United States District Court; M.D. Tennessee, Nashville Division
Cluster Daniels et al.
v.
Tennessee Department of Health and Environment et al.
No. 79-3107

February 20, 1985

NIXON, District Judge
*1 Pending is a class action seeking declaratory and injunctive relief from certain policies and practices of the defendants, the Tennessee Department of Health and Environment and its Commissioner, James Word, and the Tennessee Department of Human Services and its Commissioner, Sammie Lynn Pruett. The plaintiff class of Medicaid recipients alleges that the defendants have deprived them of certain transportation services and due process rights to which they claim entitlement under federal law. Jurisdiction is conferred on this Court by 28 U.S.C. § § 1331 and 1343. This matter is presently before the Court on three motions of the plaintiffs. For the reasons that follow, the plaintiffs' motion for a permanent injunction with regard to transportation services will be GRANTED in part and DENIED in part; the plaintiffs' motion for partial summary judgment concerning the claim for redetermination of Medicaid eligibility upon termination of Social Security Insurance (SSI) or Aid to Families with Dependent Children (AFDC) will be GRANTED; and, the plaintiffs' motion for partial summary judgment as to the right to notice and a hearing prior to Medicaid denial of a provider claim will be DENIED with leave to file a similar motion within thirty days of entry of this Memorandum and Order.

The named plaintiffs include one of the original plaintiffs, Cluster Daniels, and a number of intervenors. The Court has certified two subclasses of plaintiffs: first, Tennessee Medicaid recipients whose necessary use of ambulance or other transportation to and from providers of necessary medical services is neither compensated nor assured by the Medicaid program; and, second, Tennessee Medicaid recipients, including persons who have been Medicaid recipients at any time during pendancy of this action, who have not been notified when claims for Medicaid payments filed by providers have been denied, or have not been notified of the reasons for final denial of payment, or have not been notified of them fair hearing rights.

The first plaintiff subclass claims that the defendants have failed to provide adequate assurance of transportation to and from necessary medical care in violation of the Medicaid provisions of the Social Security Act and its implementing regulations, 42 U.S.C. § § 1302, 1396, *et seq.*, 45 C.F.R. § 431.53, the Supremacy Clause of Article VI of the United States Constitution, the Equal Protection Clause of the Fourteenth Amendment, and provisions of the Tennessee Medicaid plan. As a result of these alleged violations, the plaintiffs allegedly have been unable to obtain adequate transportation to and from medical treatment or have been denied Medicaid coverage of transportation they arranged.

The plaintiff Cluster Daniels, for example, is a recipient of Social Security Insurance and Medicaid benefits who allegedly suffers from severe bilateral thrombophlebitis, a condition requiring assistance for safe transportation to her physician or the hospital. She claims that she has outstanding ambulance bills as a result of the defendants' failure to provide coverage for adequate transportation for treatment of her condition. Plaintiff Donna Owens, a recipient of Medicaid services related to her pregnancy, required transportation at the time of her intervention in this action to the next county for prenatal care. Although she owns

© 2006 Thomson/West. No Claim to Orig. U.S. Govt. Works.

a car, she allegedly cannot afford to purchase gasoline. Plaintiff Ollie Johnson, who is a paraplegic and confined to a wheelchair, has allegedly been forced to discontinue physical therapy and skills training because of the lack of safe, regular transportation.

*2 Subsequent to the filing of the pending motions for partial summary judgment, the case was set for trial. Prior to trial, however, the parties entered an Agreed Order, pursuant to which, *inter alia,* the defendants submitted to the Court a new transportation assurance plan as required under 42 C.F.R. § 431.53. The Agreed Order also provided for an opportunity for the plaintiffs to respond to the defendants' proposal. The Court held, in place of the trial, a hearing on the defendants' proposed transportation plan on May 19, 1983. Opposing the proposed plan, the plaintiffs filed the pending motion for a permanent injunction and, at the Court's direction, submitted a counterproposal. A hearing on the plaintiffs' proposal was held on June 30, 1983.

I.

The first issue, accordingly is whether the defendants' proposed plan for assuring medical transportation for the needy comports with the requirements of federal law. Under Title XIX of the Social Security Act, 42 U.S.C. § 1936, *et seq.*, participating states may obtain matching federal funds to extend needed medical and financial assistance to certain categories of persons. The Act provides that in order to obtain these matching funds the state must formulate a "state plan" for the administration of various programs. This plan must be in conformity with the Social Security Act and the regulations promulgated thereunder by the Department of Health and Human Services (HHS), which administers the Medicaid program on the federal level. The requirement that state Medicaid programs "assure transportation" derives from one such regulation, now contained in 42 C.F.R. § 431.53 (1983):
§ 431.53 Assurance of transportation
A State plan must-
(a) Specify that the Medicaid agency will assure necessary transportation for recipients to and from providers; and
(b) Describe the methods that will be used to meet this requirement.

The Secretary of HHS has interpreted the application of the transportation assurance regulation, which has the force of law, [FN1] in the *Medical Assistance Manual* (MAM). According to the MAM, the transportation requirement is an integral component of a statutory scheme whose aim is to further the federal government's commitment to ensure adequate medical care for the needy. In the MAM, the Secretary points out that "the Medicaid program has, from the beginning (1966), encouraged States to arrange for transportation for recipients to and from necessary medical care." MAM § 6-20-00, at 2 (May 30, 1978). The regulation requiring the assurance of transportation is "based on the recognition, from past program operation experience, that unless needy individuals can actually get to and from providers of services, the entire goal of a State Medicaid program is inhibited at the start," *Id.* See *Smith v. Vowell,* 379 F.Supp. at 150-52 (discussing history and purpose of transportation assurance regulations).

FN1 Properly promulgated, substantive agency regulations have the "force and effect of law." *Chrysler Corp. v. Brown,* 441 U.S. 280, 295-296, 99 S.Ct 1705 (1979). See *Smith v. Vowell,* 379 F.Supp. 139, 148 (W.D. Tex.), aff'd, 504 F.2d 759 (5th Cir. 1974) ("there can be no question as to the authority of the regulations promulgated" by the agency regarding administration of the Medicaid program).

*3 Thus, although transportation is not mentioned in the Act itself as a Congressionally mandated service, the assurance of necessary medical transportation is nonetheless an administrative requirement having the same force and effect as the

© 2006 Thomson/West. No Claim to Orig. U.S. Govt. Works.

statutory provisions. *King v. Smith*, 392 U.S. at 317; *Smith v. Vowell*, 379 F.Supp. at 152; 42 U.S.C. § 1302 (authorizing the Secretary of HHS to make and publish such rules and regulations as are necessary to assure efficient administration of the Department's function). In addition to meeting this requirement, a state may elect to include transportation services as an option offered to recipients by permitting providers of transportation to participate in the Medicaid program as do providers of medical care. See MAM § 6-20-00, at 5. The State of Tennessee has elected to offer such an optional transportation service only with respect to ambulance service. The administrative requirement to provide transportation assurance, on the other hand, is not elective but is a mandatory duty of the State. The State has extremely wide latitude in developing the methods for meeting this requirement; however, the means chosen must assure adequate transportation to and from medical providers.

In meeting the transportation assurance requirement, the State also has a duty to hold costs to a minimum. According to the MAM § 6-20-00, at 12:
States have an obligation to assure that:
-transportation will be available for recipients to and from medical care;
-payment is made only where transportation is not otherwise available;
-payment is made for the least expensive available means suitable to the recipient's medical needs; and,
-transportation is available only to get individuals to qualified providers of their choice who are generally available and used by other residents of the community.

In objecting to the defendants' proposed transportation plan, the plaintiffs tend to overlook this additional obligation to assure that the transportation provided is absolutely necessary and is the least expensive, available mode of adequate transportation. The MAM allows the State considerable flexibility in choosing the particular means by which the transportation requirement will be met. A plan based upon arrangements made by the state with volunteer groups, for example, is expressly condoned as meeting both the obligations to assure adequate transportation and to minimize costs. MAM § 6-20-00, at 4. Such a plan, calling for a network of volunteers state-wide, has been proposed by the defendants.

The defendants' proposed plan would change the current arrangement, which has existed since 1973 or 1974, in several important respects. According to the testimony of the Assistant Commissioner for Family Assistance of the Department of Human Services, (DHS) there has been no structured, uniform system throughout the State for handling transportation needs among Medicaid recipients. Transcript of proceeding, May 19, 1983, at 38 (hereinafter ""Tr."). Instead, social workers in local Human Services offices in each of the more than 90 Tennessee counties have adopted varying practices, either referring recipient to other social agencies or seeking a volunteer. No systematized transportation program existed, no funds have been available for meeting these needs, and no formal records relating to such assistance have been kept. (Tr. 46, 66-67). Indeed, there has been no formal requirement that transportation services be provided in all circumstances.

*4 The proposed transportation plan of the defendants offers substantial reforms of these practices. The defendants have drafted a "Handbook for Coordinating Transportation Services" which describes a systematic, uniform method to be employed by case workers in each county office upon receiving a request for transportation assistance. The proposed plan would utilize special forms for use in screening requests and for keeping records of services requested and provided. A back-up mechanism would be available to the county case worker in the event that transportation assistance could not be arranged on the local level: the case worker could draw upon the assistance of the Medicaid division of the Department of Health and Environment in Nashville using a toll free number. (Tr. 38, 82). Further, each regional and county welfare director would receive detailed training on the implementation of the new program with follow-up supervision to insure the workability of the system. (Tr. 62-64).

© 2006 Thomson/West. No Claim to Orig. U.S. Govt. Works.

In addition to the establishment of this formalized structure for meeting the transportation needs of Medicaid recipients, the proposed plan includes, as a crucial component, provision for payment of volunteers. The county case worker would be able to offer reimbursement at twenty cents per mile, thus enhancing the availability of volunteers. In sum, the proposed plan, properly implemented, would remove transportation assistance services from the broad, unstructured category of general assistance and establish instead a systematic program to provide this specific service utilizing a network of paid volunteers. (Tr. 52-54).

The plaintiffs, however, have a very different sort of plan in mind. Their counterproposal calls for a complete restructuring of the state's program, including transferring the function of providing transportation assistance from the Department of Human Services to the Department of Health and Environment. They argue that DHS is overburdened and, having failed to provide adequate transportation assistance in the past, is likely to fail again. The plaintiffs also call for, among other things, a determination of eligibility for transportation assistance based upon "actual need," including, for example, an assessment of whether the recipient can afford bus fare or gasoline for a serviceable automobile. In addition, objecting to the defendants' reliance upon volunteers, plaintiffs propose the institution of cash payments or a ""voucher" or "token" system to cover the cost of the recipient's use of available public transportation and gas purchases.

In determining whether the defendants' proposed transportation plan is legally sufficient, despite plaintiffs' objections, this Court has had little legal precedent to provide guidance. In *Fant v. Stumbo*, 552 F.Supp. 617 (W.D. Ky. 1982), the Court held that Kentucky's plan, which limited recipients to four trips to medical providers per month, did not comply with federal regulations. In *Smith v. Vowell*, 379 F.Supp at 159, the Court held that Texas had violated the federal mandate, rejecting its argument that the transportation assurance regulation is not binding upon participating states:
*5 This Court holds as a matter of law that the state medical assistance plan under Title XIX must contain within its four corners: (a) a guarantee of necessary medical transportation for eligible welfare recipients and (b) a general description of the various methods to be used . . . . Of Course, we recognize as the "Program Regulation Guide" [MAM] points out, the state does not have to "stipulate in advance" every possible mode of transportation since the situation will necessarily differ with each individual. Nevertheless, the command of the language is unmistakeable- there must be some inclusive description of the primary modes of transportation that can reasonably be contemplated to be utilized.

The defendants in the case at bar concede their duty to provide such a ""guarantee" and "description of the various methods to be used." *Id.* See State Defendants' Supplemental Memorandum at 8. As they correctly point out, however, neither the *Smith* Court nor the federal regulations nor the MAM attempts to dictate the use or discuss the efficacy of one particular type of transportation program as opposed to another. That choice, within the bounds of reason, is left to the state. [FN2]

FN2 The plaintiffs place considerable reliance upon the unreported decision in *Pitts v. Stewart*, No. 75-292, consent judgment at 3 ¶ 17(b) (E.D. La. April 16, 1979), as containing "certain minimal standards for Medicaid transportation". Plaintiffs' Supplemental Memorandum in Support of Motion for Permanent Injunctive Relief, at 3. The State of Louisiana did indeed enter into an agreement to implement a more far reaching transportation plan than that proposed by the State of Tennessee. The *Pitts* consent judgment cannot, however, be set up as establishing minimal standards binding upon any other state. Nor does the development of a plan by the State of Maryland, to which plaintiffs refer, *id.* at 7-8, utilizing the option of entering into prepaid transportation provider contracts, compel the State of Tennessee to exercise such an option if Tennessee is able to fulfill the transportation assurance requirement through other means.

© 2006 Thomson/West. No Claim to Orig. U.S. Govt. Works.

After careful consideration, this Court has concluded that the defendants' proposed plan, at least in its overall scheme, conforms with the requirements of federal law. In certain specific points, as will be discussed, the plaintiffs are correct in challenging the proposed plan and the defendants will be required to alter their proposal in those respects. As to the basic structure of the proposal, however, the Court is of the opinion that the defendants have satisfied the transportation assurance requirement and, therefore, neither the preferences of the plaintiffs nor those of the Court should be substituted for the discretion of the State of Tennessee.

Moreover, the defendants assert that they considered the adoption of a program such as the plaintiffs propose, which would provide, through a token or voucher system, all public bus transportation and taxis, and direct cash payments to recipients who own their own cars. The defendants persuasively argue, however, that the plaintiffs' proposal contains no standard for determining who cannot afford bus or taxi fare or gasoline for their automobiles and, as the Assistant Commissioner for Family Assistance testified, it would be virtually impossible to make such determinations. (Tr. 57-60). Another problem would be ensuring that money, tokens or vouchers were in fact used by the recipient for medical transportation. Unless standards for eligibility and safeguards against abuse were devised, it is difficult to see how such a scheme could comport with the MAM mandate to hold costs to a minimum and provide transportation only where it is in fact necessary. Additional proposals of the plaintiffs that go far beyond the basic requirement that the State assure transportation include, for example, their proposal that the program provide payment for meals and lodging for the recipient and a traveling companion in some instances. The Court agrees with the defendants that the controlled system of volunteers defendants propose should, if properly implemented, reduce the problems of eligibility and abuse while satisfying the basic transportation assurance requirement.

*6 The Court has, however, carefully considered each of the plaintiffs' objections to the defendants' proposed plan put forward in their Memorandum in Support of Plaintiffs' Motion for a Permanent Injunction (hereinafter Plaintiffs' Mem.). First, the plaintiffs challenge the proposed eligibility tests, arguing that it is arbitrary and unreasonable for the defendants to deny transportation assistance to the recipient when the recipient or a member of his or her household owns or has access to a serviceable motor vehicle. The Court disagrees. It is not unreasonable to assume that those recipients who can afford to license and maintain an automobile can also afford to purchase gasoline for trips to medical providers. Moreover, as stated previously, the plaintiffs have offered no suggestion as to how to determine who can and who cannot actually afford to purchase gas. The Court also finds that it is reasonable to inquire into the recipient's customary means of transportation: where bus transport is ordinarily used, it is not arbitrary to assume that the bus can also be used to make medical visits. Likewise, assistance customarily given by friends or relatives may be expected under similar circumstances to continue. Indeed, the MAM contemplates full utilization of such alternative transportation sources. Cautioning that the state has an obligation to assure that transportation is provided only where it is not otherwise available, the MAM further states:
In line with the above, if neighbors, friends, relatives or voluntary organizations have been providing transportation services, it is reasonable to expect them to continue except in extreme changed circumstances or evident hardship. MAM § 6-20-00, at 12.

The Court, however, agrees with the plaintiffs in regard to subsection (2)(e) of the defendants' proposed plan, which states that the recipient will be eligible for assistance when:
[t]ransportation is requested to an appropriate Medicaid provider located in the recipient's community; however, when a Medicaid medical provider offering the appropriate Medicaid covered care is not available in the recipient's community, transportation will be furnished only to the nearest Medicaid provider of such services unless the Medicaid Medical Director approves transportation to another

© 2006 Thomson/West. No Claim to Orig. U.S. Govt. Works.

provider.

The plaintiffs challenge this provision as a violation of the recipient's right to choose any available, qualified medical provider. Such a right is recognized in the MAM. The transportation assurance requirement "is based on provisions in the [Social Security] Act and Federal regulations requiring that medical assistance be [among other things] available to eligible recipients from *qualified providers of their choice*." MAM § 6-20-00, at 2 (emphasis added). The MAM does however, impose a limitation upon this right of choice:

States have an obligation to assure that:
-transportation is available to get individuals to qualified providers of their choice who are generally available and used by other recipients *of the community*.
MAM § 6-20-00, at 12 (emphasis added).

*7 According to the MAM guidelines, Subsection 2(e) properly requires the recipient to choose among appropriate medical providers who are available within the recipient's community. The Court, therefore, will not disturb the first clause of the defendants' proposed rule.

The defendants will be required, however, to alter the remaining portion of the rule, which unduly restricts the right of choice. In *O'Bannon v. Town Court Nursing Center, 447 U.S. 773, 780 and n.8 (1980)*, the Supreme Court construed 42 U.S.C. § 1396a(23) and 42 C.F.R. § 431.51 (1979) to guarantee the "free choice of providers" to Medicaid recipients. The final clause of the defendants' proposed subsection 2(e) permits no freedom of choice for recipients when "appropriate Medicaid covered care is not available in the recipient's community." The Court will therefor ORDER that the defendants modify their proposal so as to guarantee this right to those recipients who must go outside their communities to find an appropriate medical provider.

The plaintiffs next object to the defendants' proposal in subsection 2(f) that the recipient must accept, "when necessary," transportation arranged "on a day and/or at a time other than that originally requested." The plaintiffs argue that this rule places an unreasonable burden upon the recipient to reschedule medical appointments without the assistance of the DHS worker. The Court construes the provision, from its language, to apply as a "last resort" measure and considers it reasonable as such. However, the Court agrees that in such an event, the county worker should offer assistance in rescheduling the medical appointment. The transportation assurance requirement could hardly be deemed satisfied if there were no medical appointment to which the recipient would be transported. The Court will therefore ORDER the defendants to include such a provision in the plan.

The Court also agrees with the plaintiffs' objection to subsection 2(g), which imposes a reconfirmation requirement upon the recipient. The defendants' plan requires the recipient to request transportation assistance five days in advance of the scheduled medical appointment. Proposed Rule 2(g) would impose the additional requirement that on the day before the travel date the recipient again contact the county worker who made the transportation arrangements to confirm that the recipient would be using the transportation. The Court recognizes that the defendants seek to impose safeguards against the wasted resources that could result from missed travel appointments on the part of the recipient. However, in the Court's view, the reconfirmation rule would place an onerous burden on recipients without telephones. Moreover, the lapse of only five days between scheduling and the travel date should make the need for reconfirmation less important. In addition, as the plaintiffs point out, the defendants are protected from abuse of transportation services by subsection 3(g) of the proposed plan, which provides that transportation assistance will be denied to persons who consistently fail to utilize the transportation arranged for them. The reconfirmation requirement should therefore be deleted.

*8 The plaintiffs' objection to subsection (3)(a) of the defendants' plan, however, is not warranted. Proposed subsection 3(a) states that transportation will not be available if:

© 2006 Thomson/West. No Claim to Orig. U.S. Govt. Works.

[t]he Medicaid covered care is not medically necessary or is not to be provided pursuant to a physician's or provider's plan of care of for which prior approval is required and has not been granted;

The plaintiffs raise a practical objection to this proposed limitation, arguing that it "will result in the denial of transportation to many needy Medicaid recipients simply because of the worker's unfamiliarity with the prior authorization process and resulting inability to determine quickly enough whether a medical service requires prior approval or has been approved." Plaintiffs' Mem. at 17.

The Assistant Commissioner of Family Assistance testified on the contrary, however, that the DHS county workers are experienced in handling medically-related problems, including medical terminology. (Tr. 77-78). Further, the MAM specifically contemplates that the state will not be obliged to provide transportation in similar instances:
. . . *States are not obligated* to provide for transportation to secure medical care not included under the Medicaid plan, nor provide transportation if the recipient has exhausted the amount of medical care available to him under the Medicaid plan, and prior authorization for additional care has been denied. MAM § 6-20-00, at 12 (emphasis in the original).

In the Court's opinion, the proposed Rule 3(a) is reasonably aimed at delineating those requests for transportation which the State of Tennessee is not required to meet. The plaintiffs' objections rest simply upon conjecture concerning the inability of the county workers to implement the plan properly. The Court therefore will permit the defendants an opportunity to implement the provision and demonstrate whether or not the plaintiffs are correct in their predictions.

With respect to the plaintiffs' objection that the proposed plan contains no requirement to assure certain safety features, the Court will ORDER the defendants to state in their plan a guarantee that the transportation arranged shall be appropriate for an ill or disabled recipient.

The Court will also ORDER the defendants to modify the highly restrictive conditions for eligibility for transportation by ambulance contained in proposed Rules 1200-13-.03(1)(y) and 1200-13-1-.05(10). Under the proposed rules, emergency ambulance service will be reimbursed only for the trip to the hospital and only in "life threatening" situations. As the plaintiffs correctly point out, there are numerous conditions requiring ambulance transportation which may not fit within the term "life threatening." The State of Tennessee adopted a far less restrictive view of the proper scope of emergency medical need in TENN. CODE ANN. § § 53-5201, 53-5202, and 53-5203, which imposes a duty upon hospitals to furnish emergency services. In the light of the public policy reflected in these statutes, the Court finds the proposed restriction unreasonable. The Court will ORDER the defendants to modify the proposed rules governing eligibility for emergency transportation to comport with the condition set forth in TENN. CODE ANN. § 53-5201, which requires hospitals to furnish emergency services to any applicant who applies for such services "*in case of injury or acute medical condition where the same is liable to cause death or severe injury or illness* (emphasis added)."

*9 Finally, the plaintiffs point out that the defendants' proposed plan does not indicate how recipients and providers will be notified of the new plan or how recipients will be notified of a denial of transportation when requests are denied. The defendants will be ORDERED to include provision for such notification.

Apart from the foregoing discussion of provisions requiring modification, the Court concludes that the defendants' proposed plan is reasonably calculated to meet the requirements of the federal regulations. As the defendants correctly point out, this Court's duty is not to choose or attempt to fashion what might be the best transportation assurance program.
Federal courts are not empowered to substitute their judgments for that of State

© 2006 Thomson/West. No Claim to Orig. U.S. Govt. Works.

officials charged with administrative fact-finding and decision-making having to do with the state. *Jennings v. Alexander*, 715 F2d 1036, 1044 (6th Cir. 1983) (citations omitted).

Rather, this Court's duty is to ensure that the defendants' proposal comports with federal law. The Court is of the opinion that the proposed plan meets the transportation assurance requirement and that the defendants should be given the opportunity to implement their plan. The Court will retain jurisdiction of this case for a period of twelve months after the plan is fully implemented to ensure the efficacy of the program. The Court will ORDER the defendants to submit a final State Plan for transportation assurance in conformity with this opinion within thirty (30) days of entry of the accompanying ORDER.

II.

With respect to the plaintiffs' motion for partial summary judgment on their claim that the defendants "should be required to provide notice when they propose to deny a Medicaid provider's claim for payment," Memorandum of Additional Authority in Support of Plaintiffs' Motion for Partial Summary Judgment, filed November 5, 1984, at 1 (hereinafter Mem. of Add. Auth.) the motion will be DENIED with leave to file a similar motion within thirty days. In the aforementioned Memorandum, the plaintiffs purport to rely on their memoranda "filed on October 15, 1980, November 18, 1980, supplemental affidavits filed January 12, 1981, and their Reply Memorandum in Support of Summary Judgment filed January 12, 1981." Mem. of Add. Auth., at 2. [FN3] In these memoranda, however, the plaintiffs seek, *inter alia*, the resolution of narrow issues relating to their use of ambulance services. Indeed, the plaintiffs emphasize that, with respect to the issue of their right to notice prior to denial of Medicaid payment of a provider claim, their request for procedural protections is limited solely "to cases of amount, scope or duration denials of claims for *ambulance services*." Plaintiffs' Reply Memorandum in Support of Summary Judgment, at 23 (emphasis added). Likewise, the factual and legal basis for relief set forth in these memoranda is focused upon the subject of ambulance services.

FN3 The Court assumes the plaintiffs intend to refer to their original memorandum filed on October 31, 1980 as there was no memorandum in support of summary judgment filed on October 15, 1980.

*10 Although the focus of the plaintiffs' original supporting memoranda is, thus, very narrow, their more recent filings and the development of the case as a whole have substantially expanded the scope of the relief sought. As set out previously in this opinion, the Court recently granted the plaintiffs' motion for certification of a broad subclass, including all Tennessee Medicaid recipients whose claims for all types of services rendered by health care providers have been denied without prior notice. By contrast, when plaintiffs originally filed their motion and memoranda on the notice question they were seeking certification of a very narrow subclass of "persons who receive denials of claims for ambulance reimbursement, and further limited to denials which are clearly based on a judgment that the service rendered is not within the amount, scope of duration of service provided." Memorandum in Support of Plaintiffs' Motion for Partial Summary Judgment and Class Certification, filed Oct. 31, 1980, at 42.

Clearly, this action has undergone substantial change in scope since the plaintiffs' motion on the notice issue was filed. Yet the plaintiffs' November 5, 1984, Memorandum of Additional Authority merely cites several recent cases and acknowledges the plaintiffs' concurrent filing of a new motion for certification of a subclass. The plaintiffs have failed to amend their argument on the propriety of summary judgment so as to reflect the substantial change in the nature and scope of the relief they seek. For this reason, the Court will DENY their motion for partial summary judgment on the issue of notice with leave to file a motion accompanied by an appropriate memorandum setting forth a supporting factual and legal basis for

© 2006 Thomson/West. No Claim to Orig. U.S. Govt. Works.

their motion within thirty days of entry of this opinion and order.

III.

The plaintiffs have also moved for partial summary judgment and class certification concerning the summary termination, under procedures of Tennessee's Medicaid program, of Medicaid assistance upon the termination of Supplemental Security Income (SSI) or Aid to Families with Dependent Children (AFDC). The plaintiffs claim that automatic termination of Medicaid upon the receipt of information by the Department of Human Services that the recipients' AFDC or SSI benefits have been terminated without prior redetermination of eligibility for Medicaid violates the Medicaid statute and regulations thereunder, and the Due Process Clause of the Fourteenth Amendment.

As with subclasses previously certified, the plaintiffs have established the four prerequisites to class certification under FED. R. CIV. P. 23(a): impracticability of joinder of all class members, commonality of issues of law or fact, typicality of the claims of the representatives of the parties, and adequacy of representation. The Court, accordingly, hereby certifies a subclass consisting of those individuals terminated from AFDC because of an increase in income or terminated from SSI who are consequently terminated from Medicaid under the Tennessee Medicaid program.

*11 Under Tennessee's program, individuals are eligible for Medicaid benefits if they are "categorically needy" or "medically needy." They qualify as "categorically needy," a mandatory provision for participating states, if they are eligible for AFDC or SSI. 42 C.F.R. § 435.4 (1983). They may be ""medically needy" if they are not receiving AFDC or SSI, but their income and resources, in comparison to their medical expenses, are within the limits established by the Department of Health and Human Services. 42 C.F.R. § 435.122. Tennessee has elected to provide coverage of the optional "medically needy" and "exceptionally medically needy" pursuant to 42 U.S.C. § 1396a(10)(C), and also to rely on information provided by the Secretary of HHS in determining eligibility for the "categorically needy."

It is undisputed that under current procedures the Tennessee Medicaid program automatically terminates from coverage all individuals who fail to continue to meet the eligibility requirements of the Medicaid category in which he or she was previously eligible. Thus, if the Tennessee Department of Human Services receives information from HHS that the AFDC or SSI benefits of a "categorically needy" recipient have been terminated because of an increase in income, the state agency will automatically terminate the recipients' Medicaid benefits. In that event, the state's program provides that a case worker may determine that eligibility in another category is "possible" and may advise the recipient to file a new Medicaid application. Thus, the individual would be without coverage for at least some period of time prior to redetermination even if he or she were actually eligible for another category at the time of termination.

The plaintiffs claim that the defendants' practice violates several provisions of the Medicaid statute and its implementing regulations. Pursuant to 42 U.S.C. § 1396a(a)(8), the participating state must provide Medicaid assistance "with reasonable promptness to all eligible individuals." Construing this statute, the Supreme Court in *Jefferson v. Hackney*, 406 U.S. 535, 545 (1972), observed that its purpose is "to prevent the state from denying benefits, even temporarily, to a person who has been found fully qualified." Under 42 U.S.C. § 1396a(a)(19), eligibility is to be determined "in a manner consistent . . . with the best interests of the recipients." Elaborating on these provisions, 42 C.F.R. § 435.930 requires the participating state to:
(a) furnish Medicaid promptly to recipients without any delay caused by agency's administrative procedures; [and]
(b) continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible.

© 2006 Thomson/West. No Claim to Orig. U.S. Govt. Works.

42 C.F.R. § 435.916(c), also relied upon by the plaintiffs, provides:(C) Agency action on information about changes.
(1) The agency must promptly redetermine eligibility when it receives information about changes in a recipient's circumstances that may affect his eligibility.
*12 (2) If the agency has information about anticipated changes in a recipient's circumstances, it must redetermine eligibility at the appropriate time based on those changes.

The defendants have not disputed that in many situations an increase in income resulting in the termination of AFDC or SSI benefits will not affect the recipient's actual eligibility for "medically needy" coverage. In such circumstances the plain language of 42 C.F.R. § 430.930(b) would appear to proscribe termination of benefits before redetermining eligibility. The defendants have suggested that summary termination is nevertheless permissible since Medicaid is available retroactively for a period of up to three months for recipients who were denied benefits as a result of the termination procedure. As the plaintiffs point out, however, the regulations forbid any such delays in coverage due to the agency's administrative procedures. 42 C.F.R. § 435.930(a). Moreover, retroactive coverage will not assist the individual in securing needed medical care during the gap in coverage. The needy individual may, for example, be compelled to make arrangements for the payment of providers during the lapse in coverage and be forced to approach these providers later for acceptance instead of a retroactive Medicaid card. Such burdens on recipients are the kind of impediment to assuring reimbursement to the needy for necessary medical care that the Medicaid regulations at issue are aimed at preventing.

Several recent cases, which the defendants admit are controlling, have upheld challenges to similar summary termination procedures. In *Crippen v. Kheder,* 741 F.2d 102 (6th Cir. 1984), the Sixth Circuit held that the defendants violated the implementing regulations of the Medicaid statute, including those at issue in the instant case, when they terminated the plaintiff's SSI-related Medicaid coverage without determining whether she qualified for Medicaid as a ""medically needy" recipient. The *Crippen* Court held that to comply with federal law, upon receipt of notice that an individual has been terminated from the SSI program, the [state agency] must promptly determine *ex parte* the individual's eligibility for Medicaid independent of his eligibility for SSI benefits. While this determination is being made, the state must continue to furnish benefits to such individuals. *Id.* at 107.

The First Circuit, in *Massachusetts Association of Older Americans v. Sharp,* 700 F.2d 749 (1st Cir. 1983), held that the plaintiffs, who sought a preliminary injunction, were likely to prevail on the merits of their claim that the state had violated the Medicaid statute and regulations by failing to redetermine eligibility upon termination of the plaintiff's AFDC-related Medicaid. The First Circuit relied heavily upon another case involving the termination of SSI-related Medicaid benefits, *Stenson v. Blum,* 476 F.Supp. 1331 (S.D.N.Y. 1979), *aff'd without opinion,* 628 F.2d 1345 (2d Cir.) *cert. denied,* 449 U.S. 885 (1980).

*13 In light of the foregoing, the plaintiffs' claim that the automatic termination procedure of the Tennessee Medicaid program does not comport with the federal regulatory provisions is well-founded. Because "there is no genuine issue as to a material fact and . . . the moving party is entitled to judgment as a matter of law," summary judgment is appropriate. FED. R. CIV. P. 56, *Crippen;* 741 F.2d at 104. Accordingly, this Court holds that the defendants are required under 42 C.F.R. § 435.916(C) and § 435.930(b), upon receipt of notification of a recipient's termination from SSI or AFDC, to redetermine *ex parte* the recipient's eligibility for Medicaid benefits. Pending this determination, the state must continue to provide such individuals with Medicaid benefits. [FN4] *Crippen,* 741 F.2d at 107. The Court will enter an Order GRANTING the plaintiffs' motion for partial summary judgment on the issue of summary termination, and requiring the defendants to assure the plaintiff subclass the right of redetermination for Medicaid eligibility upon termination from SSI or AFDC assistance.

© 2006 Thomson/West. No Claim to Orig. U.S. Govt. Works.

FN4 Having resolved the plaintiffs' claims on the basis of the relevant federal statute and regulations, this Court need not decide whether the defendant's challenged procedure violated the Fourteenth Amendment. *Hagans v. Lavine*, 415 U.S. 528 (1974). *Crippen*, 741 F.2d at 107 n.2.

Daniels v. Tennessee Dept. of Health and Environment
Not Reported in F.Supp., 1985 WL 56553 (M.D.Tenn.), Med & Med GD (CCH) P 34,562

END OF DOCUMENT

© 2006 Thomson/West. No Claim to Orig. U.S. Govt. Works.