.

Plaintiff Charles Fultz: Plaintiff Charles Fultz died on June 17, 2020. Plaintiffs have filed a suggestion of death on the record. (ECF 78.)

Plaintiff Michael Hill: Plaintiff Hill does not have additional documents to produce that are responsive to this request. Plaintiff Hill's disability should be evident to TennCare based on his category of eligibility, claims information, or other communication with TennCare. Plaintiff Hill has not formally stated to a TennCare representative that he requests reasonable accommodation (or an equivalent phrase) and is not known to have received any reasonable accommodations from TennCare. Plaintiff Hill's next friends or others have had difficulty accessing, understanding, or navigating the program and have had to make at least 12 calls to TennCare for assistance.

Plaintiff William Monroe: Plaintiff Monroe's disability should be evident to TennCare based on his category of eligibility, claims information, or other communication with TennCare.

Plaintiff Monroe produces the following responsive document: AMC-DS-WM-00002.

Plaintiff Monroe contends that Defendant has in its possession documents that are responsive to this request. For example, Defendant has produced the following documents: TC-AMC-0000003721; TC-AMC-0000042571; TC-AMC-000003724; TC-AMC-0000004257.

Plaintiff Linda Rebeaud: Plaintiff Rebeaud does not have any additional documents to produce that are responsive to this request. Plaintiff Rebeaud's disability should be evident to TennCare based on her claims information or other communication with TennCare. Plaintiff Rebeaud has not formally stated to a TennCare representative that they request reasonable accommodation (or an equivalent phrase) and is not known to have received any reasonable accommodations from TennCare.

Plaintiff Kerry Vaughn: Plaintiff Vaughn does not have additional documents to produce that are responsive to this request. Plaintiff Vaughn's disability should be evident to TennCare based on her category of eligibility, claims information, or other communication with TennCare. Plaintiff Vaughn has not formally stated to a TennCare representative that she requests reasonable accommodation (or an equivalent phrase) and is not known to have received any reasonable

accommodations from TennCare. Plaintiff Vaughn or others have had difficulty accessing, understanding, or navigating the program and have had to make at least 6 calls to TennCare for assistance.

Plaintiff Johnny Walker: Plaintiff Walker's disability should be evident to TennCare based on his eligibility category, claims information, or other communication with TennCare. Plaintiff Walker is on SSI and has a limited fixed income.

Plaintiff Walker contends that Defendant has in its possession documents that are responsive to this request. For example, Defendant has produced the following documents: TC-AMC-0000008234 through -35, TC-AMC-000008222.

3. For each Class Representative of the Disability Subclass, produce all documents relating to any reasonable accommodation they have received from TennCare.

RESPONSE:

Plaintiffs do not interpret this request for production as seeking documents protected by the attorney-client privilege, work product doctrine, or common interest doctrine. To the extent that Defendant interprets this request as seeking such documents, Plaintiffs object on the basis of the attorney-client privilege, work product doctrine, or common interest doctrine.

Plaintiffs intend to produce any records in searchable Adobe PDF format with bates stamps that identify the specific Disability Subclass member.

Plaintiffs have not produced responsive records contained in Defendant's production that are identified using a bates stamp prefix: "TC-AMC."

Subject to the above, Plaintiffs submit the following:

Plaintiff S.F.A.: Plaintiff S.F.A. has not identified any responsive documents.

Plaintiff Vivian Barnes: Plaintiff Barnes has not identified any responsive documents.

Plaintiff Carlissa Caudill: Plaintiff Caudill has not identified any responsive documents.

Plaintiff S.L.C.: Plaintiff S.L.C. has not identified any responsive documents.

Plaintiff Charles Fultz: Plaintiff Charles Fultz died on June 17, 2020. Plaintiffs have filed a suggestion of death on the record. (ECF 78.)

Plaintiff Michael Hill: Plaintiff Hill has not identified any responsive documents.

Plaintiff William Monroe: Plaintiff Monroe submits the following document: AMC-DS-WM-00005. Plaintiff Monroe contends that Defendant has in its possession documents that are responsive to this request. For example, Defendant has produced the following document: TC-AMC-000003713, TC-AMC-0000003721, TC-AMC-0000003726. Plaintiff Monroe has not identified any other responsive documents.

Plaintiff Linda Rebeaud: Plaintiff Rebeaud has not identified any responsive documents.

Plaintiff Kerry Vaughn: Plaintiff Vaughn has not identified any responsive documents.

Plaintiff Johnny Walker: Plaintiff Walker has not identified any responsive documents.

Respectfully submitted,

Dated: December 22, 2022

By: /s/ *Brant Harrell*

Michele Johnson TN BPR 16756
Gordon Bonnyman, Jr. TN BPR 2419
Vanessa Zapata, TN BPR 37873
Brant Harrell, TN BPR 24470
Madeline Wiseman, TN BPR 39003
TENNESSEE JUSTICE CENTER
211 7th Avenue North, Suite 100
Nashville, Tennessee 37219
Phone: (615) 255-0331
Fax: (615) 255-0354
gbonnyman@tnjustice.org
vzapata@tnjustice.org
bharrell@tnjustice.org
mwiseman@tnjustice.org

Jane Perkins (*pro hac vice*)
Elizabeth Edwards (*pro hac vice)*
Sarah Grusin (*pro hac vice*)
NATIONAL HEALTH LAW PROGRAM
1512 E. Franklin St., Ste. 110
Chapel Hill, NC 27514
Phone: (919) 968-6308
perkins@healthlaw.org
edwards@healthlaw.org
grusin@healthlaw.org

Gregory Lee Bass (*pro hac vice*)
NATIONAL CENTER FOR LAW AND ECONOMIC JUSTICE
275 Seventh Avenue, Suite 1506
New York, NY 10001
Phone: (212) 633-6967
bass@nclej.org

Faith Gay (*pro hac vice*)
Jennifer M. Selendy (*pro hac vice*)
Andrew R. Dunlap (*pro hac vice*)
Amy Nemetz (*pro hac vice*)
Babak Ghafarzade (*pro hac vice*)
David Coon (*pro hac vice*)
Bret Matera (*pro hac vice*)
SELENDY GAY ELSBERG PLLC
1290 Avenue of the Americas
New York, NY 10104
Phone: (212) 390-9000
fgay@selendygay.com
jselendy@selendygay.com
adunlap@selendygay.com
anemetz@selendygay.com
bghafarzade@selendygay.com
dcoonselendygay.com
bmatera@selendygay.com
Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing document has been served via electronic mail on this 22nd day of December, 2022 on the following individuals:

Meredith W. Bowen, Assistant Attorney General
Matthew P. Dykstra, Assistant Attorney General
OFFICE OF THE ATTORNEY GENERAL
P.O. Box 20207
Nashville, TN 37202
meredith.bowen@ag.tn.gov
matthew.dykstra@ag.tn.gov

Michael Kirk
Nicole Moss
Harold S. Reeves
William V. Bergstrom
COOPER & KIRK, PLLC
1523 New Hampshire Avenue, NW
Washington, D.C. 20036
mkirk@cooperkirk.com
nmoss@cooperkirk.com
hreeves@cooperkirk.com
wbergstrom@cooperkirk.com

/s/ Brant Harrell
On Behalf of Counsel for Plaintiffs