**IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF TENNESSEE NASHVILLE DIVISION**

| | | |
|---|---|---|
| **MELISSA WILSON, et al., individually and on behalf of all others similarly situated,** | ) | |
| **Plaintiffs,** | ) | **NO. 3:14-cv-01492** |
| **v.** | ) | **JUDGE CAMPBELL** |
| **WENDY LONG, et al.,** | ) | **MAGISTRATE JUDGE NEWBERN** |
| **Defendants.** | ) | |

## FINDINGS OF FACT AND CONCLUSIONS OF LAW

Pursuant to Fed. R. Civ. P. 52(a)(1), the Court makes the following findings of fact and conclusions of law.

## INTRODUCTION

Plaintiffs filed the instant suit on July 23, 2014. (Doc. No. 244 at 4.) The Complaint, brought on behalf of eleven named individuals and a putative class, alleges Defendants (the "State") were failing to provide timely determinations to an untold number of Medicaid applicants, in violation of 42 U.S.C. § 1396a(a)(8), and were failing to provide any sort of fair hearing on these delayed adjudications, in violation of 42 U.S.C. § 1396a(a)(3) and the Due Process Clause. (Doc. No. 1.) Plaintiffs simultaneously sought a preliminary injunction and class certification. (Doc. Nos. 2, 4.)

The Court conducted a hearing on those motions on August 29, 2014, and on September 2, 2014, certified the following class: "All individuals who have applied for Medicaid (TennCare) on or after October 1, 2013, who have not received a final eligibility determination in 45 days (or in the case of disability applicants, 90 days), and who have not been given the opportunity for a 'fair

hearing' by the State Defendants after these time periods have run." (Doc. No. 90.) On September 2, 2014, the Court also issued a preliminary injunction. (Doc. No. 91.) The preliminary injunction order required the State to provide an opportunity for a fair hearing on any delayed adjudications to anyone who had proof of an application that had not been acted on within the requisite time period. (*Id.*)

Defendants appealed the preliminary injunction ruling, and the Court of Appeals for the Sixth Circuit affirmed. (Doc. Nos. 97, 152, 159.) The case was tried without a jury on October 9 and 10, 2018, and the parties filed post-trial briefs. (Doc. Nos. 261, 262, 263.)

## I. Findings of Fact

### A. The Medicaid Act

Title XIX of the Social Security Act, 42 U.S.C. § 1396, *et seq*, popularly known as Medicaid, provides eligible low-income individuals health care insurance. Eligibility may be based on age or other qualifiers such as being an adult caregiver, a child, pregnant, or being blind or disabled. (Doc. No. 244 at 1-2.) The federal government participates in Medicaid under the aegis of the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA), of the Department of Health and Human Services (HHS). (*Id.*)

While participation by states in the Medicaid program is voluntary, all states participate and share funding responsibility with the federal government. Tennessee's Medicaid program, TennCare, is funded approximately one-third by Tennessee and two-thirds by the federal government. (*Id.*) The TennCare program is specifically approved by CMS, and CMS is the primary federal agency that the State interacts with in administering TennCare. (Doc. No. 256 at 143.)

**B. The Affordable Care Act**

Prior to the enactment of the Affordable Care Act (ACA), the federal government had no involvement in assessing eligibility for Medicaid and an individual could apply for Medicaid only by applying with the state in which he lived. (*Id.* at 194.) The State of Tennessee processed all TennCare applications through a 1990s mainframe computer using a system called ACCENT. (*Id.* at 191.)

Under that system, TennCare applicants would apply at a county office of the Tennessee Department of Human Services, with the documents needed to verify their income, residency, citizenship, and other facts bearing on eligibility for Medicaid. Once all of the necessary documentation was provided, an employee of the Department of Human Services would enter this information into the ACCENT computer system, and if the person had provided the correct documents, the program would determine whether or not that person was eligible for TennCare. (*Id.*)

The ACA created an online federally administered insurance exchange, known as the Federally Facilitated Marketplace (the "FFM"), where individuals could purchase commercial insurance. The ACA also made substantial changes to the Medicaid application and eligibility determination process. (Doc. No. 244 at 2.) As an initial matter, everyone purchasing insurance through the FFM is automatically evaluated for eligibility for Medicaid and other federal programs and subsidies. (*Id.* at 2.)

The ACA attempted to standardize across all states the methodology for determining whether an individual met the income requirements for Medicaid. The ACA did so by mandating a new methodology for calculating income called modified adjusted gross income ("MAGI").

MAGI is used to calculate income eligibility for Medicaid for certain categories of individuals, such as children, pregnant women, and parents of dependent children. Such groups are referred to as "MAGI categories." (*Id.*) Approximately 80 percent of TennCare's total enrollment is eligible in a MAGI category. (*Id.*) The remaining 20 percent of enrollees are eligible in non-MAGI categories of Medicaid, i.e., eligibility based on age, blindness, or disability. (*Id.*)

Whether an individual applies to a state or the FFM, the applicant must first be screened for MAGI categories. If the individual is not eligible for coverage in a MAGI category but has included information in her application that indicates that she may be eligible for non-MAGI categories or has requested a full Medicaid determination, the State will then determine eligibility in the non-MAGI categories. (*Id.*)

The ACA created a data hub that aggregated information from a variety of federal sources, such as the Social Security Administration, the Internal Revenue Service, and the Department of Homeland Security. The ACA data hub allows states and the federal government to verify online applications in real time to confirm an application matches the information in the data hub. (Doc. No. 256 at 193-194; *see also* 42 U.S.C. § 18083(c); 42 C.F.R. § 435.949.) The ACA also mandated the use of a streamlined application that would allow applicants to be considered for multiple programs, such as Medicaid, CHIP, state-level programs, and tax credits, by filing a single application with either the state or the FFM. (Doc. No. 244 at 2.)

The ACA implementing regulations give states two options for structuring their Medicaid eligibility determinations. A state may elect to have the FFM make final determinations of MAGI eligibility (determination states), or a elect to have the FFM assess likely eligibility, leaving the final determination to the states (assessment states). Tennessee has been a determination state at all times relevant to this lawsuit. (*Id.*)

When an individual who is a resident of a determination state applies for Medicaid with the FFM, the FFM may do one of three things. First, it may approve the applicant for MAGI-based Medicaid coverage. Second, the FFM may deny coverage upon finding that the applicant is not MAGI-eligible and the applicant did not request a full determination of Medicaid eligibility or provide information indicating she may be eligible in a non-MAGI category. Third, the FFM may find that the individual is not eligible for MAGI-based Medicaid coverage but *might* be eligible for coverage in a non-MAGI category. In this third situation, the application is sent to the State to determine whether the individual is eligible for coverage in a non-MAGI category. (*Id.* at 2-3.)

States were required to begin applying the MAGI rules to determine Medicaid eligibility by October 1, 2013. (*Id.* at 3.) Tennessee intended to handle eligibility determinations with a new application system called Tennessee Eligibility Determination System, or "TEDS." TEDS was not ready on October 1, 2013, and is still not fully operational. (*Id.* at 3, 9.) Tennessee's pre-ACA eligibility system, ACCENT, was deemed too antiquated to be modified to make MAGI determinations. (Doc. No. 256 at 198.)

To address the facts that TEDS was not yet operational and Tennessee was unable to make determinations of MAGI eligibility, the State entered into a Mitigation Plan with the federal government. The Mitigation Plan provided that the State would direct applicants to the FFM to be evaluated for MAGI eligibility. This Mitigation Plan has been amended and re-approved by CMS in the years since 2014 and remains in effect today. (Doc. No. 244 at 3.)

**C. Eligibility Determination Delays During the First Year (2014)**

1. Delays Related to "Inconsistency Applications"

Pursuant to the Mitigation Agreement, TennCare directed the vast majority of applicants to file an application with the FFM for a determination of MAGI status. (Doc. No. 244 at 3.) CMS screened the information in the FFM application against information in the federal data hub. (Doc. No. 256 at 194.) If the data in an application did not match the data in the federal data hub, an "inconsistency" was created and applicants were requested to submit additional documentation to resolve the inconsistency.

The eligibility determinations became delayed because CMS, after requesting verification data, set the applications aside and did not continue the assessment. (Doc. No. 256 at 208-9.) This resulted in a large number of applications sitting in limbo waiting for their inconsistencies to be resolved. (*Id.*) Compounding the delay, CMS did not notify the State that it was not processing inconsistency applications. The State became aware of the pending inconsistency applications in July 2014. (*Id.*) CMS did not send information necessary to resolve the inconsistencies to the State until approximately two months later. (*Id.*) Since that time, the State and CMS have developed a protocol for handling inconsistency applications. (*Id.* at 10.)

This case was filed soon after the State had been notified of the delay in processing inconsistency cases and before CMS and the State had developed a process for resolving these applications. (*Id.* at 210.) At that time, individuals whose applications had not been resolved had no recourse. The State did not have in place a process for applicants to appeal a delayed eligibility determination.

2. Delays Impacting Pregnant Women and Newborns

Also in early 2014, the State became aware of delays in processing applications from pregnant women and citizen-babies of non-citizen mothers. (Doc. No. 256 at 205-07.) At the time, pregnant women received a 45-day presumptive eligibility from the State and were required to complete an application for full-coverage during this period. (*Id.* at 204-205.) Some women had their presumptive coverage terminated before receiving a determination from FFM. (*Id.*) The State also became aware that newborn children of non-citizens were having difficulty getting Medicaid eligibility determinations from the FFM. (*Id.* at 207). To close this coverage gap while applications were pending, the State extended the period of presumptive eligibility for pregnant women to provide coverage until they received a determination from FFM and established a new category of presumptive eligibility for newborns. (*Id.* at 206-207.)

The open-ended presumptive eligibility for pregnant women continued until 2016 at which time it resumed standard presumptive eligibility processing. (*Id.* at 245-46.) Under the standard processing protocol, the State determines presumptive eligibility for the pregnant woman, but the woman must file a timely application with the FFM. If the FFM approves the application, CMS notifies the State and the State places the woman on full-coverage. If the FFM forwards the application to the State as a non-MAGI referral or as an inconsistency, the State continues the presumptive coverage until the application is resolved. (Doc. No. 257 at 86.) If the woman does not apply with the FFM, coverage terminates at the end of the presumptive period. (Doc. No. 256 at 246.) Currently, if a pregnant woman files a delayed application appeal, TennCare will automatically extend her presumptive coverage while the appeal is pending. (Doc. No. 257 at 87-88.) [1]

[1] This policy of extending presumptive eligibility while an appeal is pending was implemented to avoid a lapse in coverage if there were problems transmitting application information between

### D. The Court's Preliminary Injunction and Subsequent Delayed Application Appeals Process

On September 2, 2014, the Court entered a preliminary injunction requiring an opportunity for a fair hearing on any delayed Medicaid applications of which the applicant has proof that an application was filed. (Doc. No. 91.) After the Court issued the preliminary injunction, the State implemented a delayed application appeal process that allows individuals who wish to appeal a delay in the processing of their Medicaid or Medicaid Savings Plan application to do so. (Doc. No. 244 at 4.) The State has since adopted permanent TennCare regulations codifying the appeals system. (TENN. COMP. R. & REGS. 1200-13-19 *et seq*.) The parties stipulate that the State has complied with the preliminary injunction. (Doc. No. 244 at 6.)

Notice of the opportunity to appeal a delayed application is provided through the TennCare call center and on the TennCare website. (Doc. 257 at 37.) The call center's phone number is printed on flyers, handouts, and posters, as well as on presumptive eligibility notices sent to people in presumptive eligibility categories. (*Id.* at 111.) Call center operators are required to notify callers of their right to file a delayed application appeal if the caller indicates she has an application that has been pending for a long time. (*Id.* at 37-38.) Plaintiffs presented no evidence of applicants who suffered a delayed application but were unable to appeal because they did not know about the delayed application appeal process.

Applicants can file a delayed application appeal through the Tennessee Health Connection (a State contractor) by phone, fax, or mail. (Doc. No. 244 at 5.) Before the appeal can be accepted by TennCare, there must be some proof that the application was filed at least 45 days before the

---

CMS and TennCare. In April 2017, TennCare learned that CMS was not forwarding approvals of pregnant women to the State. As a result, the State was terminating coverage at the end of the presumptive period based on the women's failure to file an application. CMS resolved this issue on May 1, 2017. (Doc. No. 257 at 14; Plaintiffs' Exhibit 9.)

appeal (90 days for disability claims). (*Id.*) TennCare looks for proof of application in available databases and if it cannot find one, will request proof from the applicant. (*Id.*) Acceptable proof includes a screenshot of an online application, correspondence from FFM, and proof of mailed or faxed applications. (*Id.*)

**E. Current Status of the Delayed Application Appeals Process**

Since August 2015, every delayed application processing appeal for which there was proof of a delayed application has been closed because 1) the appellant failed to provide the requested information necessary to process his/her application; 2) an eligibility determination was made and a hearing was no longer necessary; or 3) a fair hearing on the reason for the delay was provided within 45 days. (*Id.* at 6.)

The parties agree that the State is currently complying with the Court's September 2014 Preliminary Injunction. (*Id.*) Plaintiffs stipulated the delay appeal process, codified in TennCare Rules at 1200-13-19 *et seq.*, is presently available to class members upon request when their applications for Medicaid are not acted upon with reasonable promptness. (*Id.*)

**F. Current Status of the TennCare Application Process**

The State continues to operate under a Mitigation Plan with the federal government. (Doc. 244 at 3.) The Mitigation Plan has been amended and reapproved by CMS in the years since 2014. (*Id.*)

In the years since this case was initiated, TennCare has implemented procedures to identify and resolve problems that cause delays in eligibility determinations. The State primarily relies upon the appeals data as the "ultimate indicator" of whether there are systemic issues occurring with TennCare. (Doc. No. 257 at 80.) Internally, the State may learn of problems through management reports, the Tennessee Department of Health, the TennCare complaint department,

and the TennCare call center. (*Id.*) The State uses community input to identify issues with the TennCare application process, including input from advocacy groups, legislators, and healthcare provider groups. (Doc. No. 256 at 244; Doc. No. 257 at 82.) Dr. Wendy Long, Director of TennCare, testified that TennCare still has delayed applications, but that "unlike back in 2014, when we were identifying these sorts of system problems and developing systemic solutions, we don't see these sorts of problems anymore." (Doc. No. 256 at 179.) Dr. Long testified that although some cases are delayed for various reasons, those delays are specific to individual cases and do not represent systemic problems. (*Id.* at 179-81)

TennCare experienced a widespread delay in processing applications in November-December 2017 during open enrollment. During this time period, the State received nearly twice as many applications as the prior year and applications were unexpectedly delayed as a result. In response to the influx of applications, the State shifted resources and approved over-time pay in order to process applications as quickly as possible. It also sent notices to applicants informing them of the delay and highlighting the delayed applications appeal process. (Doc. 257 at 95-96; Defendants' Exhibit 12.)

During 2017, the last full year for which application data was submitted as evidence, fewer than 1% of applicants filed a delayed application appeal. (Doc. No. 257 at 105; Defendants' Exhibit 16.)

**G. Specific Cases of Delayed Applications**

At trial, Plaintiffs presented testimony from three people whose applications for TennCare were delayed.

Mr. Donald Adams, one of the named plaintiffs in this case, applied for TennCare benefits for himself and his newborn son on February 27, 2014. (Doc. No. 256 at 34.) Mr. Adams'

applications were approved in July 2014 after being held up for some time due to "inconsistencies" during the time before CMS and the State resolved the problems with processing these applications. (Doc. No. 257 at 97.) Mr. Adams testified that while his application was pending, he incurred medical debt, delayed medical treatment, and experienced significant stress as a result of being without health insurance.

Ms. Amy Foster applied for TennCare for her cousin, Brian Lee Foster ("Lee"), in December 2017. (Doc. No. 257 at 50-52.) On March 6, 2018, she received a letter from TennCare indicating that Lee's application was delayed, but that TennCare was working on it. (*Id.* at 52-54.) On April 6, Ms. Foster filed a delayed application appeal. (*Id.* at 54.) Lee's application was approved on May 18, 2018. (*Id.* at 64.) Ms. Foster testified that Lee was unable to receive adequate mental health care during the time his application was pending and that his health was negatively affected. (*Id.* at 64-69.)

Ms. Kayla Krouse applied for TennCare on December 13, 2016, and was granted presumptive coverage. Ms. Krause testified that she filed more than one application for TennCare through the FFM starting in December 2016. (Doc. 256 at 79-80.) The State acknowledged that when more than one application is filed on the federal exchange, only the date of the most recent date is saved. (Doc. No. 257 at 120-122.) The FFM records showed an application date of February 13, 2017. (*Id.*) On April 4, 2017, Ms. Krause filed a delayed application appeal. (Doc. 256 at 91.) She was approved for TennCare on April 11, 2017. (*Id.* at 92.) Ms. Krause testified that while her application was delayed she was unable to afford medical tests related to her pregnancy and that she worried she would not have medical insurance before the baby was born. (*Id.* at 85-93.)

## II. CONCLUSIONS OF LAW

### A. Legal Standards

Plaintiffs bear the burden of proof to demonstrate that the requirements for injunctive relief have been met. *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). In order to obtain permanent injunctive relief, the Plaintiffs must (1) actually succeed on the merits (that is, prove an actual violation of the law); (2) prove that they will suffer irreparable harm absent permanent injunctive relief; (3) prove that the balance of equities tips in their favor; and (4) prove an injunction is in the public interest. *Winter*, 555 U.S. at 20, 32; *see also Amoco Prod. Co. v. Village of Gambell*, 480 U.S. 531, 546 n.12 (1987).

"[B]ecause equitable relief is an extraordinary remedy to be cautiously granted, . . . the scope of" injunctive relief must "be strictly tailored to accomplish only that which the situation specifically requires." *Aluminum Workers Int'l Union, AFL-CIO, Local Union No. 215 v. Consolidated Aluminum Corp.*, 696 F.2d 437, 446 (6th Cir. 1982) (reversing a grant of injunctive relief because it was not "strictly tailored to accomplish only that which the situation specifically requires"); *see Williams v. Owens*, 937 F.2d 609 (6th Cir. 1991) (table decision) ("An injunction should be narrowly tailored to give only the relief to which the plaintiff is entitled.").

Under the Declaratory Judgment Act, 28 U.S.C. §§ 2201, 2202, Plaintiffs likewise bear the burden of proving a violation of law and that they are entitled to declaratory relief. *See Angell v. Schram*, 109 F.2d 380, 381 (6th Cir. 1940). In other words, "[t]he plaintiff must establish facts which give rise as a matter of law to an existing or imminent invasion of his rights by the defendant which would result in injury to him." *Id.* Because "[a] request for declaratory relief is barred to the same extent that the claim for substantive relief on which it is based would be barred,"

*International Ass'n of Machinists & Aerospace Workers v. Tennessee Valley Auth.*, 108 F.3d 658, 668 (6th Cir. 1997), if Plaintiffs fail to prove a violation of law, declaratory relief is inappropriate.

**B. Section 1396(a)(3) and the Due Process Clause**

Plaintiffs argue Defendants failed to provide Plaintiffs with adequate notice and a meaningful opportunity for fair hearings, in violation of 42 U.S.C. § 1396a(a)(3) and the Due Process Clause. Section 1396a(a)(3) provides that a State plan must "provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness." 42 U.S.C. § 1396a(a)(3). The Due Process Clause likewise requires that state Medicaid applicants and participants have the right to adequate notice and a fair hearing. *See Hamby v. Neel*, 368 F.3d 549, 559–60 (6th Cir. 2004); *Ability Ctr. of Greater Toledo v. Lumpkin*, 808 F. Supp. 2d 1003, 1026 (N.D. Ohio 2011) ("Applicants to Medicaid have a property interest in the benefits for which they hope to qualify and are, therefore, entitled to the due process protections imposed by the federal Medicaid statute and regulations and *Goldberg v. Kelly*, 397 U.S. 254 (1970)."). The Court finds Defendants have satisfied the relief sought by Plaintiffs under these claims and that any further relief pursuant to Section 1396(a)(3) or the Due Process Clause would be inappropriate.

Throughout the course of this lawsuit, Plaintiffs have consistently requested (1) a declaration that Defendants are violating Section 1396a(a)(3), and (2) an injunction that requires Defendants to provide TennCare applicants with an opportunity for a fair hearing to contest delays in determining their eligibility for TennCare. (Doc. No. 243). The stipulated facts and evidence at trial establish Plaintiffs have received what they requested. Specifically, the parties stipulated that a delayed application appeals process is both codified in the TennCare regulations, TENN. COMP. R. & REGS. 1200-13-19 *et seq.*, and available to all class members. (Doc. No. 244 at 7.)

Defendants demonstrated at trial that they have no intention of abandoning this process in the absence of judicial supervision. Plaintiffs offer no evidence to the contrary. The Sixth Circuit presumes good faith on the part of government officials when a change in conduct is made, and "such self-correction provides a secure foundation for a dismissal based on mootness so long as it appears genuine." *Bench Billboard Co. v. City of Cincinnati*, 675 F.3d 974, 981 (6th Cir. 2012); *see also Rio Grande Silvery Minnow v. Bureau of Reclamation*, 601 F.3d 1096, 1116 n.15 (10th Cir. 2010) (citing similar cases applying the same presumption).

Plaintiffs argue that even though TennCare has established an appeals process, that it does not provide adequate notice of the opportunity to appeal. Plaintiffs would like this Court to find that an opportunity for a fair hearing requires individualized notice such that every applicant whose eligibility was not timely resolved would receive personal notice of the opportunity to appeal the delay. At trial, Defendants testified that notice of the opportunity to appeal is communicated on the TennCare website in several locations, and is given to persons calling the TennCare call center to inquire about the status of their application. (Doc. No. 257 at 35-37; *Id.* at 110-11.) Section 1396a(a)(3) does not mandate individualized notice. The Court will not inject such a requirement into the regulations because the notice currently provided is sufficient to meet the requirements of the Medicaid statute and of the Due Process Clause.

Though it may not be a perfect system, Defendants have implemented and codified the process Plaintiffs sought through this lawsuit: fair hearings required under Section 1396a(a)(3) for TennCare applicants whose applications are not processed within 45 or 90 days. Thus, Plaintiffs are unable to establish at least one of the requirements for the extraordinary remedy of a permanent injunction: that they will suffer irreparable harm absent permanent injunctive relief. *Winter*, 555 U.S. at 20, 32. To the contrary, the evidence at trial established Defendants have provided

TennCare applicants with an opportunity for a fair hearing to contest delays in determining their eligibility for TennCare, and have codified that process at TENN. COMP. R. & REGS. 1200-13-19 *et seq.*. Accordingly, there is no further injunctive relief for this Court to grant on Plaintiffs' Section 1396a(a)(3) claim. Because any original violations of Section 1396a(a)(3) were remedied by this Court's preliminary injunction and Defendants' subsequent enactment of TENN. COMP. R. & REGS. 1200-13-19 *et seq.*, Plaintiffs fail to show there is any "existing or imminent invasion" of their rights so that they are entitled to declaratory relief. *Angell*, 109 F.2d at 381.

Through the course of this litigation, Plaintiffs have treated the Section 1396a(a)(3) and Due Process Clause theories and requests for relief as virtually one and the same. *See* Doc. No. 248 ("Defendants Violate Plaintiffs' Rights Under 42 U.S.C. § 1396a(a)(3) and the Due Process Clause by Failing to Provide a Meaningful Opportunity for Fair Hearings."); *see also* Doc. No. 257 at 165 (Plaintiffs' counsel) ("The (a)(3) [claim] . . . maps onto our third claim, which is, of course, under the due process clause itself. And I think all the parties recognize those two are relatively indistinguishable. I suppose there are some distinctions around the margins.").

Accordingly, the Court denies Plaintiffs' request for relief under Section 1396a(a)(3) and the request for relief under the Due Process Clause.

**C. Section 1396(a)(8)**

Plaintiffs assert that Defendants violate 42 U.S.C. § 1396a(a)(8) by failing to determine Medicaid eligibility with "reasonable promptness." Plaintiffs request a permanent injunction that would require: (1) additional systems to track the timeliness of eligibility applications; and (2) new steps to address systemic problems causing delays. In addition, Plaintiffs ask for a declaration that Defendants are in violation of section 1396a(a)(8) for failing to make determinations on TennCare eligibility within the federally prescribed time periods. (Doc. No. 263 at 57.)

Defendants assert that Section 1396a(a)(8) does not create an individual right that can be enforced under 42 U.S.C. § 1983. Pursuant to this Court's Order of November 11, 2018, regarding the enforceability of Section 1396a(a)(8) as a claim under 42 U.S.C. § 1983, the Court will address the merits of Plaintiffs' Section 1396a(a)(8) claim.[2]

The Medicaid Statute requires that a state's Medicaid plan must "provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals." 42 U.S.C. § 1396a(a)(8). Implementing regulations in 42 C.F.R. § 435.912 obligate the state to make eligibility determinations with 45 days (90 days for disability) after an application is submitted except when a delay in making eligibility determinations is caused by "unusual circumstances" such as when there is an administrative or other emergency beyond the agency's control. *Id.* at § 435.912(e).

State Medicaid plans are evaluated based on "substantial compliance" with the applicable regulations. 42 U.S.C. §1396c. For purposes of substantial compliance, a state Medicaid plan is reviewed by "category or parts of the State plan" so that if some parts of a plan comply substantially with the regulations while others do not, the entire plan is not non-compliant. *Id.*

The law does not require that a state Medicaid agency implement a flawless program. *Unan v. Lyon*, 853 F.3d 279, 288 (6th Cir. 2017). *See Frazar v. Gilbert*, 300 F.3d 530, 544 (5th Cir. 2002) ("Perfect compliance with such a complex set of requirements is practically impossible, and

[2] *See* Order (Doc. 258) in which the Court noted that it previously rejected Defendants' argument regarding the applicability of 42 U.S.C. § 1983 when it issued a temporary injunction in 2014. This Court further reasoned that although there are no Sixth Circuit opinions addressing this question, other courts have found that Section 1396a(a)(8) is privately enforceable under § 1983 and the Court would, therefore, consider the merits of Plaintiffs' Section 1396a(a)(8) claim. See e.g., *Koss v. Norwood*, 305 F. Supp. 3d 897, 911 (N.D. Ill. 2018); *Romano v. Greenstein*, 721 F.3d 373, 377-79 (5th Cir. 2013); *Ability Ctr. of Greater Toledo v. Lumpkin*, 808 F. Supp. 2d 1003, 1019-22 (N.D. Ohio 2011).

we will not infer Congressional intent that a state achieve the impossible"), *rev'd on other grounds*, *Frew v. Hawkins*, 540 U.S. 431, 436 (2004). As Judge Thomas Wiseman insightfully explained, "[P]erfection cannot be the standard by which a program as large and complex as TennCare's [] program is judged, for problems will invariably and necessarily arise from time to time in any such program. Instead, the State's substantial compliance must be assessed based upon whether the State has a sound system in place, one pursuant to which problems can be reliably identified and addressed as they arise." *John B., et al. v. Emkes*, 852 F.Supp.2d 957 (M.D. Tenn. 2012). In *Emkes*, the Court evaluated substantial compliance with a consent decree, not compliance with the Medicaid statute itself, but the logic behind his statement is applicable here. Even Plaintiffs agree that "courts may not demand perfection from agencies implementing complex programs," but note that "'the persistence of a systemic problem' in reviewing eligibility may constitute a violation of the Medicaid Act." (Doc. No. 263 at 52 (citing *Unan v. Lyon*, 853 F.3d 279, 287 (6th Cir. 2017).)

The number of eligibility applications not resolved within the required time period has steadily decreased over time. Currently, over 99% of TennCare applications are adjudicated within the required 45 or 90 days period.[3] (Defendants' Exhibit No. 16.) Since August 2015, every delayed application processing appeal for which there was proof of a delayed application has been resolved. (Doc. No. 244 at 6.)

Plaintiffs presented three witnesses who experienced delayed applications. (*See supra* Part I,G.) The Court finds that the causes of delays for these applications have been resolved by the State, were caused by unforeseeable circumstances and therefore excepted from the timeliness standard, or were otherwise not indicative of systemic problems. Mr. Adams filed an application for himself and his newborn son at the very start of the ACA enrollment when there were yet-to-

[3] Of those for which a delayed application appeal was filed, 100% were resolved either through a determination of eligibility or a hearing within the 45 or 90 day appeal period.

be-discovered systemic problems with an entire category of applications – the "inconsistency applications." Those delays, which have long since been resolved, gave rise to the instant case. Ms. Foster applied for TennCare for her cousin in December 2017 during a period that TennCare was experiencing an abnormal and unanticipated surge in applications. The Court finds that this was an unusual circumstance. Ms. Krause applied for TennCare in December 2016 or February 2017. Though her application was delayed, there is no evidence that the delay was due to a systemic problem.

The Court finds that there is no evidence of on-going systemic problems in the TennCare application process. Though the implementation of the new eligibility system was fraught with problems that caused significant delays in processing applications, there is no evidence in the record that these types of delays persist. To the contrary, Defendants have demonstrated that they have addressed the previous problems and have established systems to identify new potential issues if they should occur. There is no evidence to suggest that the less than 1% of applications currently experiencing delays is anything more than what is typical of a large administrative program.

Moreover, the Court declines Plaintiffs' invitation to rework the procedures and mechanisms of Medicaid eligibility determinations by the State. This Court will not inject itself into the complex Medicaid regulatory scheme by imposing new reporting and application tracking requirements upon the State. Such action is unwarranted by the evidence of substantial compliance in the record, and the Court is ill-equipped and constitutionally limited in its ability to craft new regulatory requirements when Congress and the appropriate regulatory authority did not impose such requirements. Simply put, the proposed additional layer of requirements Plaintiffs seek to

impose on the State by judicial order appear to be a solution in search of a problem given the State's new regulations and changes since 2014.

The Court finds that Defendants are in substantial compliance with section 1396a(a)(8). Thus, Plaintiffs are unable to meet the requirements for the extraordinary remedy of a permanent injunction: an actual violation of the law. Additionally, Plaintiffs fail to show there is any "existing or imminent invasion" of their rights, thus they are not entitled to declaratory relief. *Angell*, 109 F.2d at 381.

Therefore, the Court denies Plaintiffs' request for relief under Section 1396a(a)(8).

**CONCLUSION**

For these reasons, the Preliminary Injunction (Doc. No. 91) is **VACATED** and Plaintiffs' requests for a permanent injunction and declaratory judgment is **DENIED**. [4]

It is so **ORDERED**.

WILLIAM L. CAMPBELL, JR.
UNITED STATES DISTRICT JUDGE

[4] The Court need not reach the abundant and somewhat confusing legal arguments presented by the parties because the case has been decided on other dispositive legal grounds.