Medicaid Eligibility Call Centers: Questions for LEP & Disability Access

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Call centers are often the primary way that Medicaid enrollees interact with the Medicaid agency. Many states have moved away from directing people to local offices and instead have pushed people to using online portals and centralized call centers. While CMS is monitoring call center volume, wait time, and abandonment rates, this data may hide a number of problems at call centers. Advocates and enrollees have been reporting issues for people with disabilities and who have limited English proficiency (LEP), including dropped calls, failure to provide accommodation or interpreting, wrong information about individuals' rights and what assistance may be available, and general problems not meeting the needs of these callers.

To help advocates question states about call center operations and whether access is being provided to all callers, NHeLP created a list of questions regarding call centers and outreach they may sometimes provide. While these questions are not exhaustive of what an advocate may ask on these issues, they may be helpful in getting discussions started about call center functionality.

General Questions

1. Does the call center use any type of call center management tools, like interactive voice response (IVR) or integrated voice prompt (IVP), automatic call distribution (ACD), automatic or intelligent call routing; chatbots or other AI?
    - Are these tools accessible for LEP and people with disabilities?
    - How does someone who does not speak English very well understand what prompts to press to get to a representative to request language assistance?
    - Do the systems work with voices impacted by disability or accents?
    - Do the systems time out if a person does not input a number quickly enough? If so, what happens to the call?
    - Are the systems programmed to allow a person who is LEP or a person with a disability to "get out" of the automated system easily if they need to because they cannot use the automation (either because they cannot understand

English prompts or because of a disability) and need to reach a representative without going through the system?

- Can a person request an interpreter or accommodation to avoid being routed to Call Center staff who cannot provide the assistance needed?
- Are only certain staff trained to assist LEP or people with disabilities? If yes, how does an LEP individual or person with a disability get to these designated staff?
- Will the state consider a dedicated telephone line for individuals who are LEP or have disabilities so they do not have to navigate an IVP/IVR? And do such lines connect callers to targeted, specifically-trained staff?

2. Does the call center have the function to call a person back if an interpreter is not available when the LEP person calls?
   - If yes, when the Call Center calls back, does the Call Center representative connect to an interpreter **before** calling the enrollee or how does the rep communicate with the LEP individual?
   - Does the function indicate when the person will be called back?
   - Is the call back tracked in the person's file?

3. Does the call center reliably work with video relay interpreting?
   - What happens if a call with VRI is dropped?

4. Are the call center policies about language access and reasonable accommodations consistent, and work in concert, with state Medicaid agency and other contractors' policies regarding meeting the needs of people who are LEP and/or have disabilities?
   - If, for example, the call center policies direct employees to connect or refer callers to another agency to either request or receive an accommodation or connect with an interpreter, do the policies of that agency reflect that they will fulfill this function and how to respond to a referral?
   - Are there policies for a "warm handoff" so that the person does not have to repeat their request, which could act as a significant barrier or sufficiently impair access to the person with LEP and/or a disability that they cannot access the program.
   - Are there tracking mechanisms so that a referral to another agency is tracked, as is the success of that referral?
     - What mechanisms does the call center or state have to prevent a "referral whirlpool" so that employees can ensure the person gets the help they need?

Training

1. What training do call center staff receive? Does it include policies and procedures for providing language access, accommodations or other assistance, including:
    - What accommodations they can provide and what requests need to be forwarded elsewhere and how, including any tracking or noting in the system?
    - What referrals are available and any processes for a warm handoff and tracking of the referral?
    - When to escalate a call to a supervisor or other dedicated staff better equipped to provide assistance to a person with a disability?
    - Do they recognize requests for assistance that are not explicit requests for "reasonable accommodations" and that such requests may be for accommodations other than communication aides, such as alternate format, but may include help understanding a notice, more time to complete a task, or other assistance?
    - How to work with an OPI (over-the-phone interpreter) or VRI (video relay interpreter)?
    - If TTY or texting is available, do they recognize the differences between ASL and English; disabilities and how a person's disabilities may impact their ability to respond to complex information or requests, or to remain "calm" or follow directions?
    - How to identify or mark a language need or disability in the system, if that function is available, including any requests for accommodation, so that language or accommodation is consistently provided in the future?
    - How to share general information on communicating effectively with people with LEP and disabilities; cultural competency; civil rights; obligations of the state to provide language and disability access and what that means; and other critical information to providing access?

2. Are employees trained on how to screen for language, disability and related needs? How to use information available in the system to help inform them regarding disability? How to update or input that information themselves?

3. How often does training occur? Is the training provided varied or the same video or module every time? Does quality monitoring check for compliance with meeting the needs of people who are LEP and people with disabilities?

Data

1. What data does the call center track regarding language access and accommodations? Callers with LEP and/or disabilities? Does data stay in a caller's file so it is available for any subsequent calls?

2. Can call center staff see information about whether the caller speaks a non-English language or has disabilities? For example:
   - Whether the caller needs an interpreter in a particular language?
   - Whether the caller has currently approved accommodations, or has requested or been granted accommodations in the past, and of what type?
   - Is there a mechanism for call center employees to screen for language, disability and related needs? And a way to track that in the caller's file?

3. Does the call center keep analytics and hold employees accountable for analytics?
   - Are there exceptions or more generous time goals when a caller is LEP or has a disability as such calls often take longer?
   - If so can the employee mark that call so that it is clear they are meeting performance metrics or otherwise won't be incentivized to not provide meaningful access to the caller with LEP or a disability by rushing them off the call or not providing the assistance necessary?

4. Does the call center track accommodations offered/requested, approved or accepted, and provided?
   - If the call center forwards requests elsewhere, is there tracking of whether those referrals resulted in assistance or accommodations provided?

5. Does the State provide the call center with data to prepare staff in terms of training and readiness to provide assistance/accommodations based on data from the state about language and disability prevalence in the population served?

6. Are outreach and informing activities by the call center, including any advertising, accessible? Same with any state outreach and advertising.
   - Is there clear information offered in outreach and education materials? about how to request assistance based on language and disability?
   - Do websites have taglines and information about requesting assistance?
   - How do notices or other education resources inform people about assistance available and how to request it? Does it clearly offer assistance at no charge or merely an opportunity to complain?

- Are phone numbers provided to help LEP individuals and people with disabilities bypass IVP systems to get directly to Call Center staff for help?
- Do state outreach videos include closed captioning or are they available in non-English languages?

7. Does the state target outreach and education efforts to communities or people with LEP and disabilities that will likely experience difficulties completing the redetermination process?

8. Does the state monitor procedural terminations to see if there is a disparate impact on people with LEP and disabilities relative to population prevalence?

9. Does the state monitor eligibility terminations to determine whether categories based on disability are having terminations that are unexpected based on typical stagnancy of the category or population size? *E.g.,* are people previously eligible under DAC or Pickle categories being terminated for income?

Specific Issues related to Individuals with Limited English Proficiency

1. Does the call center have a contract with an over-the-phone interpreting (OPI) company? If yes, which one?
   - How many calls are connected with an interpreter?
   - How many calls were dropped when a transfer was attempted?
   - What languages were accessed?
   - How many minutes **in total** are billed each month?
   - How many minutes **by language** are billed each month?
   - Has the state done any analysis to identify why some calls may be shorter/longer based on language?

2. What is the **average** length of time of a "regular call" versus a call with an interpreter?
   - Does the average differ by language?
   - If the OPI call is shorter than a "regular" call, has the state done any analysis as to why? (generally, using an interpreter for consecutive interpreting would likely result in a longer call so a shorter call may indicate other issues)

3. When a call is dropped during a connection with the OPI, does the call center call back?
    - If no, why not?
        - Do they send an email/text?
        - Does the email/text have taglines?
    - If yes, do they call back already connected with the OPI to help identify the LEP caller's language needs?

4. Given any data the agency has on language needs (either Medicaid applications or state data), does it seem that fewer LEP individuals are calling than expected?
    - If yes, what is the state doing to outreach to LEP individuals?
    - Is it conducting outreach messaging in non-English languages, including in-language media?
    - Is it conducting outreach to CBOs who may work with LEP individuals – refugee resettlement organizations, immigrant-serving organizations, etc.?

Specific Issues related to Individuals with Disabilities

1. Call Center Functionality:
    - Does the call center allow people to make appointment times for calls?
    - People with disabilities may have limited windows in which they are prepared to talk with the call center because they need to have someone assist them with the call and that assistance is limited; because they need to talk when they are not receiving services, such as HCBS; or because there are certain windows or times during the day when they feel well enough to talk and understand what is being said, either because of disability, medications, or other considerations.

2. Reasonable Accommodations — What policies does the call center have about reasonable accommodations?
    - What accommodations are offered at what level of call center employee?
    - Are the accommodations provided by the call center sufficient to meet the needs of the communities covered by Medicaid in that state?
        - For example, most states will need to be able to help a person understand a notice or what is required of them to meet the requested action in a notice, such as providing verifications or documentation. This is a helpful service for most Medicaid recipients, but often a needed accommodation for many people with cognitive disabilities, including those affected by traumatic brain injuries, intellectual disabilities, psychiatric disabilities, etc.

This often requires more than simply reading the notice, but helping the person to understand by explaining the request or notice in a different way, but maintaining accuracy.

- Is there sufficient capacity for providing needed accommodations based on the prevalence of disability by type in the state's Medicaid population?
- Is it clear in policies and trainings that lower level employees **may not** deny requests for accommodation?[1]
- Can call center employees grant individuals more time to respond to renewal forms, RFIs, or appeal due to requested accommodations?

3. Do the call center accommodations policies direct employees to assume a request for help or similar asks are for an accommodation and escalate as necessary?

4. Do the call center policies or scripts direct employees to offer alternative types of assistances without a direct ask? E.g., if the person seems to be struggling to hear over the phone or otherwise seems to be having problems:

   - Can the call center employee offer a referral to in-person assistance?
   - Do call center policies on accommodations direct employees to proactively ask if the person has received the help they needed? People with disabilities may be hesitant to ask for assistance and there should be a clearly open door to receive help.

5. Are there metrics tracked regarding requests for, offers of, and provision of assistance and reasonable accommodation? By type? Including timeline between request and provision and how the person's deadlines were adjusted, if at all?

6. Is the process for reasonable accommodations easy to access?

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[1] Under DOJ guidance, lower level employees should not be making decisions about approving or denying accommodation requests. U.S. Dep't of Justice, Title II Primer. Therefore, if the frontline call center staff cannot provide the assistance requested or think that it is not assistance the call center provides, the request should be forwarded to upper level staff to make decisions about reasonable accommodations. For at least auxiliary aids and services the decision that a particular aide or service is an undue burden or fundamental alteration must be made by a high level official, no lower than a department head, and be accompanied by a written statement of the reasons for reaching that conclusion. That policy should apply broadly to requests for assistance by people with disabilities as that analysis applies to all reasonable accommodation requests.

- Is it clear there is a process for people with disabilities to requests help?
- Does the process require administrative burdens, such as filling out forms or proof?
- Are there reasonable accommodations available for the reasonable accommodation process?
  - Note: a reasonable accommodation process that requires filling out forms and providing verifications will likely limit access when the very process the person is requesting help with is one of filling out forms and providing verifications.
- Is the person readily offered assistance rather than having to request it?

7. Once a reasonable accommodation is provided, is it provided on an ongoing basis without the person having to request it in the future?
   - Examples: A person who has troubling filling out forms due to manual dexterity issues has requested the accommodation of filling out forms over the phone, so that individual is called each time they are sent such requests. Or a person with intellectual disabilities has requested an alternate and oral explanation of notices so is contacted each time a notice is sent. Or a person who has requested large print notices is sent notices in such a format for all Medicaid communications.

NHeLP is helping address Medicaid redeterminations issues during the unwinding of the continuous coverage provision, including access issues for people with disabilities and LEP. If advocates would like assistance or have questions regarding call centers, access, or other unwinding issues, please reach out to Mara Youdelman (youdelman@healthlaw.org) and Elizabeth Edwards (edwards@healthlaw.org).

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

Chianne D.; C.D., by and through her mother and Next Friend, Chianne D.; and A.V., by and through her mother and Next Friend, Jennifer V., Plaintiffs, v. Jason Weida, in his official capacity as Secretary for the Florida Agency for Health Care Administration, and Shevaun Harris, in her official capacity as Secretary for the Florida Department of Children and Families, Defendants.	Civil Case No. COMPLAINT

VERIFIED CLASS ACTION COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

I. INTRODUCTION

1. Defendants are terminating tens of thousands of Floridians from Medicaid coverage without providing them adequate individualized written notice of the reason for the termination and the opportunity for a pre-termination fair hearing as the Constitution and Medicaid Act require.

2. During the COVID-19 pandemic, federal legislation made generous, enhanced federal funding available to state Medicaid programs. This funding was conditioned on states agreeing to maintain their Medicaid eligibility rolls by curtailing the eligibility redetermination procedures that would otherwise apply at least annually. The requirement to maintain coverage ended March 31, 2023. As a result, states are reinstituting Medicaid eligibility redeterminations.

3. Starting March 1, 2023, Florida began redetermining eligibility for those whose coverage was maintained during the pandemic. This process, commonly referred to as "unwinding," is scheduled to be completed by May 2024. This class action challenges the standardized notices that Defendants use to inform Medicaid enrollees that they are no longer eligible and that their Medicaid coverage will end.

4. Among other things, Defendants routinely fail to include in the Medicaid notices the legal or factual basis for the agency's decision. Instead, the notices use a set of standardized "reason codes" many of which provide little or no explanation of the actual reason for the agency's decision.

5. These standardized notices have been used for years. Since before the COVID pandemic, Defendants have been "well aware that notices sent to beneficiaries generate confusion" and that the "current notices that describe applicants as ineligible are considered to be not sufficiently explicit in terms of an explanation." State Health Access Data Assistance Center (SHADAC), *Medicaid*

Eligibility, Enrollment, and Renewal Processes and Systems Study: Case Study Summary Report – Florida, 12 -13 (Oct. 19, 2018), https://www.macpac.gov/wp-content/uploads/2018/11/Florida-Summary-Report.pdf.

6. Defendants did not remedy these deficiencies before restarting eligibility determinations for Floridians after having paused redeterminations for three years during the pandemic.

7. As a result, Plaintiffs and class members are losing Medicaid coverage without meaningful and adequate notice, leaving them unable to understand the agency's decision, properly decide whether and how to contest their loss of Medicaid coverage, or plan for a smooth transition of coverage that minimizes disruptions in necessary care. Without Medicaid coverage, Plaintiffs are unable to obtain care they need, including prescription drugs, children's vaccinations, and post-partum care.

8. Absent this court's intervention, improper terminations will continue for the foreseeable future. Plaintiffs seek preliminary and permanent declaratory and injunctive relief to require Defendants to stop terminating Florida Medicaid enrollees until adequate notice and an opportunity for a pre-termination fair hearing has been provided.

II. JURISDICTION AND VENUE

9. Jurisdiction is conferred on this Court by 28 U.S.C. § 1331, which provides for original jurisdiction over all civil suits involving questions of federal law, and 28

U.S.C. § 1343(a)(3) and (a)(4), which grant this Court original jurisdiction in all actions authorized by 42 U.S.C. § 1983 to redress the deprivation under color of State law of any rights, privileges, or immunities guaranteed by the U.S. Constitution and Acts of Congress.

10. Plaintiffs seek declaratory, injunctive, and other appropriate relief pursuant to 29 U.S.C. §§ 2201 and 2202; Fed. R. Civ. P. 57 and 65; 42 U.S.C. § 1983; 42 U.S.C. § 12133; and the Fourteenth Amendment to the U.S. Constitution.

11. Venue for this action lies in this District pursuant to 28 U.S.C. § 1391(b), because a substantial part of the events or omissions giving rise to Plaintiffs' claims occurs here.

III. PARTIES

12. Plaintiff Chianne D. is 25 years old and a resident of Jacksonville, Duval County, Florida.

13. Plaintiff C.D. is two years old and a resident of Jacksonville, Duval County, Florida. She brings this case by and through her mother and Next Friend, Chianne D.

14. Plaintiff A.V. is a one-year-old resident of Miami-Dade County. She brings this case by and through her mother and Next Friend, Jennifer V.

15. Defendant Jason Weida is the Secretary of the Florida Agency for Health Care Administration (AHCA). AHCA is designated as the "single state agency" to

administer the state's Medicaid plan. 42 U.S.C. § 1396a(a)(5); Fla. Stat. §§ 409.902, 409.963 (2022). Defendant Weida is responsible for the implementation of the state's Medicaid program in compliance with the Constitution and federal law. Secretary Weida is based in Tallahassee, Leon County, Florida which is also where AHCA is headquartered. He is sued in his official capacity.

16. Defendant Shevaun Harris the Secretary of the Florida Department of Children and Families (DCF). AHCA has delegated to Ms. Harris, as Secretary of DCF, to direct and oversee all Medicaid eligibility determinations, including issuing notices relating to Medicaid eligibility determinations. Fla. Stat. § 409.902(1). Secretary Harris is based in Tallahassee, Leon County, Florida which is where DCF is headquartered. She is sued in her official capacity.

IV. CLASS ALLEGATIONS

17. Plaintiffs bring this class action on behalf of themselves and all other individuals similarly situated in the State of Florida pursuant to Rule 23(a) and (b)(2) of the Federal Rules of Civil Procedure.

18. Plaintiffs bring this case on behalf of a statewide class with two subclasses, defined as:

> All Florida Medicaid enrollees who are members of either of the two subclasses listed below and who on or after March 31, 2023, have been or will be found ineligible for Medicaid coverage.

Subclass A: Individuals issued a written notice that includes no reason code or only uses reason code(s) that do not identify the eligibility factor(s) Defendants relied on to determine the individual is ineligible for Medicaid. For purposes of this definition, eligibility factors are age, residency, income, assets or other non-cash resources, receipt of Social Security Administration benefits, Medicare enrollment, citizenship, immigration status, or Social Security Number, disability status, pregnancy, and incarceration status.

Subclass B: Individuals issued a written notice that relies on a reason code that states the individual or household is over income for Medicaid eligibility but does not identify the household income used in the eligibility determination or the applicable income standard.

19. The requirements of Rule 23(a) and (b)(2) of the Federal Rules of Civil Procedure are met for the following reasons:

a. The classes are so numerous that joinder of all members is impracticable.

i. As of February 28, 2023, there were 4,979,982 people enrolled in Florida's Medicaid program who will go through redetermination, including receiving a notice of action, during the 12-month unwinding period. *See* Florida Unwinding

Baseline Report, 2 (Mar. 8, 2023), https://www.floridahealthjustice.org/uploads/1/1/5/5/115598329/florida_unwinding_baseline_report_03.08.2023.pdf.

ii. As of June 30, 2023, the State reported that 182,857 people had been terminated from Medicaid or CHIP (Children's Health Insurance Program) due to ineligibility. *See* Kaiser Fam. Found., Medicaid Enrollment and Unwinding Tracker (July 31, 2023), https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-state-enrollment-and-unwinding-data/ (under "STATE DATA" tab, Figure 2).

iii. Defendants continue to issue notices that rely on the standardized "reason codes" that they used before the pandemic. Data obtained through public records requests from 2017 through 2019 show that Defendants routinely include the same handful of standardized reason codes in their notices communicating Medicaid ineligibility. For instance, during that timeframe more than 1 million individuals received a notice with the reason "YOUR HOUSEHOLD'S INCOME IS TOO HIGH TO QUALIFY FOR THIS PROGRAM"; more than 1.2 million received the reason "YOUR MEDICAID FOR THIS PERIOD

IS ENDING"; more than 1.5 million people received notices with the reason "YOU ARE RECEIVING THE SAME TYPE OF ASSISTANCE FROM ANOTHER PROGRAM"; more than 2 million received a notice with the reason "NO HOUSEHOLD MEMBERS ARE ELIGIBLE FOR THIS PROGRAM"; and nearly 900,000 received notices stating "WE REVIEWED YOUR CASE, YOU ARE STILL ELIGIBLE FOR MEDICAID, BUT IN A DIFFERENT MEDICAID COVERAGE TYPE."

b. The claims of the named Plaintiffs and putative class and subclasses raise common questions of law and fact. The named Plaintiffs received notices with Defendants' standardized reason codes. The notices also uniformly omit information regarding the applicable standards of eligibility for an individual's current Medicaid eligibility category or any information about what additional eligibility categories Defendants considered. Each notice also includes the same stock paragraph regarding fair hearings and appeal rights, which does not set forth complete information on how to request a fair hearing or accurately inform recipients about their appeal rights. Questions common to the class, therefore include:

i. Whether the reason codes used by Defendants satisfy the State's obligation under the constitution to provide notice "detailing the reasons for a proposed action," including the "legal and factual bases" for the decision, *Goldberg v. Kelly*, 397 U.S. 254, 267-68 (1970); or its obligation under the Medicaid Act to clearly inform the individual of the specific reasons for the intended action under 42 U.S.C. § 1396a(a)(3) and its implementing regulation, 42 C.F.R. § 431.210(b).

   A. For Subclass A, whether notices that provide no reason for the State's determination of ineligibility for Medicaid satisfy Defendants' obligations under the U.S. Constitution and/or the Medicaid Act.

   B. For Subclass B, whether a reason code that states someone is "over income" without identifying the household income or the applicable income standard satisfies the U.S. Constitution and/or the Medicaid Act.

ii. whether the standardized language that appears in notices regarding Medicaid fair hearings accurately reflects Defendants' policies and adequately explains the method for obtaining a hearing as required by due process and the Medicaid Act;

iii. whether Defendants' template notices create an unacceptable risk of confusion that denies recipients their ability to appeal an adverse action; and

iv. what administrative burden the state would face from adding explanation to the notices. *See Mathews v. Eldridge,* 424 U.S. 319, 347 (1976).

c. The claims of the Plaintiffs are typical of the claims of the class and subclasses in that the individual Plaintiffs and members of the class and subclasses are all individuals whom the Defendants found ineligible for Medicaid during the unwinding period without providing adequate written notice, including failing to identify the underlying basis for that determination in the notice communicating Medicaid ineligibility and failing to adequately inform the recipient of their fair hearing rights.

d. The representative Plaintiffs will fairly and adequately protect the rights of the class and subclasses because they suffer from the same deprivation as the other class and subclass members and have been denied the same constitutional and federal rights that they seek to enforce on behalf of those other class and subclass members.

e. The Plaintiffs' interests in obtaining injunctive relief for the violations of their rights and privileges are consistent with and not antagonistic to those of any person within the class or subclasses.

f. The interests of the class and subclasses will be adequately protected as Plaintiffs are represented by attorneys with experience in Medicaid class action litigation.

20. Defendants have acted on grounds generally applicable to the class and subclasses by relying on notices that use standardized "reason codes" that communicate only the ultimate conclusion without an explanation of the basis for the agency's decision, contain inaccurate and incomplete explanation of how to access fair hearings and uniformly omit legally required information, thereby making it appropriate for declaratory and injunctive relief on behalf of the class under Rule of Civil Procedure 23(b)(2).

V. THE LEGAL FRAMEWORK

A. Constitutional Due Process Requirements

21. Medicaid enrollees have a statutory entitlement to Medicaid benefits protected by the Due Process Clause of the Fourteenth Amendment, U.S. Const. amend. XIV, § 1; *O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 787 (1980).

22. The Due Process Clause guarantees individuals the right to a meaningful written notice of action and an opportunity for a hearing before being deprived of property. U.S. Const. amend. XIV, § 1.

23. Medicaid enrollees must be given timely and adequate notice detailing the reasons for a proposed termination and how they can challenge the action, and they must be given an opportunity to make their case before an impartial decision-maker prior to termination of their Medicaid coverage. *Goldberg v. Kelly*, 397 U.S. 254, 267–68 (1970).

24. Notice must be reasonably calculated, under all circumstances, to inform the recipient of the pending action and give them an opportunity to present their objections. *Mullane v. Cent. Hanover Bank & Trust Co.*, 339 U.S. 306, 314 (1950). To meet this requirement, a state Medicaid agency must use a method of notice that someone "who desires to actually inform the [recipient] might reasonably adopt to accomplish it." *Id.* at 315. To provide an "adequate statement of the basis," for the state's determination, the notice must "be sufficiently specific for it to enable an applicant to prepare rebuttal evidence to introduce at" the hearing. *Billington v. Underwood*, 613 F.2d 91, 94 (5th Cir. 1980).[1]

[1] The Eleventh Circuit has adopted as binding precedent all Fifth Circuit decisions issued before October 1, 1981, as well as all decisions issued after that date by a Unit B panel of the former Fifth Circuit. *Stein v. Reynolds Secs., Inc.*, 667 F.2d 33, 34 (11th Cir. 1982); *see also United States v. Schultz*, 565 F.3d 1353, 1361 n.4 (11th Cir. 2009) (discussing the continuing validity of *Nettles v. Wainright*, 677 F.2d 404, 409-10 (5th Cir. Unit B 1982)).

B. Medicaid Requirements

25. The Medicaid Act, 42 U.S.C. §§ 1396–1396w-7, establishes a medical assistance program cooperatively funded by the federal and state governments. The purpose of the Medicaid program is to enable each state, as far as practicable, "to furnish [] medical assistance" to individuals "whose income and resources are insufficient to meet the costs of necessary medical services" and to provide "rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." *Id.* § 1396-1.

26. The Centers for Medicare & Medicaid Services (CMS) of the United States Department of Health and Human Services (HHS) is the agency that administers Medicaid at the federal level.

27. A state's participation in Medicaid is voluntary. Once a state elects to participate, it must adhere to the federal legal requirements, as provided by the United States Constitution, the Medicaid Act, and the regulations and guidelines promulgated by CMS.

28. Florida participates in Medicaid. Fla. Stat. §§ 409.901-.9205.

29. The Medicaid Act requires each participating state to designate a single state agency to administer and supervise the state's Medicaid program. 42 U.S.C. § 1396a(a)(5); 42 C.F.R. § 431.10. While a state may delegate certain responsibilities to other entities, such as other state or local agencies, the single state

agency remains responsible for ensuring compliance with all aspects of the Medicaid Act. *See, e.g.*, 42 C.F.R. § 438.100(a)(2), 438.100(d).

30. AHCA is the single state agency in Florida. *See* Fla. Stat. § 409.902.

31. States receive federal matching funding, called Federal Financial Participation (FFP), for Medicaid services provided to eligible enrollees. The federal government matches the state's Medicaid expenditures at a specified rate. 42 U.S.C. §§ 1396b(a), 1396d(b). Florida currently receives a federal matching rate of approximately 60% (60 cents of every dollar spent) for medical services. U.S. Dep't of Health & Hum. Servs., Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2022 Through September 30, 2023, 86 Fed. Reg. 67479, 67481 (Nov. 26, 2021).

32. Between March 31, 2023 and December 31, 2023 the federal matching rate for medical services is enhanced for states if they conduct eligibility redeterminations consistent with all federal requirements. 42 U.S.C. § 1396d note (amended by Consolidated Appropriations Act, 2023, Pub. L. No. 117-328, § 5131).

33. For administrative expenses, including those related to the redetermination process, states generally receive a matching rate of 50%. 42 U.S.C. § 1396b(a)(7); 42 C.F.R. § 435.1001.

34. States receive a 75% match for expenses related to the operation of a computerized eligibility determination system. 42 U.S.C. § 1396b(a)(3)(B).

35. States must make Medicaid available to all individuals who meet the eligibility criteria. 42 U.S.C. § 1396a(a)(10).

36. The Medicaid Act lists the population groups that must be covered by the state, as well as options for states to extend Medicaid to additional population groups. 42 U.S.C. § 1396a(a)(10)(A), (C).

37. The mandatory population groups include: low-income children; parents and other caretaker relatives; pregnant women; the elderly, blind, or disabled; individuals under age 26 who were in foster care until age 18; and adults who are under age 65, are not eligible for Medicare, do not fall within another Medicaid eligibility category, and have household incomes below 133% of the federal poverty level (FPL) (this last group is often referred to as the "expansion population"). 42 U.S.C. § 1396a(a)(10)(A)(i), (e)(14). In addition, individuals who receive Supplemental Security Income are automatically enrolled in Medicaid. 42 U.S.C. § 1396a(a)(10)(A)(i)(II)(aa); 42 C.F.R. § 435.120.

38. A Supreme Court decision, *National Federation of Independent Business v. Sebelius*, 567 U.S. 519, 588 (2012), bars HHS from terminating Medicaid funding to states that choose not to extend Medicaid coverage to the expansion population group. Florida does not cover the expansion population group.

39. In 2022, Florida elected the option to cover pregnant women for a continuous 12-months postpartum. Individuals who are enrolled in Medicaid or CHIP while pregnant are eligible for 12 months of postpartum coverage, regardless of changes in circumstances, like increases in income. *See* 42 U.S.C. § 1396a(e)(16); Letter from Danielle Daly, Dir. Div. of Demonstration Monitoring & Evaluation, Ctrs. For Medicare & Medicaid Servs., to Tom Wallace, Dep. Sec'y for Medicaid, Fla. Agency for Health Care Admin, 35 (Oct. 12, 2022), https://ahca.myflorida.com/content/download/20386/file/FLA_MMA_STCs_Oct_2022.pdf.

40. Florida also extends one-year continuous coverage, regardless of changes in circumstance, to children under age five and extends six-month continuous coverage to children under age 19. 42 U.S.C. § 1396a(e)(12); Fla. Stat. § 409.904(6).

41. In addition to fitting within a covered population group, an individual must have limited income and, for some population groups, limited resources or assets. Income consists of wages and tips earned through employment, unemployment compensation, pension benefits, interest or dividends, alimony received, tax refunds, rental income, or the taxable amount of social security benefits. Resources consist of cash or other real and personal property that can be liquidated or converted into cash.

42. Income eligibility is established using one of two sets of rules: (1) Modified Adjusted Gross Income (MAGI) rules, which count income based on

federal tax rules and does not include an asset or resource test, or (2) non-MAGI rules, which follow the Medicaid eligibility rules in place before implementation of the Affordable Care Act in 2014 and can include an asset or resource test. 42 U.S.C. § 1396a(e)(14); 42 C.F.R. § 435.603.

43. MAGI rules apply to most children, pregnant women, parents, and adults with low incomes. Income eligibility is based on taxable income, and the household size is determined based on the number of people in the tax household. 42 U.S.C. § 1396a(e)(14)(A); 42 C.F.R. § 435.603(b).

44. Non-MAGI rules apply to individuals who qualify for Medicaid based on blindness, disability, or age (65 or older), certain foster care children, and certain working individuals with disabilities. 42 C.F.R. § 435.603(j).

45. The income limits to qualify for Medicaid coverage vary between population groups. In Florida among the MAGI groups, the income limit for pregnant women is 196% of the federal poverty level (FPL), for children under age one it is 211%, for children ages one to five it is 145%, and for children ages six to 18 it is 138%. The income limit for parents and caretakers and young adults aged 19-20 is calculated based on the Aid to Families with Dependent Children payment levels in 1996 (when AFDC was repealed and replaced by Temporary Aid for Needy Families). This income limit is currently approximately 28% FPL. Fla. Admin. Code R. 65A-1.707; *see also* Dep't of Children & Families, CFOP 165-22, Economic Self

Sufficiency Program Policy Manual, Appendix A-7 (2023) https://www.myflfamilies.com/services/public-assistance/additional-resources-and-services/ess-program-manual.

46. For the non-MAGI groups, the income limits range between 88% to 300% FPL. The income-counting rules are based on the income counting rules of the cash assistance program most closely related to the individual's status (*e.g.*, disabled, older adult). These income rules disregard some types of income, for example the earned income of a dependent child who is a student and not a full-time employee is disregarded before comparing a household's income against the income standard. 45 C.F.R. § 233.20(a)(3)(xix). The non-MAGI groups are also subject to a resource/asset limit. Fla. Admin. Code R. 65A-1.712-.713; *see also* Dep't of Children and Families, CFOP 165-22, Economic Self Sufficiency Program Policy Manual, Appendix A-9 (2023) https://www.myflfamilies.com/services/public-assistance/additional-resources-and-services/ess-program-manual.

47. Florida also operates a "medically needy" program for otherwise eligible individuals whose incomes are too high to qualify for Medicaid. Individuals enrolled in this program have a monthly "share of cost." The share of cost varies depending on the size of the Medicaid household and their income.

48. Medically needy coverage is time limited. It does not begin in any given month until a family provides allowable medical bills that equal or exceed the share

of cost. Once the share of cost has been met, coverage lasts through the end of that month and must be met again the following month before Medicaid coverage begins.

49. States are required to administer Medicaid in "the best interests of the recipients." 42 U.S.C. § 1396a(a)(19).

50. For most Medicaid enrollees, states are required to conduct a redetermination of their eligibility (sometimes referred to as "renewal") once every 12 months, unless there is an earlier change in circumstance affecting eligibility. 42 C.F.R. § 435.916(a)(1), (b), and (d).

51. States must ensure a streamlined process for people to remain enrolled in Medicaid. 42 U.S.C. § 18083; 42 U.S.C. § 1396w-3(3). This includes attempting to renew individuals based on information already available to the agency without requesting additional information from the individual, a process known as "ex parte" redetermination. 42 C.F.R. § 435.916.

52. When the state must ask for additional information from the enrollee, the Medicaid agency must provide assistance to aid individuals seeking help with the redetermination process. 42 C.F.R. § 435.908(a).

53. During redetermination, if the state determines an individual is no longer eligible in their current population group, then the state must evaluate the individual in all other groups before terminating coverage. This includes maintaining Medicaid

coverage while requesting additional information necessary to evaluate eligibility in other groups. 42 C.F.R. §§ 435.911(c)(2), 435.916(f)(1), 435.930(b).

54. If the state determines that the enrollee is not eligible for Medicaid on any basis, it must send advance written notice prior to termination. *Goldberg v. Kelly*, 397 U.S. 254 (1970); 42 C.F.R. § 431.205(d) (state Medicaid agency must "meet the due process standards set forth in *Goldberg v. Kelly*, 397 U.S. 254 (1970)").

55. The notice must "detail[] the reasons for the proposed termination," including both "the legal and factual bases" for the decision. *Goldberg v. Kelly*, 397 U.S. at 267-68; 42 U.S.C. § 1396a(a)(3). *See also* 42 C.F.R. § 431.210 (notice must include a statement of what action the agency intends to take; the effective date of such action; "a clear statement of the specific reasons supporting the intended action"; and the specific regulations that support, or the change in Federal or State law that requires, that action).

56. Notices must "clearly" explain "the availability of an avenue of redress." *Memphis Light, Gas & Water Div. v. Craft*, 436 U.S. 1, 13-14 n.15 (1978). *See also* 42 U.S.C. § 1396a(a)(3); 42 C.F.R. § 431.206 (notice must explain the individual's right to request a hearing; the method of requesting the fair hearing; and an explanation of the circumstances when Medicaid coverage is continued if a hearing is requested).

57. Upon timely request by the enrollee, the state must ensure that Medicaid coverage is maintained pending a pre-termination hearing. *Goldberg v. Kelly*, 397 U.S. 254, 264 (1970); 42 C.F.R § 431.230.

58. The state must provide the individual an opportunity for a pre-termination evidentiary hearing to contest the termination. The hearing must provide an "effective opportunity" to challenge a termination "as resting on incorrect or misleading factual premises or on misapplication of rules or policies to the facts of particular cases." *Goldberg v. Kelly*, 397 U.S. 254, 268 (1970). *See also* 42 U.S.C. § 1396a(a)(3); 42 C.F.R. § 431.205.

59. For persons who are determined ineligible for Medicaid, the agency must assess the individual's potential eligibility for other insurance affordability programs, including CHIP and as appropriate transfer the individual's account to the Marketplace. 42 U.S.C. § 18083; 42 C.F.R. § 435.1200(e).

C. Medicaid Redetermination in Florida

60. AHCA has delegated responsibility for eligibility determinations and redeterminations to the Department of Children and Families (DCF). Fla. Stat. § 409.902(1). DCF also has responsibility for administering other public benefits programs including Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF).

61. In March 2020, to obtain enhanced funding made available by the Families First Coronavirus Response Act, Defendants implemented processes to maintain Medicaid eligibility and pause annual Medicaid redeterminations for individuals enrolled in the program.

62. After the Consolidated Appropriations Act of 2023 announced that the continuous coverage requirement would end on March 31, 2023, Florida released a "redetermination plan" describing how the State would restart Medicaid redeterminations. *See* Florida's Medicaid Redetermination Plan, https://www.myflfamilies.com/sites/default/files/2023-04/Floridas-Plan-for-Medicaid-Redetermination.pdf (last visited Aug. 21, 2023).

63. The redetermination plan estimates that the State must redetermine eligibility for approximately 4.9 million enrollees between April 1, 2023 and March 31, 2024.

64. AHCA's delegee, DCF, uses a standardized notice generated by a computer system to notify an individual that she is no longer eligible for Medicaid.

65. The notices do not adequately explain the eligibility decision.

66. The notices include sections labeled either "Medicaid" or "Medically Needy."

67. Underneath each section heading is a list of household members with the word "eligible," "enrolled," or "ineligible" next to each name. A given section may

list all household members or only some household members. The notices do not explain why particular household members are or are not listed in a given section.

68. A single notice may include multiple sections labeled "Medicaid" and multiple sections labeled "Medically Needy." The same household member may appear in multiple sections in the same notice. It is possible for a single notice to indicate in different sections that an individual is both "eligible" or "enrolled", and "ineligible" for Medicaid or Medically Needy.

69. If a particular section indicates that coverage is "approved" for some individuals in the household, while others are listed as "ineligible," there is no reason given for why the individuals who have been found ineligible are ineligible.

Medically Needy

Your application for Medically Needy dated April 21, 2023 is **approved**. You are enrolled with an estimated share of cost for the months listed below:

Name	**Jun, 2023 Ongoing**
S[redacted] D[redacted]	Ineligible
Chianne D[redacted]	Enrolled
Chandler D[redacted]	Ineligible
Share of Cost	$4833.00

Did you know you now have an on-line account with us? Go to www.myflorida.com/accessflorida. You will need your case number, [redacted] to activate your My ACCESS Account. Then you can get into your account with a user name and password of your choice.

If members of your household are not eligible for Medicaid, they may be able to get coverage from the Florida KidCare Program for children under 19 or the Federally Facilitated Marketplace (FFM). In accordance with section 1943 (b)(1)(D) of the Social Security Act , DCF is required to forward potentially eligible applications to Florida KidCare or the FFM for review. Once your information is in the possession of the FFM the State of Florida no longer has the ability to ensure its security. You do not need to submit a new application. Please check your My ACCESS Account at http://www.myflorida.com/accessflorida/ to see if your application has been forwarded to Florida KidCare or the FFM.

70. If all individuals listed in a given section are ineligible, the standardized notice is populated with one or more "reason codes." The reason codes are typically a single phrase pulled from a finite list of options.

71. The reason codes do not include any placeholders for individualized information.

72. The reason codes appear after the word "Reason:" and are printed in all capital letters.

73. Some notices use the reason code: "YOUR HOUSEHOLD'S INCOME IS TOO HIGH TO QUALIFY FOR THIS PROGRAM." Notices may also state "We have reviewed your eligibility for full Medicaid benefits and have determined you are not eligible because your income exceeds the limit for Medicaid." The notices provide no additional information, such as the calculation of income or the applicable income limit for the program.

74. Other common reason codes inform the person they have been terminated without explaining the factual basis for why the person has been found ineligible. For instance:

- "YOUR MEDICAID FOR THIS PERIOD IS ENDING"
- "NO HOUSEHOLD MEMBERS ARE ELIGIBLE FOR THIS PROGRAM"
- "YOU ARE RECEIVING THE SAME TYPE OF ASSISTANCE FROM ANOTHER PROGRAM"

- "YOU OR A MEMBER(S) OF YOUR HOUSEHOLD REMAIN ELIGIBLE FOR MEDICAID UNDER A DIFFERENT MEDICAID COVERAGE GROUP."

75. Notices that state "YOU ARE RECEIVING THE SAME TYPE OF ASSISTANCE FROM ANOTHER PROGRAM" do not identify what other program is being referenced.

Medicaid

Your Medicaid benefits for the person(s) listed below will end on May 31, 2023.

Name

C[redacted] D[redacted]

Chianne D[redacted]

Chandler D[redacted]

Reason: YOU ARE RECEIVING THE SAME TYPE OF ASSISTANCE FROM ANOTHER PROGRAM

The law that supports this action is:

(FL Admin. Code = R) (FL Statute = S), S414.095

76. Defendant DCF has stated that the reason code "YOUR MEDICAID FORTHIS PERIOD IS ENDING" is used to cover several different circumstances but the recipient is not informed what those circumstances are. For example, DCF has stated that the meaning of the reason code "[varies] based upon each [case's] individual circumstances." DCF has also stated that this reason code is "used in cases when there are multiple reasons for the action." Most recently, DCF has stated that the code is "used because it is following prior notices. . . advising the individual to perform a certain action."

77. The termination notices do not identify any factual information regarding the household, such as the age, income, pregnancy, or disability status Defendants used when making the eligibility determination.

78. The only household-specific information Defendants include in the notice are the names of the individuals in the household and certain dates, such as, the date the notice was issued, the date the Defendants completed the eligibility determination, and dates when coverage will begin or end.

79. The termination notices do not identify the population group into which the enrollee was placed prior to the decision to terminate them or why the applicable eligibility standards for that group are no longer met.

80. Knowing the individual's population group prior to the notice of termination can be essential for the individual to understand if the termination is erroneous, particularly if the person is in a coverage group entitled to continuous eligibility for six or 12 months regardless of a change in circumstances.

81. The termination notices do not indicate that household members were evaluated to determine whether they come within any other covered population groups prior to being terminated. Without information about the population groups that the state considered when making its eligibility determination, an individual cannot identify other population groups they might now be eligible for based on new circumstances, such as birth of a child or onset of a disability.

82. The notices include standardized language regarding how to request a fair hearing: "If you want a hearing, you must ask for the hearing by writing, calling the call center or coming into an office within 90 days from the date at the top of this notice."

83. The notices do not provide a physical address for mailing the request for a hearing.

84. Call center wait times can be prohibitively long.

85. Florida is in the top three among all states for long call center wait times and has the highest call abandonment rates. The average wait time is 40 minutes, and 48% of calls are abandoned. *See* CMS, *Medicaid and CHIP CAA Reporting Metrics* (July 28, 2023), https://data.medicaid.gov/dataset/7218cbef-f485-4daa-8f69-e50472eab416. CMS has recently expressed "concerns that [Florida's] average call center wait time and abandonment rate are impeding equitable access to assistance." CMS, *Florida May 2023 Unwinding Data Letter* (Aug. 9, 2023), https://www.medicaid.gov/sites/default/files/2023-08/fl-may-2023-unwinding-data-ltr.pdf. Furthermore, the barriers are significantly higher for non-Englisb speakers. The average Spanish-language caller has to wait nearly two and a half hours and 30% of Spanish-language calls are disconnected. *See* UnidosUS, "At Florida's Medicaid call center, long and discriminatory delays prevent eligible

families from keeping their health care" (Aug. 2023), https://unidosus.org/publications/long-and-discriminatory-delays-at-floridas-call-center/.

86. While the notices state that a person can ask for a hearing by coming into an office, the notices do not provide an address to a physical office where the person should go.

87. Over the years, Florida has closed many offices. There are currently fewer than 50 "storefronts" or service centers in the State. The majority of offices are located in large urban areas. *See* Fl. Dep't of Child. & Fam., "ESS Storefronts and Lobbies" https://www.myflfamilies.com/services/public-assistance/additional-resources-and-services/ess-storefronts-and-lobbies (last visited Aug. 21, 2023).

88. The notices do not inform individuals that they have the option to request a hearing via email or through an online link.

89. The notices state: "You will be responsible to repay any benefits if the hearing decision is not in your favor."

90. However, DCF policy only authorizes the recovery of overpayments in Family-Related Medicaid that are the result of "Fraud or intentional program violation." *See* ESS Program Policy Manual, §§ 3630.0200, 3630.0300, https://www.myflfamilies.com/sites/default/files/2023-02/3600.pdf (last visited Aug. 21, 2023).

91. On information and belief, the notices read at a tenth grade level, while the reading level of most adults in the United States is eighth grade.

92. The notices are confusing.

93. Defendants have been aware of deficiencies in the notices for years.

94. In 2018, state officials reported "being well aware that notices sent to beneficiaries generate confusion" and that the "current notices that describe applicants as ineligible are considered to be not sufficiently explicit in terms of an explanation." State Health Access Data Assistance Center (SHADAC), *Medicaid Eligibility, Enrollment, and Renewal Processes and Systems Study: Case Study Summary Report – Florida*, 12 -13 (Oct. 19, 2018), https://www.macpac.gov/wp-content/uploads/2018/11/Florida-Summary-Report.pdf.

VI. STATEMENT OF FACTS AS TO THE NAMED PLAINTIFFS

A. Plaintiffs Chianne D. and C.D.

95. Plaintiff Chianne D. resides in Jacksonville, Florida with her husband Chandler and their two children, Plaintiff C.D. (age two) and S.D. (age six months). For Medicaid eligibility purposes, this is a four-person household.

96. Plaintiff C.D. was diagnosed with Cystic Fibrosis in 2021 and has been on Medicaid since that time.

97. C.D. requires significant medical care including expensive prescription drugs, medical daycare, physician and therapy visits, medical equipment and periodic hospitalizations.

98. Plaintiff Chianne D. was enrolled in Medicaid when she was pregnant with S.D.

99. Plaintiff Chianne D. gave birth to S.D. in February 2023. S.D. was enrolled in Medicaid at that time.

100. In February 2023, Chianne met the eligibility requirements for 12-months continuous coverage regardless of a change in income, meaning that her Medicaid coverage should have been maintained through at least February 2024.

101. Defendant DCF issued a 12-page notice to the Plaintiff Chianne D.'s family on April 24, 2023. The notice states that their "Medicaid application/review" is denied for all family members for April, May and June 2023 with the reason "YOUR HOUSEHOLD'S INCOME IS TOO HIGH TO QUALIFY FOR THIS PROGRAM" and "YOU ARE RECEIVING THE SAME TYPE OF ASSISTANCE FROM ANOTHER PROGRAM."

102. The April 24, 2023 notice states on page eight that Medicaid will end on May 31, 2023 for Chianne and C.D. with the reason: "YOU ARE RECEIVING THE SAME TYPE OF ASSISTANCE FROM ANOTHER PROGRAM."

103. The April 24, 2023 notice did not state that either Plaintiff Chianne D. or C.D. were being referred to any other program, such as CHIP, for potential coverage and Defendants did not notify the family about any such alternative coverage.

104. The notice included three different sections labeled "Medically Needy." Two of these sections contain identical information about the eligibility status for three household members. The third section lists all four household members, but contains conflicting information about the eligibility status of the three household members identified in the other sections.

105. Plaintiff Chianne D. was utterly confused by the notice. She did not understand what action DCF was taking or why. As a result, Chianne was unable to prepare a response to the proposed termination of coverage.

106. Chianne contacted DCF. The DCF representative was unable to answer her questions regarding the meaning of the notice. The agent told her "I'm not going to sit here and answer your questions" and "I don't know why you're not getting this." When Chianne pressed for an explanation of what "YOU ARE RECEIVING THE SAME TYPE OF ASSISTANCE FROM ANOTHER PROGRAM" meant, the agent told her "I have a rule that says I cannot talk to you for over 20 minutes." Chianne explained that C.D.'s need for coverage was urgent and ongoing.

107. If Chianne had understood the status of C.D.'s Medicaid eligibility and that C.D. would retain Medicaid coverage pending the appeal, she would have submitted an appeal on C.D.'s behalf.

108. The notice did not alert Chianne that she could remain eligible for continued Medicaid through the postpartum population group. Thus, she was unaware that she could pursue a fair hearing to challenge her own loss of coverage.

109. Plaintiffs Chianne D. and C.D. lost Medicaid coverage on May 31, 2023.

110. In June, without Medicaid coverage, C.D. went without necessary medical care. Chianne had to cancel a doctor's appointment. C.D. was unable to attend medical daycare. Chianne cared for her, while also caring for her infant son and attending school full time.

111. In June, C.D. missed multiple weeks of her prescription drugs and as a result, lost her appetite and was constantly tired and moody. She developed a loud, persistent cough and had to go to the emergency room for treatment because her primary care provider would not see her without insurance coverage.

112. The hospital prescribed additional medication for C.D. Plaintiff Chianne D. has had to borrow money from a family member to pay for the prescriptions.

113. The family owes $2,800 for the hospital visit and another $1,136 for other bills, including a charge for radiology services performed by a specialist during her emergency room visit and the monthly cost of her nebulizer and related supplies.

114. The hospital bill has been sent to collections. The family is saving money to pay the bill and has had to take money out of savings to buy diapers for S.D. and delay the introduction of solid foods to S.D. because the family cannot afford them.

115. The financial burden is causing the family significant stress.

116. Plaintiff Chianne D. was able to enroll C.D. in MediKids, Florida's CHIP coverage for children ages one through four, as of July 1, 2023. This coverage costs the family $248 a month.

117. Plaintiff Chianne D. remains without coverage. In June and July 2023, she became sick multiple times but could not see a doctor.

B. Plaintiff A.V.

118. Plaintiff A.V., age one, lives with her parents and five siblings (all of whom are claimed as dependents by A.V.'s parents) in Miami Dade County. For Medicaid eligibility purposes, this is an eight-person household.

119. Plaintiff A.V. has been on Medicaid since she was born in May 2022 and her Medicaid began in June 2022. Three of her siblings who are under age 18 are on KidCare, Florida's CHIP coverage for children ages five and older. One sibling is on Medicaid because she is disabled and receives Supplemental Security Income (SSI).

120. Throughout her life, Plaintiff A.V. has relied on Medicaid to cover her medical care. This care includes all of her checkups and vaccines.

121. Plaintiff A.V. had an appointment for a vaccination on June 6, 2023. However, on or about June 5th, her mother received a call from A.V.'s pediatrician saying that she was no longer insured and that her appointment was being canceled.

122. Plaintiff A.V.'s mother then read through an 8-page notice from DCF dated May 16, 2023 that she had received by mail.

123. Plaintiff A.V.'s mother was confused by the May 16th notice. The notice had seven different sections labeled "Medically Needy," but each section had different information. Different sections listed different family members and different "share of cost" amounts for the same month. She did not understand what the "share of cost" amount is, how it was calculated, or why it changes depending on which section of the notice it is listed in.

124. The notice did not mention that Medicaid was ending until the bottom of page five where it stated "your Medicaid benefits for the person(s) listed below will end on May 31, 2023." The notice then listed everyone in the household except the child who qualifies for Medicaid because she receives SSI.

125. The reason given is: "YOU OR A MEMBER(S) OF YOUR HOUSEHOLD REMAIN ELIGIBLE FOR MEDICAID UNDER A DIFFERENT MEDICAID COVERAGE GROUP."

126. Plaintiff A.V.'s mother, Jennifer, did not understand the meaning of the phrase "REMAIN ELIGIBLE FOR MEDICAID UNDER A DIFFERENT

MEDICAID COVERAGE GROUP." She thought that A.V. should still be on Medicaid because the notice stated that she was in a "different Medicaid coverage group," and she believed that A.V. was still eligible for Medicaid because she is only one-year old. Also, based on ber prior experience with Medicaid, she thought that it could mean that her daughter was being transferred to a new Medicaid managed care plan.

127. Plaintiff A.V.'s mother is also confused that other family members were listed as having "their Medicaid benefits end," because as of May 2023, only her child with SSI (who was not listed) and A.V. were enrolled in Medicaid.

128. Plaintiff A.V.'s mother did not understand the section of the notice addressing how to request a fair hearing.

129. Plaintiff A.V.'s father also tried to find out what happened and determine whether A.V. could be covered by some type of health insurance. He called Plaintiff A.V.'s Medicaid managed care plan, the federally facilitated marketplace (FFM) and the Florida Healthy Kids Corporation (FHKC) which is in charge of the KidCare program. FHKC told A.V.'s father that the family needed to open a separate account on ACCESS and reapply for Medicaid for A.V. Plaintiff A.V.'s parents did not understand what was happening or what to do next.

130. A.V.'s mother is aware of the fact that children, like A.V., have inevitable and unpredictable medical needs. Even though A.V. is currently healthy,

she could have a sudden illness or accident. A.V. also needs to have insurance so she can go to her well-child checkups and receive necessary vaccines, including one that she missed because of her loss of Medicaid eligibility. A.V. remains without Medicaid coverage.

VII. CAUSES OF ACTION

COUNT I
Violation of Constitutional Due Process, U.S. Const., amend. XIV, § 1

131. Plaintiffs incorporate and re-allege paragraphs 1 through 130 as if fully set forth herein.

132. The Due Process Clause of the Fourteenth Amendment of the U.S. Constitution bars the state from depriving a person of their property, which includes Medicaid benefits, without affording the individual adequate advance notice and an opportunity to be heard prior to the termination of the benefits U.S. Const. amend. XIV, § 1; *Goldberg v. Kelly*, 397 U.S. 254, 267–68 (1970).

133. Defendants have deprived, and continue to deprive, Plaintiffs of due process in violation of the Fourteenth Amendment by:

a. Creating a risk of erroneous deprivation of Medicaid coverage;

b. Failing to provide timely, effective notice of the basis for the agency's decision or enrollees' rights and responsibilities pertaining to their Medicaid coverage; and

c. Failing to provide a meaningful opportunity for a fair hearing and timely corrective action as needed prior to termination of Medicaid coverage.

134. Plaintiffs seek relief on this claim pursuant to 42 U.S.C. § 1983, which provides a cause of action to redress the deprivation of their constitutional rights by persons acting under color of state law.

COUNT II
Violation of the Medicaid Act, 42 U.S.C § 1396a(a)(3)

135. Plaintiffs incorporate and re-allege paragraphs 1 through 134 as if fully set forth herein.

136. The Medicaid Act requires all state programs 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 is not acted upon with reasonable promptness." 42 U.S.C. § 1396a(a)(3).

137. Defendants have systematically failed, and continue to fail, to:

a. Provide timely, effective notice of the basis for the agency's decision or enrollees' rights and responsibilities pertaining to their Medicaid coverage; and

b. Provide an opportunity for a fair hearing and timely corrective action as needed prior to termination of Medicaid coverage.

138. Plaintiffs seek relief on this claim pursuant to 42 U.S.C. § 1983, which provides a cause of action to redress the deprivation of their rights under federal law by persons acting under color of state law.

REQUEST FOR RELIEF

WHEREFORE, Plaintiffs respectfully request that this Court grant the following relief:

a. Certify this case as a class action pursuant to Fed. R. Civ. P. 23(a) and 23(b)(2).

b. Enter a declaratory judgment, in accordance with 28 § U.S.C. 2201 and Fed. R. Civ. P. 57, declaring that Defendants' standardized notices communicating Medicaid ineligibility violated and continue to violate Plaintiffs' rights under the Due Process Clause of the Fourteenth Amendment and the Medicaid Act, 42 U.S.C. § 1396a(a)(3).

c. Issue preliminary and permanent injunctive relief prohibiting Defendants, their agents, successors, and employees from continuing the agencies' illegal policies and practices and to prospectively reinstate Medicaid coverage to Plaintiffs and all affected class members until timely and legally adequate notice of termination has been provided to them;

d. Retain jurisdiction over this action to ensure Defendants' compliance with the mandates of the Court's Orders;

e. Award Plaintiffs costs and reasonable attorney's fees and costs as provided by 42 U.S.C. §§ 1988(b) and 12133 and 29 U.S.C. § 794a(b); and

f. Order such other, further or additional relief as the Court deems just and equitable.

Dated: August 22, 2023

Respectfully submitted,

FLORIDA HEALTH JUSTICE PROJECT
By: */s/ Katy DeBriere*

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** *Application for admission pro hac vice forthcoming.*

VERIFICATION

I, Chianne D., am the mother and legal guardian of C.D., a named Plaintiff in this Class Action Complaint for Declaratory and Injunctive Relief styled *Chianne D., et al. v. Weida, et al.* (Complaint). I am personally familiar with the facts contained in the Complaint as they relate to myself, my daughter, C.D., and my family circumstances.

Pursuant to 28 U.S.C. § 1746, I verify, under penalty of perjury, that the factual statements in the Complaint concerning myself, my daughter C.D., and my family are true and correct to the best of my knowledge, information, and belief.

Executed On: Aug 20, 2023

Chianne D.

VERIFICATION

I, Jennifer V., am the mother and legal guardian of A.V., a named Plaintiff in this Class Action Complaint for Declaratory and Injunctive Relief styled *Chianne D., et al. v. Weida, et al.* (Complaint). I am personally familiar with the facts contained in the Complaint as they relate to my daughter, A.V., and my family circumstances.

Pursuant to 28 U.S.C. § 1746, I verify, under penalty of perjury, that the factual statements in the Complaint concerning myself, my daughter A.V., and my family are true and correct to the best of my knowledge, information, and belief.

Executed On: Aug 20, 2023

Jennifer V.

Jennifer V.

Medicaid Enrollees Challenge Florida's Failure to Provide Due Process During Unwinding

Miriam Delaney Heard, Sarah Grusin, Amanda Avery

Two toddlers and their mothers have filed a class action lawsuit challenging Florida's unlawful termination of their Medicaid benefits without first providing adequate written notice. The case, *Chianne D. et al v. Jason Weida*, was filed on August 22, 2023 by the National Health Law Program and the Florida Health Justice Project with claims alleging violations of the Due Process Clause of the Fourteenth Amendment and the Medicaid Act.

In 2018, Florida officials admitted that the notices sent to Medicaid enrollees create confusion and provide insufficient explanations. Nonetheless, the State continues to use these notices to inform hundreds of thousands of Floridians that their Medicaid coverage is ending. With the end of the continuous coverage provisions, Florida began redeterminations for Medicaid enrollees whose coverage was maintained throughout the pandemic. To date, some 182,857 enrollees have had their Medicaid benefits terminated because they were determined to be ineligible. The notices are extremely confusing. They give no explanation for why the agency terminated Medicaid, often using conclusory explanations such as "Your Medicaid for this period is ending." They also routinely identify persons as both eligible and ineligible for Medicaid, leading Medicaid enrollees to believe that they still had medical coverage until they were unable to access essential medications, postpartum care, vaccines, and other essential health services.

The plaintiffs spent hours on the phone attempting to obtain clarity but were not told why their Medicaid had been terminated or how to file an appeal.

Plaintiffs detailed their experiences:

- Chianne D. and her family of four depended on Medicaid for crucial medical care. She was informed by medical providers that her Medicaid coverage was about to end. When she accessed an online account, she found a 12-page document that was utterly confusing. The only explanation provided were two statements: "YOUR HOUSEHOLD'S INCOME IS TOO HIGH TO QUALIFY FOR THIS PROGRAM" and "YOU ARE RECEIVING

THE SAME TYPE OF ASSISTANCE FROM ANOTHER PROGRAM." Chianne did not understand who in her family was losing coverage, what income the agency used to calculate her family's eligibility, or what other assistance from another program she was purportedly receiving. She called the Department of Children & Families to get answers, but the agent would not answer her questions. Since her Medicaid was terminated in May, Chianne has been ill numerous times, but without Medicaid, she cannot afford to see her doctor.

- Plaintiff C.D. is Chianne's two-year-old daughter who was diagnosed with Cystic Fibrosis as an infant. C.D. depends on Medicaid to pay for life-saving medication, medical day care, physician and therapy visits, and medical equipment including a nebulizer and chest compression vest. Since her Medicaid was abruptly terminated on May 31,2023, C.D. has suffered from fatigue and a loss of appetite. She also developed a loud, persistent cough. Her family could not afford to take C.D. to her primary care physician and on June 7, 2023 she had to wait instead for hours in the hospital emergency room for treatment. The family still has an outstanding hospital bill of $2,800.00.

- Plaintiff A.V is a one-year-old girl who has been on Medicaid since she was born. She depends on Medicaid to cover her checkups and vaccines. Her mother learned that her Medicaid was terminated when A.V.'s pediatrician cancelled her June 6, 2023 appointment. When her mother, Jennifer, checked her online account, she read a notice that stated "YOU OR A MEMBER OF YOUR HOUSEHOLD REMAIN ELIGIBLE FOR MEDICAID UNDER A DIFFERENT MEDICAID COVERAGE GROUP." Jennifer did not understand that this was supposed to mean A.V. was losing coverage.

Plaintiffs have petitioned the court for preliminary and permanent injunctive relief that would reinstate the Medicaid benefits for themselves and any other enrollees who have been terminated after receiving deficient notices and prevent the state from terminating the Medicaid of other enrollees until the state provides all enrollees with adequate and timely notice.

Unwinding Issues – Disability and LEP Issues

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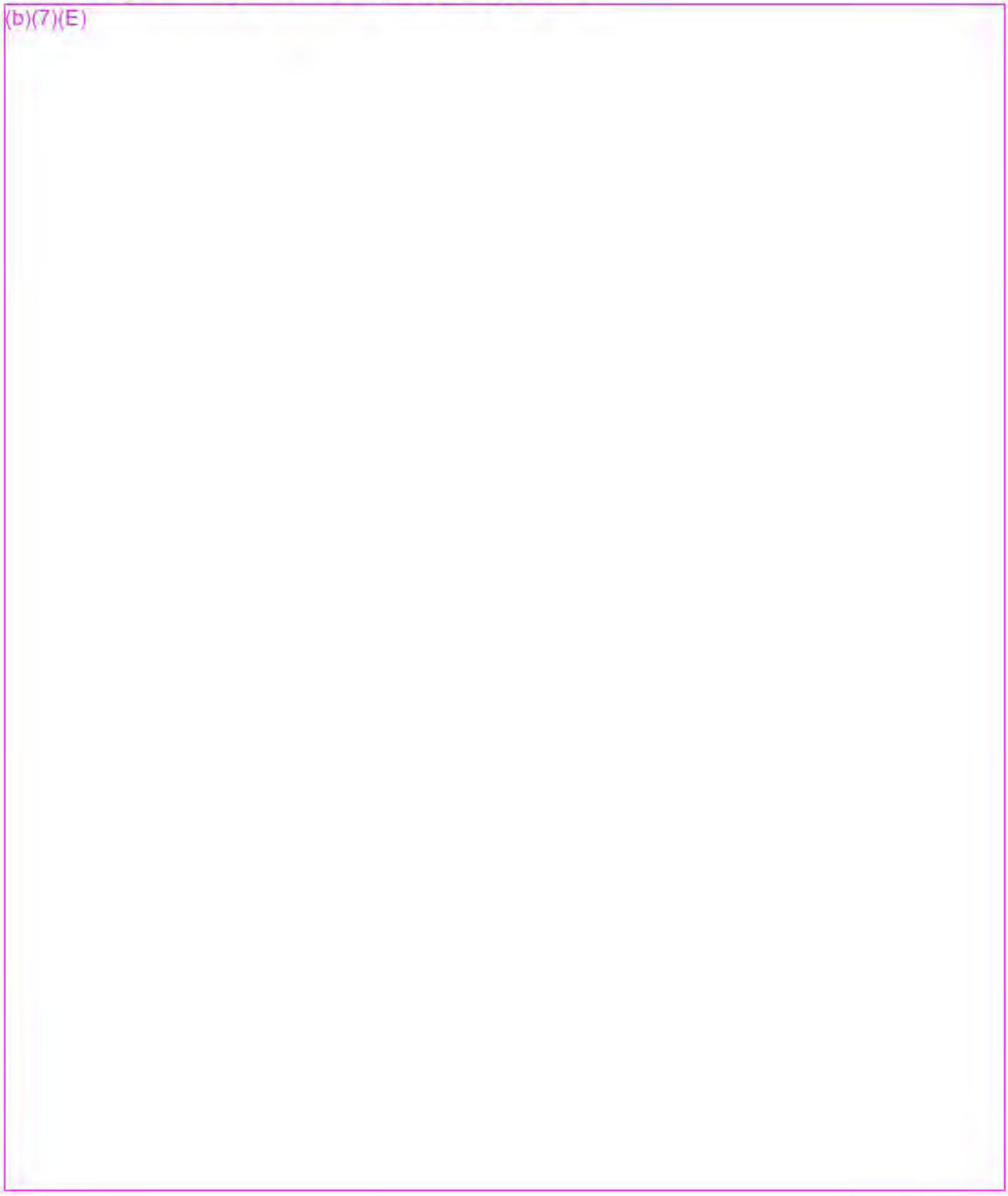
Stan Dorn, Unidos, Director, Health Policy

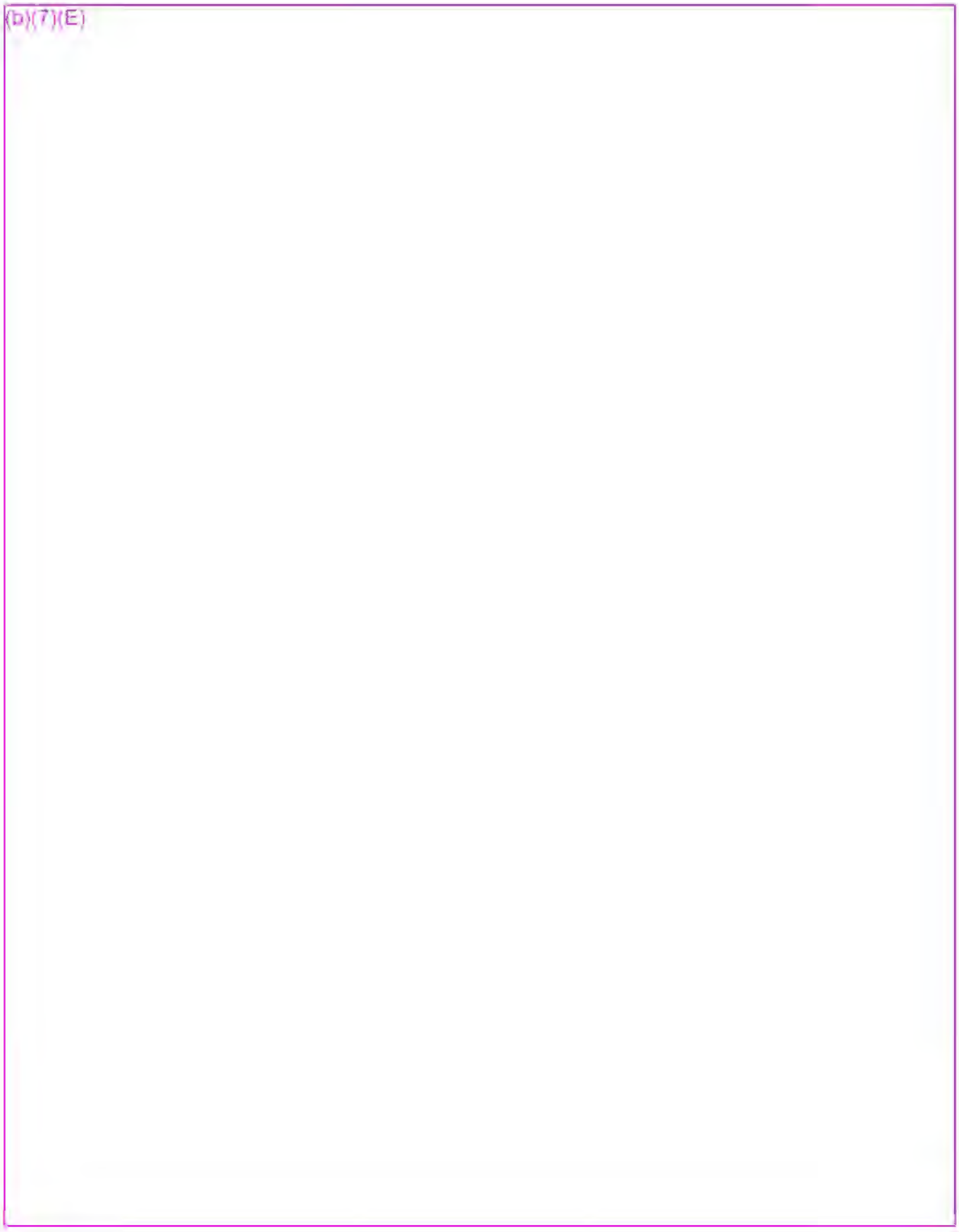
(b)(5); (b)(7)(E)


(b)(5); (b)(7)(E)

Early Complaint Resolution-CR

(b)(7)(E)

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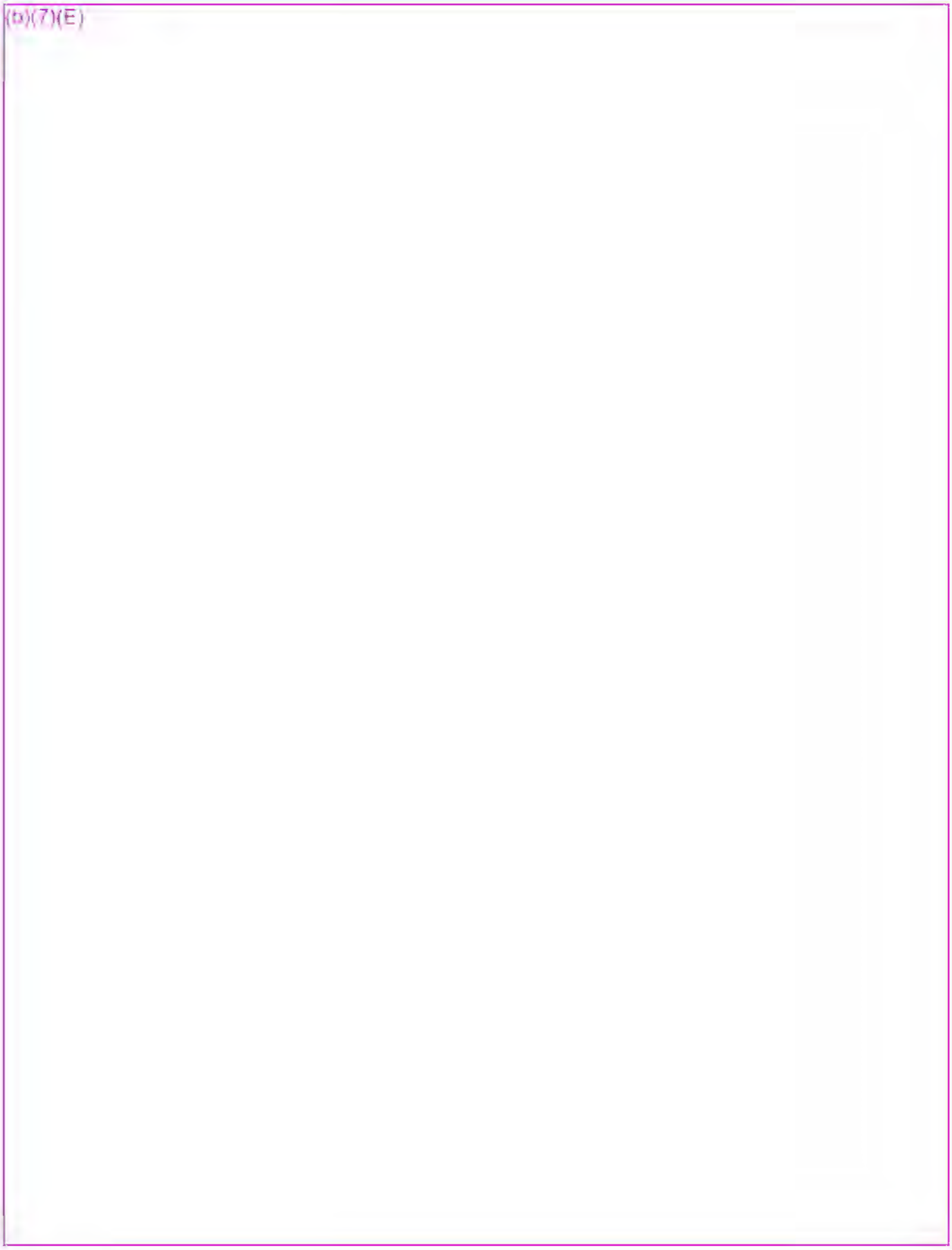
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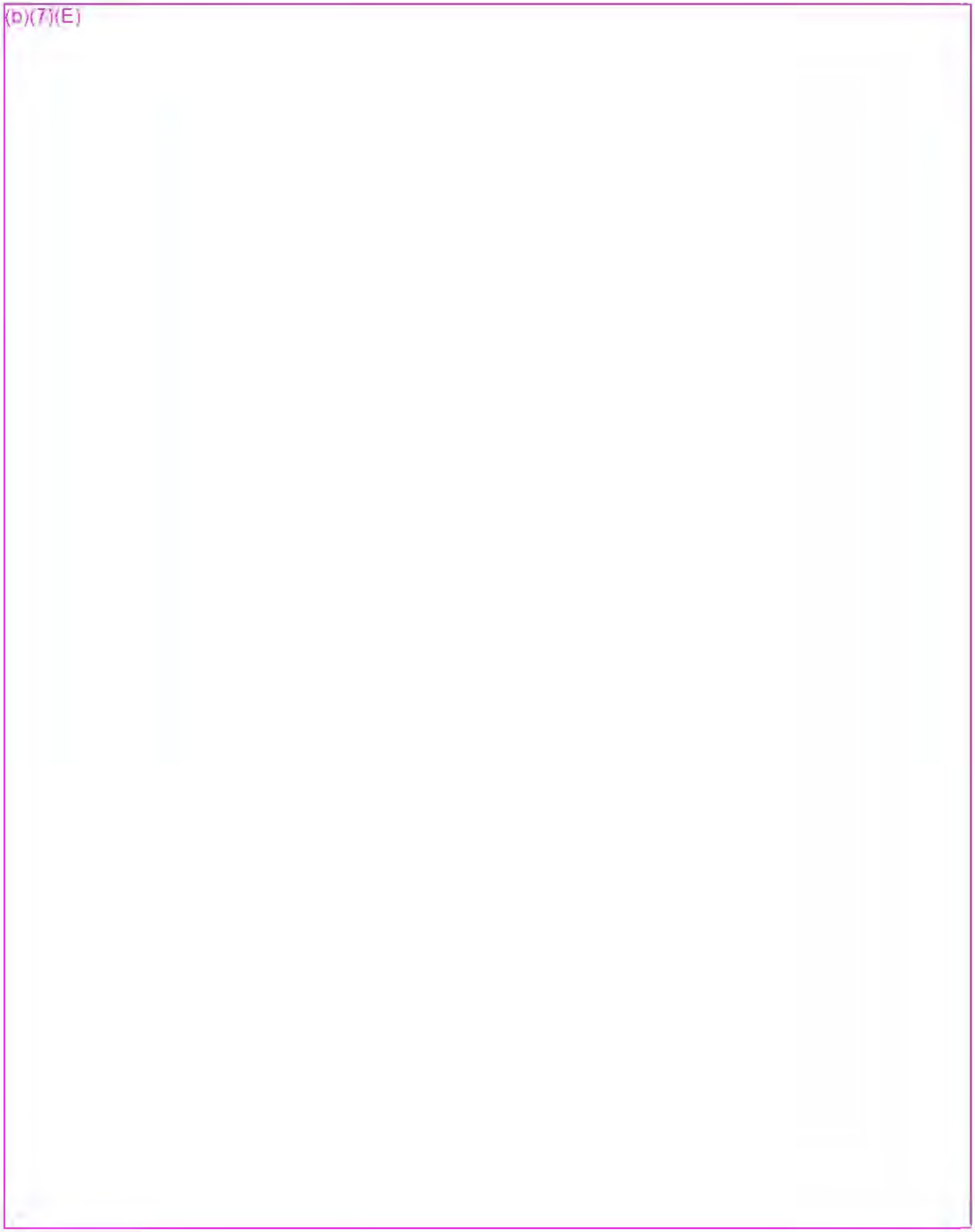
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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

A.M.C., by her next friend, C.D.C., *et al.*,

Plaintiffs,

v.

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

Defendant.

Civil Action No. 3:20-cv-00240
Chief District Judge Crenshaw
Magistrate Judge Newbern

DEFENDANT'S MEMORANDUM IN SUPPORT OF HIS MOTION FOR SUMMARY JUDGMENT

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Other Authorities

INTRODUCTION

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

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

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

ARGUMENT

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

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

A. Plaintiffs cannot show a single Medicaid Act violation.

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

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

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

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

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

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

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

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

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

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

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

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

The Sixth Circuit has held that:

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

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

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

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

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

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

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

To the extent *Rodriguez* required *more* detail, like an individualized income calculation, it is inconsistent with binding precedent. The Sixth Circuit has held that notices stating that "[t]he total income which had to be counted for your family is more than 150% of the Department's need standard so your case must be closed," *Garrett v. Puett*, 557 F. Supp. 9, 12 (M.D. Tenn. 1982), *aff'd* 707 F.2d 930 (6th Cir. 1983), "satisfy due process and statutory requirements." 707 F.2d at 931. The *Garrett* formulation is much less clear than TennCare's (it does not state what the agency thinks the individual's income is, or what the threshold is, in dollar terms). If the *Garrett* notices are adequate, then so are TennCare's.

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

C. TennCare's good cause policies are lawful.

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

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

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

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

1. NOD language and good cause hearings.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For the same reasons that TennCare's practice of not initially informing individuals of the "good cause" exception is constitutionally adequate, *see supra* at 11, TennCare's notice of the deadlines surrounding reconsideration of termination during renewal are constitutionally adequate. *See Cabrera-Ramos*, 233 F. App'x at 455; *see also Rolen v. Barnhart*, 273 F.3d 1189, 1191–92 (9th Cir. 2001) (rejecting plaintiff's argument that he was denied due process when a notice advised him of his right to appeal the dismissal of his benefits application but not that "he could have his claim considered on the merits by filing a new application").

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

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

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

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

Like the Sixth Circuit, this Court has upheld TennCare's valid factual dispute policy, noting that "the Sixth Circuit definitively rejected Plaintiffs' argument that the State must hold a hearing . . . if the only issue is one of law or policy." *Grier v. Goetz*, 402 F. Supp. 2d 876, 921 (M.D. Tenn. 2005). And Plaintiffs are bound by *Grier* because all members of the class in this

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

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

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

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

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

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

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

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

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

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

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

G. TennCare provides timely appeal hearings.

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

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

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

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

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

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

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

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

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

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

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

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

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

J. The Disability Subclass questions.

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

1. TennCare has a system for granting reasonable accommodations.

Title II of the ADA requires that "no [otherwise] qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. In implementing this statute, programs like TennCare are required to

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CONCLUSION

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

July 10, 2023

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CERTIFICATE OF SERVICE

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

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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

Class Action

Chief Judge Crenshaw
Magistrate Judge Newbern

MEMORANDUM OF LAW IN OPPOSITION TO DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

Date: July 31, 2023

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INTRODUCTION

This case, commenced in March 2020, concerns the State's unlawful termination of TennCare benefits for thousands of Tennesseans in violation of the Due Process Clause, 42 U.S.C. § 1396a(a)(3), and the Americans with Disabilities Act ("ADA"). Plaintiffs represent a class of individuals who have been involuntarily disenrolled from TennCare since March 19, 2019, and a subclass of those disenrollees who are disabled. ECF 234 ("Cert. Order") at 40. The State seeks summary judgment on all three claims, while giving short shrift to several fact-intensive and hotly contested issues. Plaintiffs' Responses to Defendant's Statement of Undisputed Material Facts ("PRSUMF") and Statement of Additional Disputed Facts ("PADF") confirm that dozens of material facts, concerning all three claims, remain in dispute. For instance: whether TennCare has actually resolved the errors in its eligibility determination system ("TEDS"), which TennCare has "struggl[ed] with" for years, ECF 179 at 36:16-18; whether enrollees find notices so confusing, discouraging, and burdensome that it interferes with their ability to challenge their loss of coverage; how TennCare applies its "valid factual dispute" and "good cause" policies; whether it resolves appeals within 90 days; and whether TennCare provides equal access to coverage for enrollees with disabilities, including through in-person assistance and other accommodations. The Court need not—and cannot—resolve those issues now under Rule 56. The State's motion therefore must be denied, and the parties' myriad factual and legal disputes must proceed to trial.

LEGAL STANDARD

"Summary judgment is appropriate only when 'no genuine dispute as to any material fact' exists and the moving party is entitled to judgment as a matter of law." *Harris v. Klare*, 902 F.3d 630, 634 (6th Cir. 2018) (quoting Fed. R. Civ. P. 56(a)). The burden is on the movant. *Rodgers v. Banks*, 344 F.3d 587, 595 (6th Cir. 2003). The Court "must accept [the non-movant's] evidence as true and draw all reasonable inferences in his favor," and the Court "may not make credibility

determinations nor weigh the evidence when determining whether an issue of fact remains for trial." *Laster v. City of Kalamazoo*, 746 F.3d 714, 726 (6th Cir. 2014).

ARGUMENT

The State fails to carry its burden to justify summary judgment on any claims or issues. Its misguided effort to preclude any consideration of Medicaid regulations runs contrary to the law in this Circuit, *e.g.*, *Waskul v. Washtenaw Cnty.*, 979 F.3d 426, 448, 454 (6th Cir. 2020), and its effort to relitigate the 2020 CMS certification is barred by the law of this case. Plaintiffs have adduced substantial evidence refuting each issue raised by the State. The record reveals that TennCare, in violation of federal law, fails to consider all categories of eligibility, issues notices that fail to explain termination decisions and how Medicaid enrollees can maintain their benefits, routinely fails to provide fair hearings to members wishing to challenge their terminations of coverage through its valid factual dispute and good cause policies, and fails to take final administrative action on appeals within 90 days. The record, including unrefuted expert testimony, also shows that TennCare, in violation of the ADA, lacks a valid and reliable system for granting reasonable accommodations to members with disabilities and fails to adequately provide in-person assistance. Summary judgment is unwarranted on any claim or issue, and the motion should be denied.[1]

I. Summary judgment is not warranted on the due process or Medicaid Act claims.

A. The Medicaid regulations are relevant to Plaintiffs' claims.

The Court should reject the State's argument that Plaintiffs' Medicaid Act claim must be narrowed to "whether TennCare fails to provide fair hearings at any time." Def.'s Mem. Supp. Mot. Summ. J. ("Br.") 5, ECF 309. *First*, the State ignores the constitutional claim, which supports

[1] Although Plaintiffs have not cross-moved for summary judgment, the Court can grant them summary judgment *sua sponte* on any issues raised by the State. *See Delphi Auto. Sys., LLC v. United Plastics, Inc.*, 418 F. App'x 374, 379–80 (6th Cir. 2011); Fed. R. Civ. P. 56(f)(1).

each of Plaintiffs' theories on the inadequacy of the state's notice and hearing procedures. *Second*, the State's assertion that 42 U.S.C. § 1396a(a)(3) may not "create[] an enforceable right," Br. 4, is contrary to binding precedent, *see Barry v. Lyon*, 834 F.3d 706, 717 (6th. Cir. 2016) ("[I]t is proper for plaintiffs to bring their [§ 1396a(a)(3)] claim for enforcement of their Medicaid rights under § 1983." (quoting *Gean v. Hattaway*, 330 F.3d 758, 773 (6th Cir. 2003)); *cf. Health & Hosp. Corp. of Marion Cnty. v. Talevski*, 143 S. Ct. 1444, 1458 (2023) (finding similarly worded, individually focused Medicaid statutes enforceable under § 1983).

Third, the State mistakenly argues that the Medicaid regulations "are irrelevant" to Plaintiffs' claims. Br. 3. Under binding precedent, when a regulation "effectuates a mandate" of an enforceable statute, the regulation is also "enforceable through the private cause of action available under the statute." *Ability Ctr. of Greater Toledo v. City of Sandusky*, 385 F.3d 901, 907 (6th Cir. 2004). The Sixth Circuit has thus repeatedly looked to Medicaid regulations to define the Medicaid Act's statutory rights. *E.g.*, *Waskul*, 979 F.3d at 448, 455–56 (finding 42 C.F.R. § 441.301 and .302 set standards for states under 42 U.S.C. § 1396n(c)(2)); *Westside Mothers v. Olszewski*, 454 F.3d 532, 544 (6th Cir. 2006) (reversing dismissal of 42 U.S.C. § 1396a(a)(43)(A) claim, in part, because "the district court ignored the Medicaid Act's implementing regulations" under 42 C.F.R. § 441.56(a)). Because § 1396a(a)(3) creates an enforceable right to a hearing, the regulations detailing the requirements of those hearings are "covered by the cause of action to enforce that section." *Harris v. Olszewski*, 442 F.3d 456, 465 (6th Cir. 2006); *see also Shakhnes v. Berlin*, 689 F.3d 244, 254 (2d Cir. 2012) (finding 90-day requirement in 42 C.F.R. § 431.244(f) "further defines or fleshes out the content" of the hearing right); *Fishman by Fishman v. Daines*, 2016 WL 11496013, at *5 (E.D.N.Y. Mar. 10, 2016) (finding 42 C.F.R. § 431.223, concerning when appeals can be dismissed, "further defines or fleshes out the scope of []§ 1396a(a)(3)"). As with

constitutional due process, for § 1396a(a)(3)'s hearing right to be meaningful, it must include adequate notice. *Cf. Mullane v. Cent. Hanover Bank & Tr.*, 339 U.S. 306, 314 (1950) (finding the "right to be heard has little reality or worth" absent adequate notice). This Court has already held that the right of action under § 1396a(a)(3) includes the notice and hearing rights conferred by its implementing regulations, including that the State's "hearing system 'must meet the due process standards set forth in *Goldberg v. Kelly*, 397 U.S. 254 (1970),'" Cert. Order 6 (quoting 42 C.F.R. § 431.205), as have numerous other courts.[2]

The State's lone citation, to *Caswell v. City of Detroit Housing Commission*, 418 F.3d 615 (6tb Cir. 2005), does not justify ignoring relevant Medicaid regulations. Br. 3–4. *Caswell* was not a Medicaid case, and the Sixth Circuit has already rejected the State's argument in a different Medicaid context: "[I]n *Caswell*, neither the plaintiff nor the court could identify any statutory provision that conferred the right at issue. Here, the authoritative regulation[s] merely supplement[] the right identified in a specific *statutory* provision." *Harris*, 442 F.3d at 464. Because the Medicaid regulations governing notice and appeal rights "merely supplement[]" § 1396a(a)(3)'s fair hearing right, *id.*, they are relevant to Plaintiffs' claims.

B. The State fails to consider all categories of eligibility.

The State asserts there is no dispute whether "TennCare considers all categories of eligibility" because of how "TEDS is programmed" and how "TennCare workers are trained." Br. 21. But the evidence shows that, in *practice*, TennCare has failed to consider all eligibility categories

[2] *See K.B. ex rel. T.B. v. Mich. Dep't of Health & Hum. Servs.*, 367 F. Supp. 3d 647, 661–62 (E.D. Mich. 2019) (finding that § 1396a(a)(3) requires notice of the opportunity for a hearing under 42 C.F.R. § 431.210); *Crawley v. Ahmed*, 2009 WL 1384147, at *26 & n.7 (E.D. Mich. May 14, 2009) (finding that § 1396a(a)(3) requires timely and adequate notice of decisions under 42 C.F.R. §§ 431.206–.211 and § 435.919 (now codified at § 435.917); *Guadagna v. Zucker*, CV 17-3397, 2021 WL 11645538, at *13 (E.D.N.Y. Mar. 19, 2021) (finding right under § 1396a(a)(3) encompasses "a number of provisions fleshing out the right to pre-termination notice").

in multiple ways: TennCare (1) terminated up to 30,000 people in "conversion status" in April and May 2023 *without* considering all categories of eligibility; (2) lacked certain data necessary to assess individuals' eligibility for the Supplemental Security Income ("SSI")-related eligibility categories of Disabled Adult Child ("DAC"), Widow/Widower, and Pickle until May 2023; (3) fails to screen individuals for DAC even when they are already enrolled in that category; (4) fails to ask questions that would elicit information necessary to assess eligibility for the SSI-related categories; (5) failed to load key indicators (the D and W indicators) used to trigger evaluation for the SSI-related categories; and (6) acknowledged an ongoing problem, unresolved as of at least November 2022, with assessing eligibility for the category of Medicare Savings Plan. *See* PRSUMF ¶ 22(a)-(g); PADF ¶¶ 6–9, 19. These facts preclude summary judgment on this issue.

The State's arguments to the contrary are meritless. The State asserts that its admittedly inaccurate determinations do not reflect "a systematic failure to screen for eligibility," Br. 22, but such a "conclusory assertion" cannot "carry the day," *Berry v. SAGE Dining Servs., Inc.*, 2021 WL 3037483, at *13 (M.D. Tenn. July 19, 2021), because "all reasonable inferences" must be drawn in *Plaintiffs'* favor at this stage, *Laster*, 746 F.3d at 726. Contrary to the State's contention, moreover, it does not "promptly rectif[y]" all incorrect eligibility decisions. Br. 22. For example, although a TennCare appeals specialist raised concerns in July 2021 that TennCare lacked historical SSI data necessary to assess eligibility for SSI-related categories, TennCare did not address the problem until after Plaintiffs used the email in depositions in April 2023. PRSUMF ¶ 24. TennCare also still fails to assess DAC eligibility. Despite asking SSI-related questions of Gentry Fields in the past, TennCare omitted such questions from his 2023 renewal packet.[3] PRSUMF ¶ 22(d). And

[3] TEDS can only run the eligibility rules based on the facts and information input into each case, *see* PRSUMF ¶ 21, which makes these omissions critically important.

despite being directly informed of Gentry's DAC eligibility by his mother during the renewal process, TennCare still sent him a termination letter. PADF ¶¶ 6–13.

C. TennCare's notices are inadequate.

As this Court has explained, before terminating coverage TennCare must provide the enrollee with timely and adequate notice that complies with due process and Medicaid requirements. *See* Cert. Order 5–6 (citing *Goldberg v. Kelly*, 397 U.S. 254 (1970); *Hughes v. McCarthy*, 734 F.3d 473, 475 (6th Cir. 2013); *Hamby v. Neel*, 368 F.3d 549, 559 (6th Cir. 2004); 42 C.F.R. §§ 431.210, 435.917). To be adequate under the Constitution, notices must "detail[] the reasons for a proposed termination," including both "the legal and factual bases" for the decision. *Goldberg*, U.S. at 267–68. Notices must also "clearly" explain "the availability of an avenue of redress." *Memphis Light, Gas & Water Div. v. Craft*, 436 U.S. 1, 13–14 n.15 (1978). And they must be "reasonably calculated" to communicate this information. *Mullane*, 339 U.S. at 314. Failure to include any of the required information offends due process, even if other aspects of the notice are sufficient. *See, e.g.*, *Memphis Light*, 436 U.S. at 14 (finding a due process violation where notice, "while adequate to apprise the [plaintiffs] of the threat of termination . . . was not 'reasonably calculated' to inform them of the availability of 'an opportunity to present their objections'"); *Barry*, 834 F.3d at 719 (finding notice inadequate where it provided "specific notice of the recipient's right to appeal," hut not "a detailed statement of the intended action" or "the reason for the change in status"). Similarly, to satisfy § 1396a(a)(3), notices must identify the action being taken, the "specific reasons" for the action, the "specific regulations," supporting the action, an explanation of the right to a hearing or in "cases of a change in law, the circumstances under which a hearing will be granted," and when benefits will continue pending the hearing. 42 C.F.R. § 431.210. States must also notify enrollees of the right to obtain a hearing and the method

for obtaining one. *Id.* § 431.206. Because TennCare's Notices of Decision ("NODs") do not meet these requirements, summary judgment is not appropriate.

1. Notices fail to adequately explain termination decisions.

The State argues that TennCare's NODs adequately explain termination decisions even though they do not provide factual details for ineligibility in all categories and, until December 2022, contained only "a stock citation to the full set of TennCare's eligibility rules." *See* Br. 5–9, 22–23. The State is wrong, and summary judgment is unwarranted.

First, termination NODs inaccurately tell each recipient that TennCare both "looked at you for different kinds of coverage" and reviewed each recipient's facts to assess their eligibility. PRSUMF ¶ 22(a)-(g); PADF ¶¶ 6–9. The State agrees that whether this language is "unlawfully mislead[ing]" depends entirely on a resolution of the factual question of whether "TennCare does consider all categories of eligibility." Br. 21 n.1. Because the evidence shows that TennCare systematically fails to consider all categories of eligibility and use all facts available to it when making eligibility decisions, *supra* Part I.B, the NODs are inaccurate and therefore misleading.

Second, NODs do not "fully apprise" TennCare enrollees of the factual bases for ineligibility determinations. *Hamby*, 368 F.3d at 561 (finding notice inadequate although it provided some explanation for the decision). For example, while TEDS is programmed to input standardized language from a reference spreadsheet into NODs explaining denial reasons for particular categories of eligibility, that sheet does not contain any language for a denial based on a purported end in SSI coverage. PRSUMF ¶¶ 41, 53. Nor does the sheet contain any language for individuals who group into DAC, Widow/Widower, or Pickle categories. *Id.*; *see also* PADF ¶ 10 (describing NOD terminating DAC eligibility that provided no reasons relevant to DAC). Such notices "hardly qualify as 'adequate'" because they lack a "determination of eligibility on all relevant grounds." *Crawley*, 2009 WL 1384147, at *26. Notices stating that individuals failed to return information do not

provide any explanation of what materials the State believes are missing. PRSUMF ¶ 41. But "[w]ithout further identifying information . . . it would be at best onerous and at worst virtually impossible to effectively gather and present relevant information refuting this general charge." *Transco Sec., Inc. of Ohio v. Freeman*, 639 F.2d 318, 323 (6th Cir. 1981). And the "non-grouping" language that TennCare uses to tell people they do not fall within any eligibility category has caused significant confusion among Medicaid enrollees and even TennCare Connect call center staff (currently AHS and previously KePro). PRSUMF ¶ 41; PADF ¶¶ 7–9, 21; *see Dozier v. Haveman*, 2014 WL 5480815, at *10-11 (E.D. Mich. Oct. 29, 2014) (finding Medicaid Act violated where notice explained that enrollee was not "under 21, pregnant, or a caretaker of a minor child . . . or over 65 (aged), blind, or disabled," but "did not contain information regarding all eligibility categories"). Each defect deprives recipients of "full access to all information relied upon by the state agency." *Mathews v. Eldridge*, 424 U.S. 319, 345–46 (1976).

Third, the stock citation in all NODs issued before December 2022 failed to adequately apprise recipients of the legal bases for their terminations.[4] *See* 42 C.F.R. § 431.210. As this Court explained, the "NODs [did] not explain how to access this document" or "cite the subpart of the document ostensibly applicable to the NOD recipient." Cert. Order 13. These omissions were unlawful. *See Rodriguez ex rel. Corella v. Chen*, 985 F. Supp. 1189, 1195–96 (D. Ariz. 1996) (holding termination notices deficient where they gave "lengthy general descriptions of program eligibility rules" but not "the applicable provision as applied to the particular case" or "where a copy of the cited legal authority c[ould] be located and reviewed"). The State's effort to distinguish *Rodriguez* on its facts, Br. 8, further undermines the appropriateness of summary judgment here.

The State's argument that "a plain English explanation" for termination decisions "is all

[4] The State's post-December 2022 revisions to NODs are addressed in Part I.C.3, *infra*.

that is required" to give a recipient adequate notice, Br. 8, mischaracterizes well-established law. The Constitution demands that notice include not only an explanation of "the reason for the change in status" but also a "citation to the specific statutory section requiring reduction or termination." *Barry*, 834 F.3d at 719; *Goldberg*, 397 U.S. at 268 (concluding that, to be adequate, notices must include the "*legal* and factual" bases for the decision (emphasis added)). The Medicaid regulations likewise impose distinct requirements to explain the reason and provide the "specific regulation." *Compare* 42 C.F.R. 431.210(b), *with* 42 C.F.R. 431.210(c).[5]

2. Notices fail to adequately explain how to seek redress.

The State's NODs are also deficient because they fail to identify available "avenue[s] of redress." *Memphis Light*, 436 U.S. at 13; *accord Barry*, 834 F.3d at 720. Due process requires Medicaid enrollees to be "adequately informed as to how to fully receive the benefits to which they were entitled, at the time they were entitled to them." *Hamby*, 368 F.3d at 561; *Elder v. Gillespie*, 54 F.4th 1055, 1064–65 (8th Cir. 2022) (finding the requirement that notice inform beneficiary of "what steps she should take to continue receiving" benefits a clearly established due process right). As this Court explained, the Medicaid regulations similarly require TennCare to provide "an explanation of the 'individual's right to request a local evidentiary hearing if one is available' and 'the circumstances under which Medicaid is continued if a hearing is requested.'" Cert. Order 6 (quoting 42 C.F.R. § 431.210). But TennCare has failed to do so.

First, the State concedes that NODs deliberately omit information about TennCare's 90-day reconsideration and good cause policies, based on TennCare's "judgment" that fully apprising enrollees of their rights could potentially cause them to miss deadlines and lose coverage.

[5] *Cahoo v. SAS Inst., Inc.*, 71 F.4th 401 (6th Cir. 2023) does not change these requirements. *See* Br. 8. *Cahoo* was neither a Medicaid case nor a summary judgment case; it was a qualified immunity case that, notably, found that the notices identified the "relevant statute." *Id.* at 410.

PRSUMF ¶¶ 60–61, 76–77. Such purposeful omissions cannot satisfy the State's obligation to employ "means . . . such as one desirous of actually informing," the enrollee. *Mullane*, 339 U.S. at 315. Further, the evidence shows that applying the 90-day reconsideration policy would not cause any gaps in coverage, PRSUMF ¶ 61, and that omitting information about the good cause policy discourages enrollees from exercising their appeal rights and creates risks that TennCare employees will provide inaccurate or incomplete information about them, *id.* ¶¶ 75, 77. Indeed, "common sense dictates that the likelihood of the state employing the [] authority is much less when a recipient (ignorant of the state's authority) does not request" it. *Bliek v. Palmer*, 102 F.3d 1472, 1477 (8th Cir. 1997). But "with the due process protection of notice in place, the risk of deprivation . . . will be reduced." *Id.* There are factual disputes regarding the impact of these omissions. The State cites *Rolen v. Barnhart*, 273 F.3d 1189 (9th Cir. 2001), Br. 15, but the *Rolen* notice "accurately stated the law, and therefore was not misleading," *id.* at 1192. The NODs here, by contrast, cannot "accurately" state the law by omitting it altogether.[6]

The State suggests that describing the good cause policy in TennCare's Appeal Resolution Notice is sufficient. *See* Br. 10–11. But individuals receive this notice only *after* electing to appeal, and thus are not aware of this avenue for requesting a hearing when deciding whether to appeal in the first instance. This Appeal Resolution Notice also comes too late to satisfy the constitutional requirement that notice must permit a recipient to "choose for himself" whether, when, or how to appeal. *Faber v. Ciox Health, LLC*, 944 F.3d 593, 603 (6th Cir. 2019) (quoting *Mullane*, 339 U.S. at 314); *see also Covington v. Dep't of Health & Hum. Servs.*, 750 F.2d 937, 943 (Fed. Cir. 1984)

[6] The language in the renewal packet cover letter does not "accurately" state the law: it omits the 90-day timeline and fails to explain the significance of submitting information within that timeframe (namely, that TennCare will backdate their coverage to fill any gap). PRSUMF ¶ 62; *see also* PRSUMF ¶¶ 59–60.

(finding notice "inadequate and erroneous" where it failed to inform recipient of "his applicable rights," because "[a] decision made 'with blinders on,' based on misinformation or a lack of information, cannot be binding as a matter of fundamental fairness and due process"). The belated Appeal Resolution Notice also cannot satisfy the Medicaid requirement to notify an affected individual of the "method by which he may obtain a hearing." 42 C.F.R. 431.206(b)(2).

In any event, the Appeal Resolution Notice's description of TennCare's good cause policy is overly narrow. It references only extreme scenarios, not those more likely to cause an enrollee to miss an appeals deadline, such as non-receipt of mail, being away from home, or loss of documents, which TennCare admits can be a basis for good cause. *See* PRSUMF ¶ 80. The language also creates confusion by stating, in bold, that "it's too late to appeal this problem." PADF ¶ 42. Plaintiffs' experiences demonstrate the impact of not informing individuals of the good cause exception or what evidence is necessary to obtain the exception. *E.g.*, PRSUMF ¶¶ 77–78, 82. When combined with the volume of appeals closed by TennCare as untimely, the evidence easily supports an inference that the State has denied many class members' appeals when they could have received good cause exceptions had they known to ask for one.

3. Notices discourage appeals.

Each of the NODs' shifting descriptions of TennCare's valid factual dispute policy discourage recipients from pursuing appeals. The NODs previously stated, "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." PRSUMF ¶ 95. After the Court raised concerns at the March 4, 2022 hearing about the "misleading" nature of this language, *see* ECF 179 at 19:2–20:15, TennCare revised the NODs in June 2022 to read, "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," PRSUMF ¶ 97 (citing ECF 213 at 2). Despite the change, the Court expressly "permit[ted] the class to litigate the

lawfulness of" the prior language. Cert. Order 18 n.10. Moreover, both the old and new versions of NODs contain the misleading and discouraging sentence "You don't have a right to a fair hearing just because you don't like this decision or think it will cause problems for you." PRSUMF ¶¶ 95, 97. The evidence shows that NODs' confusing language made it difficult to satisfy TennCare's valid factual dispute policy. *See* PADF ¶¶ 23, 50, 53. As another court observed, asking individuals to "state the reason for your appeal" is "to ask the impossible, given that the recipient is not told the 'reason' for the initial determination." *Mayhew v. Cohen*, 604 F. Supp. 850, 857 (E.D. Pa. 1984). In sum, notice of appeal rights in the NODs is both misleading and discouraging, in violation of due process, *Hamby*, 368 F.3d at 561 (quoting *Gonzalez v. Sullivan*, 914 F.2d 1197, 1203 (9th Cir. 1990)); *accord Dozier*, 2014 WL 5480815, at *11, and the prohibition on "interfer[ing] with the . . . freedom to make a request for a hearing," 42 C.F.R. § 431.221(b).

The State argues that, under *Day v. Shalala,* 23 F.3d 1052 (6th Cir. 1994), relief is available only to those class members who can individually prove detrimental reliance on an offending notice provision. Br. 18. But the State ignores that *Day* was decided after trial and found (among other things) that the agency's denial notices were inadequate. *See* 23 F.3d at 1060, 1064–66. As in *Day*, the appropriate scope of declaratory and injunctive relief in this case should be determined after trial. *Id.* at 1066–67. The State's individual-reliance argument is also wrong because reliance is not an element of any of Plaintiffs' claims. Even if it were, reliance may be presumed because the NODs contained uniform language. *See, e.g.*, *Rikos v. Proctor & Gamble Co.*, 799 F.3d 497, 512 (6tb Cir. 2015) (holding that class-wide reliance could be established with evidence that material statements were made "in a generally uniform way to the entire class").[7] As the Court has

[7] Although *Rikos* was a Rule 23(b)(3) class action, its logic extends to Rule 23(b)(2) actions like this one, where "the party opposing the class has affected the class in a way generally applicable

stated, "when the State of Tennessee makes a representation to somebody about the medical coverage," the State "intend[s] for them to read it." ECF 179 at 22:20-25.

4. The State's revisions to notices do not moot Plaintiffs' claims.

The State is mistaken in arguing that Plaintiffs' notice claims have been mooted by two revisions to NODs—one to their "generic citation" to TennCare's 95-page chapter of regulations, and the other to their language concerning appeal rights—made well after this case was filed. *See* Br. 5–6, 18; PRSUMF ¶¶ 39, 40, 46, 95, 97.[8] Such "voluntary cessation . . . moots a case only in the rare instance where subsequent events make it absolutely clear that the allegedly wrongful behavior cannot reasonably be expected to recur and interim relief or events bave completely and irrevocably eradicated the effects of the alleged violation." *Sullivan v. Benningfield*, 920 F.3d 401, 410 (6th Cir. 2019) (quotation marks omitted). The State fails to establish either element.

First, the State concedes that TennCare can unilaterally "change the citations in the NODs in the future" and walk back its current "intention [not] to revert to the earlier language." PRSUMF ¶¶ 49, 51, 98. Because "[a] future [TennCare] administration could rescind the [revised NOD language] just as easily as this administration established it," the voluntary cessation doctrine is inapplicable. *Barrios Garcia v. U.S. Dep't of Homeland Sec.*, 25 F.4th 430, 441 (6th Cir. 2022). The State also ignores that Plaintiffs' claims are not cabined to the two NOD defects that the State belatedly revised. As the Court has recognized, Plaintiffs' claims also depend on various additional

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to the class as a whole so that final injunctive or declaratory relief with respect to the entire class is appropriate," *Reeb v. Ohio Dep't of Rehab. & Correction*, 435 F.3d 639, 645 (6th Cir. 2006), and "[t]he precise identity of each class member need not be ascertained," *Cole v. City of Memphis*, 839 F.3d 530, 542 (6th Cir. 2016).

[8] The State's contention that "Plaintiffs lack standing" to challenge the State's NODs and appeals practices runs contrary to the Court's prior ruling that Plaintiffs do have standing, *see* ECF 178, 179 at 36, which, as "'law of the case,' is dispositive." *Roddy v. Tenn. Dep't of Corr.*, 2023 WL 180052, at *3 (M.D. Tenn. Jan. 13, 2023); *see also infra* Part III.

common "questions tied to the NODs," as well as common questions "that are not tied to the NODs." Cert. Order 13–14. And the Court expressly permitted Plaintiffs to "litigat[e] the past-tense version of" each common question. *Id.* at 18 n.10.

Second, class members continue to suffer the effects of the State's violations because they remain excluded from TennCare coverage, which is a cognizable and continuing injury. *E.g.*, *Hazard v. Shalala*, 44 F.3d 399, 403 (6th Cir. 1995); *Markva v. Haveman*, 168 F. Supp. 2d 695, 704 (E.D. Mich. 2001), *aff'd*, 317 F.3d 547 (6th Cir. 2003). Because the State's voluntary and forward-looking revisions to NODs do nothing to remedy this ongoing harm for individuals who already lost their coverage with inadequate notice, declaratory and injunctive relief remain available. *See Price v. Medicaid Dir.*, 838 F.3d 739, 746–47 (6th Cir. 2016) (holding that "a federal court may enjoin the state's officers to comply with federal law by awarding [public] benefits in a certain way going forward" and "may order state officers to provide recipients of public benefits with notice of ... beneficiaries' right to pursue state administrative remedies to obtain benefits in accordance with [an] injunction"). Plaintiffs are also entitled to seek relief for class members currently going through redetermination, which includes the 31,128 persons whom TennCare determined ineligible in April 2023 and who were notified using the still-inadequate NODs. PADF ¶ 103. Accordingly, the State is not entitled to summary judgment on Plaintiffs' notice claims.

D. TennCare systematically denies fair hearings.

The State is not entitled to summary judgment because it denies fair hearings that are required by the Due Process Clause, 42 U.S.C. § 1396a(a)(3), and its implementing regulations. The Supreme Court "consistently has held that 'some kind of hearing is required at some time before a person is finally deprived of his property interests.'" *Memphis Light*, 436 U.S. at 16 (citing *Wolff v. McDonnell*, 418 U.S. 539, 557–58 (1974)). The hearing must occur before termination because, although benefits "may be restored ultimately, the cessation of essential services for any

appreciable time works a uniquely final deprivation." *Id.* at 20. The State's "hearing system 'must meet the due process standards set forth in *Goldberg*,'" Cert. Order 6 (quoting 42 C.F.R. § 431.205), which held that "a recipient must be allowed to state his position orally" because "[w]ritten submissions are an unrealistic option for most recipients," 397 U.S. at 269.

Under the Medicaid Act, TennCare must grant a fair hearing to "[a]ny individual who requests it because he or she believes the agency has taken an action erroneously," unless the "sole issue is a Federal or State law requiring an automatic change adversely affecting some or all beneficiaries," 42 C.F.R. § 431.220(a), (b); "may not limit or interfere with the . . . freedom to make a request for a hearing," § 431.221(b); and must "reinstate and continue services until a decision is rendered after a hearing if . . . [a]ction is taken without the advance notice" required by the Medicaid regulations, § 431.231(c). TennCare violates these rules by using arbitrary standards and unchecked discretion to deny access to hearings. *See Logan v. Zimmerman Brush*, 455 U.S. 422, 434–35 (1982) ("A system or procedure that deprives persons of their claims in a random manner . . . necessarily presents an unjustifiably high risk that meritorious claims will be terminated.").

The State contends that TennCare "does not systematically fail to provide fair hearings at any time" unless TennCare decides (among other things) that an appeal is "found to be untimely" or "lacking a valid factual dispute." Br. 21. But the State's own data show that, even among hearings that are timely and survive review for valid factual dispute, TennCare closed a significant number of appeals without a hearing. Out of the 69,250 total redetermination- and termination-related appeals that were timely filed between March 19, 2019, and October 31, 2022, and for which a hearing was possible, TennCare conducted only 5,754 hearings—a rate of approximately 8%. *See* PRSUMF ¶ 68; PADF ¶¶ 56–57, 59–62. The State's conclusory assertion that "an individual whose appeal is delayed is given continuation of benefits and therefore has

not suffered an adverse action," Br. 20, conflicts with the evidence. Of the 63,496 appellants who were denied fair hearings, 19,425 appellants (over 30%) did not receive continuation of benefits during the appeals process. PRSUMF ¶ 68; PADF ¶ 63.

1. TennCare's valid factual dispute policy is unlawful.

Apart from the conclusory assertion by counsel that TennCare's "'valid factual dispute' policy in place today is the same one that was in place in *Rosen* [*v. Goetz*, 410 F.3d 919 (6th Cir. 2005),] and approved by CMS," Br. 16, the State offers no factual basis to support summary judgment on the policy as TennCare applies it. Several disputed facts preclude summary judgment.

There is a genuine dispute about how TennCare implements the policy. *See* PRSUMF ¶¶ 91–92. TennCare initially represented that it required a *factual* dispute, as reflected in the NODs in use at the start of the case. *See* PRSUMF ¶ 95; *supra* Part I.C.2. After this Court raised concerns that this approach precluded disputes over the application of law to fact, ECF 179 at 20:2-8, TennCare changed course and represented that it *does* accept such appeals as raising valid factual disputes (similar to the representations made in *Rosen*), *see* PRSUMF ¶ 91; *Rosen*, 410 F.3d at 926 (holding that appeals raising "matters of fact *or the application of law*" are entitled to fair hearings (emphasis added)). Yet the evidence contradicts the State's representations. In depositions, TennCare admitted that its policy is to close appeals without a hearing when they "just state that they need their coverage reinstated," PRSUMF ¶ 92, though such a statement should constitute a valid factual dispute, *see Grier v. Goetz*, 402 F. Supp. 2d 876, 922 (M.D. Tenn. 2005) ("A statement as simple as: 'I am appealing because I did not get my medicine or treatment' . . . must be treated as raising a 'valid factual dispute.'"). And TennCare's statement of facts here suggests it has reverted to the position that only a *factual* dispute suffices. *See* PRSUMF ¶ 91.

The experiences of Plaintiffs and other Medicaid enrollees demonstrate that TennCare fails to acknowledge even straightforward *factual* disputes when they are asserted. *Id.*; PADF ¶¶ 23,

49, 50, 53. This is so in part because TennCare requires individuals to identify the "correct" or "true reason" for TennCare's decision, which it admits requires review of the whole case—something individuals are not equipped to do given the limited explanations notices provide. *See* PRSUMF ¶ 91; PADF ¶¶ 23, 49, 50, 51–53. Plaintiffs' experiences are not isolated incidents. The evidence shows that between March 19, 2019 and October 31, 2022, TennCare closed at least 3,683 appeals without a fair hearing based on the valid factual dispute policy, representing approximately 5% of the total appeals filed during that period. PRSUMF ¶¶ 68, 103. In the first six months of 2023, moreover, TennCare closed approximately 7.8% of all appeals—629 out of 8,089—without a fair hearing based on the valid factual dispute policy. PRSUMF ¶¶ 68, 70, 103.[9]

The record thus amply supports the conclusion that the valid factual dispute policy violates the bedrock principle that "some kind of hearing is required" before an individual is deprived of a protected property interest. *See Memphis Light*, 436 U.S. at 16; *Goldberg*, 397 U.S. at 266 ("[T]he stakes are simply too high for the welfare recipients, and the possibility for honest error or irritable misjudgment too great, to allow termination of aid without giving the recipient a chance, if he so desires to . . . produce evidence in rebuttal."). Nor can the policy pass muster under the *Mathews v. Eldridge* factors: it simultaneously increases the risk of erroneous deprivation of a vital private interest *and* creates additional administrative burden.[10] *See Mathews*, 424 U.S. at 335. As

[9] Medical appeals data bolster the conclusion that hearing denials are commonplace under the valid factual dispute policy. While the *Grier* court cautioned that "it will be the rare case indeed that is dismissed for failure to raise a 'valid factual dispute.'" *Grier*, 402 F. Supp. 2d at 923, in 2022 TennCare closed 47% of medical appeals under the policy. PADF ¶ 55.

[10] It is undisputed that the private interest at issue here—Medicaid coverage for individuals with "hrutal need," *Crawley*, 2009 WL 1384147, at *27 (quoting *Goldberg*, 397 U.S. at 261)—is critical. The State thus misses the mark by relying on authorities concerning less compelling private interests, Br. 17: a college student's disciplinary record, *Flaim v. Med. Coll. of Ohio*, 418 F.3d 629 (6th Cir. 2005); a nontenured public employee's disciplinary record, *Codd v. Velger*, 429 U.S. 624 (1977), and a civil litigant's ability to survive summary judgment, Fed. R. Civ. P. 56.

demonstrated above, the risk of erroneous deprivations is high particularly because the valid factual dispute policy closes appeals brought by people who, by appealing, have already expressed their disagreement with the State's decision. Thus, this pool of people is particularly likely to suffer an erroneous termination. *See Yee-Litt v. Richardson*, 353 F. Supp. 996, 999–1000 (N.D. Cal.) (rejecting fact vs. policy distinction as too likely to erroneously deny hearings, and requiring hearings), *aff'd sub nom. Carlson v. Yee-Lit*, 412 U.S. 924 (1973).

While the State analogizes this policy to the requirements for litigating a case, Br. 17, 19, the Supreme Court has found procedures that are "too bounded by procedural constraints" to be unconstitutional, *Memphis Light*, 436 U.S. at 20; *see also Washington v. DeBeaugrine*, 658 F. Supp. 2d 1332, 1336–37 (N.D. Fla. 2009) ("Imposing a procedural bar to such a hearing—a formal pleading requirement that a disabled person or lay representative may be poorly equipped to meet—is the very antithesis of the right to a hearing."). Requests for additional information, a common step in TennCare's appeals process, pose an additional hurdle that causes more people, including three named Plaintiffs, to lose coverage without a hearing. *See* PRSUMF ¶¶ 91–92, 99 (Caudill, A.L.T., and S.L.T.). Each was eventually found eligible, which underscores that fair hearing denials under this policy are divorced from the merits of appeals.

As to administrative burden, the evidence supports an inference that the valid factual dispute policy increases TennCare's administrative burdens, tipping the *Mathews* scale even further toward the risk of erroneous deprivation. *See, e.g.*, *Hicks v. Comm'r of Soc. Sec.*, 909 F.3d 786, 799 (6th Cir. 2018) ("*Mathews* directs courts to weigh the private interest in a property right against the government's interest in avoiding additional or substitute process."). TennCare officials testified about the detailed review the policy requires, and multiple staff members may have to conduct such a detailed review because different staff are responsible for hearings. PADF ¶¶ 44–45. While

rescinding the policy would increase the number of hearings, it would eliminate duplicative work without changing the result when termination is indeed warranted. In any event, the burden of the additional hearings itself is not sufficient to overcome the importance of avoiding erroneous deprivation of individuals' vital interest in Medicaid coverage. *See Goldberg*, 397 U.S. at 266.

The State's arguments fail to justify summary judgment. The State argues that *Rosen* and *Grier* blessed the valid factual dispute policy as "a valid expression of the applicable Medicaid regulation, 42 C.F.R. § 431.220." Br. 15–16. But that regulation condones a narrow exception not applicable in this case: hearings may be denied "if the sole issue is a Federal or State law requiring an automatic change adversely affecting some or all beneficiaries." 42 C.F.R. § 431.220(b). In *Rosen*, new rules eliminated full categories of eligibility, 410 F.3d at 922, and in *Grier*, new rules subjected medical benefits to hard limits "for which there [were] no exceptions based on individual circumstances," 402 F. Supp. 2d at 910.[11] There was no mass change of eligibility categories here. Ignoring § 431.220(b), TennCare testified that *any* state or federal law establishing an eligibility requirement can justify denying a hearing, so it screens *all* requests for hearings under this policy.[12] PADF ¶ 48. Permitting this approach would allow this narrow exception to swallow beneficiaries' broad right to a hearing as guaranteed by due process and the Medicaid Act.

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[11] *See also Benton v. Rhodes*, 586 F.2d 1, 3 (6th Cir. 1978) (termination of optional benefits); *Davis v. Shah*, 821 F.3d 231, 253 (2d Cir. 2016) (elimination of branch of coverage); *Knapp v. Armstrong*, 2012 WL 640890 (D. Idaho Feb. 26, 2012) (mass change with no individual findings).

[12] Other Medicaid regulations confirm that § 431.220(b) is limited to changes in law. Section 431.210(d) requires notices to explain "the individual's right to request a . . . hearing" or, "[i]n *cases of an action based on a change in law*, the circumstances under which a hearing will be granted." 42 C.F.R. § 431.210(d) (emphasis added). This distinction makes little sense if *every* hearing is subject to the limitation in § 431.220(b). Nor does the State's reading of § 431.220(b) account for other federal regulations. For instance, 42 C.F.R. § 431.223(b) limits the circumstances in which "[t]he agency may deny or dismiss a request for a hearing" to instances where: (1) the beneficiary withdraws the request, or (2) the beneficiary fails to appear. The State's reading of § 431.220(b) would eviscerate these careful limitations on denying and dismissing an appeal.

2. TennCare arbitrarily denies hearings under its good cause policy.

TennCare's restrictive use of good cause exceptions deprives Medicaid enrollees of required hearings. TennCare does not authorize good cause exceptions where individuals allege they never received the NOD and, therefore, were unaware of the deadlines to appeal.[13] PRSUMF ¶ 81. Yet, to comport with due process, individuals must receive *pre*-deprivation notice. *Goldberg*, 397 U.S. at 267–68. Due process and the Medicaid Act both demand that TennCare have policies to ensure that individuals who have not received such notice have a means of redress, including prospective reinstatement until adequate notice is issued. *See Crawley*, 2009 WL 1384147, at *28 (rejecting system that "subverts the purpose of a *pre-termination* review); 42 C.F.R. § 431.231(c).

As written, TennCare's regulations would satisfy this obligation. TennCare enrollees have 40 days to appeal "unless good cause can be shown." Tenn. Comp. R. & Regs. § 1200-13-19-.06. TennCare regulations define "good cause" as "a reason based on circumstances outside the party's control and despite the party's reasonable efforts." *Id.* § 1200-13-19-.02(20). A straightforward reading would include instances in which an individual never received a notice (or other document, like a renewal packet) through no fault of their own. But, in practice, TennCare requires additional evidence to establish good cause, meaning that individuals who never received notice—but who lack enough evidence to prove as much to TennCare's satisfaction—are not allowed to appeal. PRSUMF ¶ 83; *see* Br. 13 (asserting the need to screen out "self-serving" allegations).

Compounding this due process problem, the State does not offer enrollees a hearing to present evidence of non-receipt. PRSUMF ¶ 84. Plaintiff S.L.T., for example, expressly notified TennCare of her family's non-receipt of any renewal packet or NOD, and TennCare admitted that

[13] TennCare also categorically denies good cause exceptions for all non-appeals deadlines, such as the deadline to respond to a renewal packet, leaving individuals who did not receive notice of key deadlines without recourse to challenge the loss of coverage. PRSUMF ¶ 74.

mail may have been sent to a different address, but TennCare nonetheless closed the appeal as untimely without granting a good cause exception or an opportunity to present evidence in a hearing (or otherwise). PRSUMF ¶ 73; *see also* PADF ¶¶ 31–37, (describing persistent errors with incorrect mailing address in TEDS and limitations on enrollee's ability to correct information). This practice is contrary to *Goldberg*, which held that oral presentation is a critical component of due process because of the "flexibility" it offers compared to written submissions and because, "where credibility and veracity are at issue . . . written submissions are a wholly unsatisfactory basis for decision." 397 U.S. at 269. Many good cause decisions, especially regarding non-receipt, rest on credibility and "require perhaps the most delicate of determinations, a case by case balancing of individual factual patterns against a loosely defined standard," especially where, as here, there are no "clearly defined standards circumscribing the 'good cause' determination." *Hurley v. Toia*, 432 F. Supp. 1170, 1177 (S.D.N.Y. 1977).

The State relies on cases involving entirely distinct statutory schemes that not only authorize but *require* certain actions without written notice. *See* Br. 18; *Singh v. Garland*, 2022 WL 4283249, at *3 (6th Cir. Sept. 16, 2022) (noting that the federal immigration statute at issue required an order of removal "even without the 'written notice' that the laws otherwise required"). By contrast here, consistent with *Goldberg*'s requirement for a *pre*-deprivation hearing, federal Medicaid regulations are clear that "[t]he agency *must* reinstate and continue services until a decision is rendered after a hearing if . . . [a]ction is taken without the advance notice required."[14] 42 C.F.R. § 431.231(c)(1) (emphasis added).

In sum, TennCare's refusal to apply good cause to allegations of non-receipt or to provide

[14] *See Kimble v. Solomon*, 599 F.2d 599, 605 (4th Cir. 1979) (ordering prospective reinstatement of Medicaid benefits until adequate notice is provided).

good cause hearings means that individuals who did not receive a notice are routinely deprived of a fair hearing. This policy violates the most basic requirements of due process and the Medicaid Act. *See* 42 U.S.C. § 1396a(a)(3); 42 C.F.R. § 431.231(c).

3. TennCare does not take final action within 90 days of appeal.

Due process requires the administrative hearing to occur "at a meaningful time," *Goldberg*, 397 U.S. at 267, which to be meaningful, must include the decision itself. Through § 1396a(a)(3) and its implementing regulation, 42 C.F.R. § 431.244(f), state Medicaid agencies must take final administrative action on appeals within 90 days in all but exceptional cases. *See* Cert. Order 4; *Lisnitzer v. Zucker*, 983 F.3d 578, 580 (2d Cir. 2020). Courts have consistently held that the requirement of "final administrative action" includes a written decision following a fair hearing. *E.g.*, *Shakhnes*, 689 F.3d at 254; *Thompson ex rel. Bailey v. Fitzgerald*, 558 F. Supp. 3d 1334, 1348 (N.D. Ga. 2021). Yet, TennCare's appeals data from March 2019 through October 2022 shows that it failed to conduct a hearing, much less render a written decision, within 90 days in over 64% of cases (2,933 of 4,559) in which a hearing occurred. PADF ¶¶ 56–58, 64–65. These facts preclude summary judgment.

The State contends that, since August 2022, it "has not had a *hearing* more than 90 days after a termination appeal was filed." Br. 20 (emphasis added). But the requirement is to issue a final *decision* within 90 days, not simply hold a hearing. Moreover, the post-August 2022 data set is misleading because of the significantly lower volume of appeals at that time given the COVID-19 moratorium on Medicaid terminations, which began in March 2020 and ended on April 1, 2023. *See* ECF 180, 181, 263. Plaintiffs' analysis, which also includes TennCare's own data from before the moratorium began, is a better indicator of current practice. Moreover, that TennCare *sometimes* provides hearings within 90 days does not defeat Plaintiffs' claims. *See Withrow v. Concannon*, 942 F.2d 1385, 1387 (9th Cir. 1991) (noting that for those denied hearings and decisions within

the mandated time, "it is no comfort to be told . . . the state is in 'substantial compliance'").

The State further contends that a "waiver from CMS . . . permits [TennCare] to allow appeals to go beyond 90 days as long as it provides continuation of benefits," Br. 20, but the mere existence of such a waiver does not justify summary judgment. The waiver goes into effect only when a triggering condition is met. *See* PADF ¶¶ 66–69. Assuming it has, the waiver is limited by its terms: it does not apply "to any fair hearing request where benefits cannot be provided pending the outcome of the hearing." PADF ¶ 69. Finally, the waiver is only temporary, expiring on February 28, 2025, and cannot excuse noncompliance with the Constitution's due process requirements. PADF ¶ 68. Summary judgment is therefore not appropriate.

II. Summary judgment is not warranted on the ADA claim.

A. The State lacks a valid and reliable reasonable accommodation system.

The State misses the mark in asserting that TennCare has "a system" for granting reasonable accommodations. Br. 24. The record shows that TennCare's system is fragmented, siloed, and woefully understaffed, relying entirely on one person to resolve accommodation requests from a population of 1.7 million. *See* PRSUMF ¶¶ 3, 127, 130, 136, 138, 140. TennCare's policies and practices impose additional burdens on individuals requesting accommodations, by requiring cumbersome paperwork and making circular referrals to various third parties. *Id.* These burdensome steps must be repeated anew each time an individual requires accommodation (*e.g.*, at the next renewal), even when it is identical to one they previously received. PRSUMF ¶ 27. TennCare also improperly requires individuals with disabilities to rely on family and friends to navigate the process. PRSUMF ¶ 106. As a result, as stated by Plaintiffs' unrebutted expert, "TennCare does not provide a reliable, accessible path to assistance needed to appropriately access its programs."[15]

[15] TennCare asserts that it has a system but provides no evidence that the system is effective for

Harrell Decl., Ex. 37, Report of Dr. Peter Blanck, Ph.D., J.D., at 14. The experiences of several Plaintiffs, including Walker, Monroe, and D.R., illustrate these system failures and harms. PRSUMF ¶ 141; *see also* PRSUMF ¶¶ 110, 140. This evidence is more than enough for Plaintiffs to survive summary judgment. *See Hindel v. Husted*, 875 F.3d 344, 350 (6th Cir. 2017).

A system that cannot reliably provide accommodations is insufficient under the ADA. If a state program could assert it had a "system" without any assessment of the efficacy of that system, ADA claims could always be easily defeated. *See Henrietta D. v. Bloomberg*, 331 F.3d 261, 276–77 (2d Cir. 2003) (discussing the functioning of the system for people with disabilities); *Disabled in Action v. Bd. of Elections in City of N.Y.*, 752 F.3d 189, 201 (2d. Cir. 2014) (examining an ad hoc versus effective system); *Brooklyn Ctr. for Independ. of Disabled v. Bloomberg*, 980 F. Supp. 2d 588 (S.D.N.Y. 2013). As these cases demonstrate, a claim based on the adequacy of a system does not defeat class-wide adjudication. *See also R.K. v. Lee*, 563 F. Supp. 3d 774, 783–84 (M.D. Tenn. 2021). The question certified for the Disability Subclass—"whether Defendant *actually* lacks such systems"—is still very much in contention. ECF 234 at 20–21.

Nor does TennCare satisfy its affirmative obligations under the ADA. The ADA, which was enacted to address the pattern of unequal treatment in the administration of state services and programs, creates an affirmative obligation to accommodate people with disabilities. *Tennessee v. Lane*, 541 U.S. 509, 524–27 (2004). Entities must make reasonable modifications to policies, practices, or procedures *and* not use discriminatory methods of administration. 28 C.F.R. § 35.130(b); *Ability Ctr.*, 385 F.3d at 910 (noting ADA violations may come in the form of discrimination or the denial of benefits of public services). The obligation is not limited to providing requested accommodations; entities must also evaluate the programs and services they offer to ensure that

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enrollees with disabilities. *See* ECF 311 at 5–11. Plaintiffs' expert is thus unrebutted.

people with disabilities are not denied the benefits of public services and to provide individuals the means necessary to access those services. *Ability Ctr.*, 385 F.3d at 910; *see also Pierce v. District of Columbia*, 128 F. Supp. 3d 250, 269 (D.D.C. 2015); *Henrietta D.*, 331 F.3d at 275–76. TennCare does not meet these obligations. *See* PRSUMF ¶¶ 106-07, 110-12, 114, 127, 135, 141; *see also Disabled in Action*, 752 F.3d at 201.

First, as discussed above in Part I.B, by failing to consider all categories of eligibility, in particular those based on disability status, TennCare's original design choices when implementing TEDS are methods of administration that screen out people with disabilities who should be eligible under SSI-related categories of eligibility. 42 U.S.C. § 12132; 28 C.F.R. § 35.130(b). Furthermore, TennCare lacks reliable systems to identify these errors, diligently respond to them, or check that problems impacting people with disabilities have in fact been fixed. *See* PRSUMF ¶¶ 12, 19, 22, 24, 28, 36. And even when issues were brought to TennCare's attention, it did not diligently pursue solutions. PRSUMF ¶¶ 22, 24, 28, 36. These choices compounded the harm to individuals with disabilities who were being screened out. *Id.* Much like physical barriers impairing access to buildings, TennCare's inability to accurately determine eligibility for the SSI-related categories is a barrier of TennCare's own making that must be recognized and removed. *See Ability Ctr.*, 385 F.3d at 910. TennCare's lack of planning, testing, and responsiveness to issues impacting access to the program for people with disabilities is exactly what the ADA was enacted to protect against. *See id.* (discussing ADA protection against choices that may not have intended to exclude individuals with disabilities but did so anyway); *Henrietta D.*, 331 F.3d at 265.

Second, TennCare impedes access by imposing burdens on individuals trying to request accommodations. Plaintiffs Monroe, Walker, and D.R. clearly requested accommodations by expressing that they had disabilities and needed assistance to access TennCare. PSRUMF ¶¶ 140–

42, 110–11. It took intervention of counsel to ensure these individuals could navigate the redetermination process. *Id.* The evidence also shows that individuals experienced barriers to making requests, including additional paperwork and an individual with a hearing disability who was left a voicemail by the director and sole employee of TennCare's Office of Civil Rights Compliance. PRSUMF ¶¶ 136, 140–41.

In fact, while a clear request for a modification or accommodation certainly puts a Title II entity on notice that a modification is needed, contrary to the State's assertion, Br. 26, the obligation may also be triggered if the entity knows the person has a disability and experiences limitations as a result of that disability. *See, e.g.*, *Ability Ctr.*, 385 F.3d at 910 (discussing affirmative obligations); *Robertson v. Las Animas Cnty. Sheriff's Dep't*, 500 F.3d 1185, 1197 (10th Cir. 2007) (collecting cases); *Hinojosa v. Livingston*, 994 F. Supp. 2d 840, 843–44 (S.D. Tex. 2014) (finding accommodation required where defendant had knowledge of plaintiff's disability and needs it created); *cf. Marble v. Tennessee*, 767 Fed. Appx. 647, 653–55 (6th Cir. 2019) (finding that no accommodation was required where the request was made by a third party and made no mention of disabilities, the disabled party testified that he could not recall whether the request was necessitated by his disabilities, the request was consistent with other law so would not have suggested that the request was intended to accommodate disabilities, and the state attempted to implement the request). The ADA does not require a state to be clairvoyant, but it does require an effectual accommodation system to give clear opportunities to request needed accommodations and provide them once they are determined reasonable and necessary. *Henrietta D.*, 331 F.3d at 279–80; *see also Randolph v. Rogers*, 170 F.3d 850, 858–59 (8th Cir. 1999) (finding the ADA is not so narrow as to let a public entity claim a plaintiff failed to request an accommodation when it declined to discuss the issue); *Kiman v. N.H. Dep't of Corr.*, 451 F.3d 274, 283 (1st Cir. 2006) (noting that a

person's need for accommodation is sometimes obvious); *Pickett v. Tex. Tech. Univ. Health Scis. Ctr.*, 37 F.4th 1013, 1019 (5th Cir. 2022) (noting that when ongoing accommodations have been acknowledged as necessary, they should be provided).

While TennCare has access to relevant data about Medicaid enrollees, and could collect accommodation-specific data, it has chosen not to, refusing to take even the most basic steps to evaluate whether individuals seeking to access its program require accommodations. PRSUMF ¶¶ 106, 135; PADF ¶¶ 87–101 (describing efforts to identify individuals with disabilities in 2002 using medical claims data). TennCare does not track individuals who have disabilities or who have requested accommodations in the past and require them on an ongoing basis, though the TEDS design already has fields to do so. PRSUMF ¶¶ 106, 140; PADF ¶ 84. Thus, even if enrollees with disabilities do navigate their way to receiving an accommodation, this process must be repeated each time the person needs to interact with TennCare, which impedes access. PRSUMF ¶ 106.

Third, TennCare's system is inadequate because it relies on family and friends. PRSUMF ¶ 106. The ADA's auxiliary aids and services requirements prioritize the protection of privacy and cannot be satisfied by such third-party assistance. 28 C.F.R. § 35.160(b)(2); *Nat'l Fed'n of the Blind, Inc. v. Lamone*, 438 F. Supp. 3d 510, 526 (D. Md. 2020). Even if enrollees with disabilities could access TennCare with the assistance of family and friends, TennCare's failure to provide accommodations remains an ADA violation. *See Paulone v. City of Frederick*, 787 F. Supp. 2d 360, 390–91 (D. Md. 2011) (collecting cases); *People First of Ala. v. Merrill*, 491 F. Supp. 3d 1076, 1159 (N.D. Ala. 2020) (noting plaintiffs need not show they are prohibited from the program, only that the program is not readily accessible to them).

Finally, TennCare fails to show that changing its system or methods of providing reasonable accommodations would be burdensome, much less meet the high standard required for the

fundamental alteration defense. *See Hindel*, 875 F.3d at 348–49 (holding such a determination is fact intensive and inappropriate for summary judgment); *see* PRSUMF ¶¶ 106, 133; PADF ¶¶ 87–101. And Plaintiffs are not seeking an expansion of TennCare services, but rather the removal of obstacles to requesting and receiving accommodations so that they may access the TennCare program as it exists. *See Am. Council of the Blind v. Paulson*, 525 F.3d 1256, 1267 (D.C. Cir. 2008).

B. The State does not provide adequate in-person assistance to people with disabilities.

The *adequacy* of TennCare's in-person assistance is an inherently factual question that is inappropriate for summary judgment. *See* Cert. Order 20, n.12. Plaintiffs raise disputes with each of the facts the State relies on in support of its argument and assert ten additional material facts that weigh on this highly fact-intensive certified issue. PRSUMF ¶¶ 111–15; PADF ¶¶ 73–82. According to the State, TennCare provides adequate in-person assistance through two entities: the Department of Human Services ("DHS") and the nine Area Agencies on Aging and Disability ("AAADs"). But enrollees who go to their DHS county office for help will find little more than a device and internet access. PRSUMF ¶ 111. While DHS employees will assist with the mechanics of using a kiosk, phone, scanner, or fax, and with basic tasks like logging onto an online TennCare Connect account, they have no eligibility training and refer substantive questions to the TennCare Connect call center. PRSUMF ¶ 111; *see also* PADF ¶ 73.

If AAADs provide the breadth of assistance TennCare asserts, the State has yet to produce evidence proving it. AAADs were not contractually required to provide in-person assistance with renewals generally before renewals resumed in April 2023, nor does their reporting to TennCare reflect any such assistance. PADF ¶ 75. On the main website for renewals and the current renewal packet, TennCare lists DHS, not AAADs, as the resource available to individuals who need in-

person assistance.[16] PRSUMF ¶ 114; PADF ¶ 73. Plaintiff William Monroe's interaction with the AAAD reveals the parties' disputes over the AAADs' role in providing in-person, at-home assistance with renewals. *See* PRSUMF ¶ 115.

III. The State may not relitigate the issue of CMS certification.

The State argues that summary judgment is warranted because "CMS has reviewed and certified TennCare's processes for determining eligibility." Br. 28. Because the Court has already squarely rejected this argument, ECF 139-1 at 17–22; ECF 178; ECF 179 at 31–35, it "need not reconsider the issue because tbe 'law of the case' is dispositive," *Roddy v. Tenn. Dep't of Corr.*, 2023 WL 180052, at *3 (M.D. Tenn. Jan. 13, 2023).

As the Court already concluded, tbe State misinterprets CMS's November 2020 cover letter and certification report. *See* PRSUMF ¶¶ 13–14 (citing ECF 139-5, 139-6). CMS expressly stated that its analysis "was an assessment of *information technology system functionality* and [did] not reflect a comprehensive determination of State compliance or noncompliance with all federal Medicaid policy regulations," ECF 179 at 32:14-18 (emphasis added), and the report "reinforces that all [CMS] looked at was the functionality," *id.* at 34:24-25. The State is thus mistaken in contending that CMS made any determination as to TennCare's compliance with the Medicaid Act and its attendant regulations.[17] *See* Br. 28–30. As the Court stated, "[f]unctionality doesn't equal it being legal." ECF 179 at 32:19-20.

Contrary to the State's arguments, this case is nothing like *Rosen* or *Harris*. *See* Br. 29–30. In *Rosen*, CMS filed an *amicus* brief confirming it had "reviewed and expressly approved" the

[16] The renewal packet also notes that those who receive care at a local community mental health center can get help there. PRSUMF ¶ 114.

[17] The State's focus on "critical findings" overlooks that CMS identified other issues with TEDS, the severity of which is disputed, *see* PRSUMF ¶ 15, such as how TennCare compares to other state Medicaid agencies, *see id.* ¶ 148.

State's compliance with the regulation at issue. 410 F.3d at 926–27. In *Harris*, the Sixth Circuit found the Medicare Act ambiguous as to whether incontinence products constituted "medical devices" and so deferred to DHS's position in an *amicus* brief. 442 F.3d at 459, 465–68. But CMS has not appeared in support of the State in *this* case, there is no ambiguity in the governing law, and this Court has already determined that CMS's certification concerned the separate issue of information technology system functionality, not lawfulness. *See* ECF 179 at 32:9-20, 34:3–35:2.

Nor can CMS approval dispose of the ADA claims. *See e.g.*, *Radaszewski v. Maram*, 383 F.3d 599, 601 (7th Cir. 2004) (allowing the plaintiffs' claims to proceed without regard to federal approval of the State's Medicaid plan and waiver programs); *Crabtree v. Goetz*, 2008 WL 5330506, at *2, *30-*31, (M.D. Tenn. Dec. 19, 2008) (same); *Grooms v. Maram*, 563 F. Supp. 2d 840, 844, 863 (N.D. Ill. 2008) (same). And, of course, regardless of the scope of CMS's certification, that certification is entitled to "no deference" regarding whether a constitutional violation has occurred. *New Mexico Cattle Growers' Ass'n v. U.S. Forest Serv.*, 2023 WL 2185698, at *9 (D.N.M. Feb. 22, 2023); *see also Hicks v. Colvin*, 214 F. Supp. 3d 627, 640 (E.D. Ky. 2016) (holding that "the Court must still follow the Constitution").

CONCLUSION

For the reasons discussed above, the State's Motion should be denied.

Dated: July 31, 2023

By: */s/ Babak Ghafarzade*

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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 31st day of July, 2023.

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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

Class Action

Chief Judge Crenshaw
Magistrate Judge Newbern

DECLARATION OF DONNA GUYTON

Pursuant to 28 U.S.C. § 1746, Donna Guyton declares as follows:

1. I am a 65-year-old nurse living in Nashville, Tennessee with my husband, Michael Guyton. We are the parents of Patrick Guyton and served as his co-conservators.

2. Patrick passed away on July 27, 2023, at age 37. He had lifelong medical conditions that included severe refractory seizure disorder. He was nonverbal, non-ambulatory, legally blind and experienced about 2-3 seizure episodes per week. Patrick lived with us in our home his entire life, and Michael and I were his primary caregivers. We are also caregivers for my 90-year old mother, who also lives with us.

3. Patrick was enrolled in both Medicare and TennCare health insurance. Because of the severity of his intellectual and developmental disabilities he also qualified for enrollment in a program for individuals who qualify for institutionalization in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). This Medicaid program is administered by the

Tennessee Department of Intellectual and Developmental Disabilities (DIDD) and overseen by TennCare. The program is more commonly known as the DIDD Waiver or 1915(c) Waiver.

4. Patrick enrolled in the DIDD Waiver in 1992, when he was six years old. As a DIDD Waiver enrollee, Patrick qualified for TennCare and remained on TennCare after 1992. The DIDD Waiver provided in-home support services that helped Patrick live in the community with our family rather than an ICF/IID, which is an institutional setting. These services helped Patrick go out in the community and interact with others and have a quality of life he could not have had otherwise. These services would not have been available to Patrick if he had not had TennCare, for which we are very grateful.

5. Patrick was part of a federal lawsuit, *M.A.C. v. Smith*, No. 3.21-cv-00509 (M.D. Tenn., 2021). This lawsuit was filed in in the United States District Court for the Middle District of Tennessee and was settled in 2022. This lawsuit concerned TennCare's failure to provide Patrick's home care hours approved under the DIDD Waiver as medically necessary.

6. In the past, Patrick received Supplemental Security Income (SSI) due to his disabilities, which also entitled him to receive TennCare. Patrick could thus qualify for TennCare on either of two grounds: as an enrollee in the DIDD Waiver, or as an SSI recipient.

7. After Patrick's father commenced receiving Social Security, Patrick began receiving Social Security Disability Insurance (SSDI) in April 2020 as a child's benefit, also known as a Disabled Adult Child (DAC) benefit, based on his father's work history. (Exhibit 1). Because of this change and the resulting increase in Patrick's income, Patrick's SSI stopped in June 2020. (Exhibit 2). Although he ceased to be eligible for TennCare on the basis of receipt of SSI, he still qualified for TennCare as an enrollee of the DIDD Waiver, as well as through the Disabled Adult Child (DAC) category.

8. In May 2022, Patrick enrolled in Medicare. Following receipt of a notice from Medicare, we called the Tennessee State Health Insurance Assistance Program (SHIP). After this call we received a notice from TennCare stating that Patrick was denied the Medicare Savings Plan (MSP) QMB and SLMB. However, he was still enrolled in Part B Buy-in through his TennCare coverage. This meant the state was still responsible for paying Patrick's Medicare Part B premium costs.

9. After the COVID public health emergency and related moratorium on most Medicaid terminations ended on March 31, 2023, TennCare began sending us a series of conflicting and confusing notices regarding Patrick's eligibility.

10. In a form notice TN 301.20 dated May 3, 2023, TennCare stated that Patrick qualified for continued TennCare and Part B Buy-in. The notice denied Patrick for QMB and SLMB. (Exhibit 3). The notice didn't provide any dates of coverage. The notice didn't specify Patrick's TennCare eligibility category. The notice did say that Patrick qualified for Part B Buy-in because "you have a kind of TennCare Medicaid or Katie Beckett that meets our rules for Part B Buy In."

11. Though nothing had changed with Patrick's circumstances, in a notice dated May 11, 2023, the Social Security Administration stated that Tennessee was no longer going to pay for Patrick's Medicare Part B Premium.

12. Then in a TennCare form notice TN 301.20 dated May 18, 2023, TennCare denied Patrick for QMB and SLMB coverage and was silent on Patrick's enrollment in Part B Buy-in. (Exhibit 4). On May 25, 2023, my husband and I filed an appeal over the phone with TennCare Connect, because nothing had changed, and Patrick should have still been enrolled in Part B Buy-in. We explained when we filed the appeal that nothing had changed between the May 3, 2023

notice granting him Part B Buy-in and the May 18, 2023 notice and that we did not understand why Patrick's benefits were changing.

13. Social Security took out money for the month of June 2023 from Patrick's Social Security check to pay for his Medicare Part B Premium, but Patrick was also issued a check from the Social Security Administration on June 1, 2023 which reimbursed him for that Medicare cost.

14. On May 18, 2023, TennCare also sent us form notice TN 304.13. This notice was a pretermination notice which had a seven-page series of questions. It stated that Patrick's coverage would end soon because he was "not in a group covered by TennCare…You must be in a group we cover….Some of those groups include:…people who are getting Social Security and who used to get SSI checks….people who need long-term services and supports…" (Exhibit 5). We were very worried that this might end Patrick's DIDD Waiver eligibility. This notice was also confusing because Patrick used to get SSI and also needs long term services and supports through the DIDD Waiver. The notice did not explain why Patrick's previous SSI eligibility or his participation in the DIDD Waiver did not count. TennCare knows that Patrick participates in the DIDD Waiver as it is also a TennCare program, and Patrick's former SSI status is also known to TennCare, because he only ever received SSI in Tennessee.

15. The form questions were also confusing because one question asked, "Do you have intellectual and/or other developmental disabilities and want to get HCBS (Home and Community Based Services) and participate in Employment and Community First CHOICES?" This question did not apply to Patrick because he already got home care services through the DIDD Waiver. He did not want to be on ECF CHOICES, which is a different program than the DIDD Waiver. I understand that you cannot be on both programs.

16. On May 30, 2023 I called TennCare Connect because we could see that TennCare was trying to evaluate Patrick for TennCare eligibility, but we always thought this renewal process did not apply to Patrick because he was on the DIDD Waiver. I connected with a representative and explained the situation. I asked the representative if they knew anything about the DIDD 1915(c) waiver. They did not. The representative stated that they were not sure why Patrick was going to be disenrolled from TennCare. The representative also stated that they did not know why the DIDD Waiver was not mentioned in the TennCare notices we received. The representative advised that we complete the pretermination questionnaire form and also include details and proof of Patrick's enrollment in the DIDD Waiver. The representative did not provide any referrals to other types of assistance.

17. We promptly filled out the questionnaire, flagged in the margins that Patrick was enrolled in the DIDD Waiver, and marked that Patrick used to receive SSI. (Exhibit 6). We put this information in the margins because the questions were not asked and our experience and knowledge of TennCare eligibility due to previous problems indicated we should probably include it. Based on our interactions with other families and working with the Tennessee Justice Center in the past, we think our knowledge of TennCare eligibility is above average.

18. We faxed the completed form to TennCare Connect on May 30, 2023 along with a letter I wrote and a copy of Patrick's Independent Support Plan (ISP). The ISP is a key document if you are an enrollee in the DIDD Waiver program, because it maps out a care plan and is revisited and updated at least annually. Each year and with any amendment, the plan must be approved by DIDD. The ISP indicated Patrick's eligibility for and receipt of DIDD services. It proved his TennCare eligibility as being a recipient of DIDD Waiver services, which meant that he was eligible for TennCare generally.

19. TennCare then sent two notices dated June 1, 2023. The first, form notice TN 608.5, was a Valid Factual Dispute (VFD) notice that stated that TennCare needed more information for Patrick's appeal because "You did not tell us about a mistake that, if you're right, means you qualify for our program." (Exhibit 7). However, we had explained when we filed the appeal that nothing had changed between the May 3, 2023 notice granting him Part B Buy-in and the May 18, 2023 notice. We did not know what other information was needed and we did not know what qualifies someone for Buy-in. We just knew that Patrick's situation didn't change, and so it was probably a mistake for TennCare to deny him something he was always receiving. We had already explained this in the appeal. We also thought this issue was fixed because Patrick received a reimbursement check from Social Security Administration for his Medicare costs. The second, form notice TN 304.13, was a repeat of the pre-termination questionnaire which we had just filled out and faxed to TennCare.

20. In a form notice TN 301.20 dated June 9, 2023, TennCare stated that Patrick's TennCare coverage was ending on June 29, 2023. (Exhibit 8). The notice stated that, "Before we made our decision, we looked to see if you could get other kinds of coverage we offer." I did not understand how this could be accurate because Patrick qualified for TennCare as an enrollee of the DIDD Waiver. We also understood from TJC that Patrick would have separately qualified under the DAC category, as well. The notice only stated, "The monthly income limit for the kind of TennCare Medicaid you could get is $914.00 Our records show your monthly income is over this limit." I could not understand what this meant or how this could apply to Patrick, whose income had long exceeded that amount. He was on the DIDD Waiver, which I always understood had a different income requirement.

21. Patrick's TennCare MCO nurse case manager also then informed us that Patrick's TennCare coverage was ending June 29, 2023.

22. This information came during a time when Patrick was diagnosed with pneumonia and my mother just got out of a 10-day hospital stay. I was also recently diagnosed with shingles. I was told the shingles were brought on by severe stress.

23. On June 16, 2023, I called TennCare Connect multiple times to understand what had happened to Patrick's TennCare coverage. The first call lasted approximately 1 hour and 15 minutes, because the representative had to put me on hold multiple times to speak with her supervisor. The call was then disconnected with no resolution and no call-back from the disconnected call.

24. I promptly called back the same day and spoke with a different representative and was told that I would have to start the conversation all over. This time I was transferred to a supervisor but told I could not be transferred back to the original representative. The new representative stated that they wanted to place me on hold so they could review the case. I expressed concern that when I am placed on hold with TennCare Connect I sometimes get disconnected. I was nevertheless placed on hold and then disconnected. This call lasted about 20 minutes. TennCare Connect tried to call back, but no one was on the line when I answered the phone.

25. I immediately called TennCare Connect again and spoke with yet another representative. I explained what had just happened and was told I would have to start the conversation over. I immediately asked to file two appeals. The first appeal was for the wrongful termination of Patrick's TennCare coverage. The second appeal was for the wrongful denial of Patrick's Medicare Part B Buy-in. We didn't understand how to argue that he should get Part B

Buy-in. We just knew nothing had changed, and so the denial didn't make sense, and we wanted to make sure to appeal before the deadline. This call lasted 1 hour and 27 minutes. We asked for copies of our appeals. We were first refused, but then as an exception we were told that we could send a separate request to the appeals department.

26. In a form notice TN 600.11 dated June 15, 2023, TennCare stated that it was closing Patrick's May 25th appeal regarding Patrick's Buy-in. (Exhibit 9). The notice stated that "When you appealed, you didn't give us the facts we need to work your appeal. Our letter told you what facts we needed and gave you more time to get those facts to us. You didn't give us more facts so you can't get a fair hearing." Again, we didn't understand what TennCare needed other than what we already explained in the appeal. The system is very confusing, and we don't know all of the rules and all of the requirements for TennCare's various programs. We just knew nothing had changed and that TennCare might be making a mistake.

27. While dealing with this, we were also caring for Patrick. He was being treated for a respiratory infection and then, on June 15, 2023, he was diagnosed with pneumonia. On June 22, 2023, Patrick's fever spiked to 101.5 while on antibiotics and he was having difficulty breathing, so we called 911. Patrick was transported by ambulance to Vanderbilt University Medical Center and he was placed in the medical intensive care unit. Patrick remained in the hospital until he passed away on July 27, 2023.

28. On June 23, 2023, there was a meeting of Patrick's Circle of Support (COS), which is a meeting necessary for Patrick's care coordination as a DIDD Waiver enrollee. The DIDD Middle Tennessee Director of Operations was in attendance. We asked if she could help us with Patrick's coverage. She stated that it was unlikely that DIDD could help in this situation, because it "had to play out in a process because it had gone to appeal."

29. On July 6, 2023, we received an email notice from TennCare Connect directing us to check Patrick's TennCare Connect online portal. When we logged in, his coverage dashboard showed his coverage status for TennCare Medicaid as "Approved" and the details showed his "Coverage Begin Date" as 7/2/2023. (Exhibit 10). In a form notice TN 301.21 dated July 10, 2023. TennCare stated that Patrick has "Continued Coverage-Ongoing" and that Patrick qualified "for the same coverage you had before. And, you'll have no break in coverage." It also stated that "You qualify to get or keep Part B Buy In." The portal also showed that two of Patrick's three appeals has been closed. (Exhibit 11). One of the appeals that was closed was for the May appeal on Patrick's Buy-in coverage. We don't know which appeal of our two June appeals is closed. We have not received any letters regarding the closure of one of those appeals.

30. It is also unclear whether Patrick had a gap in TennCare coverage from June 30, 2023, through July 1, 2023. Patrick was in the ICU then and likely incurred medical bills during those days.

31. After sending a screenshot of Patrick's TennCare Connect portal, Patrick's TennCare managed care contractor's case manager finally recognized that Patrick's coverage was active again on July 11, 2023. Thankfully, Patrick's independent support coordinator (ISC), who coordinated his DID Waiver services, continued to work and advocate for Patrick throughout this time, even though he wasn't receiving any other DIDD Waiver services while in the hospital.

32. While Patrick was fighting for his life, TennCare was threatening to take away his health insurance coverage and the services he relied on. Though we should have been able to focus on Patrick's care, our family was required to navigate a system that kept denying his eligibility and putting his health coverage at risk. Try as we might to understand and correct the mistakes, it was a system that would not respond. We spent hours on the phone, filed three appeals and

personally asked a senior DIDD administrator and Patrick's TennCare case manager for help. My husband and I are college educated professionals without disabilities, and we found this process very confusing, demoralizing, time consuming, and frightening. If I did not have the flexibility in my schedule to follow up on all the letters and phone calls, including long wait times, I do not know what we would have done or how we could have helped Patrick keep his necessary TennCare coverage.

33. My husband and I always carefully read every piece of mail we ever received from TennCare. If the notice had a decision by TennCare or a request from TennCare, we read the document to understand the decision TennCare made, why the decision was made, or any steps we had to take to ensure that Patrick maintained his healthcare coverage. Sometimes we didn't always understand the decisions TennCare made, even when the notice tried to explain why they made the decision. In those situations, we relied on our intuition and our past experiences with the state to take next steps, or we reached out to the Tennessee Justice Center. Even then, sometimes no one could explain why TennCare was doing what it was doing.

34. One thing that made TennCare's termination of Patrick's coverage especially frightening was our worry that it might impact his DIDD Waiver enrollment. The home and community-based services provided by the DIDD Waiver were what made it possible for him to live with our family at home, rather than in an institution. That was always critically important for him and for our family. Even with my professional nursing background and our family's full commitment to keeping Patrick safe at home, his needs were such that the Waiver services were essential, and the threat of their loss was extremely distressing. Patrick's TennCare records documented that the medical conditions that qualified him for the DIDD Waiver and TennCare were of a type that were never going to go away, and that he would always need both TennCare

were of a type that were never going to go away, and that he would always need both TennCare coverage and Waiver services. Yet TennCare did not consider his conditions or his eligibility for the DIDD Waiver when it terminated his coverage. It is concerning that not one person I spoke with at TennCare Connect knew about the DIDD Waiver program and why his enrollment in that program made him eligible for TennCare.

35. No one that I dealt with at TennCare seemed to understand that he was also eligible in the DAC category.

36. Although we have lost Patrick, Michael and I are deeply concerned for other families that rely on TennCare, many of whom lack our resources for dealing with the system's mistakes. It is so easy for the process to wear you down and overwhelm you, especially at those times when you are most vulnerable and need TennCare the most.

37. I declare under penalty of perjury that the foregoing statements are true and correct. Executed in Nashville, Tennessee this 28th day of July, 2023.

Donna Guyton

Donna Guyton

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 31st day of July, 2023.

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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

Class Action

Chief Judge Crenshaw
Magistrate Judge Newbern

DECLARATION OF ANDREA RILEY

Pursuant to 28 U.S.C. § 1746, Andrea Riley declares as follows:

1. I am 57 years old and live in Brentwood, Tennessee with my husband. I have a 26-year-old son, Joshua F. Riley, who has a disability. I am his Co-Power of Attorney.

2. Joshua has high functioning autism and ADHD along with co-existing developmental and mental health diagnoses. Co-existing developmental disabilities with a mental health component makes it impossible for Joshua to navigate the administrative parts of all of the programs listed below along witb other medical, dental, LTSS, and financial entities.

3. Joshua is currently enrolled in TennCare and the Employment and Community First (ECF) CHOCIES program. His TennCare managed care organization (MCO) is Amerigroup. ECF CHOICES is one of TennCare's Long Term Services and Supports programs for individuals with intellectual or developmental disabilities. Joshua has been enrolled in ECF CHOICES since February 2019. Joshua qualified for ECF Choices and TennCare through his developmental disability diagnoses and his eligibility for Supplemental Security Income (SSI). He received both

SSI and Social Security Disability Insurance (SSDI) benefits. Joshua now receives SSDI at a level which discontinued the SSI cash payments. Due to his SSDI benefits Joshua now qualifies for and is enrolled in a Dual Coordination Special Needs Plan which is a Medicare/TennCare plan. He also qualifies for SLMB in the Medicare Savings Program (MSP).

4. In 2019 Joshua began receiving incorrect patient liability notices. I spent 8 months in appeals trying to fix all the issues without any success. At the urging of TennCare itself and my frustration with using the customer service phone number, I created a TennCare Connect account in 2019 to monitor Joshua's TennCare coverage and TennCare notices. I hoped that navigating through an online portal would be more efficient and effective than various customer service representatives I talked with by phone. Unfortunately, I have not experienced a more efficient and effective interaction through the online portal. In fact, I have encountered the opposite. I have found it inaccurate, hard to navigate, and there is no avenue for resolving incorrect information.

5. Currently, in Joshua's TennCare Connect portal, there are two TennCare case numbers; one for his terminated case and one for his current active case.

6. TennCare not only encourages but has been actively marketing the TennCare Connect portal in anticipation of renewals to begin again. The TennCare Connect portal is marketed as a comprehensive avenue for all current recipients to completely manage all of their TennCare information including updating all contact information, especially mailing address, residential address, emails, phone numbers, and communication preferences.

7. Despite making the same updates at two separate times, Joshua's TennCare Connect portal still does not reflect the updated addresses and contact information which I entered into the portal. This process has been both confusing and discouraging.

8. At my most recent login, the TennCare Connect online portal dashboard shows Joshua's two case numbers. (Exhibit 1). Under "Head of Household Contact Information," Joshua's terminated case number, not his current active case, is shown. Furthermore, the home address listed on Bellevue Road is not correct. Joshua has not lived there since January 2021. There is no way to update any information on this terminated case. I also cannot make the dashboard display only the current active case information.

9. When I click on "View Details," I am led to a note stating that no information regarding this case can be updated or altered. This is because Joshua received SSI payments at that time. Instead, I am directed to contact the Social Security Administration ("SSA") in order to update the address or other contact information. I had previously contacted the SSA multiple times by phone and in person but was not able to get through to update Joshua's address on the SSI side. It is my understanding that TennCare pulls some contact information, especially on those receiving SSI, directly from the SSA. If I am unable to contact the SSI side of SSA to update information then any information pulled by TennCare will always continue to reflect the incorrect information in the TennCare Connect portal and I suspect in the system in such a way that calling TennCare using their customer service number will also reflect incorrect information given verbally over the phone. I found it to be a vicious cycle with no way to arrive at a resolution. For me, contacting TennCare through any mode to 'solve a problem' always ends in a dead end.

10. I next attempted to update Joshua's employment information because he works two days a week. When I went to update this, I was given two choices to enter how much income Joshua receives: (a) "Specific dollar amount received every pay period" or (b) "The amount paid per hour and the number of weekly hours." I reported Joshua's income using option (b) and reported that Joshua worked 14 hours per week while being paid $19.00 per hour. After inputting

this information in the TennCare portal, the hours per week that Joshua works show up as the dollar amount paid per hour. Under the question "On average, how many hours does Joshua F. Riley work each week at this job?," the answer is listed as "$14." (Exhibit 2).

11. When I attempted to submit the contact information changes, I received a letter for the terminated case from TennCare which stated that coverage ended (again) on July 5, 2023. (Exhibit 3). This was very confusing since I was receiving a termination letter on an already terminated case. Again, no information that I reported in the portal was updated by TennCare in the portal.

12. Despite making the updates which TennCare encouraged me to make, the portal's dashboard still shows the "Head of Household Contact Information" section with the terminated case number. (Exhibit 4) and incorrect information. Instead, the dashboard should be displaying only the current eligible case information in this section. In fact, my recommendation would be to completely remove the terminated case information from anywhere on the dashboard.

13. I did receive a letter by mail for the current active case which reflected the correct updated residential address for Joshua, but the mailing address is still incorrect even though I tried to correct it twice in the TennCare Connect Portal. (Exhibit 5).

14. When I try to use the "Communication Preferences" tab, I am always sent to a session termination page. (Exhibits 6 and 7). This is frustrating and makes using the TennCare online portal difficult, if not impossible.

15. Navigating the TennCare online portal is also difficult and confusing because the "Dashboard Tutorial" boxes are misdirected. (Exhibits 8 and 9). The tutorial box for the section "Household Documents" gives information for the "My Coverage" section. The tutorial box for the section "Manage My Account" gives information for "Household Documents."

16. I am concerned about TennCare's online portal not reflecting the correct address and contact information I attempted to update, especially considering TennCare is encouraging recipients to make these updates in anticipation of upcoming renewals.

17. Overall, it is very confusing and discouraging that TennCare's online system will not allow me to make the changes that TennCare itself has been loudly and frequently calling for. I am doing my part to complete the requested tasks and yet, the system consistently reflects incorrect information and the online TennCare platform displays incorrect information about navigating within the portal itself. The most frustrating part is there is no way to fix the issues or solve the problems. There is no portal feedback button. There is no IT phone number to contact. There is no 'get help' button. There is no FAQ section. Again, a vicious cycle with no avenue for resolution which breeds hopelessness and ultimately the non-use of the online tool.

18. I am a college graduate without disabilities in full time professional employment. Outside of my full-time job, I currently spend 15-20 hours per week navigating "the system" on behalf of Joshua. Please note that the TennCare portal is only one of the online systems that I have to navigate. I manage and navigate the following portals in addition to the TennCare portal: Joshua's SSA account, my SSA Representative Payee account, Amerigroup's Dual Plan Medicare portal, Medicare single portal, Dual Plan extra benefits ordering portal, Amerigroup's TennCare Community Care portal, SNAP and the OneDHS portal, EBT SNAP card portal, ABLE account portal, Primary Care Physician portal, Special Needs Dentist portal, counseling portal, and his banking portal.

19. Joshua is not an island reflecting only one need for TennCare as that one resource. Joshua requires and needs multiple support services and resources for his success. Navigating 'the system (and it is a system) is a time consuming, difficult, frustrating, hopeless venture filled with

more failures than successes. However, it is a venture that I must engage in and advocate within for the success of my son. Unfortunately, in my experience, the TennCare Connect online portal is not a pathway but a roadblock that hinders the forward progress of my son.

I declare, pursuant to 28 U.S.C. § 1746 and under the penalty of perjury, that the foregoing statements in this affidavit are true and correct. Executed in Davidson County, Tennessee this 29th day of July 2023.

/s/ Andrea Riley

Andrea Riley

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 31st day of July, 2023.

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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

Class Action

Chief Judge Crenshaw
Magistrate Judge Newbern

DECLARATION OF CLAIRE HOLLAND

Pursuant to 28 U.S.C. § 1746, Claire Holland declares as follows:

1. I am a 73-year-old attorney living in Northport, Alabama. I am the conservator of my 39-year-old son, James Gentry Fields ("Gentry"), who is a resident of Columbia, Tennessee. (Exhibit 1.)
2. Gentry has Down Syndrome, Attention Deficit Hyperactivity Disorder (ADHD), and issues related to the functioning of his heart, gastrointestinal tract, and urinary tract. Further, Gentry has a history of engaging in self-harm, which began after a period of abuse and unlawful restraint he experienced as a resident at an out-of-state facility. As a result of his conditions and experiences, Gentry is unable to work and has difficulty staying on task, and medication and close supervision are critical to his wellbeing.
3. In the past, Gentry received Supplemental Security Income (SSI) due to his disabilities. In 2009, after his father died, Gentry began receiving Social Security Disability (SSDI) as a

child's benefit, also known as a disabled adult child benefit, based on his father's work history. (Exhibit 2.) Because of this change, Gentry's SSI stopped. (Exhibit 3.)

4. At various points in his life, Gentry has been enrolled in Medicaid programs in Florida, Georgia, and Kentucky.

5. In 2015, Gentry became a resident of Columbia, Tennessee when he enrolled at the King's Daughter School. The school has been a good fit for Gentry, in particular due to the close supervision offered by the lower ratio of residents to staff.

6. Gentry qualifies for TennCare through the Disabled Adult Child (DAC) category. Prior to moving to Tennessee, he was eligible under DAC in Florida and Kentucky.

7. When I first applied for TennCare on Gentry's behalf in 2015, he was denied because of the monthly amount of his Social Security benefit even though that income should have been disregarded for purposes of determining DAC eligibility, since he was eligible for SSI as a child before the SSDI benefits began. During this time, I was paying out-of-pocket for deductibles and copays that Medicare did not cover for Gentry, including costs associated with scans, ambulance rides, emergency room visits, and a week-long hospital stay.

8. I reapplied for TennCare on Gentry's behalf in 2017. He was again denied because of the monthly amount of his Social Security benefit. I again appealed, and TennCare dismissed the appeal without a hearing. After several phone conversations with TennCare, Gentry was eventually evaluated for CHOICES and received TennCare coverage during the period of that evaluation. Gentry was denied for CHOICES, and I appealed. After my own research and a number of conversations with a contact I have at the Tennessee Attorney General's office, I provided that individual with a document showing Gentry's receipt of

SSDI as a disabled adult child benefit (Exhibit 2) and a document showing that this change caused his SSI payments to stop (Exhibit 3). I did not know to provide these documents earlier in my applications or appeals on Gentry's behalf because TennCare had never asked me for proof related to Gentry's receipt of SSI or SSDI. My contact at the Tennessee Attorney General's Office advised me that I should dismiss the CHOICES appeal, which I did, because Gentry was eligible for TennCare in the DAC category. He also advised me that I should reiterate the basis for Gentry's DAC eligibility in future TennCare renewals.

9. In 2018, after this intervention from the Tennessee Attorney General's Office, TennCare resolved its error and found Gentry eligible in the DAC category with coverage beginning as of the 2017 application date.

10. In April 2023, I received a renewal packet, TN 401, dated April 6, 2023, that I was required to complete in order to maintain Gentry's TennCare coverage.[1] (Exhibit 4.) None of the questions in the packet addressed past receipt of SSI, information which I knew was necessary to determine DAC eligibility. Because of my experience with TennCare failing to recognize Gentry's DAC eligibility and my own knowledge of his eligibility, I opted to complete the renewal by phone by calling TennCare Connect soon after receiving the packet, so that I could fully articulate the basis for his eligibility.

11. On the phone with TennCare Connect, I explained to the representative that Gentry's medical conditions had not changed and that Social Security remained his only source of income. As a result, I explained, he remained eligible for TennCare in the DAC category due to prior receipt of SSI as a child.

[1] As far as I am aware, Gentry did not go through the renewal process between his 2018 approval and the beginning of the COVID continuous enrollment protection.

12. The TennCare Connect representative had never heard of the DAC category. During our conversation, which was about an hour and a half long, the representative repeatedly put me on hold to speak with her supervisor. Those conversations did not appear to clear up the representative's confusion about DAC. The call was very frustrating.

13. At my request, the TennCare Connect representative made a note on the renewal packet about my wish for Gentry to remain enrolled in TennCare as a DAC; she told me that she wrote, "The mom requests that Mr. Fields's benefits not change." She did not use the term "DAC" as far as I know. I explicitly told the representative that I did not wish for Gentry to be evaluated for CHOICES. My understanding at the end of the call with TennCare Connect was that all the information TennCare needed for Gentry's renewal had been received during the phone call.[2]

14. Despite my attempts to explain Gentry's DAC eligibility and the lack of need to consider him for CHOICES, TennCare sent a Notice of Decision, TN 301 dated May 24, 2023, terminating Gentry's TennCare coverage. (Exhibit 5.) I found the notice confusing, frustrating, and deeply upsetting.

    a. The notice stated, "Before we made our decision, we looked at you for different kinds of coverage," and, "Before we made our decision, we looked to see if you could get other kinds of coverage we offer." But the notice did not say anything about DAC or why TennCare thought that Gentry was no longer eligible for DAC. I could not understand why TennCare was terminating Gentry from DAC when I knew the law had not changed since he was last determined eligible.

[2] Prior to receiving the termination notice, I missed a phone call from TennCare; I returned the call and accepted the option for a call-back, but no call-back ever came.

b. The notice said I could file an appeal if I thought TennCare made a mistake and listed reasons I could have a fair hearing, but none of the reasons seemed relevant to DAC eligibility. It was only due to my past research and experience in 2017 and 2018 that I knew what information and proof was needed to establish Gentry's DAC eligibility.

c. The notice also incorrectly indicated that Gentry had applied for CHOICES even though I told the TennCare Connect representative I did not wish for Gentry to be evaluated for CHOICES.

d. Even though I completed the renewal by phone with TennCare Connect, the notice listed as one of the reasons for termination, "You did not respond when we told you it was time to renew your benefits."

15. The same day I received the Notice of Decision, I called TennCare Connect and filed an appeal. The representative told me that the "problem" with Gentry's termination was a lack of information and predicted that because an appeal would involve review by a person rather than a computer program, the issue of Gentry's eligibility would likely be resolved.

16. I also promptly reached out to my contact at the Attorney General's Office by phone and by email. I received an email response on June 12, 2023 indicating that my contact was looking into the problem.

17. An Appeal Resolution notice, TN 600 dated June 12, 2023, later appeared in my TennCare Connect account. I saw it there during a routine review of my account; I did not receive an email notifying me that the letter had been posted. The notice indicated that TennCare was closing my appeal because it realized Gentry's renewal packet had been submitted. (Exhibit

6.) I did not understand why TennCare was closing my appeal because I had not withdrawn it, and as far as I knew, TennCare still did not recognize Gentry's DAC eligibility.

18. Days later, an Additional Information notice, TN 303 dated June 14, 2023, appeared in my TennCare Connect account. (Exhibit 7.) This notice included questions addressing past receipt of SSI, which had not been included in Gentry's April 2023 renewal packet. I immediately completed the form and submitted it to TennCare.[3] I do not understand why TennCare needed responses to these questions again when I have already provided proof of Gentry's past receipt of SSI and eligibility in the DAC category in the past.

19. Although the Coverage Details screen on my TennCare Connect account later indicated that Gentry had been approved for TennCare coverage, I did not receive a letter from TennCare for several weeks. A Notice of Decision, TN 301 dated July 13, 2023, said that TennCare had approved Gentry for continued TennCare coverage. (Exhibit 8.)

20. This process has taken a toll on me both physically and mentally and has required hours of my work, research, and attention. Although I provided TennCare with all the information they asked for and more, Gentry nearly lost his health insurance. Even with my education and contacts as an attorney, I have found this process both baffling and deeply distressing. Without my knowledge of Gentry's DAC eligibility and my ability to directly contact the Tennessee Attorney General's Office, I fear the result would have been different.

21. I am concerned about the future stability of Gentry's TennCare coverage. None of the factors affecting Gentry's DAC eligibility have changed since TennCare first determined

[3] During this process, I decided to look back at old notices in my TennCare Connect account, where I saw notice TN 304 dated July 29, 2021 (during the COVID continuous eligibility protection), which also included questions relevant to DAC eligibility. (Exhibit 9.) These questions were not included in Gentry's April 6, 2023 renewal packet.

him eligible in 2018, yet the same problems have arisen. Gentry's medical conditions have not changed and will not change, and given his inability to work, Social Security is likely to remain the exclusive source of his income.

22. I declare, pursuant to 28 U.S.C. § 1746 and under the penalty of perjury, that the foregoing statements in this affidavit are true and correct. Executed in Northport, Alabama this 18th day of July, 2023.

/s/ Claire Holland

Claire Holland

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 31st day of July, 2023.

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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

PLAINTIFFS' STATEMENT OF ADDITIONAL DISPUTED FACTS IN OPPOSITION TO SUMMARY JUDGMENT

Pursuant to Local Rule 56.01(c), Plaintiffs submit the following statement of additional disputed material facts in opposition to the State's motion for summary judgment.

1. Gentry Fields is a 39-year old resident of Columbia, Tennessee with Down Syndrome and multiple other disabilities and medical conditions, who received Medicaid as a Disabled Adult Child (DAC) in Kentucky and Florida before moving to Tennessee. Holland Decl. ¶¶ 1-4.

Response:

2. When Gentry Fields' mother, Claire Holland, who is an attorney and his conservator, applied for TennCare on his behalf in 2015, he was denied coverage in spite of his DAC eligibility, because TennCare did not ask for relevant information and she did not know what information to volunteer. Holland Decl. ¶¶ 7-8.

Response:

3. When Gentry Fields' mother, Claire Holland, applied for TennCare on his behalf again in 2017, he was denied coverage in spite of his DAC eligibility, because TennCare did not ask for relevant information and she did not know what information to volunteer. Holland Decl. ¶ 8.

Response:

4. When Gentry Fields' mother tried to appeal the 2017 denial, the appeal was dismissed without a hearing. Holland Decl. ¶ 8.

Response:

5. Gentry Fields' mother finally managed to enroll him in TennCare because of the intervention of a personal contact in the Tennessee Attorney General's Office who advised her that he was eligible in the DAC category. Holland Decl. ¶¶ 8-9.

Response:

6. When Gentry Fields came up for renewal of his TennCare coverage in April 2023, the packet he received omitted questions that he had been asked in a July 2021 TennCare questionnaire that elicited information necessary to consider eligibility for SSI-related categories. *compare* Holland Decl. ¶ 10, Ex. 4 (2023 renewal packet) *with* Holland Decl. ¶ 18 n.3 Ex. 8 (2021 questions).

Response:

7. When Gentry Fields came up for renewal of his TennCare coverage in April 2023, Ms. Holland called TennCare Connect and completed the packet by phone, so that she could explain why her son was eligible in the DAC category. Holland Decl. ¶¶ 10-11.

Response:

8. The TennCare Connect with whom Ms. Holland spoke representative was unfamiliar with DAC, and her supervisor was unable to clear up the confusion. Holland Decl. ¶ 12.

Response:

9. When TennCare redetermined Gentry Fields' eligibility in May 2023, it found him ineligible without identifying him as continuing to be eligible for DAC. Holland Decl. ¶¶ 10-14.

Response:

10. The Notice of Decision that Gentry Fields received did not say anything about his DAC eligibility or state the reason(s) TennCare thought he was no longer eligible for DAC. Holland Decl. ¶ 14, Ex. 5.

Response:

11. The notice gave as a reason for the denial that Mr. Fields had not responded to the renewal notice, even though his mother had done so by phone. Holland Decl. ¶ 14, Ex. 5.

Response:

12. In the Notice of Decision that Gentry Fields received, the "Reasons you can have a fair hearing may include" list did not include reasons relevant to DAC eligibility. Holland Decl. ¶ 14, Ex. 5.

Response:

13. When Ms. Holland attempted to appeal on Gentry Fields' behalf, the appeal was dismissed without a finding that he was eligible. Holland Decl. ¶¶ 15, 17.

Response:

14. Patrick Guyton was a TennCare enrollee who lived with this parents, Donna and Michael Guyton, until his death on July 27, 2023, at the age of 37. He had lifelong medical conditions and severe disabilities, and his parents served as his co-conservators and primary caregivers. Guyton Decl. ¶¶ 1-2.

Response:

15. Patrick Guyton was enrolled in the TennCare program that provides home and community-based services and that is administered by the Tennessee Department of Intellectual and Developmental Disabilities. He was eligible for TennCare because he was enrolled in that program, commonly known as the DIDD Waiver. Guyton Decl. ¶¶ 3-4.

Response:

16. Patrick Guyton was eligible for TennCare as a Disabled Adult Child, as well as on the basis of his enrollment in the DIDD Waiver. Guyton Decl. ¶ 7.

Response:

17. Patrick Guyton enrolled in Medicare in May 2022, and TennCare paid his Medicare Part B premium ("Part B Buy-in"). Guyton Decl. ¶ 8.

Response:

18. TennCare sent Patrick Guyton a notice on May 18, 2023 informing him that coverage would soon end because he was not in a group that TennCare covered, and the notice included a pre-termination questionnaire. Guyton Decl. ¶ 14, Ex. 5.

Response:

19. The May 18, 2023 pre-termination questionnaire that TennCare sent to Patrick Guyton did not include questions that would elicit information identifying a person as eligible as an enrollee in the DIDD Waiver. Guyton Decl. ¶ 15, Ex. 5.

Response:

20. On May 25, 2023, Patrick Guyton's parents filed an appeal over the phone with TennCare Connect asserting that she should still be eligible for the Part B Buy-in. They explained when they filed the appeal that nothing had changed between May 3, 2023, when TennCare issued a notice confirming his continuing eligibility for Part B Buy-in, and the May 18, 2023 notice telling him that his coverage would soon end. Guyton Decl. ¶ 12.

Response:

21. On May 30, 2023, Patrick Guyton's mother called TennCare Connect to explain that he was eligible because he was enrolled in the DIDD Waiver, but the representatives knew nothing about the DIDD Waiver and could not explain why Patrick was being disenrolled. Guyton Decl. ¶ 16.

Response:

22. On May 30, 2023, Patrick Guyton's mother completed and faxed the pretermination questionnaire to TennCare, along with documents proving that he was enrolled in the DIDD Waiver. Guyton Decl. ¶ 17-18, Ex. 6.

Response:

23. On June 1, 2023, TennCare sent Patrick Guyton a Valid Factual Dispute notice stating that the May 25, 2023 appeal his parents had filed on his behalf failed to allege a mistake and requesting more facts, but they did not know what further facts they could provide, since they had already explained in the appeal that nothing had changed in his circumstances that would have altered his eligibility. Guyton Decl. ¶¶ 19, Ex. 7.

Response:

24. On June 9, 2023, TennCare sent Patrick Guyton a notice informing him that his coverage would end June 29, 2023. The notice stated that his monthly income of $914 exceeded the eligibility limit for the kind of TennCare he could get. The notice did not state "what kind of

TennCare" he could get, or what the income limit was for the category TennCare was assessing. Guyton Decl. ¶¶ 20, Ex.8.

Response:

25. On June 15, 2023, TennCare sent Patrick Guyton a notice that it was dismissing his May 25, 2023 appeal because he failed to provide more facts to support his appeal. Guyton Dec. ¶ 26, Ex. 9.

Response:

26. On June 16, 2023, Patrick Guyton's mother made multiple calls to TennCare Connect to try to explain that Patrick should have still been eligible because he was enrolled in the DIDD Waiver. No one she spoke to was aware of the DIDD Waiver or how that affected his eligibility for TennCare. Guyton Decl. ¶¶ 23-25, 34.

Response:

27. No one that Patrick Guyton's mother dealt with at TennCare seemed to understand that he was also eligible in the DAC category. Guyton Decl. ¶ 35.

Response:

28. Joshua Riley is a 26-year old enrollee who lives with his parents, who share his power of attorney. He has autism, ADHD and other developmental and mental disabilities. Riley Decl. ¶¶ 1-2.

Response:

29. Since February 2019, Joshua Riley has been enrolled in the TennCare Employment and Community First (ECF) CHOICES program, which is one of TennCare's programs that provide long term services and supports for individuals with intellectual and developmental disabilities. Riley Decl. ¶ 3.

Response:

30. Co-existing mental and developmental disabilities make it impossible for Joshua Riley to navigate TennCare's administrative processes, and his mother, Andrea Riley, handles those matters for him. Riley Decl. ¶¶ 2, 4, 18.

Response:

31. Joshua Riley's mother created a TennCare Connect online account for Joshua in 2019 at the urging of TennCare and after frustrating experiences dealing with the TennCare call center. Riley Decl. ¶ 4.

Response:

32. Joshua Riley's mother has found that his TennCare Connect online portal is persistently inaccurate, hard to navigate and lacking an avenue for resolving incorrect information. Riley Decl. ¶ 4.

Response:

33. There are currently two TennCare case numbers in Joshua Riley's TennCare Connect online portal, one of which is for a terminated case and the other for his current active case. Riley Decl. ¶ 5.

Response:

34. Despite his mother's efforts to correct mistaken information in both of Joshua Riley's accounts, he continues to receive notices on the terminated case, and the online portal shows "Head of Household Contact Information" with the terminated case number. Riley Decl. ¶¶ 8, 12.

Response:

35. Despite her efforts, Joshua Riley's mother has been unable to correct a wrong mailing address in his TennCare account. Riley Decl. ¶¶ 7-9, 13, Ex. 1.

Response:

36. When Joshua Riley's mother entered his hourly earnings in his TennCare portal, the account wrongly depicted the number of hours worked as his hourly wage Riley Decl. ¶ 10, Ex. 2.

Response:

37. An enrollee or his representative cannot correct mistaken information in their online TennCare Connect portal. Riley Decl. ¶¶ 7-14, 17.

Response:

38. As of the most recent version of TEDS, every Notice of Decision TennCare sends includes the language, "Before we made our decision, we looked at you for different kinds of coverage." New Hagan Decl. Ex. 3 at TC-AMC-0000662842.

Response:

39. As of the most recent version of TEDS, when the Trigger Condition "Denied for health coverage" is met, Notices of Decision include the language: "We looked at the facts we have for you. We use those facts to review you for our coverage groups to decide if you quality. But you don't quality." New Hagan Decl. Ex. 3 at TC-AMC-0000662855.

Response:

40. As of the most recent version of TEDS, when the Trigger Condition "Denied for health coverage" is met, Notices of Decision include the following language: "Remember, we look at the facts we have for you before we make our decision. And we use those facts to review you for our coverage groups." New Hagan Decl. Ex. 3 at TC-AMC-0000662857.

Response:

41. As of the most recent version of TEDS, when the Trigger Condition "Termed for health coverage" is met, Notices of Decision include the following language: "Remember, we look at the facts we have for you before we made our decision. And we use those facts to review you for our coverage groups." New Hagan Decl. Ex. 3 at TC-AMC-0000662862.

Response:

42. As of the most recent version of TEDS, when the Trigger Condition "Renewal – Untimely Appeal" is met, Appeal Resolution notices include the following language, "We sent you a letter that said it was time to renew your healthy [sic] care coverage with us. We looked at the facts and sent you a letter telling you about our decision. You appealed our decision about your health coverage. ¶ **But, it's too late to appeal this problem.** We sent you a letter that said your health care coverage was ending or changing. In that letter we said you had 40 days to appeal. We received your appeal **after** the 40 days ended." New Hagan Decl. Ex. 14 at 23 (TC-AMC-0000661846).

Response:

43. Application of the good cause exception is an individualized, fact-intensive determination that relies on the discretion of the reviewer. Harrell Decl. Ex. 16, TennCare Dep. Leffard Excerpts 53: 9–11; 226:24–228:1.

Response:

44. TennCare has a separate unit, made up of 12 attorneys, devoted to reviewing appeals to determine whether they present a valid factual dispute. Harrell Decl. Ex. 16, TennCare Dep. Leffard Excerpts 21:14–20, 23:1–12.

Response:

45. This unit is distinct from the unit that conducts fair hearings. Harrell Decl. Ex. 16, TennCare Dep. Leffard Excerpts 21:14–20, 23:22–24:19.

Response:

46. Every appeal that TennCare closes without a hearing under the valid factual dispute policy is also closed pursuant to 42 C.F.R. § 431.220(b)'s automatic change provision. Harrell Decl. Ex. 16, TennCare Dep. Leffard Excerpts 118:10–23, 212:1–19.

Response:

47. There has been no "Federal or State law requiring an automatic change adversely affecting some or all beneficiaries" during the Relevant Time Period. *See* 42 C.F.R. § 431.220(b). Harrell Decl., Ex. 16, TennCare Dep. Leffard Excerpts 215:2-6, 14-17; 218:10-14.

Response:

48. In closing appeals without a hearing under the valid factual dispute policy TennCare relies on any federal or state law establishing an eligibility requirement to serve as the "Federal or State law requiring an automatic change adversely affecting some or all beneficiaries" within the meaning of § 431.220(b). Harrell Decl. Ex. 16, TennCare Dep. Leffard Excerpts at 123:7–124:12, 221:8-25.

Response:

49. To state a valid factual dispute under TennCare's practices, an individual must allege a dispute related to TennCare's "correct reason" for the denial or termination. Harrell Decl. Ex. 16, TennCare Dep. Leffard Excerpts 128:16–22.

Response:

50. Lack of clarity in the notices about TennCare's "true reason" for a denial or termination can be "confusing" for appellants and make it harder to establish a valid factual dispute. Harrell Decl. Ex. 16, TennCare Dep. Leffard Excerpts 127:24–128:22.

Response:

51. Determining whether an appeal presents a Valid Factual Dispute is a highly individualized inquiry that involves consideration of all facts and sources relevant to a case. Harrell Decl. Ex. 16, TennCare Dep. Leffard Excerpts 228:7–229:12.

Response:

52. TennCare staff reviewing cases for valid factual dispute rely on information beyond the notices to determine the reason for the denial and evaluate a valid factual dispute. Harrell Decl. Ex. 16, TennCare Dep. Leffard Excerpts 228:7-229:12.

Response:

53. Individuals often have a hard time articulating a Valid Factual Dispute. For example, Plaintiff D.R. when asked if she "had comments to add" to the appeal, simply said "no." Harrell Decl., Ex. 11, TC-AMC-0000007204 at 35:00-35:10. It was only because an advocate from Tennessee Justice Center was on the line and intervened that additional information was provided that was sufficient to establish a VFD. *Id.* at 35:00-38:10.

Response:

54. In calendar year 2018, following vacation of all orders in the *Grier* litigation effective January 1, 2017, TennCare received 6,663 medical service appeals, of which 32 were denied a hearing for being "untimely/ineligible." The rest were resolved in favor of the appellant without a hearing, withdrawn by the appellant, or resolved by hearing. Harrell Decl., Ex. 65, Division of TennCare, FY 2018 Annual Report, p. 19; https://www.tn.gov/content/dam/tn/tenncare/documents/tenncareannual1718.pdf.

Response:

55. In Fiscal Year 2022, TennCare dismissed 5,560 medical appeals, or 47.1% of all such appeals filed, under its valid factual dispute policy. Harrell Decl., Ex. 66, Division of TennCare, FY 2022 Annual Report, p. 19; https://www.tn.gov/content/dam/tn/tenncare/documents/tenncareAnnualFY22.pdf.

Response:

56. TennCare produced three spreadsheets containing data related to non-medical service appeals, namely TC-AMC-0000252538, -39, -40 ("TennCare Appeals Spreadsheets").

Response:

57. The TennCare Appeals Spreadsheets include a column or columns indicating whether there was a hearing or not. If there is no hearing listed on the spreadsheet, it means that no hearing occurred. Harrell Decl., Ex. 16, TennCare Dep. Leffard Excerpts 173:22-174:3.

Response:

58. The TennCare Appeals Spreadsheets contain a column or columns that indicate the date the appeal was filed or received and the date of the first hearing, most recent hearing, just "hearing date," or no hearing date. Harrell Decl., Ex. 16, TennCare Dep. Leffard Excerpts 173:22-174:3. *See* TC-AMC-0000252538, -39, -40.

Response:

59. The TennCare Appeals Spreadsheets contain a column that either states the "Final Outcome" of the appeal or the most recent "Status Reason" for appeals that have been resolved. *See* TC-AMC-0000252538, -39 (listing "Final Outcome"); TC-AMC-0000252538 –40 (listing "Status Reason").

Response:

60. The "Final Outcome" column on TC-AMC-0000252538 and -39 contains the final outcome of the appeal. For each of the following "Final Outcomes" TennCare's data indicates that there was at least one appeal in which a hearing was held: Resolution Approved, Untimely, VFD Denied, Withdrawn, Found for Appellant, Dismiss/Default, Found for State, COVID-19 Resolution, and Needs Review. *See* TC-AMC-0000252538, -39; *see also*, Harrell Decl., Ex. 15, 2023 07 17 All Timely Medicaid Renewal and Termination Appeals. Thus, it is possible for appeals with these "Final Outcomes" to proceed to a hearing. Other "Final Outcomes" were never associated with a hearing. *See T*C-AMC-0000252538, -39 (listing "FTP Closure Resolution" and "411 Closure Resolution" which are not associated with a hearing).

Response:

61. On TC-AMC-0000252540, the Current Status on all appeals is marked "Resolved," and lists the Status Reason and the date the status was effective. For each of the following "Status Reasons" TennCare's data indicates that there was at least one appeal in which a hearing was held: COVID-19, Currently Open, Order Implemented, Packet Received, Renewal Info Received, Resolved in Favor of Appellant, and Withdrawn. TC-AMC-0000252540. Thus, it is possible for appeals with these "Status Reasons" to proceed to a hearing. *Id.*

Response:

62. If TennCare's own data from the TennCare Appeals Spreadsheets is filtered to consider all Medicaid appeals involving disenrollment or redetermination with Final Outcome or Current Status codes where a hearing is possible (as described above in PADF ¶¶ 61 and 62), the data shows 69,250 timely filed redetermination or termination-related appeals between March 19, 2019 and October 31, 2022. Of those, TennCare conducted only 5,754 hearings. Thus, 63,496 of the hearings listed in TennCare's data where a hearing is possible have no record of a hearing. Harrell Decl., Ex. 15, 2027 07 17 All Timely Medicaid Renewal and Termination Appeals.pdf (summarizing data from TC-AMC-0000252538, -39, -40); Harrell Decl., Ex. 16, TennCare Dep. Leffard Excerpts at 173:22-25, 174:1-3 (stating that no hearing date listed means no hearing occurred).

Response:

63. From the figures cited immediately above, 19,425 out of the 63,496 who did not receive hearings did not have continuation of benefits, which is indicated by the COB column.

Harrell Decl., Ex. 15, 2027 07 17 All Timely Medicaid Renewal and Termination Appeals.pdf; (summarizing data from TC-AMC-0000252538, -39, -40). Harrell Decl., Ex. 16, TennCare Dep. Leffard Excerpts at 166:9-13 (stating COB means continuation of benefits).

Response:

64. Based on TennCare's own data, where there is a record of a hearing being conducted, the agency failed to hold a hearing within 90 days of receipt of an appeal in 2,933 of the 4,559 (64.35%) redetermination- and termination-related Medicaid appeals that were timely filed between March 19, 2019 and October 31, 2022, were not continued by any party, and had a hearing occur. Harrell Decl., Ex. 14, 2023 07 17 All Timely Medicaid Renewal and Termination Appeals + 90 Days.pdf (summarizing data from TC-AMC-0000252538, -39, -40).

Response:

65. Of the 2,934 appeals described above where a hearing was not provided within 90 days, 843 of the appellants did not have continuation of benefits during the appeals process. *Id.*

Response:

66. TennCare's waiver of its obligation under 42 C.F.R. § 431.244(f) to take final administrative action within 90 days of an appeal under Section 1902(e)(14)(A) of the Social Security Act is temporary and conditional. *See* Harrell Decl., Ex. 57, Ltr to Director Stephen Smith, Centers for Medicare and Medicaid Services, June 14, 2023, available at https://www.tn.gov/content/dam/tn/tenncare/documents/FairHearingTimeframeExtension.pdf (stating waiver only triggered if "the state receives more than 900 requests for a fair hearing per

day, the State is unable to complete an initial review of all fair hearing requests within 40 days of receipt of a request, or the state has fair hearing requests in the scheduling queue which were received 70 or more days ago and which cannot be scheduled due to full dockets).

Response:

67. TennCare's waiver of its obligation under 42 C.F.R. § 431.244(f) to take final administrative action within 90 days of an appeal under Section 1902(e)(14)(A) of the Social Security Act only becomes effective if one of the following conditions are met:

- the state receives more than 900 requests for a fair hearing per day;
- the state is unable to complete an initial review of all fair hearing requests within 40 days of receipt of a request (this condition is met when the state begins seeing trends indicating the state is unable to complete an initial review within 40 days); or
- the state has fair hearing requests in the scheduling queue which were received 70 or more days ago and which cannot be scheduled due to full dockets. This does not include instances when a hearing request has been continued at the appellant's request.

See Harrell Decl., Ex. 57, Ltr to Director Stephen Smith, Centers for Medicare and Medicaid Services, June 14, 2023, available at:

https://www.tn.gov/content/dam/tn/tenncare/documents/FairHearingTimeframeExtension.pdf

Response:

68. If triggered, TennCare's waiver of its obligation under 42 C.F.R. § 431.244(f) to take final administrative action within 90 days of an appeal under Section 1902(e)(14)(A) of the Social Security Act expires on February 28, 2025. *See* Harrell Decl., Ex. 57, Ltr to Director

Stephen Smith, Centers for Medicare and Medicaid Services, June 14, 2023, https://www.tn.gov/content/dam/tn/tenncare/documents/FairHearingTimeframeExtension.pdf

Response:

69. TennCare's waiver of its obligation under 42 C.F.R. § 431.244(f) to take final administrative action within 90 days of an appeal under Section 1902(e)(14)(A) of the Social Security Act does not apply "to any fair hearing request where benefits cannot be provided pending the outcome of the hearing." *See* Ex. 14, Ltr to Director Stephen Smith, Centers for Medicare and Medicaid Services, June 14, 2023, https://www.tn.gov/content/dam/tn/tenncare/documents/FairHearingTimeframeExtension.pdf

Response:

70. With respect to the missing historic SSI data, the research Ms. Hagan describes doing in April and May 2023 could have been done in July 2021 when Mr. Head raised the issue. *See* New Hagan Decl. ¶ 24 (describing review of "additional case examples").

Response:

71. With respect to tbe missing historic SSI data, the steps Ms. Hagan describes taking in April and May 2023 to convert unlinked historic-SSI interChange data into TEDS could have been taken in July 2021 wben Mr. Head raised the issue. *See* New Hagan Decl. ¶ 24(a).

Response:

72. With respect to the missing historic SSI data, the steps Ms. Hagan describes taking in April and May 2023 to identify individuals who may have been impacted by the problem could have been taken in July 2021 when Mr. Head raised the issue. *See* New Hagan Decl. ¶ 24(d).

Response:

73. Neither TennCare's main website for renewals nor its most recent renewal packet informs enrollees that AAADs are available for in-person assistance. *See* Harrell Decl., Ex. 14, Hagan Dep. Ex. 17, TennCare Renewal Website ("In-person you can visit the Department of Human Services (DHS) in your county to submit your documents or use the kiosk to completeyour renewal online . . . ."); Holland Decl. Ex. 4, Renewal Packet at 11 ("What if you need help in person with your Renewal Packet? – Your local Department of Human Services can help you . . . . If you're getting care at a local community mental health center, they can also help you.").

Response:

74. A reference guide used by frontline call center workers at Automated Health Systems as late as April 17, 2023 did not list AAADs as providing in-person assistance for renewals. Harrell Decl., Ex. 45, AHS Dep. Fields Excerpts 190:7–191:13, Harrell Decl., Ex. 59, AHD Dep. Fields Ex. 56. *But see* Harrell Decl., Ex. 4, TennCare Dep. Hagan 11:10–12:16, (stating there was new guidance as of April 10, 2023).

Response:

75. TennCare did not track or receive reports about in-person assistance with redeterminations completed by AAADs at individuals' homes before April 2023. Harrell Decl., Ex. 41, TennCare Dep. Evans Excerpts at 32:21-33:14.

Response:

76. AAAD employees are not eligibility specialists. Harrell Decl., Ex. 2, Hagan Dep. Excerpts 217:9–11.

Response:

77. AAAD employees "are not expected to be eligibility counselors or experts in the categories[,]"only have "a general understanding of the eligibility categories[,]" and are not trained to the extent that TennCare employees are trained. Harrell Decl., Ex. 7, Turner Dep. Excerpts 202:10-20.

Response:

78. AAAD employees have less expertise than TennCare's call center contractors. Harrell Decl., Ex. 7, Turner Dep. Excerpts 202:24–203:3.

Response:

79. AAAD employees "are trained to the extent that they can assist someone with *applying* for coverage," Harrell Decl., Ex. 7, Turner Dep. Excerpts 202:24–203:3, and the application process is different from the renewal process, Harrell Decl., Ex. 2, Hagan Dep. Excerpts 28:10-12.

Response:

80. AAAD employees do not have access to TEDS. Harrell Decl., Ex. 2, Hagan Dep. Excerpts 41:12-13.

Response:

81. The Tennessee Community Services Agency has no knowledge of ever referring a caller to the AAADs for assistance with a renewal. Harrell Decl., Ex. 42, TNCSA Dep. Whitfield Excerpts at 82:14–83:11.

Response:

82. To the extent AAADs have been asked to complete in-person assistance at individuals' homes, they do not receive additional funding to do so. Harrell Decl., Ex. 41, TennCare) Dep. Evans Excerpts at 26:9-27:25, 45:12–46:7.

Response:

83. Community mental health centers are not contractually required to help individuals with TennCare renewals. Harrell Decl., Ex. 2, Hagan Dep. Excerpts 265:11-21.

Response:

84. TEDS has back-end fields and could collect data regarding enrollees' disabilities that require accommodations, as well as the type of accommodation needed, but TennCare chose not to utilize them because it is "not something we needed for our business" though it could if it

wanted to collect this information Harrell Decl., Ex. 4, TennCare Dep. Hagan Excerpts 18:25-19:15, 21:10-26:23.

Response:

85. TennCare's MMIS system, known as Interchange, stores enrollees' claims data containing their diagnoses. *See* Harrell Decl., Ex. 1 Flener Dep excerpts 45:11-46:16, 106:6-107:25.

Response:

86. TennCare does not use claims data information in the eligibility redetermination and renewal process other than to determine whether there is an indication that a child is medically eligible for TennCare Standard. *See* Harrell Decl., Ex. 1 Flener Dep. Excerpts 45:9-24; Harrell Decl., Ex 2, Hagan Dep. Excerpts 265:22-266:4.

Response:

87. In 2002, TennCare established a process (the "2002 Redetermination Process") to redetermine the eligibility of all enrollees who were then covered as "waiver-eligible", a category that was being partially eliminated, to assess their continued eligibility in all available categories of coverage. *See* Harrell Decl., Ex. 60, State's Proposed Findings of Fact and Conclusions of Law, August 5, 2002, filed in *Rosen v. Tennessee Commissioner of Finance and Administration*, No. 3:93-627 (M.D. Tenn.) (*Rosen* PFFCL) at 15.

Response:

88. The 2002 Redetermination Process began with an initial notice to the enrollee, informing him that he must apply through the local DHS [Department of Human Services] office for a redetermination of eligibility. This notice and its attachments are written at a 4th to 6th grade reading level, and include a flyer, "Do you need special help?", listing free telephone numbers to call for assistance. Harrell Decl., Ex. 60, *Rosen* PFFCL at 16–17 (footnote omitted).

Response:

89. The initial required step of the 2002 Redetermination Process was simply the enrollee's submission of a signed application (a brief, two-page form) with a legible name and address to DHS by the end of the 89th day following this notice. Harrell Decl., Ex. 60, *Rosen* PFFCL at 17.

Response:

90. During the 2002 Redetermination Process enrollees assessed as severely and persistently mentally ill adults (SPMI) or seriously emotionally disturbed children (SED) were identified as such in the TennCare management information system. Harrell Decl., Ex. 60, *Rosen* PFFCL at 17.

Response:

91. During the 2002 Redetermination Process, the TennCare Bureau amended its contract with the Mental Health Association of Middle Tennessee, which advocated on behalf of SPMI/SED individuals and maintained the TennCare Partners Advocacy Line (TPAL), in order to

expand the assistance to be provided to SPMI/SED enrollees during the redetermination process. Harrell Decl., Ex. 60, *Rosen* PFFCL at 17.

Response:

92. During the 2002 Redetermination Process, TPAL's contract required it to make efforts to contact each SPMI/SED enrollee who failed to respond to DHS within 30 days of the initial redetermination notice. Harrell Decl., Ex. 60, *Rosen* PFFCL at 17.

Response:

93. During the 2002 Redetermination Process, TPAL also contacted the last known provider or case worker of the SPMI/SED enrollee and tried in a variety of ways to outreach and offer assistance and information. Harrell Decl., Ex. 60, *Rosen* PFFCL at 17.

Response:

94. During the 2002 Redetermination Process, TPAL's role also included attempting to make sure that each SPMI/SED enrollee who had failed to respond to the initial notice had someone, such as a current provider or mental health case manager at a CMHC [community mental health center], who would assist them in navigating the redetermination process. Harrell Decl., Ex. 60, *Rosen* PFFCL at 17.

Response:

95. During the 2002 Redetermination Process, a variety of accommodations were available to SPMI/SED enrollees with respect to the DHS eligibility interview that would occur

following, or contemporaneous with, submission of the signed application form. Harrell Decl., Ex. 60, *Rosen* PFFCL at 17–18.

Response:

96. During the 2002 Redetermination Process, if necessary to accommodate an enrollee's special needs, alternative arrangements would be made, including an in-home interview or an interview conducted at alternative sites, such as a community mental health center (CMHC). Harrell Decl., Ex. 60, *Rosen* PFFCL at 18.

Response:

97. During the 2002 Redetermination Process, DHS eligibility caseworkers were available to be outstationed at CMHCs [community mental health centers], which served the SPMI/SED population, to carry out the redetermination process at that alternative location. Harrell Decl., Ex. 60, *Rosen* PFFCL at 18.

Response:

98. During the 2002 Redetermination Process, every CMHC that wanted an outstationed DHS eligibility caseworker and had sufficient caseload to occupy that worker received one. Harrell Decl., Ex. 60, *Rosen* PFFCL at 18.

Response:

99. During the 2002 Redetermination Process, Department of Human Services eligibility caseworkers provided assistance to persons encountering difficulty completing the

application process, including obtaining verification of requested information for the individual. Harrell Decl., Ex. 60, *Rosen* PFFCL at 18.

Response:

100. During the 2002 Redetermination Process, TennCare reviewed claims/encounter records in TennCare's management information system (described in PADF ¶ 85-86), searching three years of clinical encounter data for diagnoses that would identify enrollees as having medical conditions that might be disabling, with the expectation that DHS staff would assist them and obtain necessary redetermination information. Harrell Decl., Ex. 60, *Rosen* PFFCL, Appendix at 1-2, 11-12.

Response:

100. During the 2002 Redetermination Process, if an SPMI/SED enrollee failed or was unable to verify assets/resources, DHS provided assistance to enrollees in obtaining resource valuation information. In addition, DHS would accept a self-declaration of resources in excess of the Medicaid limit, allowing the DHS caseworker to immediately determine ineligibility for Medicaid and proceed on to determination of eligibility for TennCare Standard. Harrell Decl., Ex. 60, *Rosen* PFFCL at 20-21.

Response:

101. In April 2023, the first month following the end of the COVID-19 public health emergency, 80,084 TennCare enrollees became due for renewal of their eligibility. Harrell Decl., Ex. 61, July 10, 2023, Division of TennCare, *Unwinding Report: April 2023 Renewals.*

Response:

102. As of July 10, 2023, TennCare had determined that of the 80,084 enrollees who were due in April 2023 for renewal of their eligibility, 31,128 were ineligible, and 5,290 were pending. Harrell Decl., Ex. 61, July 10, 2023, Division of TennCare, *Unwinding Report: April 2023 Renewals.*

Response:

103. Of the 31,128 enrollees determined to be ineligible, 23,745 (76.3%) were deemed ineligible for procedural reasons, i.e, for failure to return renewal packets (21,515) or failure to respond to requests for additional information (2,230). Harrell Decl., Ex. 61, July 10, 2023, Division of TennCare, *Unwinding Report: April 2023 Renewals.*

Response:

104. TennCare projects that the resumption of eligibility renewals, which began in April 2023, will result in a reduction of enrollment to the level before the COVID-19 public health emergency, a net reduction of at least 300,000 individuals. Harrell Decl., Ex. 62, November 2022 TennCare Budget slide presentation, "Federal Public Health Emergency: Continued Impact on Enrollment."

Response:

105. Between March 2020 and March 2023, during the public health emergency when there were relatively few disenrollments to offset new enrollments, total TennCare enrollment rose

from 1,421,442 to 1,764,876, for an average of more than 100,000 new enrollments per year. *Cf.* Harrell Decl., Ex. 63, TennCare Enrollment Data (March 2020); Harrell Decl., Ex. 64, TennCare Enrollment Data (March 2023), available at https://www.tn.gov/tenncare/information-statistics/enrollment-data.html.

Response:

Dated: July 31, 2023

By: */s/ Babak Ghafarzade*

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing document has been served via the Court's electronic filing system on this 31st day of July, 2023.

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On Behalf of Counsel for Plaintiffs

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

PLAINTIFFS' RESPONSES TO DEFENDANT'S STATEMENT OF UNDISPUTED MATERIAL FACTS IN SUPPORT OF SUMMARY JUDGMENT

Pursuant to Local Rule 56.01(b), Plaintiffs submit the following responses to the State's statements of undisputed material fact in opposition to summary judgment ("PRSUMF").

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., ECF[1] 63 ¶ 2 (May 29, 2020).

Response: Undisputed (citation sbould be to Hagan Decl. ECF 63 ¶ 1 (May 29, 2020)).

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: Undisputed.

[1] Note: Plaintiffs refer to docket entries by ECF. Defendant has referred to them as "Doc". Plaintiffs changed Defendant's SUMF's references from "Doc" to ECF to eliminate confusion.

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: Undisputed.

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. ECF 63 ¶ 2.

Response: Disputed in part. Undisputed that TennCare contractors operate two call centers, collectively known as TennCare Connect, that employ approximately 400 workers and that allow for some Tennesseans to apply for coverage, renew coverage, file eligibility appeals, and update their address and other information over the phone. It is disputed that TennCare Connect enables all Tennesseans to apply for coverage, renew coverage file eligibility appeals, and update their address and other information over the phone. *See* Declaration of Donna Guyton ("Guyton Decl.") ¶¶ 16, 22–24; Declaration of Claire Holland ("Holland Decl.") ¶¶ 10–17.

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. ECF 63 ¶ 2.

Response: Undisputed.

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". ECF 63 ¶ 3.

Response: Undisputed (citation should be to ECF 63 ¶ 4).

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

Response: Undisputed.

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: Undisputed.

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

Response: Disputed in part. It is undisputed that TEDS became operational statewide, including the ability to track and process appeals on May 30, 2019. It is disputed that TEDS was "fully functional" on May 30, 2019. *See* Declaration of Brant Harrell in Opposition to Summary Judgment ("Harrell Decl."), Ex. 1, Flener Dep. Excerpts at 36:23 (referencing post-launch enhancements); 62:6-25 (referencing ongoing testing and system defects).

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

Response: Undisputed that TEDS provide members with access to an online portal. Disputed that the portal reliably processes information entered by members or allows members to correct inaccurate information. *See* Declaration of Andrea Riley ("Riley Decl.") ¶¶ 7-14, 17.

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

Response: Undisputed.

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

Response: Disputed. TEDS fails to consider members for all categories of eligibility even if it has sufficient information to grant an automatic renewal of coverage. For example, TEDS does not evaluate individuals for the Pickle, Disabled Adult Child, and Widow/Widower eligibility categories due to a loss of previously available information (historic SDX data) necessary to screen for those categories. *See* Harrell Decl., Ex. 2 Hagan Dep. Excerpts 274:13–276:4, Harrell Decl., Ex. 3, Hagan Dep. Ex. 7 (noting that SDX data required for Pickle task to generate); Harrell Decl., Ex. 4, TennCare Dep.[2] Hagan Excerpts 27:14–32:16. TEDS has also had problems screening individuals for the Pickle, DAC, and Widow/Widower eligibility categories due to the system's failure to load a key indicator (the "D" or "W" indicator). *See* Harrell Decl., Ex. 1, Flener Dep. Excerpts 59:10–60:20; Harrell Decl., Ex. 5, TennCare Dep. Flener Excerpts 11:6–13:14. TEDS fails to identify individuals who are eligible in the Institutional Medicaid category by virtue of their receipt of home and community-based services (HCBS) in the Section 1915(c) Waivers administered by the Tennessee Department of Intellectual and Developmental Disabilities (familiarly referred to as the "DIDD Waivers"). *See* Guyton Decl. ¶¶ 14–19, 28–30, 34. TEDS continues to fail to identify individuals who are eligible in the Disabled Adult Child category, including those who are currently enrolled in that category. *See* Holland Decl. ¶¶ 10–19, 21 (describing termination of individual currently enrolled in the DAC category who was sent a pre-termination notice despite mother's notification to TennCare that individual remained eligible

[2] "TennCare Dep." indicates that the witness was testifying on behalf of TennCare under a Fed. R. Civ. P. 30(b)(6)-noticed deposition.

in DAC category). And at least as of November 2022, TennCare had an open, unresolved issue regarding consideration of the Medicare Savings Plan category of eligibility. Harrell Decl., Ex. 2, Hagan Dep. Excerpts 128:13–130:23; Harrell Decl., Ex. 6, Hagan Dep. Ex. 14 (TC-AMC-EMAIL-245008, Row 6940 (TEDS-160172)). Finally, discovery has revealed that TennCare terminated benefits for up to 30,000 people in April and May 2023 without considering them for all categories of eligibility. *See* Harrell Decl., Ex. 2, Hagan Dep. Excerpts 58:21–64:1; ECF 166 ¶¶ 22–23; *see also* Harrell Decl., Ex. 7, Turner Dep. 79:18–82:13.

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." Ltr from CMS to Stephen Smith, Div. of TennCare, re CMS Review and Assessment (Nov. 2, 2020), ECF 139-6 at 2 (Nov. 12, 2021).

Response: Disputed. The cited document does not support the State's assertion. The November 2, 2020 letter from CMS states, "This was an assessment of information technology system functionality and does not reflect a comprehensive determination of state compliance or non-compliance with all federal Medicaid policy regulations." ECF 139-6 at 1. As the Court observed during the March 4, 2022 hearing. "[f]unctionality doesn't equal it being legal." ECF 179 at 32:19–20. Moreover, the letter did not purport to certify TennCare's compliance with the laws and regulations listed by the State in its assertion above. The letter merely lists those laws and regulations among other "criteria and information used as a basis for the certification pre-visit, virtual reviews, and subsequent evaluations." ECF 139-6 at 2. Accordingly, the State fails to

establish the absence of a genuine dispute as to the scope of CMS's certification of TennCare's information technology system functionality.

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"), ECF 139-5 at 3 (Nov. 12, 2021).

Response: Disputed in part. Undisputed that the quotation appears in the cited document, but disputed insofar as the State contends that CMS "approv[ed] TEDS." As the Court correctly observed during the Mach 4, 2022 hearing, the language quoted by the State above "reinforces that all [CMS] looked at was the functionality." ECF 179 at 34:24–25. Indeed, the CMS report further states: "All comments, recommendations, and corrective actions included in this report were determined based on the information provided and functionality demonstrated during the review." ECF 139-5 at 4. Accordingly, the State fails to establish the absence of a genuine dispute as to the scope of CMS's certification of TennCare's information technology system functionality.

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

Response: Disputed in part. Undisputed only that the CMS report states: "While there were no critical findings, there are some instances where the system configuration could be improved to prevent worker error and/or improve user experience." ECF 139-5 at 8. The issues identified in the CMS report are the timeliness of eligibility determinations, capability for automatic enrollment, ability for members to opt into automatic electronic notices, masking of

Social Security numbers, use of online authentication, use of all available data sources for ex parte renewals, functionality of the mobile application, and capability for online appeals. *Id.* at 8–11.

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: Disputed. First, although the CMS report identifies eleven members of the "CMS Review Team," ECF 139-5 at 7–8, the report does not make clear which of these professionals were, as the State contends, "assigned … to perform the certification review of TEDS." The CMS report states, "The [Pilot Certification Review] was led by Rebecca Bruno (Health FFRDC), with active participation from Enitan Oduneye (the CMS State Officer for Tennessee) and other Health FFRDC team members. The TEDS team was led by Diane Langley, Raichon Morand, Kim Hagan, and other representatives from TennCare, as well David Rodriguez with KPMG, a vendor providing support to the TennCare state team, and included active participation from the state team and state vendor team (KPMG, Deloitte, NTT Data)." ECF 139-5 at 7. Second, although the CMS report states that "[t]he CMS team and Tennessee held regular (mostly biweekly) meetings starting January 2020 all the way through June 2020 leading up to the [Pilot Certification Review]," ECF 139-5 at 5, the CMS report does not make clear, as the State contends, that CMS "devot[ed] six months to review preparation." Accordingly, the State fails to establish the absence of a genuine dispute about either the number of professionals assigned by CMS to perform the certification review of TennCare's information technology system functionality or the time CMS spent preparing for the review.

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: Undisputed.

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: Undisputed only insofar as supported by the cited statement, which is that the first step of TennCare's renewal process is *ex parte* in nature, requiring no input from members.

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: Disputed in part. Undisputed only insofar as supported by the cited statement, which is that the *ex parte* process utilizes current information in TEDS and information that can be verified by approved third-party data sources. Disputed that TEDS reviews *all* available information about a member. At a minimum, TEDS does not utilize information that a person is categorically eligible in the Institutional Medicaid group by virtue of their enrollment in the DIDD Waiver. *See* Guyton Decl. ¶ 34; ECF 63 ¶ 6, n.6. Moreover, TEDS fails to consider members for all categories of eligibility even if it has sufficient information to grant an automatic renewal of coverage. For example, TEDS does not evaluate individuals for the Pickle, Disabled Adult Child, and Widow/Widower eligibility categories due to a loss of previously available information (historic SDX data) necessary to screen for those categories. *See* Harrell Decl., Ex. 2, Hagan Dep. Excerpts 274:13–276:4, Harrell Decl., Ex. 3, Hagan Dep. Ex. 7 (noting SDX data required for Pickle task to generate); Harrell Decl., Ex. 4, TennCare Dep. Hagan Excerpts 27:14–32:16. TEDS

also does not screen individuals for the Pickle, DAC, and Widow/Widower eligibility categories due to the system's failure to load a key indicator (the "D" or "W" indicator). *See* Harrell Decl., Ex. 1, Flener Dep. Excerpts, 59:10–60:20; Harrell Decl., Ex. 5, TennCare Dep. Flener Excerpts 11:6–13:14. TEDS continues to fail to identify individuals who are eligible in the Disabled Adult Child category, including those who are currently enrolled in that category. *See* Guyton Decl. ¶¶ 7, 14–19; Holland Decl. ¶ 10–19 (describing termination of individual currently enrolled in the DAC category who was sent a pre-termination notice despite mother's notification to TennCare that individual remained eligible in DAC category). Finally, discovery has revealed that TennCare terminated benefits for up to 30,000 people in April and May 2023 without considering them for all categories of eligibility. *See* Harrell Decl., Ex. 2, Hagan Dep. Excerpts 58:21–64:1; ECF 166 at ¶¶ 22-23; *see also* Harrel Decl., Ex. 7, Turner Dep. Excerpts 79:18–82:13.

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: Disputed. TEDS lacks the capacity to assess eligibility for all categories of eligibility all at once but must rely on human workers to manually determine eligibility for certain categories of TennCare coverage. *See* Harrell Decl., Ex. 8, Brooks Dep. Excerpts 58:1-25.

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

Response: Disputed in part. Undisputed that such is the intended design of TEDS, with the caveats that some categories of eligibility must be determined manually and TEDS relies on the facts and information input into each particular case. *See* Harrell Decl., Ex. 8, Brooks Dep.

Excerpts 55:11–22, 58:1-25, 62:3–19; Harrell Decl., Ex. 1, Flener Dep. Excerpts 151:7–17. It is disputed that TEDS functions in this way in practice. *See* PRSUMF ¶ 22(a)-(g).

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

Response: Disputed for at least the seven reasons outlined below.

(a) *First*, in April and May 2023, the State terminated up to 30,000 people in "conversion status" *without* considering them for all categories of eligibility. *See* ECF 166 ¶¶ 22-23 (describing that individuals would be marked in "conversions status" if the "benefits match" process in TEDS did not return eligibility in the same or higher category) ("For cases in a 'conversion status,' automated eligibility rules that would normally run and could negatively impact a member's eligibility status do not apply."); Harrell Decl., Ex. 2, Hagan Dep. Excerpts 62:5–19, 62:22–25 (confirming that treatment of cases in conversion status remained the same from the time of the declaration at ECF 166). If individuals in "conversion status" did not return a renewal packet, they were terminated without going through the COE Hierarchy in TEDS. Harrell Decl., Ex. 2, Hagan Dep. Excerpts 63:1–64:1; *see also* Harrell Decl., Ex. 7, Turner Dep. 79:18–81:21. As a result, individuals who may have remained eligible for TennCare but in a *lower* category were nonetheless terminated. *See id.*

(b) *Second*, until May 13, 2023, the State lacked certain historical SSI data, which was necessary to assess individuals' eligibility for the three SSI-related categories—DAC, Widow/Widower, and Pickle. *See* New Hagan Decl. ¶¶ 23–24, Ex. 8; Harrell Decl., Ex. 2, Hagan Dep. Excerpts 274:13–275:22 (testifying that old SDX data was missing), 90:14–24, Harrell Decl., Ex. 3, Hagan Dep. Ex. 7 (showing that SDX data is required for a Pickle task to generate); Harrell Decl., Ex. 4, TennCare Dep. Hagan Excerpts 27:14–25, 37:11–13.

(c) *Third*, the State fails to screen individuals for DAC, even when they are already enrolled in that category. *See* Holland Decl. ¶¶ 7, 10–19 (describing threatened termination of her son Gentry, who was enrolled in the DAC category, completed the renewal packet, and remained eligible for DAC); Guyton Decl. ¶¶ 7, 14–19, 35; ECF 145, 2d Noe Decl. ¶¶ 4-11 (referring to DAC-eligible individual who was terminated from buy-in program covering individuals dually enrolled in Medicare and TennCare).

(d) *Fourth*, the State fails to ask questions, such as whether an individual previously received SSI, that would elicit information necessary to consider eligibility for SSI-related categories. *See* Holland Decl. ¶ 10, Ex. D (Renewal Packet dated April 6, 2023); Harrell Decl., Ex. 1, Flener Dep. Excerpts 50:15–21, 151:4–20, 232:15–17 (Q: "Does the renewal packet have a question asking about past receipt of SSI?" A: "No."). Although TennCare asked Gentry Fields SSI-related questions in 2021, the 2023 renewal packet had no SSI-related questions. Holland Decl. ¶ 10, Exs. 4 (Renewal Packet), 8 (2021 Additional Information Questions); *see also* Harrell Decl., Ex. 1, Flener Dep. Excerpts 232:15–17.

(e) *Fifth*, the State did not screen individuals for the Pickle, DAC, and Widow/Widower categories based on the failure to load a key indicator (the D or W indicator) used to evaluate those categories. Harrell Decl., Ex. 1, Flener Dep. Excerpts 59:10–25, 60:1–20; Harrell Decl., Ex. 5, TennCare Dep. Flener Excerpts 11:6–25, 12:1–25; 13:5–14.

(f) *Sixth*, as of at least November 2022 and likely as late as April 2023, the State had an open, unresolved issue in TEDS with respect to the consideration of the Medicare Savings Plan category of eligibility, even though the issue was opened on January 31, 2021. Harrell Decl., Ex. 2, Hagan Dep. Excerpts 128:13–130:23, Harrell Decl., Ex. 6, Hagan Dep. Ex. 14 (TC-AMC-EMAIL-245008, Row 6940 (TEDS-160172)); *see also* Harrell Decl., Ex. 2, Hagan Dep. Excerpts

84:16–85:9 (testifying that when TennCare submits "change requests" for the TEDS system and then "work[s] with Deloitte to prioritize when that change request will be implemented").

(g) *Seventh*, TennCare does not seem capable of identifying as eligible individuals who qualify for coverage on the basis of their enrollment in the TennCare 1915(c) waiver known as the DIDD Waiver. *See* Guyton Decl. ¶¶ 14–18, 20, 36. TennCare's pretermination questionnaire does not ask questions that would elicit information that a person is eligible through enrollment in the DIDD Waiver. *Id.* ¶ 15–18, Ex. 6.

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

Response: Undisputed.

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: Disputed. As one example of TennCare's failure to diligently resolve issues, TennCare took nearly two years to appropriately research and address the absence of certain SSI historical data in TEDS, *see* PRSUMF ¶ 22(b); New Hagan Decl. ¶¶ 23–24, Ex. 8, well after this case was filed that raised issues eligible individuals not being properly found eligible under SSI-related categories. ECF 1 (filing date of March 19, 2020). On July 8, 2021, appeals compliance specialist Ryan Head surfaced an issue that was "leading to incorrect eligibility determinations, particularly as it relate[d] to the former SSI related categories (Pickle Passalong, DAC, and Widow/Widower)." New Hagan Decl. Ex. 8. Mr. Head described that historical SSI data had not been integrated into TEDS and that the Eligibility Operations Group had been instructed not to use the databases that did have such data, which is necessary to accurately determine eligibility in the

DAC, Widow/Widower, and Pickle categories of eligibility. *Id.* Despite concluding in 2021 that the issue was not systemic and thus did not require a systemic fix, in April 2023 TennCare performed additional research and determined that the issue *was* systemic, but only after Mr. Head's 2021 emails were introduced at depositions in this case. *See* Harrell Decl., Ex. 2, Hagan Dep. Excerpts 274:13–25, 275:1–25; Harrell Decl., Ex. 4, TennCare Dep. Hagan Excerpts 27:14–28:16, 29:5–31:18; New Hagan Decl. ¶¶ 23–24.

In addition, as of at least November 2022 and likely as late as April 2023, TennCare had not resolved an issue in TEDS that was opened on January 31, 2021 and that impacted consideration of the Medicare Savings Plan category of eligibility. PRSUMF ¶ 22(f).

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: Disputed. *First,* TEDS lacks the capacity to assess eligibility for all categories of eligibility all at once but must rely on human workers to manually determine eligibility for certain categories of TennCare coverage. *See* Harrell Decl., Ex. 8, Brooks Dep. Excerpts 55:1-58:25. *Second*, it is disputed that TEDS analyzes a person for every category of eligibility. TennCare's past failure to load the D and W indicators meant that individuals were not screened for the SSI-related categories. PRSUMF 22(e). *Third*, it is disputed as to the implication that TEDS analyzes *every* person for eligibility in every category of TennCare coverage. Up to 30,000 individuals in "conversion status" were not analyzed through the COE Hierarchy during April and May 2023 renewals. *See* PRSUMF ¶ 22(a). Those individuals were run through the TEDS COE Hierarchy only if they returned a renewal packet. Harrell Decl., Ex. 2, Hagan Dep. Excerpts 63:1–25.

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: Disputed in part. The disputes raised in PRSUMF ¶¶ 21, 22, and 25 are incorporated herein. Otherwise undisputed.

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: Disputed in part. The disputes raised in PRSUMF ¶¶ 21, 22, and 25 are incorporated herein. Otherwise undisputed.

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: Disputed in part. Disputed insofar as an individual can only "group" into a category if TEDS has sufficient and accurate information about that individual with respect to that category, and TennCare fails to ask questions sufficient to gather such information. *See* PRSUMF ¶ 22(d). The disputes raised in PRSUMF 21, 22, and 25 are incorporated herein. Otherwise undisputed.

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: Disputed in part. The disputes raised in PRSUMF ¶¶ 21, 22, 25 and 28 are incorporated herein. Otherwise undisputed.

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: Disputed. For individuals who have received SSI in the past, TennCare does not reliably pre-populate the renewal packet with information reflecting that historical receipt of SSI. *See, e.g.*, Holland Decl. ¶ 10, Ex. 4 (Renewal Packet).

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

Response: Disputed. For individuals who have received SSI in the past, TennCare does not reliably pre-populate the renewal packet with information reflecting that historical receipt of SSI. *See, e.g.*, Holland Decl. ¶ 10, Ex. 4 (Renewal Packet).

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. ECF 63 ¶ 47.

Response: Disputed in part. Plaintiffs dispute the breadth of "the types of coverage that are available." The Renewal Packet does not refer to or describe all categories of eligibility including the Pickle, Disabled Adult Child, or Widow/Widower categories. *See, e.g.*, Holland Decl. Ex. 4 (Renewal Packet). Otherwise undisputed.

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. ECF 63 ¶ 49.

Response: Undisputed.

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

Response: Undisputed.

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

Response: Disputed because individuals have been terminated or threatened with termination for failure to respond despite completing the Renewal Packet. *See, e.g.*, Holland Decl. ¶¶ 10–19.

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

Response: Undisputed as written, but TennCare does not reliably renew individuals eligible for certain TennCare categories, including DAC, despite having sufficient information to determine their eligibility. Holland Decl. ¶¶ 10–19; *see also* Guyton Decl. ¶¶ 14–19; PRSUMF ¶¶ 22(a)–(g).

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. ECF 63 ¶ 54; Ex. G to May 29, 2020 Hagan Decl., ECF 63-7 (AI Notice).

Response: Disputed in part. Undisputed that TennCare sends members requests for Additional Information but disputed that such requests are limited to information required to complete the renewal process. TennCare also requires individuals to prove that they are eligible

through enrollment in the DIDD Waiver, when that information is already in TennCare records. *See* Guyton Decl. ¶¶ 4, 6, 14–18, 34.

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"). ECF 63 ¶ 57.

Response: Undisputed.

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. ECF 63 ¶ 52.

Response: Disputed in part. It is undisputed that the NOD tells the member the specific date their coverage will end. It is undisputed, as written, that the NOD does contain *a* legal citation supporting the decision. As the Court previously observed for the cited NOD, "The record shows TennCare's NODs all include the same regulatory citation, regardless of the reason a member is terminated: 'Tenn. Comp. R & Reg. 1200-13-20'", which is to "a 95-page document that 'governs the processes for determining financial and categorical eligibility for the TennCare and CoverKids programs." ECF 234 at 12; *see* also ECF 63-2 at 13. Plaintiffs dispute that TennCare tells the member the reason their coverage is ending. *See* PRSUMF ¶ 41.

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., ECF 166-3 at 49.

Response: Undisputed.

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. ECF 166-3 at 49; *see also* New Hagan Decl. Ex. 13 (Business Reference Table listing termination explanations).

Response: Disputed. The Notice of Decision Template does include a placeholder for a <Denial Reason> that will be populated by the text listed in the "English Text" column of the Table named "TAB EDREASON" *See* ECF 166-3; New Hagan Decl. Ex. 3 (Updated NOD Template); New Hagan Decl. Ex 13 (Table "TAB EDREASON"). Some <Denial Reasons> do not include any "English Text." For instance, the reason "SSI COVERAGE HAS ENDED" includes no English Text. New Hagan Decl., Ex. 13 at 21. It is further disputed that the Denial Reasons that are included contain an explanation of "precisely why an individual was considered ineligible." For instance, one denial reason states "We sent you a letter asking for more facts but you didn't send us what we needed. So we did not have enough information to decide if you qualify." But it does not specify what information was missing, or why information that was submitted is insufficient. New Hagan Decl., Ex. 13 at 6, 10, 15. This makes it impossible for individuals to either determine whether TennCare made a mistake or take steps to provide the missing information. For instance, it was not until Plaintiff D.R., with the assistance of advocates from Tennessee Justice Center, filed an appeal and received a copy of the hearing packet that she understood that TennCare had requested income information. *See* Harrell Decl., Ex. 9, Sept. 25, 2019 Email from James Creppel to Appeals Clerk's office, TC-AMC-0000007195 ("After reviewing the hearing packet sent on September 18, 2019, we discovered that the primary issue in this matter is an unsatisfied request for income. This request is not something Ms. R[] was previously made aware of. . . . this is the first time it has been brought to her or our attention.").

Moreover, the denial reason "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" does not "precisely" explain the basis for TennCare's decision: it does not explain what income it thinks the person has or explain what types of income are counted and what can be disregarded. For instance, Dr. William Gavigan received a notice that stated "The monthly income limit for the kind of Medicare Savings Plan (MSP) you could get is $1,288.00. Our records show your monthly income is over this limit." ECF 210-2. While Dr. Gavigan "understood that being over the income limit for SLMB was the basis for the change," he "did not know what change TennCare may have received that prompted" the termination, as he had not reported any change in income. ECF 210 ¶ 6. Similarly, the NOD that Ms. Guyton and Holland received also did not explain what income TennCare thinks the person has or explain what types of income are counted and what can be disregarded. Guyton Decl., Ex. 3 at 5; Holland Decl., Ex. 5 at 4.

Moreover, the notices do not explain why an individual did not "group" into certain categories. *See* New Hagan Decl., ¶ 30. This creates significant confusion for individuals who used to group into a category, but who TEDS now believes do not "group" into that category anymore. For instance, Charlie Cooper called TennCare Connect on behalf of SLC because although an appeal had been filed on SLC's behalf he didn't understand the basis of TennCare's decision: "couldn't understand why we were getting" the NOD, "I'm wondering what the status is, or can you explain why they said we were gonna lose coverage . . . why coverage is ending? 'Cuz she was on SSI til I retired, and she's on SSA now, she's an adult disabled child, there have been no other changes, so I don't know why they're saying – why they're doing- what you're saying--why you're doing what you're doing. Do you understand? Can you explain? Can you explain? Help." Harrell Decl., Ex. 10, TC-AMC-0000002066 at 2:10–3:11.

Call center staff also rely on the NODs to try to answer questions. For instance, in one call regarding SLC, the call center staff explained "I couldn't give you any answers to that. I can only go based off of what the letter specifically says." Harrell Decl., Ex. 10, TC-AMC-0000002066 at 6:45–6:50. When asked about the Roche family's confusing and conflicting NODs, "it doesn't tell you why they are losing coverage," a TennCare Connect staff stated "No, like I said, it just gives us the notice of decisions. The only information we have is what she received as well which is the letters stating that either you are denied, approved, or coverage is ending. . . . so that's the only thing, you know, we can go off of what they give." Harrell Decl., Ex. 11, TC-AMC-0000007204 at 22:40–23:12; *see also id.* at 10:17–10:26 ("I know you have a lot of questions and whatnot, but because we don't determine eligibility, I won't be able to give you more insight about why they decided what they decided."). TennCare Connect staff have expressed confusion after reading the "non-grouping" language, noting for instance, "I'm not sure what happened, because the letter, like, didn't specify why she, um, was no longer qualified for, uh, TennCare." Harrell Decl., Ex. 12, TC-AMC-0000000970 at 16:44–17:01.

Finally, it is noted for clarity that the Denial Reason does not immediately follow the language quoted above in SUMF ¶ 40. *See* ECF 166-3 at 49–50.

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 tbe 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: Disputed in part. Undisputed that this is the language included in the Business Reference Table for Denial Reason "INCOME EXCEEDS LIMIT." Disputed that this

denial reason is always used for individuals who are over income. TennCare notices also use the language "Your monthly income does not fall within the limits for the kind of <Program Name> you can get," which lists neither the income of the household or the income limit for the program. New Hagan Decl., Ex. 13 at 11 (denial reason "YOU DO NOT FALL WITHIN THE INCOME LIMITS FOR THIS CATEGORY").

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

Response: Disputed. The cited paragraph of the declaration does not support this assertion. Moreover, it is unclear what eligibility changes Defendant is referring to. The major eligibility rule changes required by the Affordable Care Act were effective 2014. *See, e.g.*, *Program History*, Medicaid.gov, https://www.medicaid.gov/about-us/program-history/index.html ("Beginning in 2014, the Affordable Care Act . . . standardizes the rules for determining eligibility and providing benefits through Medicaid, CHIP and the health insurance Marketplace.").

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: Undisputed for purposes of summary judgment motion only.

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: Undisputed for purposes of summary judgment motion only.

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: Undisputed for purposes of summary judgment motion only.

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: Undisputed for purposes of summary judgment motion only.

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: Undisputed for purposes of summary judgment motion only.

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: Disputed in part. Undisputed for purposes of summary judgment motion only that this is TennCare's current, stated intention. However, Plaintiffs dispute the implication that this stated intention is indicative of TennCare's future actions. TennCare has made repeated sworn statements that issues raised in this litigation have been fixed and will not recur *See, e.g.*, ECF 139-2 ¶ 3 ("all of the issues with TEDS identified in my prior declarations have been resolved"). Yet many of the specific fixes TennCare claims to have made have not been implemented. For instance:

- TennCare insisted that it has added a question about prior receipt of SSI, but the current renewal packets do not contain that question. *See supra* PRSUMF ¶ 22(d).
- TennCare also assured this court that "[b]ecause conversion is not going to happen again, this issue will not repeat itself" ECF 63 ¶ 128; *id.* ¶ 26 ("These errors will not be repeated in the future – conversion has already happened. . . . there is no danger that Plaintiffs or other TennCare members will experience them in the

future."). Yet, in April and May of 2023, when redeterminations started again, TennCare renewed up to 30,000 individuals in "conversion" status, utilizing the same flawed process. *See supra* PRSUMF ¶ 22(a).

- TennCare has repeatedly submitted sworn statements insisting that it has fixed the problems screening for eligibility in the DAC category. *See, e.g.*, ECF 63 ¶¶ 25(e), 26; *id.* ¶ 152 ("TEDS is being updated in July 2020 to begin loading these indicators into the SSI detail screen in TEDS even for inactive SSI individuals to help prevent this sort of worker oversight going forward."); *id.* ¶ 150 ("no likelihood" Plaintiff Michael Hill would encounter the problem again). Yet, TennCare later acknowledged another error identifying DAC coverage in May 2021. ECF 163, Hagan Decl. ¶ 2(g) (regarding Ms. D); *see also* ECF 124. In October 2021, TennCare again failed to identify Plaintiff Hill as DAC-eligible. ECF 145. On January 4, 2022, Ms. Hagan swore that "any potentially systemic issues such as the issue experienced by Plaintiffs Vaughn and Hill have long-since been identified and corrected for both them and for all similarly situated individuals." ECF 166 ¶ 26. The problem is not fixed, however, for TennCare continues to terminate individuals despite their DAC eligibility. *See supra* PRSUMF ¶ 22(c); Holland Decl. ¶¶ 10–14; Guyton Decl. ¶¶ 7–20, 35.

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: Disputed in part. Undisputed for purposes of summary judgment motion only that this is TennCare's current, stated intention. However, Plaintiffs dispute the implication that this stated intention is indicative TennCare's future actions. *See supra* PRSUMF ¶ 49.

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: Undisputed for purposes of summary judgment motion only.

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: Undisputed for purposes of summary judgment motion only, but adding for clarity that Exhibit 13 does not appear to be the correct citation. Plaintiffs believe the correct citation is New Hagan Decl. Ex. 12, under the column for "Qualified Medicare Beneficiary (QMB)."

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: Disputed in part. Undisputed that the notice will include an English Text denial reason for each category an individual "groups" in, if there is English Text listed in the relevant Table, TAB EDREASON (New Hagan Decl. Ex. 13), for that denial reason. Disputed that

every category an individual groups into has an assigned English Text reason. For instance, the denial reason "SSI COVERAGE HAS ENDED" includes no English Text. New Hagan Decl., Ex. 13 at 21. There are also no denial reasons specific to individuals who group into Pickle, DAC, or Widow/Widower categories. *See generally* New Hagan Decl., Ex. 13. Further disputed that the English Text statements provide "specific" reasons why the individual is ineligible. For instance, TennCare notices use the language "Your monthly income does not fall within the limits for the kind of <Program Name> you can get," which lists neither the income of the household or the income limit for the program, and thus is not a "specific reason." New Hagan Decl., Ex. 13 at 11 (denial reason "YOU DO NOT FALL WITHIN THE INCOME LIMITS FOR THIS CATEGORY").

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: Undisputed.

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: Undisputed.

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: Undisputed for purposes of summary judgment. *See* ECF 311-13 at 3 ("EL1054" and "EL1055").

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. ECF 63 ¶ 57.

Response: Undisputed.

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. ECF 63 ¶ 57; New Hagan Decl. Ex. 3 at TC-AMC-000662867.

Response: Undisputed.

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

Response: Undisputed.

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

Response: Undisputed.

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). ECF 63 ¶ 57.

Response: Disputed in part. It is undisputed that the above represents one aspect of TennCare's justification for not disclosing the existence of the 90-day reconsideration before an individual has been terminated. It is disputed that the above justification comprises TennCare's complete justification for not disclosing the existence of the 90-day reconsideration period before an individual has been terminated. TennCare does not have to pay for backdated coverage if an enrollee submits a renewal packet after 90 days. *See* Harrell Decl., Ex. 7, Turner Dep. Excerpts 138:16–25, 139:1–20; Harrell Decl., Ex. 2, Hagan Dep. Excerpts at 192:20–25, 193:1–4 (stating that a renewal packet sent after 90 days is treated like an application in which case coverage begins upon submission of the application (unless the individual falls in one of the limited number of categories with retroactive coverage) and does not extend to the date of termination).

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, ECF 26-5 at 304 (Apr. 10, 2020).

Response: Undisputed as written. The cover letter accompanying the renewal packet states:

> "**Remember, to be sure you can keep coverage while we review your packet, we must get it by [date].** What if you send us your Renewal Packet on time but we get it on or close to the due date? You may have a short break in coverage. However, once we record your Renewal Packet as returned, we'll give your coverage back while we look at it.
>
> **What if you don't send your Renewal Packet by [date]?** You'll get a letter that says when the coverage you have now will end. The letter will also say how to appeal.
>
> **Even if you get a letter that says when your coverage will end you can still send in your packet and proof.** If we get your packet and proof, we'll use it to see if you qualify for coverage. We'll send you a letter that says if you qualify or not. If

you think we made the wrong decision, the letter will also say how to appeal our decision."

(emphasis in original).

However, Plaintiffs dispute that the renewal cover letter or the above-language describes TennCare's 90-day reconsideration period as implied in the State's Brief at 15 (citing SUMF ¶ 62) because neither reference the 90-day period or state that coverage for an individual found eligible will be backdated to the date of termination if submitted within the 90 day period. *Cf.* Pls.' Ex. 8, ECF 26-5 at 304 (Apr. 10, 2020); 42 C.F.R. § 435.916(a)(3)(iii); Tenn. Comp. R. and Regs. Ch. 1200-13-20.09((1)(d)(11) (stating eligibility reinstated as of date of termination); ECF 63, Hagan Decl. ¶ 57 (same); *see also* Harrell Decl., Ex. 2, Hagan Dep. Excerpts 194:3–8 (Q: "Do you use the '90-day period'?" A: "No. We just tell them, 'Get it to' – you know, 'Here's your date, and if you go past this date, you may experience a break in coverage, so tty to get it to us before the date, and if you don't get it to us, [sic] as soon as you possibly can.").

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). ECF 63 ¶ 52.

Response: Undisputed.

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

Response: Disputed. *See* PADF ¶ 62-65.

Based on TennCare's own data, TennCare failed to act on timely-appeals filed between March 19, 2019 and October 31, 2022 within 90 days for 32,228 out of 78,114 redetermination or termination-related appeals that were not associated with a continuance. Harrell Decl., Ex. 13, 2023 07 17 All Timely Medicaid Renewal and Termination Appeals – Filed to Process End

Date.pdf (summarizing data from TC-AMC-0000252538, -39, -40) (including codes associated with both hearings and no hearings).

Based on TennCare's own data, the agency failed to hold a hearing, much less issue a written decision following a hearing, within 90 days of receipt of an appeal in 2,934 of the 4,559 (64.35%) redetermination and termination-related Medicaid appeals that were timely-filed between March 19, 2019 and October 31, 2022, were not continued by any party, and involved a hearing. Harrell Decl., Ex. 14, 2023 07 17 All Timely Medicaid Renewal and Termination Appeals + 90 Days.pdf (summarizing data from TC-AMC-0000252538, -39, -40).

65. TennCare has not had a coverage ending or termination appeal take over 90 days to resolve (excluding cases in whicb the appellant requests a continuance) since August 2022 and bas 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: Plaintiffs are without sufficient information to state whether the statement is disputed or undisputed. Plaintiffs do not have access to updated appeals data from TennCare and it is only referenced in the testimony of Hagan, not supported by an exhibit, or an explanation as to what assumptions were made in calculating the figure. *See* New Hagan Decl. ¶ 39. Plaintiffs should receive updated appeals data tbrough supplementation which will occur after the time period for this response. Because the State was generally prohibited from disenrolling individuals from TennCare due to the COVID-19 moratorium on disenrollments from March 18, 2020 until April 1, *2023*, *see* ECF 180, 181, 263, Plaintiffs dispute the figure to the extent used to sbow that it is representative of data following the end of the moratorium on disenrollments in April 1, 2023.

66. During tbe 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., ECF 142-2 ¶ 71; New Hagan Decl. ¶ 38.

Response: Undisputed for purposes of summary judgment only.

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: It is undisputed that, as of June 14, 2023, CMS has provided authority, if one of three triggering conditions is met, to implement a waiver of the 90-day deadline for taking final administrative action in an appeal, provided TennCare provides the appellant COB pending resolution of the appeal. Harrell Decl., Ex. 57, Ltr. to Director Stephen Smith, Centers for Medicare and Medicaid Services, June 14, 2023, available at Plaintiffs do not dispute that this temporary waiver is currently in effect.

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

Response: Disputed. *See* PADF ¶ 62.

For redetermination and termination-related Medicaid appeals timely filed between March 19, 2019 and October 31, 2022, TennCare conducted fair hearings in only 5,754 (8%) out of 69,250 appeals that were timely filed, as disclosed by filtering TennCare's own data to consider only final outcomes or status reasons of appeals for which a fair hearing is possible (i.e., at least one shown). Harrell Decl., Ex. 15, 2027 07 17 All Timely Medicaid Renewal and Termination Appeals.pdf (summarizing data from TC-AMC-0000252538, -39, -40); Harrell Decl., Ex. 16, TennCare Dep. Leffard 173:22–25, 174:1–3 (stating that no hearing date listed means no bearing occurred).

19,425 out of the 63,496 who did not receive hearings from this data set did not have continuation of benefits. Harrell Decl., Ex. 15, 2027 07 17 All Timely Medicaid Renewal and Termination Appeals.pdf (summarizing data from TC-AMC-0000252538, -39, -40).

Further, TennCare does not grant good cause hearings at all. SUMF ¶ 84.

TennCare also denies hearings in appeals that it closes based on its no valid factual dispute policy. According to one set of data provided by TennCare in discovery, TennCare denied hearings on that basis in 3,683 cases between March 19, 2019 and October 31, 2022. Harrell Decl., Ex. 58, 2023 07 17 All Timely Medicaid and Termination Appeals VFD.pdf (summarizing data from TC-AMC-0000252538, -39, -40). According to Ms. Hagan, between March 19, 2019 and May 20, 2020, TennCare dismissed 776 appeals, or slightly less than 1% of the total of 80,855 appeals filed during that period. ECF 63 ¶ 71(i). The rate of such dismissals increased to 7.8% during the first six months of 2023, with TennCare dismissing 629 of the 8,089 appeals filed during that period. *See* New Hagan Decl. ¶ 42.

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: Disputed. *See* PADF ¶ 62. *See supra* PRSUMF ¶ 68.

70. In the last six months (January 1, 2023 to June 27, 2023), TennCare has received 8,089 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: Undisputed for purposes of summary judgment only.

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: Undisputed for purposes of summary judgment only.

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

Response: Undisputed.

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

Response: Disputed. Every appeal is not reviewed to see whether it qualifies for the "good cause exception." TennCare legal review staff decides whether an individual has "good cause" for filing a late appeal only if appellant alleges that there is good cause. In the absence of such an allegation, the clerk's office mails a letter informing the appellant that the appeal is being denied as untimely without the appeal going to legal review. Harrell Decl., Ex. 16, TennCare Dep. Leffard Excerpts 50:21–51:25, 56:15–24. And the TennCare eligibility appeal form does not include any question that would prompt an individual to describe good cause for an untimely appeal. Harrell Decl., Ex. 16, TennCare Dep. Leffard 190:13–191:5; Harrell Decl., Ex. 17, TennCare Dep. Leffard Ex. 11. For instance, in March 2019, after learning at the pediatrician's office that her son had lost coverage, Plaintiff S.L.T. called TennCare Connect, who told her that his coverage had in fact ended months earlier, in July 2018, because the family had failed to return to a renewal packet for J.L.T. Harrell Decl., Ex. 18, TC-AMC-0000007726 03_25_2019_095028007_3151_3151.wav at 7:21–7:52; Harrell Decl., Ex. 19, TC-AMC-0000007727 03_25_2019_100406300_3151_3151.mp3 at 1:44–2:38. S.L.T. filed an appeal over the phone. *See id.* at 5:30–8:30. She explained that they had never received a renewal packet or

notice that J.L.T.'s coverage was ending. *Id.* She further explained that they had taken J.L.T. to the doctor since July 2018 with no problems, and that the issue seemed to have started more recently when she called to update her family's address a few weeks ago, that the family had received and completed renewal packets for other family members, and only J.L.T.'s coverage had ended while the rest of the family's coverage remained active. *Id.* Moreover, the TennCare Connect agent stated that "you probably didn't receive it because I see a [different address] on the account," where the renewal packet and termination notice was sent. Despite these strong indications that some error had occurred, and that the family had not received J.L.T.'s renewal packet or termination notice, on April 22, 2019, TennCare sent a notice closing the appeal as untimely and did not offer the family any opportunity to submit additional information showing they had not received the termination notice. Harrell Decl., Ex. 20, April 22, 2019 Letter, TC-AMC-0000007253.

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: Undisputed, but incomplete. TennCare regulations define "good cause" as "A legally sufficient reason. In reference to an omission or an untimely action, a reason based on circumstances outside the party's control and despite the party's reasonable efforts." Tenn. Comp. R. & Regs. § 1200-13-19-.02(20). Although the regulation does not limit the policy to appeals, the Defendant refuses to grant good cause for any "omission or … untimely action" other than an untimely appeal or request for continuation of benefits (COB). Harrell Decl., Ex. 16, TennCare Dep. Leffard Excerpts 56:4–9. Therefore, TennCare does not permit good cause exceptions in circumstances where an individual did not timely respond to a renewal packet for reasons outside of their control. *Id.*

TennCare does not permit individuals to appeal the denial of good cause. *Id.* at 55:8–18.

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

Response: Disputed. Individuals who call TennCare Connect after the appeal deadline are either not offered appeals after the deadline or are told their appeals are untimely without any opportunity to provide good cause allegations. ECF 63 ¶ 113 (Hagan: "The TennCare Connect agent did not suggest an appeal because it would have been dismissed as untimely"). For instance, Ms. Surrett was told it was too late to file an appeal, despite the fact that she had informed TennCare Connect representatives that she had been away from her home for an extended period while serving as a caretaker for her aunt and dealing with her mother's fall and subsequent hospitalization. *See* Harrell Decl., Ex. 12, TC-AMC-0000000970 at 3:19–3:30 (stating she did not have the NOD with her, because her mother, Ms. Barnes "had a fall, an emergency"); *id.* at 24:40 –25:10 (stating she had been away from home while serving as a caretaker for her aunt). *Cf.* Harrell Decl., Ex. 16, TennCare Dep. Leffard Excerpts 58:18– 59:1 (testifying that being out of the country or taking care of a sick relative could constitute good cause for not filing a timely appeal). Harrell Decl., Ex. 21, TC-AMC-0000000971 at 8:01–8:40.

When next friend CMA called TennCare Connect after learning that SFA's coverage was ending, the representative told her that SFA was terminated due to failure to respond to an information request from TennCare. Harrell Decl., Ex. 22, TC-AMC-0000000626 at 9:28–11:22. CMA told the representative she never received any requests or notices from TennCare and asked what she could do to get SFA's coverage reinstated. *Id.* The representative told her that she could appeal but that because she was filing the appeal *after* coverage had ended, there was no way to get immediate reinstatement. The representative did not mention the good cause exception to the

appeals deadlines. *Id.*; *see also* Harrell Decl., Ex. 23, TC-AMC-0000000627 3:26-3:53 (being advised by a different representative to reapply, without mention of good cause exception).

Indeed, the TennCare's 30(b)(6) witness on appeals testified that she would be concerned if the TennCare Call Center *did* inform enrollees about the good cause exception. Harrell Decl., Ex. 16, TennCare Dep. Leffard Excerpts at 9:8–19, 49:3– 22.

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

Response: Undisputed.

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. ECF 63 at ¶ 53.

Response: Disputed in part. It is undisputed that this is TennCare's asserted belief. It is disputed that providing information about the good cause exception would induce individuals to miss their deadline. Rather, the failure to include that information causes individuals to not be able to evaluate whether to pursue appeals at all. For instance, Ms. Surrett was told by TennCare Connect that her appeal was untimely and advised to reapply. *See* Harrell Decl., Ex. 21, TC-AMC-0000000971 at 8:01-8:40; ECF 63 ¶ 113. In fact, the TennCare Connect representative relied on the language in the NOD to explain that it was too late to file an appeal, stating ". . . the last letter we sent out does mention an appeal, but taking a look into that letter, it says you have until August 31st to have filed the appeal on time. After August 31st, um, it looks like, you know it is too late to file the appeal." Harrell Decl., Ex. 21, TC-AMC-0000000971 at 8:01-8:40. As a result, she

submitted a new application rather than an appeal. Moreover, the lack of notice means that individuals do not know to offer information that would be relevant to the good cause exemption.

Plaintiffs also dispute the implication that concern about possibly confusing enrollees is the sole or even primary motivation for the Defendant's refusal to inform enrollees about the good cause regulation. Ms. Hagan testifies that it is TennCare's policy to limit good cause to "extraordinary circumstances" because of "the importance of filing deadlines in running an efficient and effective appeals process, particularly one that processes thousands of appeals every month." ECF 63 ¶ 71(c).

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: Disputed to the extent that the statement implies that all or even most late appeals are reviewed for good cause. TennCare legal review staff decides whether an individual has "good cause" for filing a late appeal only if appellant alleges that there is good cause. In the absence of such an allegation, the clerk's office mails a letter informing the appellant that the appeal is being denied as untimely without the appeal going to legal review. Harrell Decl., Ex. 16, TennCare Dep. Leffard 50:21–51:25, 56:15–24. Plaintiffs also note for needed context that the TennCare eligibility appeal form does not include any question that would prompt an individual to describe good cause for an untimely appeal. *Id.* at 190:13–191:5; Harrell Decl., Ex. 17, TennCare Dep. Leffard Ex. 11. Further, it is disputed that TennCare reviews all information in its possession to evaluate good cause. For instance, in March 2019, after learning at the pediatrician's office that

her son had lost coverage, Plaintiff S.L.T. called TennCare Connect, who told her that his coverage had in fact ended months earlier, in July 2018, because the family had failed to return to a renewal packet for J.L.T. Harrell Decl., Ex. 18, TC-AMC-0000007726 03_25_2019_095028007_3151_3151.wav at 4:23-4:56 (describing learning of lost coverage at pediatrician's office), 7:21-7:52 (explaining coverage ended July 2018), Harrell Decl., Ex. 19, TC-AMC-0000007727 03_25_2019_100406300_3151_3151.mp3 at 1:44-2:38 (explaining termination was due to failure to return renewal packet). S.L.T. filed an appeal over the phone. *See id.* at 5:30-8:30. She explained that they had never received a renewal packet or notice that J.L.T.'s coverage was ending. *Id.* She further explained that they had taken J.L.T. to the doctor since July 2018 with no problems, and that the issue seemed to have started more recently when she called to update her family's address a few weeks ago, that the family had received and completed renewal packets for other family members, and only J.L.T.'s coverage had ended while the rest of the family's coverage remained active. *Id.* Moreover, the TennCare Connect agent stated that "you probably didn't receive it because I see a [different address] on the account," where the renewal packet and termination notice was sent. Despite these strong indications that some error had occurred, and that the family had not received J.L.T.'s renewal packet or termination notice, on April 22, 2019, TennCare sent a notice closing the appeal as untimely and did not offer the family any opportunity to submit additional information showing they had not received the termination notice. Harrell Decl., Ex. 20, April 22, 2019 Letter, TC-AMC-0000007255.

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: Disputed. TennCare staff assesses good cause only in those cases in which the appellant alleges a basis for good cause. Harrell Decl., Ex. 16, TennCare Dep. Leffard Excerpts

at 51:22–25, 56:15–24. And written list of examples that the clerk's office follow in deciding whether to forward to the legal review staff for an assessment of good cause contain no instruction to "err on the side of the appellant." *See id.* at 64:3–66:19; *see also id.* at 73:1–14 (testifying that attorneys in legal review do not rely on any written guidelines other than the good cause policy itself), 74:24, 75:6 (testifying that there is no written policy regarding length of hospitalization and staff is instructed to "use their best judgment"). On the contrary, it is the policy of TennCare that, "Because of the importance of filing deadlines in running an efficient and effective appeals process, particularly one that processes thousands of appeals every month, good cause exceptions are limited to extraordinary circumstances." ECF 63 ¶ 71(c).

Further, it is disputed that TennCare in fact errs on the side of the appellant. For instance, in March 2019, after learning at the pediatrician's office that her son had lost coverage, Plaintiff S.L.T. called TennCare Connect, who told her that his coverage had in fact ended months earlier, in July 2018, because the family had failed to return to a renewal packet for J.L.T. Harrell Decl., Ex. 18, TC-AMC-0000007726 03_25_2019_095028007_3151_3151.wav at 7:21-7:52, Harrell Decl., Ex. 19, TC-AMC-0000007727 03_25_2019_100406300_3151_3151.mp3 at 1:44-2:38. S.L.T. filed an appeal over the phone. *See id.* at 5:30-8:30. She explained that they had never received a renewal packet or notice that J.L.T.'s coverage was ending. *Id.* She further explained that they had taken J.L.T. to the doctor since July 2018 with no problems, and that the issue seemed to have started more recently when she called to update her family's address a few weeks ago, that the family had received and completed renewal packets for other family members, and only J.L.T.'s coverage had ended while the rest of the family's coverage remained active. *Id.* Moreover, the TennCare Connect agent stated that "you probably didn't receive it because I see a [different address] on the account," where the renewal packet and termination notice was sent. Despite these

strong indications that some error had occurred, and that the family had not received J.L.T.'s renewal packet or termination notice, on April 22, 2019, TennCare sent a notice closing the appeal as untimely and did not offer the family any opportunity to submit additional information showing they had not received the termination notice. Harrell Decl., Ex. 20, April 22, 2019 Letter, TC-AMC-0000007253.

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: Disputed. The language Defendant's reference in the Appeal Resolution Notice does not state that individuals can submit "any information about a potential good cause." TennCare's regulations define good cause to mean "A legally sufficient reason. In reference to an omission or an untimely action, a reason based on circumstances outside the party's control and despite the party's reasonable efforts." Tenn. Comp. R. & Regs. § 1200-13-19-.02(20). The Appeal Resolution Notice does not mention that regulation or use that definition. Instead, the Appeal Resolution Notice limits good cause to instances where "something very bad happen[ed] to you or a close family member (like a serious illness or death)?" or instances where someone's "health, mental health, or learning problem, or a disability" made it hard "to file your appeal on time." New Hagan Decl. Ex. 14 at 24 (TC-AMC-0000661847) ("Do you have a health, mental health, or learning problem, or a disability? And did that problem make it hard for you to file your appeal on time? Or did something very bad happen to you or a close family member (like a serious illness or death)? If so, tell us in writing why you could not file your appeal on time. If we agree, your appeal may be reopened."). Furthermore, TennCare requires the information to be "in writing," precluding individuals from providing "any information about a potential good cause" to TennCare Connect

or otherwise over the phone. The language also omits many other reasons outside of someone's control that may constitute good cause. For instance, the NOD language does not inform individuals that they can substantiate allegations of non-receipt with additional evidence to establish good cause, or explain what additional evidence would be sufficient. And TennCare does not send requests for more information if the individual does not provide sufficient details in the first instance. Harrell Decl., Ex. 16, TennCare Dep. Leffard Excerpts at 74:18–21, 82:25–83:7. TennCare staff asserts that they accept evidence related to other circumstances, such as being away from home or being impacted by a storm or natural disaster. *Id.* at 58:18–59:1. But the language in the untimely appeal closure notice does not communicate those options. New Hagan Decl. Ex. 14 (Appeal Resolution Notice).

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: Undisputed.

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: Disputed. The underlying paragraph of the declaration does not support the claim that individuals allege non-receipt "*when they learn they have been disenrolled* or have missed a deadline" or the implication that these allegations are knowingly false. Rather, the underlying paragraph states that when individuals who have missed deadlines claim non-receipt, TennCare often does not have access to other evidence to corroborate their claim. The statement is further disputed because it is also extremely common for individuals to state they did not receive a notice or renewal packet when they, in fact, did not receive the packet or notice. For instance, in

March 2019, Plaintiff S.L.T. found out that her son, Plaintiff J.L.T. (who was at the time four years old) had lost coverage when she tried to take him to a pediatrician's appointment, but the doctor's office said he was uninsured. She called TennCare Connect, who told her that his coverage had ended months earlier, in July 2018, because they had failed to respond to a renewal packet. Harrell Decl., Ex. 18, TC-AMC-0000007726 03_25_2019_095028007_3151_3151.wav at 7:21-7:52, Harrell Decl., Ex. 19, TC-AMC-0000007727 03_25_2019_100406300_3151_3151.mp3 at 1:44-2:38. S.L.T. filed an appeal over the phone. *See id.* at 5:30–8:30. She explained that they had never received a renewal packet or notice that J.L.T.'s coverage was ending. *Id.* She further explained that they had taken J.L.T. to the doctor since July 2018 with no problems, and that the issue seemed to have started more recently when she called to update her family's address a few weeks ago, and that only J.L.T.'s coverage had ended, the rest of the family's coverage remained active. *Id.* Moreover, the TennCare Connect agent stated that "you probably didn't receive it because I see a [different address] on the account," where the renewal packet and termination notice was sent. Despite these strong indications that some error had occurred, and that the family had not received J.L.T.'s renewal packet or termination notice, on April 22, 2019, TennCare sent a notice closing the appeal as untimely and did not offer the family any opportunity to submit additional information showing they had not received the termination notice. Harrell Decl., Ex. 20, April 22, 2019 Letter, TC-AMC-0000007253.

Plaintiff E.I.L.'s mother also attempted to file a late appeal after not receiving the relevant notice of decision. Harrell Decl., Ex. 24, TC-AMC-0000003446 (4:14–5:50). Her son was born in June 2019, but TennCare did not start his coverage until over a month later, on July 30, 2019. But it wasn't until January 2020, that E.I.L.'s mother learned of TennCare's erroneous decision. *Id.* At that time, her pediatrician refused to see E.I.L for his six-month well-child visit because she had

accumulated over $2,000 in unpaid medical bills in July. *Id.* E.I.L.'s mother filed an appeal over the phone, explaining that E.I.L. should have been eligible as a newborn at the time, and stating that she had not received a notice with the July 30th start date. *Id.* Nonetheless, TennCare closed the appeal as untimely, without offering any opportunity to submit additional evidence to corroborate that she had in fact not received the termination notice. *See* Harrell Decl., Ex. 25, January 21, 2019 Notice Closing Appeal, TC-AMC-0000003325.

Likewise, Plaintiff D.R. and her family explained that they missed the deadline to complete the renewal packet because they did not receive the packet prior to receipt of the notice of decision. As an Administrative Law Judge later recognized "allegations that Petitioner did not receive notice and was having difficulty obtaining the verifications are relevant to whether good cause existed for Petitioners' failure to timely comply." Harrell Decl., Ex. 26, Order granting continuance for D.R. and family, TC-AMC-0000004147 at -53.

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: Undisputed.

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

Response: Undisputed.

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: Undisputed.

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

Response: Disputed. The 5% figure cited here refers only to the period between March 19, 2019, and the date of Ms. Hagan's execution of her May 29, 2020 declaration, ECF 142-2 ¶ 71(c) ("Since March 19, 2019, out of the 147,897 eligibility-related appeals filed, 6,910 (4.7 percent) have been closed as untimely."). Defendant offers no factual support for the assertion that the cited 5% figure is representative of TennCare's historical appeals data. Accordingly, the State fails to establish the absence of a genuine dispute as to TennCare's historic rate of closing appeals for untimeliness.

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; ECF 63 ¶ 71(e).

Response: Undisputed for purposes of summary judgment only.

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. ECF 63 ¶ 71(e), (j).

Response: Disputed in part. It is undisputed that the resolution unit investigates an appeal and will approve a member for coverage if the unit determines that member is eligible. Disputed to the extent that the statement implies that the resolution unit always reviews "all information available to TennCare." *See* PRSUMF ¶ 19.

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

Response: It is undisputed that if TennCare's resolution unit is unable to approve a member for coverage, the appeal is then sent to TennCare's legal review unit.

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. ECF 63 ¶ 71(f).

Response: Disputed in part. It is undisputed that the legal review unit assesses each appeal that it receives to determine whether there is a valid factual dispute. It is disputed to the extent that the statement implies that cases dismissed for lack of a "valid factual dispute" could not be resolved through appeal, were a hearing provided to the appellant. *See* PRSUMF ¶ 102.

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. ECF 63 ¶ 71(f).

Response: Disputed in part. Undisputed that the statement reflects TennCare's stated practice. However, Plaintiffs note that Tenn. Comp. R. & Regs. 1200-13-19-.02(33) define a valid factual dispute as, "A dispute that, if resolved in favor of the appellant, would prevent the state from taking the action that is the subject of the appeal." The text of the regulation is not limited to "factual mistakes," although the Defendant has made inconsistent representations regarding TennCare's actual practice. Ms. Hagan first testified, in the May 29, 2020 declaration Defendant cites, that to establish a valid factual dispute, an individual must "allege[] a factual mistake that if resolved in favor of the appellant would entitle the appellant to relief." ECF 63 ¶ 71(f). When the Court expressed concern during the March 4, 2022 proceedings that TennCare's policy as described by Ms. Hagan was inconsistent with *Rosen v. Goetz*, 410 F.3d. 919 (6th Cir. 2005), Defendant backtracked and assured the Court that an enrollee can establish a VFD by not only alleging a mistake of fact but also by alleging that TennCare has mistakenly applied fact to law. ECF 179 at 19:2–21:20. TennCare subsequently represented that it had changed its notices to

reflect that broader definition of VFD. ECF 213. However, as evidenced by the current statement of undisputed fact, TennCare has reverted to Ms. Hagan's more stringent definition.

TennCare's practice does not conform to the regulatory definition. For example, if an enrollee fails to submit required information or a timely appeal because he never received a renewal packet, TennCare acknowledges that he should not be terminated for failure to respond.

However, an enrollee whose appeal asserts not receiving notice is not enough, in the absence of proof, to establish a valid factual dispute and to gain a hearing at which to prove non-receipt. Br. 13 (rejecting Plaintiffs' claim that "*unsworn* statements alleging nonreceipt are enough to rebut the presumption that notice was effective, or at least require a hearing" (emphasis in original)); *cf.* ECF 142-2 at ¶ 71(f) (Hagan declaration) ("Assertions that an appellant did not receive a NOD are *typically* deemed to raise a valid factual dispute entitling the appellant to a fair hearing." (emphasis added)).

Moreover, TennCare does not routinely recognize factual disputes even when individuals articulate one: For instance, Plaintiff S.L.T. called TennCare Connect on June 18, 2019 to file an appeal following a notice stating two of her three children were not eligible for TennCare because they had failed to provide requested information. Harrell Decl., Ex. 27, June 18, 2019 Call, TC-AMC-0000007730 h.06_18_2019_01_14_PM_[Redacted].mp3. When asked to explain the reason for the appeal she stated that "I don't know what you want me to say, we're eligible. If my husband and I and my other kid gets it, then my other two kids should have insurance as well. And the letter that I received did not say it was for [A.L.T.]'s insurance, it said it was for the food stamps." *Id.* at 7:58–8:30. Nonetheless, TennCare did not identify the statement "we're eligible" as a valid factual dispute and instead sent letters to the two children, A.L.T. and J.L.T. requesting more information. Harrell Decl., Ex. 28, TC-AMC-0000007281 (J.L.T.); Harrell Decl., Ex. 29, TC-AMC-

0000007237 (A.L.T.). The deadline to respond was August 21, 2019. On August 30, 2019, Plaintiff T.L.T. (the children's father) called the Appeals Clerk's office. Harrell Decl. Ex. 30, TC-AMC-0000007728 8-30-19- [Redacted].mp3 at 2:32–3:18. He explained that the family had been having "major issues" with not receiving mail or receiving it very late, including from other senders, not just TennCare. *Id.* They wanted to know if they could still provide the information. *Id.* The clerk's staff person did not know the answer, but provided an email address for the Appeals Clerk's office. *Id.* at 3:00–4:54. On September 3, 2019, T.J.T. sent an email to the Clerk's office. Harrell Decl., Ex. 31, TC-AMC-0000007621. That email stated that over the past several months they had learned that their son, J.L.T. "was mistakenly purged from the program without our prior knowledge," and as a result "did not have insurance for over six months prior to us knowing, and at no point during that time did TennCare communicate this change with us." *Id.* He further explained that "We have provided TennCare with all information requested on multiple occasions. However, TennCare has either acknowledged receipt of such and provided no follow-up aside from duplicated requests for the same already submitted information, or failed to even communicate that such information was received." *Id.* Finally, T.J.T. explained that both A.L.T. and J.L.T. are minors whose income is below the required limits and therefore should be eligible. *Id.* The next day, TennCare sent two letters closing the children's appeal for failing to provide enough information to establish a valid factual dispute. Harrell Decl., Ex. 32, TC-AMC-0000007229 (closing A.L.T.'s appeal); Harrell Decl., Ex. 33, TC-AMC-0000007273 (closing J.L.T.'s appeal). Likewise, TennCare failed to recognize articulated disputes of William Gavigan, M.D. TennCare notified Dr. Gavigan in January 2022 that it had received a report of an undisclosed change in his daughter's income and would no longer cover her Medicare premiums under the Medicare Savings Program. ECF 210, ¶¶ 5–10. The notice also included the "non-grouping" language. ECF 210-2.

Dr. Gavigan filed a timely appeal and on the appeal form itself stated "Jeanne is getting social security and used to get SSI checks. I believe she is in the group that allows her the benefit of MSP." ECF 210-3 at 4. Dr. Gavigan submitted a copy of the relevant regulation governing the calculation of her income establishing her continued eligibility. ECF 210 ¶ 9; ECF 210-3 at 5. And further attached a letter asking TennCare to review her eligibility in the "Special Group of Former SSI Recipients . . . under the Social Security Act, Section 1634C, Disabled Adult Children or Childhood Disability Beneficiaries." ECF 210-3 at 6. TennCare did not accept this explanation as sufficient to establish a valid factual dispute and instead sent Dr. Gavigan another notice demanding more information in order to establish a valid factual dispute, but without specifying what was needed. ECF 210-5. Dr. Gavigan had already provided all of the relevant information and was at a loss to know what else to submit. ECF 210 ¶ 11. TennCare closed his daughter's appeal without a hearing on the purported grounds that he had not described the mistake that he thought TennCare made. ECF 210 ¶ 14, 210-6. According to TennCare this was a proper application of the VFD policy because, although the notice of decision included the non-grouping language, that wasn't actually relevant to TennCare's decision. ECF 218 Hagan Decl, ¶¶ 20-21. Thus, TennCare concluded that Mr. Gavigan's comments about DAC eligibility were "entirely irrelevant" to the MSP income question. *Id.* ¶ 15. Because Mr. Gavigan could not discern the actual reason for TennCare's decision, he was unable to address the issue TennCare thought necessary to proceed to a hearing. Else to submit. ECF 210 ¶ 11.

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: Disputed. *See* PRSUMF ¶ 91. TennCare closes appeals when individuals "just state that they need their coverage reinstated." Harrell Decl., Ex. 16, TennCare Dep. Leffard Excerpts at 195:13–17; *see also* Harrell Decl., Ex. 1, Flener Dep. 224:20–225:12 (describing as insufficient, "I need health care"). But that should be construed as a valid factual dispute. *See Grier v. Goetz*, 402 F. Supp. 2d 876, 922 (M.D. Tenn. 2005), *order clarified*, 421 F. Supp. 2d 1080 (M.D. Tenn. 2006) ("A statement as simple as: 'I am appealing because I did not get my medicine or treatment' . . . must be treated as raising a 'valid factual dispute.'"). When asked to explain why they want to appeal, individuals often express why their TennCare coverage is important to them. Plaintiff Carlissa Caudill, for instance, filed an appeal on June 13, 2019 by phone, explaining that she wanted to appeal because she needed treatment for her COPD, chronic pneumonia, and she could not afford other insurance or treatment. Harrell Decl., Ex. 34, June 13, 2019 call TC-AMC-0000001610 at 6:38–9:50. TennCare sent her a request for additional information over a month later. *See* Harrell Decl., Ex. 35, July 31, 2019 letter (at TC-AMC-0000001490-91) (Request for additional information following June 13, 2019 appeal). Ultimately, TennCare closed her appeal in September 2019 because she did not provide additional information to establish a valid factual dispute to TennCare's satisfaction. Harrell Decl., Ex. 36, Sept. 6, 2019 notice (TC-AMC-0000001520). Moreover, TennCare, as a matter of policy, always sends a request for additional information to individuals when they appeal a denial for not "grouping" in a particular category. Harrell Decl., Ex. 16, TennCare Dep. Leffard Excerpts at 195:19–196:2 ("[T]hat is something that we would VFD AI."). Thus, in the Guytons' cases, TennCare did not recognize the appeal as a valid factual dispute when they alleged that TennCare had changed Patrick's eligibility when none of his circumstances had changed, and instead sent another request for information. Guyton Decl. ¶¶ 18, 24–25.

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: Disputed. The NOD speaks for itself. It directs individuals to access an online appeal form. Then it states: "If you write your appeal on plain paper, **be sure you include** . . .

- The reason why you want to appeal – tell us as many facts as you can
- Any proof that shows why you think we made a mistake"

New Hagan Decl. Ex. 3 at TC-AMC-0000662871 (NOD Template) (emphasis in original).

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

Response: Undisputed for purposes of summary judgment only.

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, ECF 213 at 1–2 (June 9, 2022).

Response: Undisputed, but incomplete. The full paragraph reads:

> 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. You don't have a right to fair hearing just because you don't like this decision or think it will cause problems for you.

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

Response: Undisputed for purposes of summary judgment motion only. Additionally, all NODs still contain the sentence "You don't have a right to fair hearing just because you don't

like this decision or think it will cause problems for you." *See* ECF 213 at 2; New Hagan Decl., Ex. 3 (NOD Template) at TC-AMC-0000662871.

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." ECF 213 at 2.

Response: Undisputed, but incomplete. As reflected in PRSUMF ¶ 91, notwithstanding the language of the current notice, the Defendant's representations to the Court, and the text of the TennCare regulation, TennCare still requires enrollees to allege a "factual mistake" in order to establish a valid factual dispute. Thus, the revision of the notice to remove the language requiring a "mistake of fact" makes it a less accurate statement of the standard an enrollee must meet in order to gain a hearing. Moreover, all NODs still contain the sentence "You don't have a right to fair hearing just because you don't like this decision or think it will cause problems for you." *See* ECF 213 at 2; New Hagan Decl., Ex. 3 (NOD Template) at TC-AMC-0000662871; ECF 311-3 at TC-AMC-0000662859 (stating "Do you think we made a mistake? If so, you can file an appeal. . . . **Keep reading this letter to find out how to appeal if you think we made a mistake.**" (emphasis in original)).

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

Response: Undisputed for purposes of summary judgment motion only. *See* PRSUMF ¶¶ 91, 92, 97.

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. ECF 63 at ¶ 71(f); ECF 63-7 (VFD AI Notice).

Response: Undisputed for purposes of summary judgment only. Plaintiffs note for clarity that the citation for the VFD AI Notice should be ECF 63-11, and that TennCare requires the additional information to be provided in writing. *See* ECF 63-11 at 3 ("[Y]ou **MUST** tell us in writing."); Harrell Decl., Ex. 30, TC-AMC-0000007728 8-30-19-[redacted].mp3 at 1:37–2:32 (T.L.T. calling the Appeals Clerk's office to confirm that information must be sent in writing).

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

Response: Undisputed, but incomplete. TennCare will also close appeals for no valid factual dispute when a request for additional information is not returned. Harrell Decl., Ex. 16, TennCare Dep. Leffard Excerpts at 136:4–9.

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. ECF 63 ¶ 71(h); Ex. L to May 29, 2020 Hagan Decl., ECF 63-12 (VFD Closure Notice).

Response: Disputed in part. It is undisputed that the cited notice refers the appellant to petition to Chancery Court if they disagree with TennCare's decision. However, Defendant's description implies that its notice closing an appeal for no valid factual dispute provides the appellant with instructions on how to petition the Chancery Court (e.g., "how [appellants] can petition for review"). The cited exhibit notice does not support the asserted fact, stating only, "Do you disagree with our decision that you can't get a fair hearing? You can file a petition for review in the Davidson County Chancery Court," without any instruction as to how to file such a petition. *See* ECF 63 ¶ 71(h); Ex. L to May 29, 2020 Hagan Decl., ECF 63-12 (VFD Closure Notice).

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: Disputed. Ms. Hagan provides no facts to support her conclusory assertion that VFD dismissals occur where there is no relief that an administrative judge could order that would resolve the appeal favorably for the appellant. Undisputed facts are to the contrary. For example, TennCare dismisses appeals for failure to present a valid factual dispute when appellants allege that the reason for their failure to provide requested information was that they never received notice. Br. 13 (rejecting Plaintiffs' claim that "*unsworn* statements alleging nonreceipt are enough to rebut the presumption that notice was effective, or at least require a hearing" (emphasis in original)). However, if the appellant were able to prove the allegation at a hearing, the administrative judge could order their reinstatement, and TennCare would be required to take corrective action pursuant to such order. 42 C.F.R. § 431.246.

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

Response: Disputed. The partial data cited states that 1,405 appeals were dismissed for lack of a valid factual dispute during periods totaling 20 months. Between March 19, 2019 and May 20, 2020, TennCare dismissed 776 appeals, or slightly less than 1% of the total of 80,855 appeals filed during that period. ECF 63 ¶ 71(i). The rate of such dismissals increased to 7.8% during the first six months of 2023, with TennCare dismissing 629 of the 8,089 appeals filed during that period. *See* New Hagan Decl. ¶ 42. Other data disclosed by the Defendant in response to discovery requests record the dismissal of 3,683 appeals based on the valid factual dispute policy during the period between March 19, 2019 and October 31, 2022. Harrell Decl., Ex. 58, 2023 07

17 All Timely Medicaid and Termination Appeals VFD.pdf (summarizing data from TC-AMC-0000252538, -39, -40).

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. ECF 63 at ¶ 72.

Response: Undisputed.

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. ECF 63 at ¶ 72.

Response: Undisputed for purposes of summary judgment only.

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: Disputed. TennCare's policies and procedures for renewal—and the entire program more generally—create barriers for and impede the access of individuals with disabilities. Harrell Decl., Ex. 37, Expert Report of Dr. Peter Blanck, Ph.D., J.D. ("Blank Report") at 24–70. Frontline staff at the TennCare Connect call center, the individuals most likely to first interface with individuals with disabilities, are not adequately trained and do not understand their responsibilities under the ADA. *See id.* at 49–55; New Hagan Decl. Ex. 2 at TC-AMC-0000663526 (Notice Control Document – Special Help Attachment) (listing TennCare Connect number under prompt, "Do you have questions or need help with TennCare? Or, do you need help because you have a health, mental health, learning problem or disability?"). The process for requesting and ultimately receiving assistance is overlapping and confused, and the various groups involved do not understand one another's roles. Harrell Decl., Ex. 37, Blank Report at 58–68. DHS's role is

limited to providing an internet connection and devices to access the online portal, upload paperwork, or call the TennCare Connect call center, the only entity that can answer substantive questions. PRSUMF ¶ 110. The assistance AAADs provide in practice is disputed by the parties. *Compare* New Hagan Decl. ¶ 7(c), *with* PRSUMF ¶ 111.

Further, TennCare has no valid system for collecting and tracking disability-related information about enrollees, meaning that when an enrollee contacts TennCare, they are likely to interact with someone who knows nothing about their disability-related needs, including the need for reasonable accommodation. Harrell Decl., Ex. 37, Blank Report at 68–70; *see, e.g.*, Harrell Decl., Ex. 4, TennCare Dep. Hagan Excerpts 18:25–19:15 (testifying that TennCare does not track data in the backend TEDS field "has a disability that will require accommodation"), 21:17–22:7 ("type of accommodation"); Harrell Decl., Ex. 8, Brooks Dep. Excerpts 158:22–159:16 (testifying that there is no tracking of individual's specific disability in TEDS); Harrell Decl., Ex. 37, Blanck Report at 11–14, 73–75. Instead, only Talley Olson, the sole employee of TennCare's Office of Civil Rights Compliance, maintains information about certain requests for assistance and their outcomes in her confidential case files. *Id.* at 65–68; *see* Harrell Decl., Ex. 38, Olson Dep. Excerpts 163:3-164:4. Because an individual's past interactions with TennCare are not tracked by anyone other than Ms. Olson—including any requests for or grants of reasonable accommodation—a person must request needed assistance each and every time they interact with the TennCare system. Harrell Decl., Ex. 37, Blanck Report at 13–15, 68–70; *see* Harrell Decl., Ex. 38, Olson Dep. 166:17–20 ("So TennCare on their own – or AHS [which runs the TennCare Connect call center] certainly would have probably no knowledge of members who receive reasonable accommodations, probably.").

Furthermore, TennCare's policies and procedures limit access by requiring individuals with disabilities to rely on family members and friends to navigate the program. *See* Harrell Decl., Ex. 37, Blanck Report at 16–18, 47 (describing Plaintiffs who had to rely on family members and friends to help navigate the program), Harrell Decl., Ex. 42, TNCSA Dep Whitfield Excerpts at 104:3–22. But this has "serious practical limitations," informal help is not always available, individuals may be hesitant to ask for assistance with particularly complex or technical tasks, and friends and family may not have the expertise, time, willingness or availability to provide necessary help. *See* Harrell Decl., Ex. 37, Blanck Report at 16–18; Pls.' Resps. & Objs. To Def.'s First Set of Interrogs. And Requests for Produc. To All Pls.' ("Pls.' R&Os"), 6–7 (Dec. 22, 2022), Ex. F to Def. SUMF (ECF 310-5) (describing how next friends of Plaintiffs Hill, S.L.C., and Barnes had difficulty understanding and navigating TennCare program on their behalf).

TennCare also lacks policies and procedures related to assessment, oversight, and monitoring of its program to ensure access. TennCare "does not funnel and share data and other information in a coordinated way that can be aggregated and analyzed by TennCare." Harrell Decl., Ex. 37, Blanck Report at 72. OCRC does not monitor the prevalence of disabilities among the TennCare population, nor assess the potential need for accommodations among TennCare enrollees. *Id.* OCRC does not bave access to TEDS to monitor or evaluate issues related to redeterminations. *Id.* Nor does OCRC take steps to evaluate whether issues raised on behalf of individuals might be systematically impacting others. *Id.* at 73. The disputes described in PRSUMF ¶¶ 110–12, 114, 127 are also incorporated herein.

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: Disputed. The disputes described in PRSUMF ¶¶ 106, 110–12, 114, 127, 129, 130, 133, 135, 136, 138, 140–41 and Harrell Decl., Ex. 37, Blanck Report at 24–76, are incorporated herein.

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

Response: Undisputed.

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

Response: Undisputed.

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: Disputed in part. Undisputed that individuals may visit DHS county offices, but disputed as to the extent of "in-person assistance" or "help" provided there. DHS assistance is limited to providing access to and help using computer kiosks to gain online access to TennCare Connect; access to and help with phones to call the TennCare Connect call center; and access to and help with scanning and faxing documents to TennCare. Harrell Decl., Ex. 39, DHS Dep. Bryson Excerpts 13:4–14:16, 18:20–20:15, 36:20–37:4; *see also* Harrell Decl., Ex. 40, Hagan Dep. Ex. 17, TennCare Renewal Website ("In-person you can visit the Department of Human Services (DHS) in your county to submit your documents or use the kiosk to complete your renewal online . . . ."). Plaintiffs dispute any implication that DHS provides any individual casework assistance or advice related to TennCare eligibility. *See* Harrell Decl., Ex. 39, DHS Dep. Bryson Excerpts at 132:15–134:17 (does not provide individual casework). DHS employees are not

eligibility specialists. Harrell Decl. Ex. 2, Hagan Dep. 217:7–8; Harrell Decl. Ex. 39, DHS Dep. Bryson 36:20-39:24, 125:15–126:9.

DHS staff do not have access to TEDS and merely refer individuals to TennCare for specific questions about their eligibility. Harrell Decl. Ex. 39, DHS Dep. Bryson 43:21–44:13; Harrell Decl., Ex. 2, Hagan Dep. Excerpts 41:1–5. Plaintiffs also dispute any implication that DHS provides reasonable accommodations as may be required by individuals with disabilities to be able to successfully establish their TennCare eligibility. *See* Harrell Decl., Ex. 39, DHS Dep. Bryson Excerpts at 113:20–114:8 (DHS would refer requests for accommodation to TennCare); 34:18–35:14 (DHS does not provide help gathering documents); 35:15–36:1 (DHS does not make home visits to assist a person who is homebound due to disabilities); 115:16–25 (DHS does not grant extensions of time to complete eligibility paperwork). This limited assistance is insufficient to meet the needs of people with disabilities, who may have difficulty waiting on the phone to a call center, processing and responding to information provided over the phone; understanding information provided to them and then taking the appropriate actions, or trouble physically completing such tasks. Harrell Decl., Ex. 37, Blanck Report at 15. Thus, "help" is not available to many individuals with disabilities at the DHS offices.

For example, after being unable on her own to successfully reapply for TennCare for her son J.Z., Plaintiff D.R. went to the Shelby County DHS office to seek in-person assistance. ECF 202 ¶ 424. She explained that she had been trying to get TennCare coverage for her son who was sick and that she was unable to do so without help. *Id.* She explained she needed someone to please help her because she was anxious about it and felt like she was having an anxiety/panic attack because she felt like no one would help her. *Id.* When told that DHS did not handle TennCare anymore and could not help her, she became emotionally distraught. Instead of offering assistance,

TDHS staff told her to calm down or she would be removed. *Id.* D.R. left the office without receiving any help or being told where she could get the type of in-person assistance that she needed. *Id.*

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: Disputed in part. Plaintiffs do not dispute for purposes of summary judgment that AAADs provide some in-person assistance at home to individuals applying for or receiving long term services and supports (LTSS) through the TennCare CHOICES program. But as of April 2023, TennCare did not report or track any in-person assistance performed by AAAD for any individuals other than CHOICES enrollees, Harrell Decl., Ex. 41, TennCare Dep. Evans Excerpts 33:8–34:9, and the agency has not allocated additional funding to the AAADs to fulfill those duties post-April 2023. *Id.* at 45:23–46:7. Moreover, it is disputed that all "[e]nrollees" can access AAAD assistance. CHOICES enrollees comprise only about 31,000 of TennCare's total enrollee population of more than 1.7 million individuals. ECF 63 ¶¶ 2, 6 n.6, 56 (CHOICES enrollment figures are counted in the Institutional Medicaid/HCBS category); SUMF ¶ 3. Further disputed as to the scope of assistance provided by the AAADs. The ability of AAAD staff to provide advice and knowledgeable eligibility assistance even to CHOICES enrollees is limited, as AAAD does not have access to TEDS. Harrell Decl., Ex. 2, Hagan Dep. Excerpts 41:8-13.

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: Disputed in part. Undisputed that TennCare can make referrals to the AAAD on behalf of enrollees, at least with respect to completing PAEs for CHOICES applications and

renewals. Plaintiffs dispute that, in practice, enrollees are in fact referred to AAADs to request help with renewals. *See* PADF ¶ 74 (At least until April 17, 2023, Reference guide for TennCare Connect call center did not list AAADs as providing in-person assistance with renewals.) Harrell Decl., Ex. 42, TNCSA Dep. Whitfield Excerpts 81:10–83:11. Neither TennCare's main website for renewals nor its most recent renewal packet informs enrollees that AAADs are available for in-person assistance. PADF ¶ 73 Further, Plaintiffs dispute the suggestion that the process of connecting enrollees to in-person assistance through the AAADs is adequate to effectively accommodate the needs of enrollees who, due to their disabilities, require such assistance in order to complete the renewal process and maintain their eligibility. *See* Harrell Decl., Ex. 37, Blanck Report at 11–12, 15, 28–34, 39–42.

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. ECF 63 at ¶ 65.

Response: Disputed in part. Undisputed as to the contractual language. Plaintiffs dispute that AAADs have performed in-person assistance for renewals in a meaningful way. As of April 2023, TennCare did not report or track any in-person assistance performed by AAADs besides assistance offered as part of the CHOICES program, Harrell Decl., Ex. 42, TennCare Dep. Evans Excerpts 33:8–34:9, and the agency has not allocated additional funding to the AAADs to fulfill those duties post-April 2023. *Id.* at 45:23–46:7. *See* PRSUMF ¶¶ 111, 112.

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

Response: Disputed in part. Undisputed that the renewal packets state, "What if you need help in person with your Renewal Packet? Your local Department of Human Services can

help you. . . . If you're getting care at a local community mental health center, they can also help you. . . ." *See* Holland Decl. Ex. 4 (Renewal Packet) at 11. Disputed that in-person assistance is in fact "60nxiety60n[e]." *See* PRSUMF ¶¶ 110–111.

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. ECF 63 at ¶¶ 170–72.

Response: Disputed. The contention is overbroad and not fully supported by the cited paragraphs. As noted in paragraph 171 of the cited declaration, the AAAD referral for Mr. Monroe was made for the specific purposes of completing a PAE. ECF 63 ¶ 171 (". . . a referral had been made to the AAAD to contact Mr. Monroe regarding his PAE."); *see also id.* ¶ 65 ("[TennCare's contracts with each AAAD] provide that for individuals whose eligibility is ending or for individuals who are going through renewal, the AAAD will assist in assessing eligibility for the CHOICES and ECF CHOICES programs."). Undisputed that an AAAD representative went to Mr. Monroe's home to perform a PAE, including an interview. There is no support for the assertion that TennCare made the AAAD referral in response to Mr. Monroe's disability-related request, or that the AAAD representative was tasked with helping or in fact did help Mr. Monroe with the renewal process beyond completing a PAE. *See* Harrell Decl., Ex. 43, TC-AMC-00003718 (e-mail from TennCare to TJC concerning Mr. Monroe's PAE).

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

Response: Undisputed for purposes of summary judgment only with understanding that "submit" means the actual act of sending renewal packets for disabled enrollees, not substantive assistance.

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: Disputed in part. Plaintiffs do not dispute that some enrollees in the LTSS population will receive some assistance with the process. Plaintiffs dispute the implication that an enrollee in that population is assured of receiving such assistance, or that such assistance will be effective in enabling eligible enrollees to retain their TennCare coverage. *See, e.g.*, Guyton Decl. ¶¶ 16-17, 20, 23–25, 28, 34; PRSUMF ¶ 22(g).

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: Undisputed for purposes of summary judgment only.

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: Undisputed for purposes of summary judgment only.

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., ECF 166-1; *see also* ECF 166 at ¶ 40; New Hagan Decl. ¶ 7(h).

Response: Undisputed only that, relative to TennCare's prior redetermination process, TEDS has enabled TennCare to conduct more extensive verification of necessary information when evaluating potential enrollees by leveraging third-party databases.

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: Undisputed for purposes of summary judgment only and add for clarity that automated renewal will only work if data is correctly loaded into TEDS, and TEDS is programmed to correctly identify eligibility in all categories. *See supra* PRSUMF ¶ 22.

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: Disputed in part. Undisputed only that individuals receiving SSI are eligible for TennCare and *should* be automatically renewed. Plaintiffs dispute that, in practice, that receipt of SSI "automatically" results in a person's actual receipt of the TennCare coverage to which he is entitled. TennCare has not always reliably enrolled or maintained coverage for individuals receiving SSI. ECF 63 ¶ 35(a).

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: Disputed. For individuals who have received SSI in the past, TennCare does not reliably pre-populate the renewal packet with information reflecting that historical receipt of SSI. *See, e.g.*, Holland Decl. ¶ 10, Ex. 4 (Renewal Packet).

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: Undisputed for purposes of summary judgment only.

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: Disputed in part. Plaintiffs do not dispute that TennCare maintains a contract with TNCSA to operate the TennCare Advocacy Call Center. Harrell Decl., Ex. 42, TNCSA Dep. Whitfield Excerpts at 15:15–18. Plaintiffs dispute that TNCSA provides more than very limited help to a small percentage of enrollees attempting to navigate the renewal process. The contract includes funding for just two "mental health advocates" who provide information to individuals with mental health needs regarding available services. *Id.* at 31:9–11, 34:16–18 ("Basically, they would make the person aware that the services are available to them through TennCare."). As far as assisting any enrollees with their TennCare eligibility, TNCSA does not have access to TEDS. Hagan Dep. At 41:1–7. TNCSA provides basic information only, and if someone has questions about renewal or redetermination, TNCSA refers them to TennCare Connect. Harrell Decl. Ex. 42, TNCSA Dep Whitfield Excerpts at 101:10-25, 164:7-16. TNCSA's assistance is limited to providing information that is in the TennCare member handbook or online, helping callers who are

illiterate understand forms and, if desired, stay on the line while connecting them to the TennCare Connect call center. *Id.* at 59:521, 118:22-119:9. As for other types of accommodation, TNCSA:

- Does not grant more time for individuals to complete forms or provide documents (*id.* at 97:10-98:25);
- Does not help gather information or documents, beyond advising the enrollee to ask a family member for help (*id.* at 104:3–22);
- Does not provide in-person assistance (*id.* at 83:2–11).

TNCSA refers callers to AAADs for help applying for LTSS and for transportation, but has never referred someone to an AAAD for in-person assistance with a renewal or redetermination. *Id.* at 81:10–23. TennCare Connect has never referred an enrollee to TNCSA for help obtaining in-person assistance. *Id.* at 83:2–11.

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: Undisputed for purposes of summary judgment only.

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: Disputed. An expert analysis of TennCare's systems and methods of administration concluded that, "[T]ennCare does not have effective and appropriate systems to provide reasonable access to individuals with disabilities, including evaluating and granting requests for accommodations." Harrell Decl., Ex. 37, Blanck Rep. at 11. TennCare's system is not

adequately resourced. It relies on one individual, Ms. Olson, to respond to the requests of a TennCare population of 1.7 million people. *Id.* at 11, 70–72. It is also extremely siloed. Ms. Olson does not regularly communicate with TennCare eligibility staff. *Id.* at 72.

The system lacks internal coordination. For example, TennCare has no system for tracking individuals who may or will need accommodation of their disabilities to navigate the redetermination process. Harrell Decl., Ex. 44, Def.'s Resp. to Pltfs.' RFA 40 (referring only to complaint log maintained by Talley Olson); Harrell Decl., Ex. 2, Hagan Dep. Excerpts 240:8–20. Different components of the TennCare eligibility process do not communicate as necessary to ensure that enrollees receive reasonable accommodation of their disabilities. For example, Talley Olson, who is responsible for overseeing compliance with the A.D.A., expects Automated Health Systems (AHS), which operates the TennCare Connect call center, to grant individuals additional time as needed to meet deadlines for submitting paperwork. Harrell Decl., Ex. 38, Olson Dep. Excerpts at 61:4–62:11. But AHS does not believe that it has authority to extend more time to enrollees who need it to complete the redetermination process. Harrell Decl., Ex. 45, AHS Dep. Fields Excerpts at 157:20–158:2. Individuals who need special help are referred to DHS, but once there are likely to be referred back to TennCare Connect if they need anything more basic than assistance submitting documents. *See* PRSUMF ¶¶ 110, above. TennCare assumes that help navigating the redetermination process is available from TNCSA and the AAADs, but the assistance those entities provide is very limited in scope and in the numbers of people assisted. *See* PRSUMF ¶¶ 111, 125; *see generally* PRSUMF ¶¶ 106, 107.

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: Undisputed as to the quoted content of Dr. Blanck's testimony, but Plaintiffs dispute any suggestion that such testimony undermines Dr. Blanck's conclusions with respect to the validity or reliability of TennCare's "system," as outlined in his report. *See generally* Harrell Decl., Ex. 37, Blanck Report; PRSUMF ¶ 127.

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: Undisputed.

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: Disputed in part. It is undisputed as to the instruction itself, but Plaintiffs dispute Ms. Hagan's account of the substance of the assistance TennCare Connect representatives are able to provide. *Compare* New Hagan Decl. ¶ 9 (indicating that representatives can "explain notices to enrollees"), *with, e.g.*, Harrell Decl., Ex. 45, AHS Dep. Fields Excerpts 99:6-16 ("We do not – we would assist and maybe read [a notice] for [a caller who is cognitively disabled], but we don't generally offer advice on what the notice contents are other than specific instructions for returning some type of documentation or something like that. . . . I was just calling out the explain the notice point."). Further, Plaintiffs clarify that the sort of assistance AHS is "able to provide" is extremely limited—it primarily includes speaking loudly over the phone or reading notices to an individual—and does not encompass the needs of many individuals with disabilities. Harrell Decl.,

Ex. 37, Blanck Report at 58–61 (Identifying "gaps around critical assistance that individuals with disabilities need to navigate TennCare's system, including: in-person assistance, extra time, and someone to answer questions and explain the content of the notices."). Particularly because AHS staff are not provided adequate training on how to identify and respond to the needs of individuals with disabilities. *Id.* at 49–54, 56.

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: Disputed. The cited deposition testimony does not support the factual contention. *See* Harrell Decl., Ex. 38, Olson Dep. Excerpts 66:9–12 ("[AHS has] never sent me what would be considered a true request for reasonable accommodation. They are just mitigating measures that are already in place."). The State has not put forth evidence to establish this fact as undisputed. Moreover, the limited assistance provided by AHS, to which Ms. Olson is referring, does not meet the needs of individuals with disabilities in many cases. *See* PRSUMF ¶ 130.

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: It is undisputed that TennCare Connect representatives can read a notice aloud to callers, but representatives may not be able to offer broader explanations for notices and do not have the ability to offer notices in formats that individuals would be able to read themselves. Harrell Decl., Ex. 45, AHS Dep. Fields 95:21–96:21, 99:6–16 (testifying that requests for "conversion of documents into any alternate format, such as braille, large font, audio format, or electronic data format," must be made on a person by person basis to OCRC, and that AHS

representatives "don't generally offer advice on what the notice contents are other than specific instructions . . ."); Harrell Decl., Ex. 37, Blanck Report at 33.

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: Disputed in part. The cited deposition testimony does not fully support the factual contention. *See* Harrell Decl., Ex. 38, Olson Dep. Excerpts 67:2–10 (testifying that providing documents in an alternate format, like large print, is not a reasonable accommodation but instead a "necessary aid or service"). Ms. Olson testified that requests for documents in alternate formats are completed on an ad hoc, person-by-person basis. *Id.* at 87:6–19. Further dispute the implication that this process is not burdensome because it does not require a "special" accommodation. Requiring escalation to OCRC at all adds burden to enrollees who require alternate format notices: "frontline staff should understand how to print or enlarge a normal notice to meet large print needs." Harrell Decl., Ex. 37, Blanck Report at 50. And the burden is exacerbated because the alternate format needs to be requested anew each time. Harrell Decl., Ex. 38, Olson Dep. Excerpts 87:6–88:11.

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: Disputed. For example, as noted above in PRSUMF ¶ 133, requests for documents in alternate formats are met on an ad hoc, person-by-person basis. Harrell Decl., Ex. 38, Olson Dep. Excerpts 87:6–88:11. Further disputed that other types of assistance, such as in-person assistance, requests for more time, someone to answer questions about TennCare's

eligibility determinations are "available" to all TennCare enrollees. *See* PRSUMF ¶¶ 110–12, 125, 127, 130–31.

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

Response: Undisputed as written, but dispute the implication that this means TennCare has no ability to anticipate commonly-needed accommodations. TennCare can evaluate its population as a whole and identify commonly-needed and requested accommodations. Harrell Decl., Ex. 37, Blanck Report at 23 ("To ensure that it is able to provide access, a public program such as TennCare must understand the prevalence and nature of disability as well as related estimates of need for reasonable accommodation in the population the program serves. This understanding is necessary to provide adequate resources and appropriate procedures to meet the estimated need."), 26 (describing how system should anticipate commonly needed auxiliary services and accommodations and listing several common needs), 71 ("effective entities typically have monitoring processes to understand the needs of the population served and measure whether access is being appropriately provided to people with disabilities."). *See also id.* at 18, n 49 (citing CMS guidance regarding ensuring access to Medicaid programs). Yet TennCare does not do so. *See* Harrell Decl., Ex. 44, Def.'s Response to Pltfs.' RFA 40; Harrell Decl., Ex. 37, Blanck Report at 23-24, 71.

Further dispute the implication that TennCare's system need not track past assistance or offer it again in the future. A particular individual's need for assistance with respecting to navigating TennCare's renewal process will often be ongoing. Harrell Decl., Ex. 37, Blanck Report at 32. Moreover, TennCare has access to information regarding Medicaid enrollees that give it

insight regarding the particular accommodations. Harrell Decl., Ex. 2, Hagan Dep. Excerpts, 31:24–32:3.

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: Disputed in part. Undisputed that following a corrective action plan, AHS is now instructed to escalate requests to Ms. Olson. Disputed as to other contractors. "There is no written policy regarding how DHS, TNSCA, or the AAADs should escalate requests for accommodations to TennCare." Harrell Decl., Ex. 37, Blanck Report at 61. Plaintiffs incorporate the disputes in PRSUMF ¶ 127, 130–32 regarding AHS's ability to screen for and identify for those requests. Further, as to Ms. Olson, the cited paragraph does not fully support the factual contention because it does not speak to the process that Ms. Olson follows upon receiving an escalated request. *See* New Hagan Decl. ¶ 9. And it is disputed that Ms. Olson follows the stated process. In Dr. Blanck's expert opinion, Ms. Olson lacks any policies or guidelines that govern her response to requests. There are "no policies outlining timelines for review of accommodation requests . . . no written policies discussing who has authority to grant or deny requests or outline criteria for decision making in response to accommodation requests." Harrell Decl., Ex. 37, Blanck Report at 65. Plaintiffs do not dispute that Ms. Olson regularly asks for more information but add that these requests are often duplicative of information already received and impose additional procedural burdens on individuals with disabilities. *See id.* at 63–65. Further, AHS testified that there was no process in place with the TennCare Office of Civil Rights Compliance for processing reasonable

accommodations prior to January 2022. Harrell Decl., Ex. 45, AHS Dep. Fields Excerpts 119:9–22, Harrell Decl., Ex. 46, AHS Dep. Fields Ex. 4.

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: It is undisputed that TennCare has multiple avenues to receive a reasonable accommodation request. It is disputed that each of these avenues are navigable, ultimately reach OCRC, or that TennCare's reasonable accommodation system is valid and reliable overall. *See* PRSUMF ¶¶ 127, 136, 138.

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: It is undisputed that TennCare has multiple ways or "doors" to receive a reasonable accommodation request. It is disputed that each of these ways are navigable, that all requests reach OCRC, or that TennCare's reasonable accommodation system is valid and reliable overall. *See* PRSUMF ¶¶ 127, 136.

Since 2015, TennCare has never granted a true reasonable accommodation request for redetermination. *See* SUMF ¶ 140, Harrell Decl., Ex. 38, Olson Dep. At 17:14–17, 75:24–76:4. Talley Olson, who is in charge of TennCare's ADA Compliance, does not have access to TEDS and cannot access the enrollee's casefile to see whether a TennCare Connect call center employee noted any assistance. *Id.* at 204:12-18. TennCare Connect, likewise, does not have access to Ms. Olson's Complaint log or case files. *See id.* at 163:23–164:19. Before a Corrective Action Plan in January 2022, TennCare Connect's call center vendor had "no process in place" around reasonable accommodations, Harrell Decl. Ex. 45, AHS Dep. Fields Excerpts 119:9–22, and did not know that ADA compliance was part of its responsibilities until a corrective action plan was instituted in

January 2022. *Id.* at 144:2–145:3. With respect to other contractors, "[t]here is no written policy regarding how DHS, TNSCA, or the AAADs should escalate requests for accommodations to TennCare. As a result, it is likely that some individual requests do not make their way to OCRC." Harrell Decl., Ex. 37, Blanck Report at 61. According to Dr. Blanck's expert testimony, "the result of this internal lack of coordination is that a seemingly small number of requests for assistance with eligibility procedures make their way to Ms. Olson in the OCRC." *Id.* at 62.

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: Disputed in part. It is undisputed that enrollees may request assistance through TennCare Connect, communications through an MCO, by e-mail, or by filling out a form provided by TennCare. It is disputed that the form is provided expressly for the purpose of requesting assistance or a reasonable accommodation; TennCare uses discrimination complaint forms for reasonable accommodation requests and requests for assistance. *See* Harrell Decl., Ex. 38, Olson Dep. Excerpts 71:21–24, Harrell Decl., Ex. 47, Olson Dep. Ex. 6 (TC-AMC-0000263579); Harrell Decl., Ex. 48, AHS Dep Fields Ex. 10 (TC-AMC-0000264547); Harrell Decl., Ex. 37, Blanck Report at 63.

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: It is undisputed that Ms. Olson testified that she has never had a request for a "true reasonable accommodation" but disputed that the explanation above constitutes the full or only basis for such testimony. TennCare does not have a valid and reliable reasonable accommodation system, *see* PRSUMF ¶ 127, and the TennCare Connect call center contractor charged with providing some assistance was unaware that compliance with the Americans with Disabilities Act, which include reasonable accommodation obligations, were part of its responsibilities until well after the start of its contract. Harrell Decl. Ex. 45, AHS Dep. Fields Excerpts at 144:2–145:3. Furthermore, the record shows that Ms. Olson does not reliably track requested accommodations. First, Ms. Olson imposes additional paperwork burdens on individuals before accepting a request for accommodations on behalf of a person with a disability. Harrell Decl., Ex. 37, Blanck Rep. at 63–64. For instance, one notation on Ms. Olson's log indicates the individual "did not report having a disability or 73nxiety73nation [sic]," and that she was sending a missing information letter, even though the individual "reported needing TC [TennCare] for one year because legally blind, has stomach issues, and 73nxiety [sic]." *Id.* at 64–65 (citing TC-AMC-245007). Ms. Olson's paperwork requests often ignore the very disability the individual is asking for accommodation with. For instance, in response to to a request from an individual having trouble hearing TennCare Connect over the phone, Ms. Olson called and left a voicemail. *Id.* at 73 (citing TC-AMC-245007 (row 429)). In Mr. Monroe's case, although TennCare had been alerted that Mr. Monroe had difficulty collecting and responding to paperwork, Ms. Olson sent a request for more information requiring that he provide a *written* response and complete more paperwork. Harrell Decl., Ex. 49, TC-AMC-0000003707 to -08. She did not consider whether he was able to collect and provide the required documents listed because "we were not at the level of him needing a reasonable accommodation." Harrell Decl., Ex. 38, Olson Dep. Excerpts at 220:1-6.

Moreover, Ms. Olson does not reliably track the requests she receives. Ms. Olson's logs show "no consistent criteria for inclusion." Harrell Decl., Ex. 37, Blanck Report at 62. For instance, the written request for accommodation submitted on behalf of Mr. Monroe does not appear in Ms. Olson's complaint log. Harrell Decl., Ex. 50, TC-AMC-000003465 to –66 (Monroe accommodation request letter); Blanck Rep. at 68. This is because, although Ms. Olson acknowledged that "The Tennessee Justice Center told us you may want to ask us for reasonable accommodation," Harrell Decl. Ex. 49, TC-AMC-0000003707 to –08, Ms. Olson believed "he did not actually need an accommodation." Harrell Decl., Ex. 38, Olson Dep Excerpts 215:3–20.

Thus, in the expert opinion of Dr. Blanck, the "small number" of requests acknowledged by Ms. Olson is likely due to the "internal lack of coordination," the burdens individuals face making their requests, and Ms. Olson's inconsistent and unreliable documentation. Harrell Decl. Ex., 37, Blanck Report at 62. Furthermore, "[t]he absence of effective policies provides individual decision makers broad discretion and creates substantial risk of unreliable and inconsistent responses to requests for accommodation." *Id.* at 65–66.

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: Disputed. Defendant's description of the cited transcript passage is inaccurate and does not support the asserted fact. Defendant has failed to demonstrate absence of a genuine dispute. The transcript states: 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." *See* Harrell Decl., Ex. 51, Blanck Dep. Excerpts 81:18–82:9 (ECF 310-3 at 10–11). Moreover, there is no reference to "meaningful access" in Dr. Blanck's testimony. The only use of the word "meaningful" appears in a question on page 34 where counsel is quoting a description of Dr. Blanck's past research, which "My research examines organizational systems, policies, and practices related to meaningful access to and 'methods of administration' of public programs." Harrell Decl., Ex. 51, Blanck Dep. Excerpts at 34:4–10.

Further, Plaintiffs have identified several individuals who requested accommodations and who experienced gaps in coverage and other significant burdens accessing the program. For instance, D.R. sought in-person assistance at the Shelby County DHS office. ECF 202 ¶ 424. She explained that she had been trying to get TennCare coverage for her son who was sick and that she was unable to do so without help. *Id.* She left without receiving the assistance she needed, leaving her son uninsured. *Id.* Plaintiff Walker, who suffers from significant cognitive disabilities, did not respond to a pre-term questionnaire sent by TennCare. ECF 202 ¶¶ 464-67. Mr. Walker did not understand the notice and could not respond. *Id.* Mr. Walker's coverage ended, leaving the family to pay for essential medications out of pocket. Because the family was unable to pay, Mr. Walker's health deteriorated. *Id.* ¶ 471. Mr. Walker's sister and friends called on his behalf to file an appeal, explaining that Mr. Walker had significant disabilities that prevented him from responding to the notice to the form. And requested that TennCare make exceptions to the timelines for processing appeal. Harrell Decl., Ex. 52, TC-AMC-0000008234 at 5:40–7:09 (asking to "speed along the process"); Harrell Decl., Ex. 53, TC-AMC-0000008235. Yet, the TennCare stated, "There's not

really anything we can do right now," because the appeal was only 23 days into the 90-day timeline." TC-AMC-0000008235 at 12:25–53, 13:23–14:06, 15:23–32. The request for an exception to the timelines was never raised to a supervisor or routed to the OCRC to determine whether an accommodation to the typical appeal process could be offered given that Mr. Walker's disability had prevented him from completing the form initially, and he now had urgent medical needs. Harrell Decl., Ex. 37, Blanck Report at 48–49. TennCare both failed to offer assistance or accommodations necessary to enable Mr. Walker to comply with the preterm questionnaire requirement and compounded the harm by refusing to consider exceptions to their policies regarding continuing benefits. *Id.* Finally, Mr. Monroe required the assistance of counsel to access an accommodation seeking extra time to complete necessary forms and maintain his coverage. *See* ECF 202 ¶ 368; Harrell Decl., Ex. 37, Blanck Report at 66–68. Nonetheless, TennCare terminated his MSP coverage, and as a result, Mr. Monroe was unable pay his rent and feared he would be evicted. ECF 202 ¶ 373.

While it is true that all Disability Subclass representatives or declarants currently have some form of Medicaid coverage the gaps in coverage and additional burdens imposed on individuals with disabilities in order to maintain coverage deny those individuals access to TennCare. *See* Harrell Decl., Ex. 37, Blanck Rep. at 32 ("Requiring such effort thwarts 18 access and raises unnecessary and formidable barriers to access").

Further, Plaintiffs dispute that TennCare has a valid and reliable accommodation system, *see* PRSUMF ¶ 127. Notably, TennCare imposes burdens on enrollees by not effectively offering assistance or reaching out at a later redetermination even when accommodations have been necessary in the past. *See* Harrell Decl., Ex. 37, Blanck Report at 49, 56; Harrell Decl., Ex. 38,

Olson Dep. Excerpts 166:12–167:7 no need to do that."). Thus all enrollees facing redetermination must navigate a cumbersome process each time they go through redetermination.

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. ECF 63 ¶ 41.

Response: Disputed in part. It is undisputed that in March 2020, TennCare suspended its annual renewal processes and halted some disenrollments except for a small set of acceptable reasons and halted the renewal process as a result of a declared public health emergency. Plaintiffs dispute that TennCare did not disenroll individuals improperly or wrongfully on or after March 2020. *See* ECF 63 at ¶ 25(e); ECF 142-15 (showing 3,605 total erroneous terminations); ECF 145 ¶ 7 (2d Noe Decl. Nov. 8, 2021).

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: Undisputed.

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: Disputed in part. It is undisputed for purposes of summary judgment only as to the fact that TennCare has worked with CMS to comply with applicable federal statutes and regulations as part of restarting renewals. Plaintiffs dispute that TennCare has operated its renewal processes in a manner that reduced the number of individuals terminated from TennCare for

procedural reasons given that TennCare prioritized up to 30,000 individuals in "conversion status" for renewals. *See* PRSUMF ¶ 22(a).

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

Response: It is undisputed that CMS has provided temporary authority for waivers if triggering conditions are met. *See, e.g.*, Harrell Decl., Ex. 57, Ltr to Director Stephen Smith, Centers for Medicare and Medicaid Services, June 14, 2023, available at https://www.tn.gov/content/dam/tn/tenncare/documents/FairHearingTimeframeExtension.pdf. Plaintiffs do not dispute State's assertion that TennCare has sought and obtained approval for nine Section 1902(e)(14)(A) waivers from CMS.

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: Undisputed, but noting that these waivers are temporary.

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: Undisputed for purposes of summary judgment only.

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: Disputed. First, the cited paragraph from Ms. Hagan's declaration does not support the purported fact asserted by the State. Ms. Hagan's declaration states that she and others at TennCare "have been informed that, at this point, Tennessee is one of only 16 states to not be placed under a mitigation plan by CMS as a result of deficiencies in the state's eligibility process." New Hagan Decl. ¶ 6. Nothing in Ms. Hagan's declaration shows the matter asserted to be true. Second, the material cited by the State cannot be presented in a form that would be admissible in evidence. *See* Fed. R. Civ. P. 56(c)(1)(B), (c)(2). "An affidavit or declaration used to support or oppose a motion must be made on personal knowledge, set out facts that would be admissible in evidence, and show that the affiant or declarant is competent to testify on the matters stated." Fed. R. Civ. P. 56(c)(4). Ms. Hagan does not purport to have personal knowledge regarding CMS's decisions to place or not place states other than Tennessee under mitigation plans, and Ms. Hagan may not testify to matters beyond her personal knowledge, *see* Fed. R. Evid. 602. Moreover, the State may not offer through Ms. Hagan the out-of-court statements of others for the truth of tbe matters asserted in such statements, *see* Fed. R. Evid. 801, 802. Accordingly, the State fails to establish the absence of genuine dispute over the scope and extent of any CMS mitigation plans for states other than Tennessee.

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: Undisputed for purposes of summary judgment only.

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: Undisputed for purposes of summary judgment only.

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: Undisputed for purposes of summary judgment only.

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: Disputed in part. Undisputed for purposes of summary judgment only that TennCare provides MCOs with "an identification of those enrollees actively receiving services through a Community Mental Health Center." *See* New Hagan Decl. ¶ 8(a). Disputed that the cited paragraph from Ms. Hagan's Declaration supports the inference that providing enrollee information to MCOs somehow enables CMHCs to "provide outreach and assistance to those individuals who likely have a cognitive or mental impairment and are going through renewal." The State does not explain how provision of information to one organization enables another to provide the described outreach.

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: Disputed. The material cited by the State cannot be presented in a form that would be admissible in evidence. *See* Fed. R. Civ. P. 56(c)(1)(B), (c)(2). "An affidavit or declaration used to support or oppose a motion must be made on personal knowledge, set out facts that would be admissible in evidence, and show that the affiant or declarant is competent to testify on the matters stated." Fed. R. Civ. P. 56(c)(4). Ms. Hagan does not purport to have personal knowledge regarding the internal motivations and incentives of third-party CMHCs to make sure that treated individuals maintain TennCare coverage, and Ms. Hagan may not testify to matters beyond her personal knowledge, *see* Fed. R. Evid. 602. Accordingly, the State fails to establish the absence of a genuine dispute over the incentives and motivations of third-party CMHCs.

154. In its August 9, 2022 memorandum opinion and order certifying the class, ECF 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, ECF 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: Disputed in part. Undisputed that the Court certified the foregoing fifteen class issues, in addition to the various permutations of those issues noted by Defendant in paragraph 155. However, the Court also identified twelve (12) additional class issues, as Plaintiffs noted in the parties' November 1, 2022 Proposed Amended Case Management Order, ECF 249 at –6. Specifically, Plaintiffs assert that the following issues are also in dispute:

a. whether Plaintiffs must show they relied upon NODs to their detriment in order to obtain class-wide relief and, if so, whether Plaintiffs relied on the NODs to their detriment (*see* ECF 234 at 17 n.8);

b. whether "requiring reinstatement for all class members until they are given adequate pre-termination notice would be the appropriate injunctive remedy" (ECF 234 at 17 n.9);

c. whether the State is likely to repeat its past misidentification of SSI eligibility in future redeterminations and, if so, whether such misidentification is likely to result in wrongful terminations class members' coverage (*see* ECF 234 at 22–24);

d. whether the State is likely to repeat its past income miscalculations and, if so, whether such miscalculations are likely to result in wrongful terminations class members' coverage (*see* ECF 234 at 27);

e. whether any class member "who should have received a good cause exception … lacks coverage" (ECF 234 at 29);

f. whether any class member lost coverage as a result of the NODs' "allusion to the [State's] valid factual dispute policy" (ECF 234 at 30);

g. whether the difference in language concerning institutional-care eligibility in different version of the State's preterm notice questionnaire violates/violated 42 U.S.C. § 1396a(a)(3) and/or the Due Process Clause and, if so, whether any class members lost coverage based on the different language (*see* ECF 234 at 32);

h. whether the State's deliberate omission of members' income calculations in NODs concerning disenrollment for excess income violates/violated 42 U.S.C. § 1396a(a)(3) and/or the Due Process Clause and, if so, whether any class members lost coverage as a result (*see* ECF 234 at 34 & n.25);

i. whether any class members lost coverage as a result of the NODs' citation to the 95-page compendium of TennCare regulations (*see* ECF 234 at 34);

j. whether any class members whose timely appeals took longer than 90 days were denied COB (*see* ECF 234 at 36–37);

k. whether any class members whose timely appeals contests the State's application of facts to law or policy were denied a hearing based on the State's valid factual dispute policy (*see* ECF 234 at 37–38); and

l. whether the State in practice refuses to "consider disputes over applications of facts to the law" (*see* ECF 234 at 39).

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." ECF 234 at 14.

Response: Undisputed.

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: Undisputed.

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: Undisputed.

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: Undisputed that S.F.A., Barnes, Caudill, and Walker should be auto-renewed with no need to submit anything to TennCare. Disputed as to any suggestion that such a result is assured. *See* PRSUMF ¶ 22.

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

Response: Undisputed.

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: Undisputed except for any implication that enrollment in a category that *could* be auto-renewed assures that result.

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: Disputed. Plaintiffs incorporate the disputes identified in PRSUMF ¶ 141 here.

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: Undisputed.

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: Undisputed.

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: Undisputed.

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

Response: Disputed as to the phrase "undisclosed." Plaintiffs' interrogatory responses addressing "every reasonable accommodation he or she requires to apply for or maintain through

redetermination" utilized the phrase "including but not limited to," before identifying several specific accommodations. Plaintiffs are not withholding information about their needs, but rather utilized the phrase "including but not limited to" to indicate there may be other forms of assistance needed to navigate TennCare's renewal process depending, in part, on the possibility that their medical conditions and needs may evolve to require additional accommodations. And to hold open the possibility that"additional accommodations wi"l be necessary to respond to particular requests for verification or information that TennCare may send during the renewal process. Otherwise undisputed.

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

Response: Undisputed that Plaintiff Barnes has not formally stated to a TennCare representative that she requested a reasonable accommodation (or equivalent phrase).

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

Response: Undisputed.

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

Response: Disputed in part. Undisputed that Ms. Surrett received "an" NOD, but Ms. Hagan's cited assertion it was a "July 22, 2019 notice informing her that her Medicaid was ending on August 31, 2019" is not confirmed by the recording of the call. ECF 63 ¶ 113. *Cf.* Harrell Decl., Ex. 12, TC-AMC-0000000970 at 3:19–3:4

On the call, Ms. Surrett explicitly stated that she could not confirm the date of the letter she received, because she did not have it with her, because her mother, Ms. Barnes "had a fall, an

emergency." *Id.* at 3:19–3:40. On June 11, 2019, TennCare had sent a Notice of Decision that stated that Ms. Barnes remained *eligible* for TennCare Medicaid, but was denied QMB coverage. ECF 63 ¶ 110. That notice had two consecutive pages that showed Ms. Barnes as eligible for TennCare Medicaid on the first, and denied for QMB on the next. Harrell Decl. Ex. 54, Barnes June 11, 2019 Notice of Decision, TC-AMC-0000000835. In a November 1, 2019, call, Ms. Barnes explained that she was unaware that her mother's TennCare coverage had ended, and in an apparent reference to the June 11th notice, stated:

> We got all this paperwork and I filled it out back in the summer and one page says she's denied and one page says she's still good. And I had spoken to someone on the phone and they said that she still qualified for TennCare, but, yet now we're at the point that she doesn't have it and we had no idea."

Harrell Decl., Ex. 21, TC-AMC-0000000971 at 1:59-3:08. Ms. Hagan confirmed that Ms. Surrett had also received a June 11, 2019 Preterm Notice that Ms. Barnes had completed and returned to TennCare. ECF 63 ¶ 111. The Defendant fails to refute Ms. Barnes sworn statement that she did not receive the crucial NOD.

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

Response: Undisputed.

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

Response: Disputed in part. Undisputed that Ms. Surrett expressed confusion over letters received from TennCare over the summer of 2019. Disputed as to the implication that this statement means that Ms. Surrett acknowledged receiving the July 22, 2019 NOD in particular, or that her sworn statements were not truthful. TennCare sent two different NODs in the summer of 2019. One was issued on June 11, 2019 and also came with a Pre-Term notice with questions for Ms. Surrett to complete. *See* Harrell Decl., Ex. 54, Barnes June 11, 2019 Notice of Decision, TC-

AMC-0000000835; Harrell Decl., Ex. 55, Barnes June 11, 2019 Preterm Notice, TC-AMC-0000000861. Ms. Surrett and TennCare both acknowledge that she completed and returned the PreTerm notice. ECF 63 ¶ 111; Harrell Decl., Ex. 21, TC-AMC-0000000971 at 1:59-3:08 ("We got all this paperwork and I filled it out back in the summer."). The other NOD was sent July 22, 2019. Harrell Decl., Ex. 56, TC-AMC-0000000883. Both notices contain two consecutive pages with two different eligibility decisions, one on each page. The June 11, 2019 NOD, however, states that Ms. Barnes remained eligible for TennCare. The calls do not make clear which of the NODs Ms. Surrett acknowledged receiving because she did not have the notice with her at the time.

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

Response: Disputed in part. Undisputed that Ms. Surrett never filed an appeal. Ms. Surrett explained to a TennCare Connect representative that she did not file an appeal because the NOD she received suggested that Ms. Barnes still had TennCare coverage, explaining that "the one page said no, the other page said yes, so I'm thinking well, she's got it, it says yes, she's still covered. So I didn't do anything else, because the way I read it, she still had it." Harrell Decl., Ex. 12, TC-AMC-0000000970 at 32:07–32:24; *see* Harrell Decl., Ex. 54, Barnes June 11, 2019 Notice of Decision, TC-AMC-0000000835 (stating Ms. Barnes is eligible for TennCare on one page and ineligible for QMB on the next). Moreover, once she realized that Ms. Barnes's coverage had ended, Ms. Surrett called TennCare Connect asking how to regain coverage. *See* Harrell Decl., Ex. 21, TC-AMC-0000000971 at 3:17, 4:07–13 ("I'm trying to figure out how to get her TennCare back because we desperately need it . . . what do we have to do to try to get that back."). She was twice advised by TennCare Connect representatives that it was too late to file an appeal and no one suggested she could apply for a good cause exception, even though she stated that she had been

away from home serving as a caretaker for her aunt. *See* Harrell Decl., Ex. 12, TC-AMC-0000000970 at 24:40–25:10 (stating she had been away from home while serving as a caretaker for her aunt), *id.* at 31:39–31:45 ("What happened is, because that letter was sent out in July, it's too late to file the appeal."); Harrell Decl., Ex. 21, TC-AMC-0000000971 at 8:01–8:40 ("So, what I would personally recommend to do at this point is reapply for the benefits. Because the last letter we sent out does mention an appeal, but taking a look into that letter, it says you have until August 31st to have filed the appeal on time. After August 31st, um, it looks like, you know it is too late to file the appeal.").

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

Response: Disputed. TennCare denied Ms. Surrett the opportunity to file an appeal on behalf of her mother by not informing her in any notice they sent, or on any call with TennCare Connect, that she could request a good cause exception for missing the appeal deadline. Ms. Surrett could have claimed good cause due to the fact that she had been away from her home for an extended period while serving as a caretaker for her aunt and while dealing with Ms. Barnes's fall and subsequent hospitalization, meaning that she did not receive the notice terminating Ms. Barnes' Medicaid coverage. *See* Harrell Decl., Ex. 12, TC-AMC-0000000970 at 3:19–3:30 (stating she did not have the NOD with her, because her mother, Ms. Barnes "had a fall, an emergency,") *id.* at 24:40–25:10 (stating she had been away from home while serving as a caretaker for her aunt); Harrell Decl., Ex. 16, TennCare Dep. Leffard Excerpts at 58:18–59:1 (testifying that being out of the country, taking care of a sick relative could constitute good cause for untimely appeal).

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

Response: Undisputed that as of December 14, 2022, Plaintiff Caudill did not require any reasonable accommodations to navigate TennCare's process. Add for clarity that "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." Pls. R&Os at 4.

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: Undisputed.

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

Response: Disputed in part. Disputed as to the phrase "undisclosed." Plaintiffs' interrogatory responses addressing "every reasonable accommodation he or she requires to apply for or maintain through redetermination" utilized the phrase "including but not limited to" before identifying several specific accommodations. Plaintiffs are not withholding information about their needs, but rather utilized the phrase "including but not limited to" to indicate there may be other forms of assistance needed to navigate TennCare's renewal process depending, in part, on the possibility that their medical conditions and needs may evolve to require additional accommodations. And to hold open the possibility that additional accommodations will be

necessary to respond to particular requests for verification or information that TennCare may send during the renewal process. Otherwise undisputed.

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

Response: Undisputed that Plaintiff S.L.C. has not formally stated to a TennCare representative that she requested a reasonable accommodation (or equivalent phrase).

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: Undisputed.

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

Response: Disputed in part. Disputed as to the phrase "undisclosed." Plaintiffs' interrogatory responses addressing "every reasonable accommodation he or she requires to apply for or maintain through redetermination" utilized the phrase "including but not limited to" before identifying several specific accommodations. Plaintiffs are not withholding information about their needs, but rather utilized the phrase "including but not limited to" to indicate there may be other forms of assistance needed to navigate TennCare's renewal process depending, in part, on the possibility that their medical conditions and needs may evolve to require additional accommodations. And to hold open the possibility that additional accommodations will be

necessary to respond to particular requests for verification or information that TennCare may send during the renewal process. Otherwise undisputed.

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

Response: Undisputed that Plaintiff Hill has not formally stated to a TennCare representative that he requested a reasonable accommodation (or equivalent phrase).

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: Undisputed.

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

Response: Disputed in part. Disputed as to the phrase "undisclosed." Plaintiffs' interrogatory responses addressing "every reasonable accommodation he or she requires to apply for or maintain through redetermination" utilized the phrase "including but not limited to" before identifying several specific accommodations. Plaintiffs are not withholding information about their needs, but rather utilized the phrase "including but not limited to" to indicate there may be other forms of assistance needed to navigate TennCare's renewal process depending, in part, on the possibility that their medical conditions and needs may evolve to require additional

accommodations. And to hold open the possibility that additional accommodations will be necessary to respond to particular requests for verification or information that TennCare may send during the renewal process. Otherwise undisputed.

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

Response: Undisputed.

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

Response: Undisputed.

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: Undisputed.

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

Response: Disputed in part. Disputed as to the phrase "undisclosed." Plaintiffs' interrogatory responses addressing "every reasonable accommodation he or she requires to apply for or maintain through redetermination" utilized the phrase "including but not limited to" before identifying several specific accommodations. Plaintiffs are not withholding information about their needs, but rather utilized the phrase "including but not limited to" to indicate there may be other forms of assistance needed to navigate TennCare's renewal process depending, in part, on the possibility that their medical conditions and needs may evolve to require additional

accommodations. And to hold open the possibility that additional accommodations will be necessary to respond to particular requests for verification or information that TennCare may send during the renewal process. Otherwise undisputed.

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

Response: Undisputed that Plaintiff Rebeaud has not formally stated to a TennCare representative that she requested a reasonable accommodation (or equivalent phrase).

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

Response: Undisputed that as of December 19, 2022, Plaintiff Vaughn did not claim to require any reasonable accommodations to navigate TennCare's process. Add for clarity that "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." Pls.' R&Os at 5.

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

Response: Undisputed that Plaintiff Vaughn has not formally stated to a TennCare representative that she requested a reasonable accommodation (or equivalent phrase).

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

Response: Undisputed.

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: Undisputed.

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

Response: Disputed in part. Disputed as to the phrase "undisclosed." Plaintiffs' interrogatory responses addressing "every reasonable accommodation he or she requires to apply for or maintain through redetermination" utilized the phrase "including but not limited to" before identifying several specific accommodations. Plaintiffs are not withholding information about their needs, but rather utilized the phrase "including but not limited to" to indicate there may be other forms of assistance needed to navigate TennCare's renewal process depending, in part, on the possibility that their medical conditions and needs may evolve to require additional accommodations. And to hold open the possibility that additional accommodations will be necessary to respond to particular requests for verification or information that TennCare may send during the renewal process. Otherwise undisputed.

Dated: July 31, 2023

By: */s/ Babak Ghafarzade*

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing document has been served via the Court's electronic filing system on this 31st day of July, 2023.

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UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

A.M.C., et al.,	)	
Plaintiffs,	)	Civil Action No.
v.	)	3:20-cv-00240
STEPHEN SMITH,	)	
Defendant.	)	

REPORT OF EXPERT WITNESS
DR. PETER BLANCK, PH.D., J.D.

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I. Qualifications of Expert

I hold the rank of University Professor at Syracuse University, the highest faculty rank granted to only eight prior professors in the history of the University. I serve as Chairman of the Burton Blatt Institute ("BBI") at Syracuse University, whose mission is to advance the civil, economic, and social participation of persons with disabilities worldwide.[1] I have a Ph.D. in Social Psychology from Harvard University and a J.D. from Stanford University, where I was President of the *Stanford Law Review*. For my post-doctoral appointment at Harvard University, among other areas, I examined and have written about methods to study organizational systems, behavior, and culture, such as in policies and practices, leadership, and program oversight.[2]

My research has focused on the implementation of disability laws and policies. This program of study has included quantitative and qualitative case studies and large-scale empirical evaluations of institutional policies and practices in the identification, assessment, and accommodation[3] of persons across a wide spectrum of physical, cognitive, mental, intellectual, and psychiatric disabilities. I have published books, chapters, articles, and studies on topics such as the: (1) implementation of the Americans with Disabilities Act as amended ("ADA") and related health and welfare federal and state public programs; (2) provision of ADA disability accommodations, policy, and practice; and (3) nature of bias and discrimination facing persons with disabilities and who have intersectional and multiple minority identities, such as disability

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[1] I hold other appointments at Syracuse University in Law, Colleges of Arts and Sciences, and Education, and in the Maxwell and Falk Schools, and teach courses relating to disability research, policy, and law.
[2] *See, e.g.,* Peter Blanck & Arthur Turner, *Gestalt Research: Clinical Field Research Approaches to Studying Organizations, in The Handbook of Organizational Behavior*, 109-125 (J. Lorsch ed., 1987).
[3] The terms "accommodations" "reasonable accommodations," and "reasonable modifications" are used interchangeably throughout this report and have the meaning of reasonable modification under 35 C.F.R. 35.130(b)(7) for purposes of this report.

and race, in the provision of accommodations.[4] I examine the application of these issues to the social programs, services, and activities of public entities.[5]

My articles and books are published in peer-reviewed journals, and other scholarly venues, of the highest quality.[6] They are used in educational, governmental, and practice settings across the United States and internationally.[7] My research has been supported by grants from the U.S. Departments of Health and Human Services, Labor, Education, and Veterans Affairs, and by the National Council on Disability, and the Annenberg Foundation, among others.[8] A copy of my *curriculum vitae* is presented in Attachment A to this report and contains a list of publications I have authored in the last 10 years.

II. Research Approach and Methods

In the area of reasonable accommodations, my colleagues and I—including researchers at the Job Accommodation Network ("JAN")[9]—have conducted extensive quantitative and

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[4] *See, e.g.,* Peter Blanck, Fitore Hyseni, & Fatma Altunkol Wise, Diversity and Inclusion in the Legal Profession: Discrimination and Bias Reported by Lawyers with Disabilities and Lawyers Who Identify as LGBTQ+, *American Journal of Law & Medicine*, 47, 9-61 (2021).

[5] *See, e.g.,* Peter Blanck, *Disability Law and Policy* (2020); Peter Blanck, *Advanced Introduction to U.S. Disability Law* (2023 forthcoming). I have been invited to speak to federal and state government bodies in the United States and internationally, including before Congress and the Equal Employment Opportunity Commission (EEOC).

[6] Among the editorial boards on which I have served are *Psychology, Public Policy and Law, Disabilities Studies Quarterly*, and *Behavioral Sciences & The Law*. I have served on the editorial boards of leading peer-reviewed scientific journals and as a referee for manuscripts submitted to peer-reviewed journals. I was co-editor of the *Disability Law and Policy* book series published by Cambridge University Press.

[7] *See, e.g.,* Peter Blanck et al., *Disability Civil Rights Law and Policy* (2003, 2005, 2009, 2014).

[8] For example, I am Principal Investigator at Syracuse University of the Southeast ADA Center (https://adasoutheast.org/), providing regional information, guidance, and training on the ADA in Tennessee and other states in the region.

[9] The Job Accommodation Network (JAN) is a leading source of guidance on accommodations and a service of the U.S. Department of Labor. *See, e.g.*, http://askjan.org/links/about.htm.

qualitative studies of ADA accommodations.[10] We examine accommodation needs, requests, and provision for people with disabilities in the public and private sectors.[11] Conducted prior to and during the COVID-19 pandemic, our studies demonstrate that many organizations effectively accommodate individuals with disabilities using a variety of strategies, trainings, and programs, and in ways that do not necessarily unduly interfere with the integrity and cost-effectiveness of the programs offered.

I also examine effective training and supervision in the identification, assessment, and accommodation of persons across the spectrum of disabilities. My research examines organizational systems, policies, and practices, related to meaningful access to, and "methods of administration" of, public programs offering benefits and services, and accommodations to persons with disabilities.

For example, with partners, I have overseen implementation of the "New York Makes Work Pay" project under a Comprehensive Employment System Medicaid Infrastructure Grant ("MIG") to the New York State Office of Mental Health from the U.S. Department of Health and Human Services. The MIG was a state-wide project to develop research, policy, training, and technical assistance to advance the employment prospects of individuals with disabilities. MIG

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[10] *See, e.g.*, Disability Case Study Research Consortium, Conducting Benchmarking Inclusive Employment Policies, Practices, and Culture (December 19, 2008), (http://www.dol.gov/odep/research/CorporateCultureFinalReport.pdf); Lisa Schur, Douglas Kruse, & Peter Blanck, *People with Disabilities: Sidelined or Mainstreamed?* 75-79 (2013). *See also* Peter Blanck et al., Implementing Reasonable Accommodations Using ADR Under The ADA: A Case of a White Collar Employee with Bipolar Mental Illness, 18 *Mental & Physical Disability L. Rep.* 458 (1994); Helen Schartz, Kevin Schartz, D.J. Hendricks, & Peter Blanck, Workplace Accommodations: Empirical Study of Current Employees, 75 MISS. L.J. 917 (2006); Helen Schartz, D.J. Hendricks, & Peter Blanck, Workplace Accommodations: Evidence-Based Outcomes, 27 *Work: A J. Prevention, Assessment & Rehabilitation* 4, 345 (2006).

[11] *See, e.g.*, Peter Blanck, Americans with Disabilities and their Civil Rights, *Univ. Pitt. L. Rev.*, 66, 687-719, 706-707 (2005).

project activities included assistance in delivery of benefits and work incentives to persons with disabilities, many of whom live in poverty. One of the major project goals was to enable individuals with disabilities to make meaningful choices among accessible public service and program options.

I study the shorter- and longer-term effects of attitudinal and structural discrimination towards persons with disabilities who may need accommodation. This includes the failure to provide effective accommodations in programs and services offered by public entities.[12]

I have been retained by state and local governments to examine accommodation policies and practices involving individuals with disabilities in such areas as the implementation of ADA Transition and Self-Evaluation Plans.[13] I have served on advisory and professional panels regarding disability accommodation research and policy, including as former Chair of the American Psychological Association's ("APA") Committee on Disability Issues.[14]

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[12] *See* Peter Blanck, "The Right to Live in the World": Disability Yesterday, Today, and Tomorrow, *Texas J. C.L. & C.R.*, 13, 367-401 (2008). My studies consider organizational policies (e.g., mission, regulations), procedures (e.g., standards and quality assurance assessment), training (e.g., protocols, guidelines, and manuals), and professional standards of practice that lessen the effects of bias when public organizations offer accommodations in their services to persons with disabilities. My studies employ social science research methods such as archival and content analyses.

[13] *See, e.g., Americans with Disabilities Act—ADA Update: A Primer for State and Local Governments*, U.S. DOJ, https://www.ada.gov/regs2010/titleII_2010/title_ii_primer/ (last updated Feb. 28, 2020) [hereinafter DOJ ADA Title II Primer] ("The 1991 ADA regulation required all public entities, regardless of size, to evaluate all of their services, policies, and practices and to modify any that did not meet ADA requirements. In addition, public entities with 50 or more employees were required to develop a transition plan detailing any structural changes that would be undertaken to achieve program access and specifying a time frame for their completion. Public entities were also required to provide an opportunity for interested individuals to participate in the self-evaluation and transition planning processes by submitting comments. While the 2010 regulation does not specifically require public entities to conduct a new self-evaluation or develop a new transition plan, they are encouraged to do so."). In addition, I have authored and reviewed ADA transition and self-evaluation plans for cities such as Sioux Falls, SD.

[14] I have served as Chair of APA's Committee on Standards in Research, President of the American Association on Mental Retardation's Legal Process and Advocacy Division, Commissioner on the American Bar Association's Commission on Mental and Physical Disability Law, Senior Fellow of the Annenberg Washington Program, member of the President's Committee on Employment of Persons with

I have served in court-appointed roles relating to the provision of social services for persons with disabilities. From 1995 to 2001, I served as the court-appointed Facilitator in the settlement of the class action *Chris S. et al. v. Jim Geringer, et al.*, 2:94-CV-00311-ABJ (D. Wyo.),[15] and from 1991 to 1996, as Chairman of the Quality Assurance Committee and a member of the Compliance Advisory Board in the settlement of the class action *Weston v. Wyoming State Training School*, 2:90-CV-0004 (D. Wyo. 1994). In this capacity, I provided oversight in the methods of administration of, and provision of reasonable accommodations in, programs to support community integration for mentally, cognitively and developmentally disabled class members and implementation of policies and practices to ensure quality staffing and supports for navigation of governmental programs; reviewed fiscal recommendations of the Wyoming Legislature and Governor's Office on accommodations and staffing; provided testimony to the Wyoming Legislature Select Committee on Mental Health Issues regarding fiscal matters as to the provision of state services for persons with mental and physical disabilities; and conducted evaluations and assessments of organizational systems for clients with disabilities.

In the settlement of the class action case *M.F. v. NYC Department of Education*, No. 18-CV-6109 (E.D.N.Y 2023), I have been appointed as an External Court Monitor.[16] This assignment involves my monitoring the New York City Department of Education and other City

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Disabilities, and a board member of the National Organization on Disability. My views herein are my own and do not reflect the views of Syracuse University or any other entity with which I engage in my professional capacity.

[15] In this capacity, I monitored the implementation of state and community services for persons with serious and persistent mental illness, and related conditions, to ensure their administration in a manner consistent with the ADA.

[16] *See, e.g., Disability Rights Advocates, M.F. v. NYC Department of Education*, https://dralegal.org/case/m-f-v-new-york-city-department-of-education/.

agencies to systemically ensure that students with diabetes and attendant disabilities can attend school safely and have access to the same educational benefits as their peers with provision of reasonable accommodations under Section 504 of the Rehabilitation Act of 1973, the ADA, and the New York City Human Rights Law.[17]

My opinions in this report are based on my education, writings, and professional experiences. My evaluation of TennCare's systems for providing access to TennCare for the Disability Subclass,[18] as manifested in its policies, practices and institutional structure, uses well-recognized social science research methods to "triangulate"[19] sources using a disability policy framework[20] to evaluate the operations of public sector organizations and associated access for qualified individuals with disabilities. As part of this process, I compare and contrast data sources to reach conclusions. The touchstone for my analysis is whether the system is

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[17] In the last four years, I have been deposed as an expert witness and testified as an expert witness in the administrative hearing *J.P. by Ogden v. Belton Sch. Dist. 124*, 4:20-CV-00189-NKL (W.D. Mo. 2020). I have been deposed as an expert witness in: *Weisenberg v. AdvantageCare Physicians, P.C.* 1:18—CV-05645 (S.D.N.Y. 2019), *Riley v. City of Tacoma* (Sup. Ct. Wash. 2022), and *Li v. Northeastern Univ.*, 22-CV-004444-LK (W.D. Wash. 2022), each case involving issues of reasonable accommodation. As of this writing, I have not testified as an expert in trial in the last four years.

[18] *See* ECF 234, Memorandum Opinion and Order (Aug. 9, 2022) [hereinafter "Memorandum Opinion"], at 40 ("(2) The Court hereby certifies a "Disability Subclass" consisting of "Plaintiff Class members who are 'qualified individuals with a disability' as defined in 42 U.S.C. § 12131(2)." 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 will serve as representatives of the Disability Subclass."). Electronic Case File ("ECF") 202, Am. Complaint at 32-34 *et seq*. (Alleging injuries to the Named Plaintiffs [including Disability Subclass members]).

[19] *See, e.g.*, Peter Blanck & Arthur N. Turner, *Gestalt Research: Clinical-Field Research Approaches to Studying Organizations, in Handbook of Organizational Behavior* (1987); Jennifer C. Green, *Understanding Social Progress Through Evaluation, in Handbook of Qualitative Research* 981(2000) (evaluating welfare reform through triangulation of data sources); Margaret B. Hargreaves, Mathematica Policy Research, Inc., *Evaluating System Change: A Planning Guide*. (2010) (case studies as appropriate qualitative method of analysis for systems with complex dynamics). *See also* U.S. General Accounting Office, GAO-10-30, *Program Evaluation: A Variety of Rigorous Methods Can help Identify Effective Interventions*, Report to Congressional Requesters (2009).

[20] *See, e.g.*, Robert Silverstein, *Emerging Disability Policy Framework: A Guidepost for Analyzing Public Policy*, 85 *Iowa L. Rev.* 1691 (2000).

achieving what it is supposed to; and is it doing so in a valid and reliable way. Put another way, I examine the extent to which qualified individuals with disabilities are able to adequately and fairly access the public programs, with reasonable accommodations when needed. By "valid," I mean the extent to which the system is serving the people it is supposed to serve in the ways that it is set up to operate. This is evaluated by comparing the purpose of the system and the outcomes. By "reliable," I mean that the system is doing so with a consistent approach across individuals.

My data sources include thousands of pages of documents (and recordings) such as TennCare reports, policies, and information from Disability Subclass members. The materials I reviewed are listed in Attachment B. In addition to the items identified in Attachment B, I reviewed publicly electronically available organizational and social science research materials, much of which is cited in this report. Thus, to formulate my opinions I have relied on an array of materials to rigorously examine organizational systems, policies and practices that impact access to accommodations and TennCare programs for the Disability Subclass.[21]

III. Assignment

I have been retained by the Plaintiffs to systematically review materials pertaining to policies and practices of TennCare, which administers Tennessee's Medicaid program. I have been asked to evaluate TennCare's policies and practices related to ensuring access to

[21] My compensation in this matter is a mix of flat fees and my standard rate of $750 per hour. For the first phase of this engagement, including my review of relevant case files, review of information produced in discovery, and preparation of this report, I have been compensated with a flat fee of $75,000. For future phases of this engagement, including preparations for deposition and trial, I will charge my standard rate of $750 per hour. No portion of my compensation is tied to any outcome in this case.

individuals with disabilities to the program. I was asked to examine aspects of TennCare program operations in light of Title II of the ADA[22] as applicable to the "Disability Subclass" in this matter (also referred herein as "persons with disabilities" and "qualified individuals with disabilities" and "beneficiaries"[23]).[24] This Court has defined the Disability Subclass to be members of the class who are "qualified individuals" with disabilities for purposes of ADA Title II.[25] As discussed below, the Subclass exceeds 200,000 people.

Among other areas, I have examined whether the Disability Subclass has access to TennCare coverage, whether TennCare meets its obligations to not discriminate against the Disability Subclass, and whether TennCare sufficiently monitors its program and contractors to provide coverage to the Disability Subclass.

My review concerns *system-level organizational processes* for policies and practices, and methods of administration, that affirmatively provide access to TennCare's program through redetermination processes that: (1) identify and provide needed accommodations; (2) do not screen out beneficiaries with disabilities; (3) provide appropriate monitoring and oversight of program accommodations and modifications; and (4) provide appropriate monitoring and oversight of access to the TennCare program redetermination process.

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[22] Defendant is a "public entity" for purposes of Title II of the ADA.
[23] For purposes of this report the term "beneficiary" refers to those currently enrolled in TennCare and those applying for TennCare. It is inclusive of individuals with disabilities who may be assisting TennCare enrollees and applicants, whether serving as their authorized representative or informally providing assistance.
[24] Memorandum Opinion, at 19-22.
[25] Memorandum Opinion, at 40 (Title II as defined in 42 U.S.C. § 12131(2)).

First, I address Plaintiffs' contention that Defendant lacks effective and appropriate system(s) and methods of administration to *evaluate and monitor access to the TennCare program for qualified individuals with disabilities.*[26]

Second, I analyze Plaintiffs' contention that Defendant lacks effective and appropriate system(s) and methods of administration to *evaluate and grant requests for reasonable accommodations.* I examine these primary issues to address whether and, if so, to what extent, TennCare has a comprehensive and effective set of systems, policies and procedures, to provide TennCare coverage for, implement reasonable accommodations for, and otherwise not discriminate against the Disability Subclass.[27]

This analysis includes systematically assessing TennCare's methods of administration to ensure that its policies and practices do not directly, or through contract or other arrangements, have the effect of defeating or substantially impairing accomplishment of the program objectives with respect to the Disability Subclass (i.e., the validity and reliability of the program objectives and operations).

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[26] Plaintiffs contend, for example, that "Members of the Disability Subclass, including Vivian Barnes, D.R., William C. Monroe and Johnny Walker, are harmed by these systemic defects. The failure of TennCare to implement and maintain a system of ensuring reasonable accommodations, as mandated by the ADA, results in enrollees with disabilities being unable to comply with complex redetermination procedures without assistance. Consequently, Defendant terminates these persons' benefits, or places them at imminent risk of having their benefits terminated." Am. Complaint at 32. Plaintiffs also contend that "TennCare employs methods that tend to screen out individuals with a disability from the redetermination process, including failing to provide reasonable accommodations for people with disabilities as necessary to enable them to complete the redetermination process or obtain a fair hearing." Am. Compl. at 7; *see also*, Memorandum Opinion at 20.

[27] Am. Complaint at 125 *citing* 28 C.F.R. § 35.130(b)(3)(i), (ii).

IV. Summary of Opinions

I offer opinions as to the systems and methods of administration that members of the Disability Subclass must navigate to access TennCare, based on my review of materials in this case. Overall, my conclusion is that TennCare does not have effective and appropriate systems to provide reasonable access to individuals with disabilities, including evaluating and granting requests for accommodations.

TennCare's system, which does not have a uniform (i.e., valid and reliable) mechanism to track reasonable accommodation requests,[28] places one person, Ms. Talley Olson, as the sole reasonable accommodation decision maker[29] for an enrollee population of over 1.7 million.[30] Ms. Olson, who has served in this role since 2015, and is also tasked with ensuring TennCare's compliance with multiple other civil rights laws, stated that she has never had a "true" reasonable accommodation request come to her attention.[31]

Enrollees face a maze of program referral circles, complaint processes, and administrative burdens to access TennCare. Should an enrollee find her way to Ms. Olson, she faces additional paperwork and required information that TennCare often already appears to have, such as the nature of her disability. Each time a Disability Subclass member must interact with TennCare, they must often navigate this same burdensome process to get basic assistance.[32]

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[28] Def.'s Response to RFA 40; Hagan Depo 240.
[29] Olson Depo 73 ("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.")).
[30] TennCare, TennCare Enrollment Report (March 2023), https://www.tn.gov/content/dam/tn/tenncare/documents2/fte_202303.pdf.
[31] Olson Depo 17, 22, 66, 167; *but see*, TC-AMC-0000648149 (Row 263 showing "RA granted" in Olson's Discrimination Complaint Log).
[32] Olson Depo 166-67 (Q: "Do you know whether anyone reaches out to enrollees previously granted accommodations to see at the next redetermination cycle whether they continue to need them?" A: "For –

To be effective at the systems level, a Medicaid program like TennCare must effectively define roles, policies, and processes in policies, trainings, and monitoring mechanisms so that those staff interacting with beneficiaries: (1) understand their functions; (2) know how and when to refer an individual to other supporting programs and offices; (3) know how to properly and reliably document the interaction in the case file; (4) know how to validly identify accommodation and other needs; and (5) know how to appropriately escalate cases to supervisors and others as needed for resolution. In these regards, TennCare's systems, structures and policies for compliance with disability access are insufficient and not adequately organized with different aspects of the beneficiary-facing systems referring to one another to provide assistance—with little adequate assistance provided outside of document submission.[33]

The main call center, TennCare Connect, is an initial point for enrollees with disabilities trying to navigate TennCare's system and evidences numerous deficiencies. Prior to a Corrective Action Plan (CAP) in 2022, the vendor operating TennCare Connect:

- did not understand that ADA compliance was part of its responsibilities,[34]

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as far as redetermination, I can say as far as I am aware, I have never had to grant an accommodation to a member for a renewal packet. So there would be no need to do that.").

[33] Turner Depo 204-05 (stating that an individual with disability who needed assistance could ask a TennCare Connect representative for a referral to TNCSA who would then make a referral to the AAAD for in-person assistance); TNCSA Depo Whitfield 80-81, 83 (stating TNCSA does not assess callers who might need in person assistance and cannot recall reaching out to AAAD to connect somebody with in-person assistance through the AAAD); DHS Depo Bryson 166 (expressing uncertainty as to which TennCare partners would provide in-person assistance); AHS Depo Fields 115 (Q: "What does AAAD perform in terms of in-person assistance?" A: "I'm not as educated as much on AAAD, but I would think there's similar support [to DHS support] that's given there.").

[34] AHS Depo Fields 144-45 (Q: "Did [TennCare's Director of Civil Rights Compliance] explain why a Corrective Action Plan [concerning ADA compliance] was necessary?" A: "She did." Q: "What did she say?" A: "I can't tell you specifically, but I can recollect I asked why we would be receiving a Corrective Action Plan for something that we hadn't been responsible for previously." Q: "I'm sorry. You trailed off there. I didn't catch the end of your response." A: "The fact that we were receiving a Corrective Action Plan for something that was just being introduced to us.").

- had no process in place concerning reasonable accommodations,[35]
- had no reference material for reasonable accommodations,[36]
- through its Call Center Operations Director asked TennCare's Office of Civil Rights Compliance (OCRC) "[w]hat all is included in reasonable accommodations,"[37] and
- received no reasonable accommodation training other than that mentioned in a more general civil rights training.[38]

Of TennCare's total enrollment, well over 200,000 beneficiaries can be expected to have a disability.[39] At that scale, and given what is well known about the capacities and limitations associated with different types of disability, the expected needs for assistance to be able to navigate TennCare's eligibility process are reasonably large and complex. To meet those needs, TennCare must have systems and resources in place that are readily available and designed for valid and reliable success. TennCare must also have the clear processes and coordination needed to connect individuals to those resources on a timely and effective basis as necessary. An effective (i.e., valid and reliable) system for ensuring the accessibility of TennCare needs to monitor and assess the efficacy of its methods of assisting individuals with disabilities, with the ability to adequately adjust its resources for assisting such individuals in light of the limitations revealed by such monitoring.

When a public benefits system is not effective (i.e., not valid and reliable), qualified individuals with disabilities likely are not able to access or maintain those benefits. For health care benefits, this uncertainty can have devastating effects and cause long-lasting harm to

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[35] AHS Depo Fields 119 (A: "Because before that, there was no process in place around that specific topic." Q: "Before this e-mail, there was no process regarding reasonable accommodations at AHS?" A: "As it pertains to a specific process with the OCRC, that's correct.").
[36] AHS Depo Fields 119, Ex. 4.
[37] AHS Depo Fields 119, Ex. 4.
[38] AHS Depo Fields 199-200.
[39] *See* nn. 51-52, below, and surrounding text.

beneficiaries. Systems without valid and reliable organizational processes and monitoring are likely to create, through choices or inaction, gaps and ineffective processes that unfairly thwart access to the program. Qualified individuals with disabilities therefore will have the predictable outcome of falling through the gaps in accommodation policies and general access protections, and likely only those few who complain hard enough (and usually with support of others) will garner compliance attention.

Because of these deficiencies, TennCare does not provide a reliable, accessible path to assistance needed to appropriately access its programs. The agency has fragmented systems with inadequate policies and procedures rather than a comprehensive and coordinated plan regarding accessibility and accommodation for individuals with disabilities. It appears that TennCare's structures and policies are reactive only. Thus, they do not anticipate or appropriately plan for the system needs of the large number of individuals with diverse disabilities that such Medicaid programs serve.

V. Opinion

A. Prevalence and Impact of Disability.

Before discussing the bases for my primary opinions that adversely impact the Disability Subclass, I provide background information on ways in which disabilities may impact how people interact with programs such as TennCare. Thereafter, I discuss the estimated prevalence of disability in TennCare to situate my conclusions.

1. Impact of Disabilities on Access.

Affording individuals with disabilities the means to understand their rights and responsibilities with regard to a public program, and to communicate effectively the information required to establish and maintain their eligibility for the program's services, is foundational to

ensuring accessibility of such a program. Hearing disabilities, for example, can make phone-based conversations difficult and may require video relay interpretation, assistive listening devices, captioning services, amplifiers, and other modifications.[40] Similar modifications may be needed for in-person interactions and other changes, such as using a more private space away from ambient noise or making appointments when an assistant is available.[41] People with visual disabilities may need alternate formats for documents, which may require more time to complete depending on the alterations.[42] Mobility impairments, and mental and intellectual disabilities, often make it an undue hardship, or even impossible, for beneficiaries to complete administrative functions such as filling out complex forms and providing documentation.[43]

For some individuals with disabilities, direct, in-person assistance is necessary to successfully navigate complex administrative processes like those required to retain their Medicaid eligibility. Disabilities often impact a person's ability to spend time waiting on the phone to a call center; to process and respond to information provided over the phone and to ultimately understand information provided to then take the appropriate actions; and, to physically complete such tasks. These issues can stem from physical disabilities, such as the

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[40] Ctrs. Medicare & Medicaid Servs., *Improving Communication Access for Individuals Who Are Deaf or Hard of Hearing* (Aug. 2022), https://www.cms.gov/files/document/audio-sensory-disabilities-brochure-508c.pdf.

[41] *Id.*; Ctrs. Medicare & Medicaid Servs., *Improving Communication Access for Individuals Who Are Blind or Have Low Vision* (Aug. 2022), https://www.cms.gov/files/document/omh-visual-sensory-disabilities-brochure-508c.pdf.

[42] *Id.*

[43] *Working With Consumers with Disabilities*, https://marketplace.cms.gov/technical-assistance-resources/training-materials/consumers-with-disabilities.pdf. National Disability Resource Collaborative. How Can Navigators Ensure Effective Communication with People with Disabilities?, https://nationaldisabilitynavigator.org/ndnrc-materials/disability-guide/how-can-navigators-ensure-effective-communication-with-people-with-disabilities/; National Disability Resource Collaborative, What types of accommodations should Navigators know about?, https://nationaldisabilitynavigator.org/ndnrc-materials/disability-guide/what-types-of-accommodations-should-navigators-know-about/.

functional ability to handle paperwork or the stamina to wait on the phone. Similarly, cognitive impairments and learning disabilities may make it difficult to concentrate and remember information, which can lead to an inability to understand and follow through on action requests. Individuals with severe mental health impairments frequently cannot cope with the telephone or written communications and need the active, personal assistance of individuals with substantive knowledge of the program requirements the individual must meet, as well as training in assisting individuals with mental health impairments.

People with disabilities may also rely on assistance and support from others to complete complex tasks—assistance that is often time limited, which leads to long wait times, unclear information, and multiple referrals that can be time-consuming and leave little time for completing a task. People with disabilities may also be hesitant to request accommodation due to the burden of meeting the process requirements and other barriers.[44]

Reliance on family members or friends to meet an individual's need for accommodation has serious practical limitations, especially if the individual with disabilities needs help satisfying administrative requirements that are complex or time-consuming. Informal helpers cannot be expected to have sufficient understanding of TennCare's technical eligibility

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[44] Lisa Schur et al., *Accommodating Employees With and Without Disabilities,* Hum. Res. Mgmt. (July 2014), available in pre-print at https://bbi.syr.edu/wp-content/uploads/application/pdf/bio/2014-adya-blanck-accomodating-employees-disabilities-prepublication-draft-accessible-AD.pdf (discussing that there may be fewer perceived costs associated with requesting accommodations when such requests are perceived as normal or common within a broader culture of flexibility*); see also* Andrew Pulrang, *For People with Disabilities, Asking for Help Carries Hidden Costs,* Forbes (Nov. 12, 2019).

requirements to provide effective assistance.[45] Informal assisters may not have the time,[46] willingness, or ability[47] to provide consistent help, which can result in a failure to follow through to complete tasks that are subject to deadlines.

Completing paperwork can present a range of challenges for people with disabilities, including needed alternate formats such as large print; assistance due to dexterity issues from physical or neurological issues; help understanding what is being requested, including explaining the request orally or in an alternative way; extensions of time due to delays in gathering needed information or arranging for help due to limited mobility or cognitive issues; and other accommodations.[48]

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[45] *See, e.g.,* Pltfs.' Response to Def.'s 1st Interrogatories, No. 3 (describing call S.L.C.'s father had in which he requested a sit-down meeting after being unable to understand or be understood by the TennCare representative, which he reported was rejected by TennCare; *see also* Hagan Depo 21-22 (describing Medicaid eligibility as a complicated subject and something she is still learning about).

[46] Many of the Plaintiffs have had to have repeated calls to TennCare to request assistance. See, e.g., Pltfs.' Response to Def.'s 1st Interrogatories, No. 3 (describing 15 calls to TennCare for assistance from Plaintiff S.F.A.'s next friends or others, 6 calls from Plaintiff S.L.C.'s next friends or others to TennCare for assistance, 12 calls to TennCare for assistance from Plaintiff Michael Hill's net friends or others, 7 calls to TennCare for assistance from Plaintiff).

[47] For example, Plaintiff William Monroe, who reported to TennCare that he lives alone, cannot drive, is hard of hearing, has spinal stenosis, lost use of his hands, lost use of one of his legs, had been hospitalized for approximately a four-month period, and needed someone to get his mail because he could not do it himself, stated that had to navigate TennCare's process by himself after the woman who was helping with his mail died. Pltfs.' Response to Def.'s 1st Interrogatories, No. 3.

[48] Paperwork can intimidate anyone, but may have especially restrictive consequences for persons with disabilities. Complex criteria administered in a seemingly arbitrary and less than methodical or systematic way may contribute to the confusion and anxieties of persons with communication related disabilities. *ADA Requirements: Effective Communication*, U.S. Dep't of Justice Civil Rights Div., https://www.ada.gov/resources/effective-communication/ (updated Feb. 28, 2020); *see also*, Working With Consumers with Disabilities, https://marketplace.cms.gov/technical-assistance-resources/training-materials/consumers-with-disabilities.pdf. National Disability Resource Collaborative, How Can Navigators Ensure Effective Communication with People with Disabilities?, https://nationaldisabilitynavigator.org/ndnrc-materials/disability-guide/how-can-navigators-ensure-effective-communication-with-people-with-disabilities/; National Disability Resource Collaborative, What types of accommodations should Navigators know about?, https://nationaldisabilitynavigator.org/ndnrc-materials/disability-guide/what-types-of-accommodations-should-navigators-know-about/; *see also* Office of Management and Budget - Office of Information and Regulatory Affairs Memo, Strategies for Reducing

Reasonable accommodations are not just limited to ramps or large print—there is a broad range of disabilities and accompanying needs for accommodation. It is important to remember that the overall goal is to find a practical solution that fits the circumstances, including the nature, length, and complexity of the agency's communication or interaction with the individual, and the person's needs.[49] In addition, the fact that a person may happen to have assistance from a family member or friend does not necessarily mean that the individual does not need assistance from the public entity. A person may be using a family member or friend because they prefer it or because that's the only way they can access the program; if it is the latter, this would be an indicator of access issues to a program.

Disability-related access issues often are compounded when an individual has to overcome administrative barriers to receive the accommodations she needs each time she interacts with the system. If a cognitively impaired enrollee who has requested extra time in the past needs to review a TennCare notice, understand that it includes a deadline that requires action, and go through the process to request additional time, including additional paperwork, she likely has encountered multiple unnecessary barriers in retaining her TennCare coverage as opposed to receiving extra time from the beginning and throughout the process. In some cases, receiving help with the notice and initial response may not be the end of the process when they

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Administrative Burden in Public Benefit and Service Programs, https://www.whitehouse.gov/wp-content/uploads/2022/12/BurdenReductionStrategies.pdf (describing several strategies to reduce administrative burdens for public benefit recipients).

[49] Ctrs. Medicare & Medicaid Servs., *Improving Communication Access for Individuals Who Are Deaf or Hard of Hearing* (Aug. 2022), https://www.cms.gov/files/document/audio-sensory-disabilities-brochure-508c.pdf; Ctrs. Medicare & Medicaid Servs., *Improving Communication Access for Individuals Who Are Blind or Have Low Vision* (Aug. 2022), https://www.cms.gov/files/document/omh-visual-sensory-disabilities-brochure-508c.pdf.

must provide additional information to prove eligibility or appeal an adverse decision and manage that process as well to maintain access to the program.

Similarly, if an enrollee with a disability who has requested help understanding information sent from TennCare by having that information explained orally has to go through that process of recognizing she needs assistance with the information, then requesting and awaiting the accommodation, she likely will have limited access to retaining her TennCare coverage. This is especially true when a program, such as TennCare, requires time-limited responses to often complex eligibility-related requests.

If an enrollee with a disability needs to request an accommodation anew each time, the time to respond is more likely to elapse before she can receive the accommodation, especially if the process for requesting accommodations is time-consuming and not clearly articulated. Even if the undue time does not elapse, the enrollee will have used valuable time needed to complete the requested action in getting needed assistance or other accommodations. For these and other reasons, people with disabilities are therefore less likely to be able to comply with requests for information or verification of factors like income due to the lack of accommodation for their disabilities.

Without reasonable accommodations to help an individual meet such redetermination obligations, they often face the consequences of no longer being able to access and maintain TennCare. Providing needed accommodations in a timely and effective manner, along with methods of administration that minimize burden and maximize assistance, is critical in programs such as TennCare in which renewal of benefits typically requires timely completion of a lengthy

redetermination packet of questions and requests for verifying financial, citizenship, and other information.[50]

The impact of disability on navigating and dealing with systems such as TennCare are exacerbated in the absence of reasonable accommodations, uniform and comprehensible notices that inform enrollees with disabilities of the availability of assistance and the process to request such assistance (for example, requirements to repeatedly request needed accommodations, lack of adequate staff training, and failures by the system to monitor and proactively address barriers).

2. Prevalence of Disability within the TennCare Population.

To put my conclusions in context, it is necessary to have a basic understanding of the prevalence, type, conditions, and severity of disability among TennCare Disability Subclass participants and how these disabilities impact the TennCare Disability Subclass's access to the program through the redetermination process used by TennCare.

The Disability Subclass includes all qualified individuals who have a disability, a number that exceeds 200,000. Based on public records, at least 212,143 beneficiaries receive TennCare based on their disability.[51] There are also substantial numbers of individuals with disabilities who

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[50] As discussed in the Memorandum Opinion, TennCare's typical redetermination process occurs annually, includes completion of a renewal packet within 40 days, responding to additional requests for information within 20 days, but there has been under a moratorium on disenrollment in response to the COVID-19 pandemic. ECF 234 at 2-6.

[51] This includes 26,487 individuals enrolled in SSI-related categories as Pickle, DAC or Disabled Widow/er and 28,978 persons eligible for Institutional Medicaid. ECF 166 (Hagan 1/4/2022 Decl.), at 2. The total also includes 156,678 disabled individuals who are eligible for TennCare by virtue of their current receipt of SSI. *Id.* at 5; Social Security Administration, *SSI Recipients by State and County, 2021 – Table 3 – Tennessee*; https://www.ssa.gov/policy/docs/statcomps/ssi_sc/2021/tn.pdf. Note that Ms. Hagan states that the total number of SSI beneficiaries receiving TennCare is 215,804, nearly 50,000 more than the total figure of 166,783 reported by the Social Security Administration. The 212,143 total does not include 253,571 beneficiaries in the Medicare Savings Program, some percentage of whom are eligible on the basis of their receipt of Social Security Disability Insurance. ECF 166 (Hagan 1/4/2022) Decl., at 2.

are enrolled in TennCare in categories for which disability is not an eligibility criterion. They include an estimated 33,000 adults eligible for TennCare as caretaker relatives of children.[52] Another group comprises women undergoing active treatment for breast or cervical cancer, a significant percentage of whom will at any given time have disabling conditions, although disability is not a condition of their eligibility. For purposes of evaluating prevalence and anticipated accommodation needs of the TennCare population the number of individuals with disabilities is also appreciably larger than those enrolled in TennCare in a disability-based category, because those categories of eligibility require an individual to meet the Social Security definition of disability, which is substantially more restrictive than the ADA's definition of disability as a physical or mental impairment that substantially limits one or more major life activities.

The Centers for Disease Control and Prevention (CDC) assesses the prevalence of disability using a definition of disability tbat measures several conditions that would substantially limit a major life activity and are likely to be associated with difficulties navigating

[52] According to a February 12, 2018, fiscal note prepared by the Fiscal Review Committee of the Tennessee General Assembly, more than 300,000 adults are enrolled in TennCare as caretaker relatives at any given time. https://www.capitol.tn.gov/Bills/110/Fiscal/HB1551.pdf . The fiscal note analyzed that population using data from the U.S. Census Bureau's American Community Survey. The ACS currently reports that the five year average rate of disability among Tennesseans under age 65 is 11.0% available at https://www.census.gov/quickfacts/fact/table/TN/PST045221.

the TennCare eligibility process.[53] The CDC estimates that 1,552,858 individuals, or 29% of adults in Tennessee, meet that definition of disability.[54] Within the disability population, the CDC reports that:

- 14 percent of adults in Tennessee have a mobility disability with serious difficulty walking or climbing stairs.
- 13 percent of adults in Tennessee have a cognition disability with serious difficulty concentrating, remembering or making decisions.
- 8 percent of adults in Tennessee have an independent living disability with difficulty doing errands alone.
- 7 percent of adults in Tennessee are deaf or have serious difficulty hearing.
- 6 percent of adults in Tennessee have a vision disability with blindness or serious difficulty seeing even when wearing glasses.
- 4 percent of adults in Tennessee have a self-care disability with difficulty dressing or bathing.[55]

Without accommodation, such limitations on functioning due to disability often act as barriers to applicants and recipients in obtaining or retaining benefits.

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[53] CDC surveys ask the following questions:

1. Are you deaf, or do you have serious difficulty hearing?
2. Are you blind, or do you have serious difficulty seeing, even when wearing glasses?
3. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?
4. Do you have serious difficulty walking or climbing stairs?
5. Do you have difficulty dressing or bathing?
6. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

CDC, Disability and Health, Disability Datasets, available at https://www.cdc.gov/ncbddd/disabilityandhealth/dhds/data-guide/status-and-types.html; https://www.cdc.gov/ncbddd/disabilityandhealth/dhds/index.html.

[54] CDC, Disability & Health Home, Data & Statistics, Disability & Health U.S. State Profile Data: Adults 18+ years of age: Tennessee, available at https://www.cdc.gov/ncbddd/disabilityandhealth/impacts/tennessee.html. CDC defines a mobility disability as serious difficulty walking or climbing stairs, a cognition disability as serious difficulty concentrating, remembering, or making decisions, an independent living disability as serious difficulty doing errands alone, such as visiting a doctor's office, a hearing disability as deafness or serious difficulty hearing, a vision disability as blind or serious difficulty seeing, even when wearing glasses, and a self-care disability as difficulty dressing or bathing.

[55] *Id.* As a general matter the ACS survey data uses a broader definition of disability than that used by the ADA, but ACS data are commonly used to estimate disability prevalence.

These state-level estimates confirm that the number of individuals in the Disability Subclass likely is large, and that various types of disability occur in substantial numbers in the Subclass. To ensure that it is able to provide access, a public program such as TennCare must understand the prevalence and nature of disability as well as related estimates of need for reasonable accommodation in the population the program serves. This understanding is necessary to provide adequate resources and appropriate procedures to meet the estimated need.

TennCare compiled and used such disability estimates in the past.[56] I understand that TennCare does not currently do so, however, leaving the state without the data needed to structure necessary policies, procedures, and capacities to reliably meet the needs of beneficiaries with disabilities.[57] It appears that outside of a complaint log maintained by Talley Olson,

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[56] In 2002, before the State redetermined the eligibility of all non-Medicaid TennCare beneficiaries, TennCare and DHS, in consultation with experts, developed policies and procedures specifically designed to anticipate and address the needs of individuals with disabilities. Defendant's Proposed Findings of Fact and Conclusions of Law, submitted August 5, 2002 in *Rosen v. Tennessee Commissioner of Finance and Administration,* No. 3:98-627 (M.D. Tenn.), [hereafter *Rosen* PFFCL] AMC-ALL-0003 – AMC-ALL-0004. That process began by estimating the number of individuals with disabilities who would likely be impacted by the process. At that time, TennCare provided special benefits to individuals it identified as severely and persistently mentally ill (SPMI) adults or severely emotionally disturbed (SED) children, and it analyzed data in its management information system to identify those individuals. *Rosen* PFFCL, AMC-ALL-00017, AMC-ALL-0033 – AMC-ALL-0034. The State reviewed records in TennCare's management information system showing eligibility in particular disability-related categories, and it searched three years of clinical encounter data for diagnoses that would identify enrollees as having medical conditions that might be disabling. *Rosen* PFFCL, AMC-ALL-0017; Appendix to Defendant's Proposed Findings of Fact and Conclusions of Law, submitted August 5, 2002 in *Rosen v. Tennessee Commissioner of Finance and Administration,* No. 3:98-627 (M.D. Tenn.), [hereafter *Rosen* Appendix] AMC-ALL-0103; TennCare Medical Condition List, AMC-ALL-0258 – AMC-ALL-0259. In 2002, my understanding is that eligibility was determined by DHS through a largely manual process that lacked the technical functionality now available in TEDS, and eligibility criteria differed significantly. Still, the process the state employed then stands as an acknowledgement by TennCare of the challenges the eligibility process poses for many individuals with disabilities, and it contrasts with the largely reactive and uncoordinated process TennCare has in place today.

[57] Def.'s Response to RFA 40 (admitting that aside from a complaint log maintained by TennCare's Director of the Office of Civil Rights Compliance, TennCare does not maintain either a record of individuals who have been identified as having a disability that requires a Reasonable Accommodation, or the type of Reasonable Accommodation required to enable such individuals to establish and maintain

TennCare's one-person Office of Civil Rights Compliance (OCRC), TennCare does not track reasonable accommodation requests,[58] reasonable accommodations granted for an original application,[59] or reasonable accommodations granted to previously navigate the renewal process.[60]

Further, TennCare does not track the number of enrollees subject to redetermination who are visually impaired,[61] deaf,[62] hearing impaired,[63] cognitively impaired,[64] or unable to use their hands to write or type[65] in any aggregate or centralized way.[66] Without such information, TennCare cannot effectively monitor its performance to understand whether its methods of administration are ensuring that the program is accessible to individuals with disabilities.

B. TennCare's Systems, Policies, and Structure Impede Beneficiary Access to the Program.

To substantially avoid the apparent unfair and harmful impacts on individuals with disabilities identified above, a public benefits program such as TennCare needs to have a range of valid and reliable systems and processes to reasonably ensure that beneficiaries have access to its programs and services. Among other components, a program needs to: (1) have a valid and reliable system for collecting information about disability-related needs and appropriately record

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their TennCare eligibility); *see also*, Hagan Depo 205-206, 216, 219, 222, 223, 224-25, 225, 238, 239-44; TennCare Depo Hagan 19-26.

[58] Def.'s Response to RFA 40; Hagan Depo 240; After the CAP, AHS also began maintaining a reasonable accommodation log that it sends to Ms. Olson, and those requests are transferred to her log, though Ms. Olson stated she did not require this and found the logs "redundant." Olson Depo 243-44.

[59] Hagan Depo 243 (stating "LTSS may track those for whom the AAADs went out and helped . . . establish a PAE." "But outside of that?" "No.").

[60] Hagan Depo 242; Olson Depo 166-67.

[61] Hagan Depo 241.

[62] Hagan Depo 241.

[63] Hagan Depo 241.

[64] Hagan Depo 241-42 (outside of the ECF Choices program).

[65] Hagan Depo 241-42.

[66] Flener Depo 247-50; *see* Hagan Depo 238.

disability status and requested aids and services and accommodations in the individual's case records using standardized language and ensuring that such disability-related information is adequately available and displayed in relied upon computer systems, such as the Tennessee Eligibility Determination System (TEDS), so that staff who may interact with the individual can readily access it; (2) ensure staff receive adequate training on accommodations; (3) maintain processes to provide initial and ongoing accommodations, including alternate document formats and auxiliary aids and services, that ensure the effective provision of requested accessible document formats, auxiliary aids and services, and accommodations; and (4) use available data and systems to proactively identify accommodation and access issues and monitor for ongoing compliance.

1. TennCare and Its Contractors Provide Insufficient Assistance and Connection to Reasonable Accommodations.

It appears that TennCare does not have a comprehensive, effective, and coordinated plan regarding accessibility. TennCare's systems are deficient in the components identified above: (1) The points at which beneficiaries interact with TennCare do not validly and reliably collect and record information about disability status, disability-related needs, and do not provide effective mechanisms to request and receive reasonable accommodations; (2) Trainings provided to frontline staff are not adequate and do not enable such staff to effectively assist enrollees with disabilities to access assistance and the reasonable accommodation process; (3) The reasonable accommodation process generally is unclear to staff, administratively burdensome, and likely deters beneficiary requests; and (4) TennCare does not have adequate monitoring and oversight of its accommodation processes to ensure access for individuals with disabilities.

Based on my research and experience reviewing and evaluating benefits and other programs and services of public entities, I have found that to provide reasonable, effective, and

consistent access to individuals with disabilities, entities should have a system to identify disability-related needs, track needed accommodations using a standardized method that provides the information at needed steps and interaction points, and should monitor access for people with disabilities with proactive and reactive measurements. This system should include standard mechanisms to record the auxiliary aids and services, and other accommodations, needed by beneficiaries, and to effectively employ that information in communicating with beneficiaries.

Program accessibility should be considered at all points that beneficiaries interact with a given system process. Accessibility thus is critical from the beginning of how beneficiaries are informed about available assistance and the process to request accommodations, to frontline staff interactions including training and policies, to appeals processes, and to the reasonable accommodation process, complaint process, and ongoing access mechanisms. In the context of a public benefits system such as TennCare, information about accessibility needs of beneficiaries should be available to eligibility and customer service workers who are interacting with the public and may be accessing a person's case file to effectively perform their duties. At a minimum, the available information should indicate to the case worker whether the person has a disability and has requested any accommodation.

For example, a system should: (1) allow a case worker to identify that the person has a disability, and (2) provide a "drop-down" or other such list of commonly requested auxiliary aides and services and other accommodations, as well as an option to indicate "other needs" and special unique case notes. Commonly requested auxiliary aides and services include large print, accessible digital files, interpreters, audio recordings or "read aloud" notices, explanations of forms and notices, extra time, and human assistance with reading forms and paperwork.

As part of their ongoing training, case workers should be able to operate these systems and understand the meanings of the different accommodation selections. The system should also be capable of noting to case workers those accommodations that have been offered (currently and prior) and the result (e.g., denied, provided, or declined). This approach may greatly reduce predictable barriers created when individuals with disabilities must repeatedly request accommodations at each interaction with case workers.

TennCare acknowledges that it does not maintain regular records of or track individuals who have been identified as having a disability who require reasonable accommodations, or the types of reasonable accommodations required to enable individuals to establish and maintain their TennCare eligibility in TEDS (i.e., the system TennCare largely relies on for beneficiary information in the eligibility process), or in a place other than a complaint log maintained by one person at TennCare.[67]

TennCare also "broadly …[does not] track disability data of all of its members in TEDS."[68] The disability data that TennCare collects within TEDS consists of one indicator for blindness in one of its categories of eligibility, basic information about members in categories of eligibility that have a disability component, or information that may be in an individual's unique case notes.[69] TennCare does not have other tracking systems outside of TEDS that could be

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[67] *See* Def.'s Response to RFA 40; Hagan Depo 238-40 (stating no reasonable accommodation tracking outside of long-term services and supports recipients); TennCare Depo Hagan 19-26, Ex. 4; Olson Depo 166.

[68] Flener Depo 239-40; Olson Depo 54-55.

[69] *See* Flener Depo 239-40 (stating "broadly, no, we don't track disability data of all of our members in TEDS. We do have some indicators that, when they come through on an interface . . . we will indicate if a person is blind."); 247-48 (disability field is only used for Institutional Blind category); Hagan Depo 238.

validly and reliably used by case workers interacting with beneficiaries to provide accommodations on an ongoing and timely basis.[70]

The processes TennCare has identified thus offers a difficult, often circular, system for assessing and providing reasonable accommodations to enrollees with disabilities. The process relies on referrals that are likely to go back and forth among TennCare staff and contractors due to lack of effective policies and staff understanding about which entity provides what assistance

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[70] *See* Olson Depo 166 (Q: "If reasonable accommodations are granted to enrollees, does AHS or TennCare reach out at the next redetermination process to those enrollees to inquire whether or not they still need those reasonable accommodations?" A: "So TennCare on their own –or AHS certainly would have probably no knowledge of members who receive reasonable accommodations, probably." Q: "Why is that?" A: "Because they're my individual cases that are kept as confidential as possible.") 167 (also stating that TennCare has never granted a reasonable accommodation concerning a renewal packet so there is no need for TennCare to reach out the next renewal period); *see* Def.'s Response to RFA 40; Olson Depo 52, 72, 244-45 (stating that complaint log is just Ms. Olson's "own internal tracking.").

and to whom.[71] There is limited tracking[72] and monitoring[73] to ensure that referrals are effectively connecting people with disabilities to the assistance and accommodations they may need. As a result, in my experience people with disabilities are likely to give up and exit the "referral merry-go-round" due to confusion and the burdens involved. Further, in my experience, this likely leads to individuals with disabilities giving up on redeterminations or struggling to meet the requirements and thus failing due to disability-related challenges.

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[71] *See, e.g.*, DHS Depo Bryson 35-36, 37-38 (referencing referral back to TennCare for individual who asked for assistance completing the renewal packet in their home or had questions about eligibility), 166 (DHS uncertain as to which TennCare partners would provide in-person assistance); Turner Depo 204-05 (stating that an individual with disability who needed assistance could ask a TennCare Connect representative for a referral to TNCSA who would then make a referral to the AAAD for in-person assistance); TNCSA Depo Whitfield 80-83 (stating TNCSA does not assess callers who might need in person assistance and cannot recall reaching out to AAAD to connect somebody with in-person assistance through the AAAD); Olson Depo 164-65 (stating "[I] want to say that with renewal packets, there were zero requests that came to me for in-person assistance" in response to question about whether Olson referred any enrollees to the AAAD for help completing renewal packets); *see also*, TNCSA Depo Whitfield 49 (referencing referral back to TennCare Connect for questions as to "why" something happened concerning coverage) 129 (referencing referral back to TennCare Connect for specific questions about what a category requires); AHS Depo Fields 115 (Q: "What does AAAD perform in terms of in-person assistance?" A: "I'm not as educated as much on AAAD, but I would think there's similar support that's given there[,]" but that belief is only based on representations from TennCare).

[72] See, e.g., DHS Depo Bryson 116-19 (DHS stating it is uncertain as to whether it tracks the number of requests for accommodations it receives from TennCare enrollees, the number of individuals it has assisted who are blind or have visual impairments, whether it tracks any data regarding the types of accommodations that are requested, whether DHS reports to TennCare the types of requests for accommodation or types of accommodations DHS provides) (stating DHS would not be able to document that a particular enrollee came in for assistance seeking documents in large print, assuming DHS would forward information to TennCare, but stating that DHS was unaware of any training, written document, or written material); *see also*, Hagan Depo 175-77 (Ms. Hagan only reviews DHS county-level reports about assistance for TennCare enrollees as needed); TNCSA Depo Whitfield 91 (stating TNCSA does not have a mechanism to track reasonable accommodation requests "[b]ecause we have not had anything of that nature that TNCSA can recall.").

[73] Olson Depo at 204 (Q: "Are you able to determine whether or not the AHS customer service representative has, in fact noted the help in the enrollee's TEDS case file?" A: "Am I able to do that on my own?" Q: "Yes." A: "I do not have access to TEDS."); Hagan Depo 176-77 (stating that Ms. Hagan is the only person at TennCare who receives reports from DHS about its contractual obligations with TennCare, that she reviews them as needed but "can't swear that every single week I pull it up and study it…", does not delegate review to anyone, and will occasionally talk to DHS about the reports if there is a question about someone going to DHS); TennCare Depo Evans 32-33 (stating that the AAADs have not supplied reports to TennCare on in-person assistance concerning renewals until April 2023).

A person can interact with TennCare in various ways. Beneficiaries seeking to renew their TennCare can call the TennCare Connect number, 855-259-0701, which connects them to a call center currently operated by Automated Health Services (AHS); visit a local Department of Human Services (DHS) office (of which there is at least one in every county); use the TennCare Connect online portal either through the website or app, mail a renewal packet, or fax a renewal packet.[74] TennCare also contracts for the operation of a separate call center by the Tennessee Community Services Agency (TNCSA), sometimes referred to as the TennCare Advocacy Program,[75] as well as the provision of certain services by each of the nine Area Agencies on Aging and Disability (AAAD) that together serve all counties.[76] A new contract has recently been signed with the Rural Health Association of Tennessee (RHAT) for five individuals to conduct outreach to some beneficiaries.[77]

The TennCare Connect portal allows users to electronically access their accounts to view coverage information, view letters, and upload documents, and the TennCare phone app allows the same.[78] The TennCare Connect call center operated by AHS is supposed to help with questions about applying for TennCare, reporting a change, completing a renewal packet, or help filing an appeal.[79] TennCare materials, including the website, notices, and flyers, also direct individuals to the TennCare Connect number and portal for assistance.[80] Some beneficiaries can

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[74] Hagan Depo 161-62, Ex. 17.
[75] Hagan Depo 34.
[76] Flener Depo 251-52; Turner Depo 199, 201-02; Hagan Depo 158.
[77] Hagan Depo 34-37, 258-59.
[78] Div. TennCare, Welcome to TennCare Connect!, https://tenncareconnect.tn.gov/.
[79] Div. TennCare, Members/Applicants, https://www.tn.gov/tenncare/members-applicants/member-applicant.html.
[80] *See e.g., id.*; Hagan Depo 161-62, Ex. 17; TC-AMC-0000244905 to-32 (TennCare Notice of Decision).

get assistance at an AAAD, depending on the need.[81] Beneficiary notice inserts and websites also refer beneficiaries to TennCare Connect, and to the number for the TennCare OCRC.[82]

As detailed further below, the front-line functions are not clearly defined. The existing policies do not create an effective structure that identifies when one beneficiary access point will assess the need for assistance, provide such assistance, and refer the individual to another entity.[83] As a result of the lack of well-defined program roles, the various entities themselves seem to have different understandings of what function each other serves.[84]

For instance, if an individual is seeking in-person assistance with their redetermination packet, the TennCare Connect call center will refer the person to DHS.[85] But DHS typically refers people back to TennCare Connect for individualized questions or explanations.[86] Similarly, enrollees may be referred to the AAADs for assistance, but, until April 2023, the

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[81] Hagan Depo 270-71; Turner Depo 201-03; TennCare Depo Evans 18-23, Exs. 1, 2.
[82] TC-AMC-0000244645 to -46 (Special Help Attachment). The TennCare Renewals website, at the bottom of the page with "Upcoming Community Renewal Events" and under "Do you need help with your Renewal Packet?" directs people to the TennCare Connect number, but also says "Your local DHS office can help you with your renewal packet." And refers people who get or need long term care to a list of options, and to TNCSA if the person is getting help at a local community mental health center. Division of TennCare, Renewals, https://www.tn.gov/tenncare/members-applicants/redetermination.html.
[83] DHS Depo Bryson 34-44 (describing the limitations of their assistance and discussing referrals to TennCare Connect); AHS Depo Fields 42-45 (discussing assistance AHS can provide), 57-61 (discussing the goal of meeting caller needs but lack of knowledge about trainings specific to callers with disabilities), 84-87 (discussing referrals to DHS and AAADs for assistance); TNCSA Depo Whitfield 44-45, 129-31, 133-35 (discussing referrals to TennCare Connect).
[84] *See, e.g.*, Turner Depo 204-05 (stating that an individual with disability who needed assistance could ask a TennCare Connect representative for a referral to TNCSA who would then make a referral to the AAAD for in-person assistance); TNCSA Depo Whitfield 80-81, 83, 140 (stating TNCSA does not assess callers who might need in-person assistance and has not made referrals to AAAD for anything other than long-term services and supports and transportation help); DHS Depo Bryson 166 (expressing uncertainty as to which TennCare partners would provide in-person assistance); AHS Depo Fields 115 (Q: "What does AAAD perform in terms of in-person assistance?" A: "I'm not as educated as much on AAAD, but I would think there's similar support [to DHS support] that's given there.").
[85] AHS Depo Fields 84-85.
[86] DHS Depo Bryson 42-44 (describing referrals to TennCare, including for individualized information beyond DHS's "very broad, general knowledge . . . of [eligibility] categories"); Brooks Depo 205-06.

AAADs have not reported to TennCare in-person assistance provided to enrollees.[87] When individuals reach the TennCare Advocacy Program, TNCSA's ten advocates provide phone service and refer callers to DHS or TennCare Connect if they are seeking anything more than general information about TennCare that an informed layperson may be able to provide.[88]

For its part, TennCare Connect does not grant reasonable accommodation requests itself. It refers people to OCRC after a call is escalated to a call-center supervisor. In my experience reviewing and working with public benefits organizations, the lack of consistent and interconnected policies among the beneficiary-facing entities predictably means the process cannot validly and reliably provide a reasonably clear path to reasonable accommodations. The effect is to impose additional burdens on individuals with disabilities seeking assistance.

These burdens are exacerbated by TennCare's lack of a system to track accommodations required on an ongoing basis, meaning individuals must repeatedly follow the same circuitous path at each interaction with TennCare. To ensure that the program is providing access to TennCare eligibility, the agency should ensure the ongoing provision of needed document formats, auxiliary aids and services, and other accommodations for all interactions with that individual, unless the person indicates they are no longer needed. Equal access to programs and services such as TennCare likely cannot occur if people with disabilities must request the same accommodation at each and every point of contact with the system. Requiring such effort thwarts access and raises unnecessary and formidable barriers to access.

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[87] TennCare Depo Evans 33-34.
[88] TNCSA Depo Whitfield 49, 59, 73, 84-85.

a) The TennCare Connect Call Center Provides Insufficient Assistance and Connection to Reasonable Accommodations.

The TennCare Connect Call Center, which is currently operated by AHS, provides certain assistance to beneficiaries seeking help with the redeterminations process.[89] However, prior to a Corrective Action Plan (CAP) regarding ADA compliance issues in 2022, AHS did not understand that it was responsible for ADA compliance.[90]

TennCare Connect customer service representatives (CSRs) provide general assistance, including reading notices aloud, answering general questions, and speaking more loudly to persons who are hard of hearing.[91] CSRs are trained to collect information from callers, process documents received by fax and mail, and input information into TEDS.[92]

However, TennCare Connect employees do not have the authority to grant or deny reasonable accommodation requests, including granting extensions of time or providing notices or forms in alternate formats.[93] TennCare Connect employees regularly do not screen for disability-related assistance needs or record a person's requests for assistance according to any policies.[94]

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[89] The TennCare Connect call center was previously operated by Kepro, with the AHS contract beginning on Feb. 15, 2021. Fields Depo Ex. 2.

[90] AHS Depo Fields 144-45 (Q: "Did Talley Olson explain why a Corrective Action Plan [concerning ADA compliance] was necessary?" A: "She did." Q: "What did she say?" A: "I can't tell you specifically, but I can recollect I asked why we would be receiving a Corrective Action Plan for something that we hadn't been responsible for previously." Q: "I'm sorry. You trailed off there. I didn't catch the end of your response." A: "The fact that we were receiving a Corrective Action Plan for something that was just being introduced to us.").

[91] AHS Depo Fields 93-94, 114.

[92] AHS Depo Fields 82-83.

[93] AHS Depo Fields 83, 84, 89-90, 150-51, 156-57.

[94] AHS Depo Fields 86-87, 98, 101-02.

AHS policies and operational trainings direct CSRs to refer callers who need in-person assistance to DHS and the AAADs.[95] The policy regarding referrals to DHS for in-person assistance is broad, including situations where a caller is struggling to complete the packet even with AHS assistance over the phone.[96] Similarly, AHS refers people who are older or disabled to the AAADs.[97] However, there is no apparent follow-up or tracking of referrals to either entity to assess if people received the assistance they needed.[98]

If a person indicates they need help due to their disability, more recent policies direct CSRs to refer that person to their supervisor, who follows a "reasonable accommodation script," collecting information, filling out the Reasonable Accommodation Request Log, and emailing the log to a distribution list that includes OCRC.[99] However, this script only results in the caller being told generally that someone will reach out, with no timeline or contact in the interim if they do not receive a response or need help more immediately.[100] The AHS policies, scripts, and trainings were put in place in 2022, as part of a CAP required by the OCRC.[101] The CAP was put

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[95] AHS Depo Fields 84-87, 137-40 (testifying that there are policies in InfoTrack to direct callers to DHS for in-person assistance, expressing uncertainty about policies on AAAD referrals, and testifying to training about these referrals), 190-91, Ex. 56.

[96] AHS Depo Fields 190-91, Ex. 56 ("If the caller is struggling with completing the packet even with your assistance over the phone, please don't hesitate to offer that they go to their local DHS office for in-person assistance.").

[97] AHS Depo Fields 84-87, 115-16. AHS relies on information provided by TennCare as to the function of DHS and the AAADs. AHS Depo Fields 115-16.

[98] AHS Depo Fields 85, 87, 191.

[99] AHS Depo Fields 89-90, 96-97, 120-23, Exs. 9, 10.

[100] AHS Depo Fields 167, Ex. 24. Additionally, the script frames the request as asking the caller "Can you tell me what happened? (i.e., the facts of the reasonable accommodation: what is the issue, what is the request)?" AHS Depo Fields Ex 24.. This script frames the request as an event that happened and is being reported on rather opening the door to how a person can be helped, what would be helpful to them, what they are having trouble with, etc. How a person is welcomed to request help makes a significant difference in whether they will make the request.

[101] Def.'s Response to RFA 54 ([redacted]).

in place after issues were raised through disability-related complaints or eligibility appeals.[102] Outside of the CAP, during the relevant time period for this case, TennCare relied on form assurances and documents from the contractors, Kepro and then AHS, to the OCRC regarding civil rights compliance for paper review.[103] Prior to the CAP, AHS did not have processes for reasonable accommodations and TennCare had not asked for reasonable accommodation procedures, despite the compliance assurances.[104] According to TennCare, no other CAPs or contract compliance actions have been issued by TennCare to contractors involved in the redetermination process that related to ADA compliance, requests for reasonable accommodations, or disability discrimination complaints.[105] Prior to AHS, Kepro training indicates that it used a process reliant on the complaint form, which was processed as either a discrimination complaint (including a request for accommodations, alternate formats, etc.) or a discrimination allegation, which once completed, went to OCRC.[106]

Both before and after the CAP, neither TennCare nor OCRC has affirmatively and consistently monitored TennCare Connect directly through sampling of calls or other testing of

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[102] [redacted] Olson Depo 221, 225-231, Ex. 20.

[103] TC-AMC-0000153748 to -60 (Kepro Nondiscrimination Compliance Questionnaire 2019-2020); TC-AMC-0000263618 to -29 (AHS Nondiscrimination Compliance Questionnaire 2020-2021); TC-AMC-0000264504 (AHS Assurance of Compliance 4/30/21); AHS Depo Fields 118-19, 135-136, 144 (not aware of Olson requesting ADA compliance or information specific to reasonable accommodations prior to requests related to the CAP in January 2022).

[104] AHS Depo Fields 118-19, 144.

[105] Def.'s Responses to RFAs 53 and 57.

[106] TC-AMC-0000156751. Other than requests for forms in large print or braille, which were directed to the Kepro compliance coordinator, the supervisor would forward the form to OCRC. *Id.* Phrases that would trigger a discrimination complaint included reasonable accommodation, disability ("I need help because of my disability"), rights are being violated, and ADA. *Id.* at 19. A person could fill the form out with Kepro or use the copy on the TennCare website, on the health plan websites, in the member handbook, or have a copy of the form sent to them. *Id.* at 23.

the call center through calling to check for compliance with ADA policies.[107] Ms. Olson testified she has not test called the call center and does not believe other testing of staff learning is useful.[108] AHS does file quarterly and annual reports that include information on auxiliary and interpreter services provided.[109] While AHS randomly samples calls in general, AHS is unaware of whether disability is specifically part of the assessments of calls or of customer satisfaction surveys.[110]

b) DHS Offices Provide Limited Assistance.

Each county has at least one DHS office. These are the local human services offices to which people go to apply for benefits from programs, such as SNAP ("food stamps"), that DHS administers. DHS's role in administering TennCare eligibility ended before TEDS was developed and DHS does not participate in TennCare eligibility decisions.[111]

The main function DHS serves for the Disability Subclass is as a place to receive assistance with basic communication with TennCare: submitting needed documentation via fax or uploading to TennCare Connect, to use a kiosk to access the TennCare Connect online portal

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[107] Olson Depo 155-56 ("Q. How do you determine which calls to listen to? A: Usually it's when I get something like an allegation or a complaint.· Or if something comes over in the reasonable accommodation log, then I pull those specific calls and listen to them.· Or if something comes in -- a cause from appeal, either something with discrimination or -- sometimes, like, the field worker will say, hey, why don't you listen to this call and see what you think.· And I'll listen to it that way, I mean, too."), 104-06 (testifying that she has never called the call center to test ADA compliance and that she is not specifically aware of anyone else in TennCare doing so).

[108] Olson Depo 104-105 (has not test called the call center); 225 (there was not testing of learning from trainings to staff and that "[s]studies show that quizzes do not improve learning capacity" *But see* U.S. Dep't of Justice, *Americans with Disabilities Act Access for 9-1-1 and Telephone Emergency Services*, (July 15, 1998), available at https://archive.ada.gov/911ta.htm.

[109] AHS Depo Fields 20-22.

[110] AHS Depo Fields 56-57.

[111] DHS Depo Bryson 123-124.

or use a phone to call the TennCare Connect call center.[112] DHS employees do not have access to the worker-side of the online portal (i.e., they do not have access to TEDS).[113] DHS employees are not TennCare eligibility specialists and cannot answer anything more than general, high-level questions about the renewal process or TennCare eligibility.[114] Thus, DHS staff do not have access to the worker-side TEDS, do not receive training on categories of eligibility based on past receipt of SSI; meaning they cannot answer even generalized questions about these categories, which serve individuals with disabilities.[115]

DHS employees do not help individuals collect verifications requested by TennCare to complete the redetermination process.[116] DHS employees do not go to someone's home to provide in-person assistance for renewals or otherwise.[117] Requests for assistance beyond use of the phone, computer kiosks, or faxing and uploading documents are referred mostly to TennCare Connect.[118]

The DHS offices do not help people request reasonable accommodations from TennCare. In those cases, DHS refers back to TennCare Connect.[119] DHS employees are not trained in the TennCare accommodation process or how to help beneficiaries obtain accommodations. They are not trained to recognize and provide reasonable accommodations beyond a basic civil rights

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[112] DHS Depo Bryson 114-15.
[113] DHS Depo Bryson 23-24.
[114] Hagan Depo 217; DHS Depo Bryson 37-39, 65-66, 118, 125-26.
[115] DHS Depo Bryson 215-16, 221-230 (stating "[A]nd then it looks like – and then just to make sure we're clear, it looks like the section on the SSI-related categories [in Worker Guide] was deleted?" A: "That's what it looks like, yes."), Ex. 7.
[116] DHS Depo Bryson 34.
[117] Hagan Depo 222-23.
[118] DHS Depo Bryson 19-21, 36-38, 43, 105-10, 114-15, 152-54, 184-85.
[119] DHS Depo Bryson 113-14.

training at hiring, nor do they track such requests or help beneficiaries request them from TennCare other than providing the connection to TennCare Connect.[120]

Although DHS relies on kiosks for enrollees to access TennCare Connect by phone or through the portal, DHS was uncertain as to whether its staff are trained on how to ensure accessibility of the kiosks, such as whether computers or tablets at the kiosks can be adjusted for accessibility (e.g., changing font size or contrast or volume).[121]

TennCare Connect call-center staff are instructed to refer to DHS for in-person assistance.[122] But DHS does not provide the type of in-person assistance that people with disabilities often need in terms of understanding TennCare notices, what would fulfill the requests for information, and how to get needed paperwork and submit it to TennCare. DHS was unable to identify partner agencies it would refer an individual to if they needed this kind of individualized, in-person assistance.[123] If a person needs more help than DHS provides, they are referred back to TennCare Connect, which is often the agency that referred them to DHS.[124]

DHS does not track relevant information about beneficiaries with disabilities, either to monitor its own performance or to assess the demand for its services from beneficiaries with

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[120] DHS Depo Bryson 15, 60-63, 105-06,108-10, Ex. 7.
[121] DHS Depo Bryson 65, 77-79, 118-19. Although the kiosks are available, reports indicate many people who come to DHS for assistance say they will return home to access TennCare Connect. *See* Hagan Depo Exs. 23, 24, 25 (e.g. TC-AMC-0000648566).
[122] AHS Depo Fields 137-39, Ex. 56.
[123] DHS Depo Bryson 166 (Q: "[D]o you know if there's anywhere where DHS can refer an individual to get that kind of in-person question and answer for TennCare?" A: "There may be through partners or others that could provide some assistance. I think if – if and when there were instances where someone needed that, we would work to try to see if there's you know, that feasibility.").
[124] DHS Depo Bryson 196-97 (Q: "[I]f someone didn't understand what verifications TennCare was asking them for or what documents would be sufficient to establish whatever information is missing, and they came to DHS to get clarification, what would you expect DHS staff to do?" A: "To refer them to TennCare for that question.").

disabilities.[125] While DHS tracks minimal information about non-disability specific assistance provided regarding application, redetermination, and kiosk usage, the agency does not regularly track information about accommodations requested or provided.[126] Because DHS does not track requests for accommodation, it appears that it does not use such information to prepare local offices for commonly needed accommodations or ensure that auxiliary aids and services are available. Without tracking requests for accommodations or an understanding of the needs of beneficiaries with disabilities in the local population, DHS has little information to be adequately prepared to provide access to those who are likely to come to DHS for assistance.

c) Area Agencies on Aging and Disability Do Not Provide Meaningful In-Person Assistance.

There are nine AAADs distributed across the state for geographic districts,[127] but TennCare and its contractors seem to lack awareness and clarity as to the AAADs' role or duties concerning in-person assistance.[128]

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[125] The monitoring process that TennCare established during the redetermination of eligibility in 2002 represents one such approach to identifying and correcting problems providing reasonable accommodations. *Rosen* Appendix, AMC-ALL-135 – AMC-ALL-140.

[126] *See* DHS Depo Bryson 108-12, 116-17; Def.'s Response to RFA 60.

[127] Hagan Depo 158.

[128] TennCare formerly recognized the importance of in-person assistance in accommodating many types of disabilities and provided such assistance by multiple means. In 2002, renewal of eligibility generally involved a face-to-face interaction at an enrollee's local DHS office. To accommodate enrollees with disabilities, DHS offered to assist them by making home visits or providing in-person assistance at other sites. *Rosen* Appendix, AMC-ALL-0107, AMC-ALL-0111. DHS also out-stationed eligibility workers at community mental health centers and contracted with private organizations to conduct individualized outreach to individuals with mental illness who did not respond to redetermination notices and connect them to case managers to help them complete the process. *Rosen* Appendix; AMC-ALL-0111 – AMC-ALL-0121; *Rosen* PFFCL, AMC-ALL-0030.

For purposes of eligibility, AAADs typically provide assistance regarding long-term care.[129] AAADs are not eligibility specialists,[130] "are not expected to be eligibility counselors or experts in the categories[,]"[131] only have "a general understanding of the eligibility categories[,]"[132] and have less expertise than TennCare's call center contractors.[133] AAADs do not have access to TEDS[134] and "are trained to the extent that they can assist someone with applying for coverage[,]"[135] which is a separate process than renewals.[136]

TennCare's contracts with the AAADs previously covered in-person assistance with eligibility renewals only with respect to those individuals enrolled in TennCare's Long Term Services and Supports ("LTSS") programs.[137] TennCare amended its contracts with the AAADs to require them to report in-person assistance with renewals beginning in April 2023, but it did not increase the amount TennCare pays the agencies for their work.[138]

The AAADs' in-person assistance services concerning renewals seem not well-publicized. As of April 13, 2023, on the agency's renewal webpage, TennCare only listed in-person assistance being provided at DHS county offices and did not list AAADs as providing in-

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[129] Turner Depo 202.
[130] Hagan Depo 217.
[131] Turner Depo 202-03.
[132] Turner Depo 202.
[133] Turner Depo 202-203.
[134] Hagan Depo 41.
[135] Turner Depo 202-203.
[136] Hagan Depo 28.
[137] See, e.g., TennCare's contract with the East Tennessee Human Resources Agency (ETHRA), available at https://www.tn.gov/content/dam/tn/tenncare/documents2/EastTennesseeHRA.pdf (original grant contract at 1, 14).
[138] TennCare Depo Evans Depo 45-46.

person assistance with renewals.[139] Until April 10, 2023, TennCare Connect used a pre-TEDS reference guide that did not list AAADs as providing in-person assistance with renewals.[140]

The AAADs' in-person assistance function also appears not well known among TennCare's contractors and not well understood in practice within TennCare. DHS was uncertain as to which TennCare contracting partners would provide in-person assistance[141] and AHS expressed uncertainty as to what AAADs did with respect to in-person assistance.[142] TennCare's Deputy Director of Member Services, Ms. Angela Turner, testified that an individual with a disability who needed assistance could ask a call center representative for a referral to the TNCSA who would in turn refer the individual to the AAAD "particularly if the person needed in-person assistance."[143] But when asked, TNCSA's representative stated that there have not been referrals for in-person assistance, including with the renewal process.[144]

TennCare has not tracked the in-person assistance provided by AAADs for renewals. Until April 2023, TennCare did not request or receive reports from the AAADs that document in-person assistance with renewals.[145] TennCare has not been tracking the requests for or the provision of in-person assistance for redeterminations but plans to begin when redeterminations resume.[146] Unless in-person assistance is provided as part of a specific case, TennCare's Director

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[139] Hagan Depo 148-52, 161-165, Ex. 17.
[140] AHS Depo Fields 190, Ex. 56; TennCare Depo Hagan 9-10, Ex. 3 (same as Fields Ex. 56).
[141] DHS Depo Bryson 166-67.
[142] AHS Depo Fields 115 (Q: "What does AAAD perform in terms of in-person assistance?" A: "I'm not as educated as much on AAAD, but I would think there's similar support that's given there.").
[143] Turner Depo 205.
[144] TNCSA Depo Whitfield 127-28.
[145] TennCare Depo Evans Depo 33-34.
[146] Def.'s Response to RFA 59(f). TennCare plans to receive reports from the AAADs that provide information regarding the provision of in-person assistance after the redeterminations resume following the end of the PHE moratorium. *Id. See also*, Hagan Depo 243.

of Civil Rights Compliance does not have access to databases or reports related to in-person assistance.[147]

d) The Services of the Tennessee Community Services Agency Have Limited Reach and Scope and Do Not Include the Reasonable Accommodation of Disabilities.

The Tennessee Community Services Agency (TNCSA) provides limited outreach under a contract with TennCare.[148] TNCSA interacts with TennCare members exclusively by phone and does not provide in-person assistance for redeterminations.[149] The agency operates the TennCare Advocacy Program, a call center service offered to individuals with mental health needs. Two of the ten TNCSA advocates assigned to the TennCare contract have an educational background in social sciences or psychology and are more knowledgeable of available mental health services; however, these mental health advocates receive the same training as other TNCSA advocates.[150] TNCSA advocates have the ability to view information in InterChange,[151] which allows them to inform callers about the status of their TennCare coverage.[152] They provide TennCare members with information about their Managed Care Organizations ("MCOs") and the benefits available to them.[153] TNCSA recently gained limited access to a submenu of TEDS, enabling the agency

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[147] Olson Depo 63-64.
[148] TNCSA Depo Whitfield 165-68.
[149] *Id.* at 38, 80-82.
[150] *Id.* at 34-35.
[151] InterChange is another name for the Medicaid Management Information System. It is TennCare's eligibility system of record, is not an eligibility determination system like TEDS, sends eligibility information to TennCare's Managed Care Organizations, and contains some claims data. Flener Depo 102, 106-07.
[152] TNCSA Depo Whitfield 18-19.
[153] *Id.* at 49-51.

to view letters a caller has received from TennCare along with the status of a caller's application.[154]

TNCSA considers itself the entity that people call when they "don't know who else to call."[155] TNCSA prides itself on providing extra time to talk with callers to understand their issues.[156] TNCSA advocates are not enrollment specialists, and their knowledge is limited to information that is publicly available on the TennCare website and in the member handbook.[157] The advocates' role is to listen to a caller and identify the group that may help with their question or problem.[158] For anything more than basic questions about eligibility, redetermination, or appeals, TNCSA refers callers to the TennCare Connect call center by providing the phone number, transferring the call, or remaining on the line with the caller.[159]

TNCSCA trains staff with customer service principles and to listen to the caller to determine how to best communicate with them, but does not provide specific trainings on providing reasonable accommodations to callers or how to request reasonable accommodations from TennCare.[160] Apparently, TNCSA has not received a reasonable accommodation request from a caller, and if the agency did, the advocate would either refer the caller to TennCare Connect or escalate the call to a supervisor, who would reach out to someone other than Talley Olson at TennCare.[161] If a caller informed a TNCSA advocate of a disability, the TNCSA advocate would not inform the TennCare Connect CSR because of concerns about privacy and

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[154] *Id.* at 175.
[155] *Id.* at 26-27.
[156] *Id.* at 68-72, 75-76.
[157] TNCSA Depo Whitfield 43, 51-53, 59, 135.
[158] *Id.* at 26-27, 69-70.
[159] *Id.* at 44-45, 129-31, 133-35.
[160] *Id.* at 62-65, 93.
[161] *Id.* at 93-95, 97-101.

because TNCSA may not consider the information to be relevant.[162] Apparently, TNCSA has not received a referral from TennCare Connect related to in-person assistance and has not referred a caller to an AAAD for in-person assistance.[163]

e) TennCare's Appeals Unit Fails to Provide Reasonable Accommodations.

Appeals are an important period to discover potential errors in eligibility determinations and ensure that eligible individuals maintain access to the program.[164] TennCare's appeals process is administratively burdensome because it is heavily reliant on paperwork and submission of forms and information to support an appeal and because it involves time-sensitive deadlines.[165] Individuals can file an appeal by phone through TennCare Connect, on a DHS kiosk or on paper at a DHS office, by mail, or by fax.[166] After an appeal is submitted to TennCare, it is reviewed by the clerk's office in the appeals unit for timeliness. Individuals who work in the clerk's office and who perform this timeliness review are not trained or instructed to review an appeal for signs that the appellant might need help or accommodations.[167]

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[162] TNCSA Depo Whitfield 122, 199-201. As an example, the TNCSA designee, testified, ". . . what benefit would -- would it be for TennCare Connect to know that this person was dealing with breast cancer and they're completing an application? What business is it of theirs." TNCSA Depo Whitfield 199-200.

[163] TNCSA Depo Whitfield 80-83, 140. In the past, referrals to AAADs have exclusively related to LTSS and transportation help. TNCSA Depo Whitfield 139-40.

[164] TennCare Depo Leffard 25-27 (testifying about the Quality Improvement and Compliance Team in the appeals unit, which, among other roles, analyzes whether TennCare is correctly considering the categories of eligibility).

[165] *Id.* at 27 (describing the 20-day deadline to appeal with continuation of benefits and the 40-day deadline to appeal without continuation of benefits), 91-92 (describing the valid factual dispute policy and the 10-day deadline to respond to a valid factual dispute additional information notice).

[166] *Id.* at 29 (call center); DHS Depo Bryson 43 (DHS); https://www.tn.gov/tenncare/members-applicants/how-to-file-an-eligibility-appeal.html (describing mail).

[167] TennCare Depo Leffard Depo 201-02.

The appeals operation group at TennCare routes member requests for reasonable accommodations in the appeals process through Talley Olson in OCRC.[168] Talley Olson is responsible for reasonable accommodation requests as they relate to appeals.[169] The appeals operation group is unaware of an instance in which it has routed a reasonable accommodation request to Talley Olson in the last two years.[170] At least one request was routed in the year prior to that, and an appellant who was deaf and only read lips was provided an in-person hearing.[171]

f) Difficulties Navigating TennCare's Assistance Process Thwart Access to the Program for Individuals.

Records of individuals interacting with frontline staff at the various entities involved in TennCare redeterminations show a lack of agreement and clarity about which entity can help and how, and demonstrate how this can impose additional burdens on enrollees seeking assistance. These records also show how TennCare's structures regarding assistance, or lack thereof, result in missed opportunities to assess whether the person needs assistance, provide it, and, where needed, record it so that assistance is readily available to the person in the future.

DHS kiosk reports[172] document individuals seeking assistance but often being sent to another entity with no assurance the individual would receive the assistance and no communication to TennCare regarding the individual's identified needs. In one example, a

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[168] *Id.* at 194-96.
[169] *Id.* at 199.
[170] *Id.* at 199-200.
[171] *Id.* at 200-01, 233-34.
[172] [redacted] *See* DHS Depo Bryson 203; Hagan Depo 172-177.

couple came into a DHS office saying they were told by the "appeals people that they needed to come [to DHS] to get an authorization form(?) and contact [AAAD]."[173] The report reflects that DHS staff gave them the form and AAAD number, which the couple already had, but further notes that the couple went to yet another office to see if they could get the assistance they needed regarding the appeal.[174] This couple had already been referred by another entity, was clearly confused, and was referred yet again. Although the report indicates that DHS staff recognized the confusion, there is no record of assistance contacting the AAAD or alerting either the appeals unit or OCRC to the couple's likely need of assistance navigating the appeal process.

In another example, "a person called with a sign language translator to say they are having issues with TennCare."[175] The individual had been referred to DHS by a unit within TennCare, but DHS simply referred the person back to the same unit and told the person to speak with a supervisor.[176] There was no connection to an appropriate contact at TennCare Connect or other assistance offered with respect to the caller's disability status. There are other examples in the reports showing that DHS routinely refers to TennCare Connect questions about the status of a person's coverage, the meaning of conflicting notices, or the reason for a loss of coverage.[177]

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[173] [redacted]

[174] *Id.*

[175] [redacted]

[176] *Id.*

[redacted]

Recordings of the named Plaintiffs interaction with the TennCare Connect call center illustrate frustrated attempts to navigate TennCare's processes, even with family and friends helping, and document the limited assistance the call center ultimately provides. Plaintiff Vivian Barnes was found ineligible for TennCare following a 2019 redetermination. Her daughter, an advocate, and a medical provider called TennCare Connect on her behalf, in several calls.[178] In multiple cases, call center staff could not confirm the status of Ms. Barnes's coverage, nor explain what the information in the online TennCare Connect portal meant, noting in one call that "sometimes the online and mobile app will have you running in circles."[179] Various call center staff noted repeatedly that it appeared to them that something had changed with Ms. Barnes's receipt of SSI, but no one could explain why TennCare thought she had lost SSI, when she had not. When asked, one call center staff responded, "We don't make the decisions"[180] and, "We're just the middle person . . . we have no power in deciding."[181] Ms. Barnes's daughter sought further help from the advocacy line at TNSCA, but received no additional information.[182]

[redacted]

[178] TC-AMC-0000000975; TC-AMC-0000000973; TC-AMC-0000000978; TC-AMC-0000000970; TC-AMC-0000000972; TC-AMC-0000000969.
[179] TC-AMC-0000000976.
[180] TC-AMC-0000000974.
[181] TC-AMC-0000000975.
[182] TC-AMC-0000000978.

Ms. Barnes was provided with the phone number for the AAADs to determine whether she was eligible for Long Term Services and Supports, a process which would not address TennCare's mistake regarding her receipt of SSI and which the call center advised could take 90 days.[183]

When asked what callers could do to ensure Ms. Barnes regained coverage, no call center staff offered accommodations—for instance, filing an untimely appeal with continuing benefits, expedited application processing, or an alternate way of verifying SSI receipt. These omissions occurred even though the callers explained that Ms. Barnes was paying out of pocket to get ambulance transportation to doctor's appointments.

Plaintiff Johnny Walker's sister called after learning at the pharmacy that he had lost coverage.[184] According to TennCare he had not responded to a questionnaire, but Ms. Walker stated they had not received it. Ms. Walker explained that Mr. Walker has a substantial disability and that they had only one day's worth of medication that is vital for his physical and mental health.

Ms. Walker made requests for assistance to maintain Mr. Walker's coverage: she asked whether they could do anything to "speed along this process" since he needed the medication. The call center staff stated an appeal was the fastest way, but later stated it could take ninety days. Ms. Walker filed the appeal over the phone. Second, Ms. Walker asked if she could get the questionnaire faxed to them so they could fax it back the same day in an effort to get the coverage restored before the medication ran out. The call center staff stated no, that the only option was to mail it. Staff advised the Walkers to pay for the medication out of pocket and seek reimbursement at a later date.

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[183] TC-AMC-0000000970.
[184] TC-AMC-0000008234.

A few weeks later a friend called on Mr. Walker's behalf and asked if there was anything he could do to get the coverage restored because Mr. Walker could not afford his medication and was in terrible shape.[185] Once again, the call center staff stated, "There's not really anything we can do right now," because he was only 23 days into the 90-day timeline. In neither call was the issue raised to a supervisor or routed to the OCRC to determine whether an accommodation to the typical appeal process could be offered given Mr. Walker's disability and urgent medical need.

Plaintiff SLC's father called to ask about the status of an appeal and to understand why TennCare found SLC ineligible when she previously received SSI and received LTSS. When the call center staff could not sufficiently answer his questions, he asked, "Could I request a sit-down meeting?" to which the call center representative stated "No, everything is over the phone," including interactions with the appeals group and any hearing itself.[186] As these examples illustrate, the failure to have clear policies regarding what assistance can be offered by frontline staff and how to escalate requests that seek more assistance can impose significant burdens on individuals with disabilities, including loss of benefits.

2. TennCare Does Not Adequately Train Staff.

One key part of a public benefits system and providing access to people with disabilities is the training of the frontline staff who will commonly interact with beneficiaries.[187] TennCare's training in this regard is not adequate. Prior to the CAP issued to AHS in January 2022

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[185] TC-AMC-0000008235.
[186] TC-AMC-0000002066.
[187] DOJ Title II Primer.

concerning ADA compliance, AHS, the vendor that operates the TennCare Connect phone center, did not understand that it was responsible for ADA compliance.[188]

In my experience and research, without adequate training and monitoring, some staff may avoid or minimize the need for accommodation.[189] Policies should be in place that inform staff how to recognize a request for accommodation, how to note the request in the system for future use, and how to provide the accommodation, including giving primary consideration to the individual's preferred accommodation as appropriate.[190]

Frontline staff should be trained in recognizing the need for common accommodations, which should be in their authority to provide or arrange. For example, frontline staff should understand how to print or enlarge a normal notice to meet large print needs, or in the case of in-person frontline staff such as DHS and the AAADs, understand how to offer a private place to go over a notice orally or otherwise work with the person to provide needed accommodations.

Frontline staff should be trained to identify requests for accommodations that require approval or action outside of their authority. For example, frontline staff should know how to

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[188] AHS Depo Fields 144-45 (Q: "Did Talley Olson explain why a Corrective Action Plan [concerning ADA compliance] was necessary?" A: "She did." Q: "What did she say?" A: "I can't tell you specifically, but I can recollect I asked why we would be receiving a Corrective Action Plan for something that we hadn't been responsible for previously." Q: "I'm sorry. You trailed off there. I didn't catch the end of your response." A: "The fact that we were receiving a Corrective Action Plan for something that was just being introduced to us.").

[189] Stereotypes may be difficult to assess due to well-established social desirability bias against public acknowledgment of prejudicial attitudes and are resistant to change due to cognitive bias toward information that is consistent with and reinforces pre-existing stereotypes. *See, e.g.*, Dianna Stone & Adriene Colella, *A Model of Factors Affecting the Treatment of Disabled Individuals in Organizations*, 21, 352-53 (2) *Acad. Mgmt. Rev.* 352 (1996); Peter Blanck, *Civil War Pensions and Disability*, 62, 139-40 *Oh. St. L. J.* 109 (2001).

[190] DOJ ADA Title II Primer ("It is important that staff – especially front line staff who routinely interact with the public – understand the requirements on modifying policies and practices, communicating with and assisting customers, accepting calls placed through the relay system, and identifying alternate ways to provide access to programs and services when necessary to accommodate individuals with a mobility disability."

read a notice aloud, but may need to refer a request to a supervisor to provide additional explanation of the notice other than simple reading to help the person understand what action the notice is requesting of the person. Also, enrollees often need to access subsequent help understanding a notice. Notices for public programs, including those used by TennCare, can be long and complex and people may need more than one-time help with understanding a notice. If the frontline staff reads aloud the notice, an enrollee may need to have it read again or have questions about what a particular part means after they have tried to take the action requested by the notice, like gathering certain documents.

Frontline staff should be trained to direct the person to the necessary process for requesting and receiving approval for assistance and providing help with accessing that process as needed. An effective process for requesting reasonable accommodations should be straightforward and simple, but even if simple, there may be people who need assistance getting through that process and staff should understand how to provide that assistance or where to refer when outside the scope of what they can do. Training for frontline staff should emphasize that they cannot deny a requested accommodation or decide that it would constitute an undue burden or fundamental alteration. These are decisions for a higher-level employee.[191]

Disability-related training should be part of the ongoing training provided to frontline staff, but refresher training should occur periodically, ideally at least twice per year. In my experience, absent adequate training on the above topics, frontline staff may impose significant, unnecessary barriers to individuals with disabilities.

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[191] DOJ ADA Title II Primer ("The decision that a particular aid or service would result in an undue burden or fundamental alteration must be made by a high level official, no lower than a Department head, and must be accompanied by a written statement of the reasons for reaching that conclusion").

TennCare's trainings provided to frontline staff during most of the relevant time period for this case do not adequately provide information on providing access for people with disabilities, screening for reasonable accommodations, and directing people how to receive needed assistance and accommodations. It appears that identical and cursory civil rights trainings are offered to new hires and on an annual basis. Based on the materials I have reviewed, these trainings appear to provide skeletal information.[192] In at least one instance, after ADA compliance issues were identified with an individual employee, more specific re-training was provided,[193] but the lack of adequate training for staff seems to remain.

The TennCare new hire and annual civil rights trainings provide basic information about effective communication and auxiliary aids and services for people with disabilities, but provide limited information about how employees should recognize and respond to requests for such aides and services.[194] The trainings do not instruct TennCare Connect staff regarding how to provide other accommodations besides auxiliary aides, stating instead that requests such as needing more time may be noted in a person's casefile.[195] The trainings thus likely miss the important cues that employees should recognize when beneficiaries with disabilities are seeking accommodations but do not use terms such as "auxiliary aids and services." Such cues may include, for example, a beneficiary asking the TennCare representative to speak more slowly and enunciate due to trouble hearing or understanding, or saying that they need help with handling paperwork because of arthritis. As another example, a beneficiary may express difficulty

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[192] *See* Olson Depo Ex. 31 (Civil Rights New Hire Training, TC-AMC-0000153836); TC-AMC-0000153794 - 834) (Civil Rights Annual Employee Training).
[193] AHS Fields Depo, at 124-29, Ex. 12.
[194] Olson Depo Ex. 31 (TC-AMC-0000153836); TC-AMC-0000153794 - 834 (Civil Rights Annual Employee Training).
[195] *Id.*

understanding what a letter is asking them to do because they have "nerve" or mental problems or had difficulty in school.[196]

The staff training slides generally explain auxiliary aids and services such as sign language interpreters to listing whom to contact to arrange for such aids and services.[197] However, the trainings have limited information about reasonable accommodations and generally restate the law. Examples of reasonable accommodations are not provided, nor is the process for requesting, granting, and denying reasonable accommodations mentioned in the training materials, including, for example, standards or criteria for decisions, timelines, or authority for granting or denying requests.[198]

The CAP process included, for the first time, reasonable accommodation training delivered to AHS staff, on a one-time only basis.[199] However, instead of instructing staff to address those requests, this AHS training includes the directive that requests for reasonable accommodation "are considered to be discrimination complaints."[200] Further, while this training offers examples of reasonable accommodations and provides examples of "key words and phrases" that might "alert" staff to inquire further about a request, it does not adequately describe a process for assessing and making determinations regarding those requests, short of contacting

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[196] In the past, by contrast, all DHS workers were trained to offer and make reasonable accommodations "to those who request this, as well as those who staff observe may need accommodations." *Rosen* Appendix, AMC-ALL-0105, AMC-ALL-131. In every conversation between DHS and a client, the client was asked in general terms if she needed any assistance from DHS. *Rosen* Appendix, AMC-ALL-0106. DHS call center operators offered reasonable accommodations not just to those who requested it, but to whose circumstances indicated a need for them. *Rosen* Appendix, AMC-ALL-0107. Meetings with DHS staff workers emphasized DHS's desire and obligation to ensure that clients were accommodated. *Rosen* Appendix, AMC-ALL-0105.

[197] Olson Depo Ex. 31 (TC-AMC-0000153836); TC-AMC-0000153794 (Civil Rights Annual Employee Training).

[198] *Id.*

[199] AHS Depo Fields 175-76.

[200] Olson Depo Ex. 35 (TC-AMC-0000252549).

the supervisor or the AHS nondiscrimination coordinator. Failing that, supervisors are to help the caller complete the discrimination complaint process.[201]

As with the other civil rights trainings, the AHS reasonable accommodation training provided as part of the CAP appears inadequate and confusing. It instructs staff to recognize accommodation requests, but fails to describe any actual process, such as lines of authority and timing, but more fundamentally, the actual standards for addressing and resolving those requests besides channeling them though complaint procedures.

Call center staff thus lack adequate training to understand the range of possible accommodations that a person with disabilities may need or request over the phone and how they may present those needs on a call. TEDS does not give call center staff notice of disabilities that a beneficiary is known to have, or of the accommodations that a beneficiary has sought and received in the past.[202]

Call center staff also do not appear to have a clear and comprehensive list of accommodations they may provide, such as speaking more loudly and slowly, reading notices aloud, or setting appointments for a call if a person needs assistance from family, friends, or others. In addition, even when the call is referred to the supervisor, that individual is steered to fill out a complaint form to trigger the next steps in the accommodation process, potentially delaying the provision of accommodations. The lack of clarity in the process and complicated procedures will also likely lead to inconsistent processing of requests and potential denials and abandonment of the accommodation requests. Through the different contractors during the

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[201] *Id.*

[202] *See* Flener Depo 239-40 (stating TEDS broadly does not track disability data, but will indicate if person is blind based on SDX data).

relevant time period, call center staff are trained initially and potentially at annual trainings, unless there is an identified individual compliance issue.[203]

As with AHS call center staff, DHS employees receive inadequate training and do not maintain that training such that they can be expected to have the skills needed to provide access to beneficiaries. DHS employees are trained on disability policies when they are hired and review informational memoranda as they are issued.[204] This means that years may have elapsed since DHS staff who interact with beneficiaries received their training, and there is no apparent process to ensure that staff understand how they are to put into practice the requirements in an informational memorandum.

Agency staff, especially those frontline staff who will interact with beneficiaries, should receive ongoing training regarding people with disabilities, accommodations, and providing access to the program and services.[205] This training needs to help staff understand how to assist people with disabilities receive assistance, whether from them or through other processes or referrals, and inform front-line employees that they should not make unilateral decisions to deny or discourage requests for accommodations. The training needs to effectively help staff understand the relevant policies and how to identify the situations to which they need to apply those access policies. Training periodically should cover how to document and provide information about the need for assistance and accommodation.

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[203] AHS Depo Fields 196 (stating reasonable accommodation training only given to new AHS hires and not after); Olson Depo 151; DHS Depo Bryson 111-12.
[204] DHS Depo Bryson 107, 112.
[205] DOJ ADA Title II Primer; The State's acknowledgement of this need was reflected in the extensive, ongoing training DHS provided in 2002 to ensure that staff would reliably implement the state's comprehensive reasonable accommodation policies. *Rosen* Appendix, AMC-ALL-0130-134.

3. TennCare's Process for Requesting Reasonable Accommodations Limits Access.

Entities such as TennCare must maintain processes to ensure the timely and effective provision of requested accessible document formats, auxiliary aids and services, or other accommodations. TennCare's processes for requesting reasonable accommodations does not ensure effective, prompt, and consistent (i.e., valid and reliable) provision of accommodations.

a) TennCare Lacks Screening Procedures and Fails to Alert Enrollees on How to Request Accommodations.

TennCare policies and training do not mandate a consistent or structured general disability screening and assessment to generate accommodations. TennCare policy instructs call center staff to be alert to disability issues raised by enrollees on the call but does not provide staff with information that TennCare has that indicates an accommodation may be warranted. As previously noted, to ensure that it is accessible to people with disabilities, a program like TennCare should record and utilize information on a beneficiary's disabilities and previously acknowledged need for accommodation. But TennCare does not provide guidance on how CSRs can use the information that is available in TEDS. For example, TennCare could train CSRs to access eligibility information in TEDS that would at least alert them if a caller's coverage history has been based on a finding of disability or that there are current indicators of disability. As a practical matter, a screening system would have staff using practices that clearly offer assistance and open the door to requests for reasonable accommodations, with information regarding disability facilitating how staff ensure the person understands that they may request assistance and helping them to do so. The lack of meaningful, comprehensive screening systems and training on such systems contributes to the limits of accommodation provision because the range of disabilities and needed accommodations are apparently not being surfaced.

TennCare also does not adequately alert enrollees regarding how to request accommodations.[206] TennCare uses an insert in its Notice of Decision (NOD) template, titled: "Do You Need Special Help?"[207] This notice asks "[D]o you need help because you have a health, mental health, learning problem or disability?" and directs persons to TennCare Connect.[208] The notice does not describe what a "disability" may be, and it does not distinguish between that status and a "mental health" or "learning problem." The notice gives the sole example of needing help "talking with us or sending what we send you" and provides information regarding discrimination complaints.[209] There is no apparent information about requesting and obtaining a decision regarding reasonable accommodations as a right of persons who are disabled.

AHS staff also do not routinely inform callers who are disabled that they have a right to request accommodations.[210] As a result, when a person contacts TennCare, they may not be

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[206] By contrast, notices employed by the state during the 2002 renewal process [*Rosen* Appendix, AMC-ALL-0126] were clear and unambiguous:

> If you have a health, learning or nerve problem, you may have legal rights under the Americans with Disabilities Act (ADA); You may also have these rights if you have a problem: a child or relative who lives with you has a health, learning, or nerve problem. If this applies to you, then: If you cannot do something we asked you to do: We can help you do it, or We can change what you have to do. Here are some of the ways we can help: We can call or visit if you are not able to come to our office. We can tell you what this letter means....We can help you to appeal. If you need some other kind of help, ask us. Call your worker or call: 1-888-863-6178 for Families First or Medicaid problems ...

[207] Olson Depo Ex. 26.
[208] *Id.*
[209] *Id.*
[210] AHS Depo Fields 172 (stating that reference to a right to request a reasonable accommodation would not be standard scripting, but may be in other documents).

aware of the availability of reasonable accommodations due to a lack of information.[211] The notices contain directions to get help, but this leads to TennCare Connect. Although the online complaint form, which is also referenced in the member handbook, is the only form available for requesting accommodations, the form or its instructions does not adequately indicate that it is used for that purpose.[212]

b) TennCare's Process for Requesting Reasonable Accommodations Is Confusing and Burdensome.

TennCare lacks an effective (i.e., valid and reliable) process for requesting, reviewing, and approving or denying accommodations as evidenced by the absence of written policies and

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[211] Standard taglines on notice templates refer individuals to TennCare Connect to request special help, *see* Olson Depo Ex. 26 (TC-AMC-0000244645 (Special Help Notice)), but TennCare Connect generally refers requests for reasonable accommodation to OCRC *after* a call is escalated to a manager, AHS Depo Fields 90, 198, and the individual is invited to file a discrimination complaint. *See id.* at 90, 120-23, Ex. 10. The "Need Special Help?" insert, Olson Depo Ex. 26 (TC-AMC-0000244645 to -46) also refers individuals to Talley Olson at the OCRC and directs individuals to file a complaint, which is a multi-page document with nine other questions or fields to complete besides contact information and a signature. *See* Olson Depo 123, Ex. 7. And while Ms. Olson's testified that informal requests for reasonable accommodation can be processed by TennCare, Olson Depo 71-72, the results of TennCare's actual process show that requests, whether they are formal or informal, are unlikely to succeed. Ms. Olson reports never having seen a true request for accommodation. Olson Depo 74 (stating "[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."), 167 ("For – as far as redetermination, I can say as far as I am aware, I have never had to grant an accommodation to a member for a renewal packet[.]"). The number of complaints logged by OCRC is but a small fraction of the number of requests for accommodation that are to be expected in a program the size of TennCare. Aside from this, the Special Help Insert Olson Depo Ex. 26 (TC-AMC-0000244646), informs enrollees with mental illness that if they need help with the letter they can contact the TennCare Advocacy Program, also known as TNCSA, which has little knowledge of TennCare eligibility and provides limited help outside of reading a letter or referring people to TennCare Connect or DHS. TNCSA Depo Whitfield 130-31, 162-63. People with disabilities other than mental illness may be confused as to who they should call for assistance.

[212] Olson Depo 72; Olson Depo Ex. 7 (also available at https://www.tn.gov/content/dam/tn/tenncare/documents/complaintform.pdf); TennCare Member Handbook (2022), 5 (available at https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/blue_handbook_2022.pdf). The treatment of reasonable accommodation requests as complaints is unclear as Olson appears to say that to make a reasonable accommodation request a beneficiary has to make a complaint of discrimination. Olson Depo 195-96, Ex. 35 (reasonable accommodation training indicating reasonable accommodations are considered to be discrimination complaints), but then later says it may optionally be used to do that. Olson Depo 72.

the disagreement among the various officials and entities involved in the process. This lack of efficacy creates unnecessary barriers to program access for individuals who require accommodations and leaves predictable gaps in the assistance offered by TennCare.

Ms. Olson, who comprises the OCRC asserts that she is the one person at TennCare with the authority to grant reasonable accommodations.[213] However, there appears to be disagreement among different entities regarding what types of assistance constitute accommodations that require Ms. Olson's approval and what call center staff at TennCare Connect may offer to TennCare enrollees without Ms. Olson's involvement. According to Ms. Olson, the call center staff have the ability to provide a variety of "mitigating measures" such as asking for more time, in-person assistance filling out forms, arranging for in-home assistance, having a notice read to them over the phone, explaining a form to an individual with a cognitive disability, getting electronic documents, or getting text messages.[214]

Ms. Olson described "mitigating measures" as forms of assistance that are in place and available to anyone upon request, without regard to whether they have a disability,[215] although she appears to use the term inconsistently.[216] In her view, the referrals from AHS are not necessary because the call center staff are already providing needed assistance as mitigating

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[213] Olson Depo 55-56, 73, 103.

[214] *Id.* 61-63, 66, 70-71, 107-08. Similarly, Ms. Olson indicated that if a person with a cognitive disability needs more help than that which can be provided by the call center, "there's an advocacy group" that can provide assistance, which is part of TNSCA. *Id.* at 70-71, 162, TNCSA testified it would refer such callers to the TennCare Connect call center. *See* TNCSA Depo Whitfield 138-39 (referring to individuals with disabilities that made it difficult to deal with paperwork).

[215] Olson Depo 61, 66-68.

[216] *See* TC-AMC-0000648149 (row 263) (OCRC Complaint Log) (referring to extension of time as a reasonable accommodation and stating "requested an additional 30 days to send in requested information due to having 3 emergency surgeries and bad lungs. Reached out to Response Unit for assitane [sic] including AAAD referral. RA granted and letter sent to person on April 21 telling her and closing case."); Olson Depo 138 (noting that she filed a request for in-person assistance as a reasonable accommodation request even though "it's still, like, a mitigating measure").

measures.[217] Thus, Ms. Olson does not monitor whether these types of assistance are provided to individuals with disabilities who need them,[218] nor does she have access to the TEDS system, the centralized database in which interactions with enrollees are logged to monitor assistance requested and provided.[219]

However, it appears that AHS is not familiar with "mitigating measures" as Ms. Olson describes them.[220] AHS asserts that the two ways their staff can assist an enrollee without getting OCRC involved is by raising their voice to speak more loudly over the phone or by reading notices to an individual.[221] Beyond those two items, the call center understands that it has no authority to provide individuals with disabilities what it calls reasonable accommodations and Ms. Olson calls mitigating measures and would instead escalate all such requests to Ms. Olson.[222]

Thus, while Ms. Olson believes that AHS can explain and answer questions about the content of the notice, AHS describes their role as more limited: "we would assist and maybe read for them, but we don't generally offer advice on what the notice contents are other than specific instructions for returning some type of documentation or something like that."[223] Likewise,

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[217] Olson Depo 61-62, 76-77; *see also* Olson Depo 229-30.
[218] Olson Depo 108.
[219] *Id.* at 64.
[220] AHS Depo Fields 87-88 (AHS representative only heard the term mitigating measures in conversations with counsel prior to deposition).
[221] *Id.* at 95-96 (testifying that AHS would make request to OCRC for notices in alternative formats), 98 ("[W]hether it's something on the call we can assist the person with, whether it's reading a notice with them or, you know, speaking up loudly if they request us to, which, again, we consider an accommodation that we can do for them right at that point in time. If it goes beyond that, generally they're going to ask for some additional assistance, and that's when we would then pick up on that and escalate the call to make a request to OCRC.").
[222] *See* AHS Depo Fields 95-96, 156-62.
[223] *Id.* at 98-99. *But see* AHS Depo Fields 100 (stating that AHS may be able to help a caller with understanding a document).

apparently in contrast to Ms. Olson's understanding, AHS does not grant requests for more time.[224] This apparent disagreement leaves gaps around critical assistance that individuals with disabilities need to navigate TennCare's system, including: in-person assistance. extra time, and someone to answer questions and explain the content of the notices.

There appears further disagreement around how requests for accommodation make their way to Ms. Olson in the OCRC. There is no written policy regarding how DHS, TNSCA, or the AAADs should escalate requests for accommodations to TennCare. As a result, it is likely that some individual requests do not make their way to OCRC. [redacted] Rather than send information regarding this request to OCRC, the DHS worker "[r]eferred her to TennCare Solutions Unit for resolution," which also put the burden on the individual to call another number and make the request again.

With respect to AHS, prior to the CAP, there was no written policy regarding how call center staff were to identify or forward requests for accommodation.[226] Following the CAP, requests received by call center CSRs were to be escalated to call center supervisors who review them and add them to logs that Ms. Olson receives.[227] Yet it appears that there is limited oversight of this process[228] and the accommodation logs do not record any response to the

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[224] AHS Depo Fields 157-58 *cf.* Olson Depo 61-63, 66, 70-71, 107-08.

[redacted]

[226] Olson Depo 245-46; Olson Depo, Ex. 4; *see* Olson Depo 243-44.

[227] AHS Depo Fields Depo 156-58; AHS Depo Fields, Ex. 22; Olson Depo 239-40, 243-44.

[228] The process is under the ostensible supervision of a Nondiscrimination Compliance Coordinator designated by AHS pursuant to a requirement in its TennCare contract. AHS Depo Fields 29-30, 109-110. However, the person currently in that role is the executive vice president for human resources at AHS headquarters in Pittsburgh, with responsibility for managing the company's 1,000 employees at operations across the country. AHS Depo Fields 109-10. Further, while there is a quality assurance group at AHS that randomly samples calls and reports the results to TennCare, there is no report on whether

request.[229] Ms. Olson seems to suggest the accommodation log is not helpful because it is redundant of the reports AHS was previously sending.[230]

Tbe result of this internal lack of coordination is that a seemingly small number of requests for assistance with eligibility procedures make their way to Ms. Olson in the OCRC. According to Ms. Olson, neither AHS nor DHS has sent her what she would consider a "true" request for reasonable accommodation.[231] In this regard, I was unable to conduct meaningful quantitative analysis because of TennCare's lack of data. I reviewed certain copies of Ms. Olson's complaint logs, which appear to overlap somewhat, but covered different sets of date ranges.[232] I found the log to be generally unhelpful as a means of tracking requests for reasonable accommodations.

It seems that the complaint log began in August of 2015, when Ms. Olson began her position, but it is not clearly related to written policies regarding tracking complaints or reasonable accommodations.[233] There also appears to be no consistent criteria for inclusion on the log.[234] Ms. Olson testified that she includes on the log: (1) "complaints that come in, whether or not tbey are complete." (2) if she "has a request for reasonable accommodation or something that may be requests, whether or not it is an actual request, it might go in here," and (3) "things

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CSRs in fact record in an enrollee's case file actions taken on requests for assistance or reasonable accommodation. AHS Depo Fields 162-63. Ms. Olson has never considered calling the call center to test their ADA compliance. Olson Depo 104.

[229] AHS Depo Fields Ex. 13.

[230] Olson Depo 243-44.

[231] *Id.* at 66-67, 74.

[232] *See* TC-AMC-245007 (approximately August 2016 through September 2022); *see also* TC-AMC-0000648149 (approximately January 2019 through February 2023), Olson Depo Ex. 8, TC-AMC-O000153690 (approximately August 2015 through October 2020).

[233] Olson Depo 17, 126.

[234] *Id.* at 128-29 (noting that "sometimes" she records various items on the log).

like that may be a question or other issues that take up a considerable amount of my time."[235] The log does not clearly distinguish among these three items. Neither Ms. Olson's log nor the AHS log seems to consistently track the outcome of the requests or complaints.[236] Ms. Olson did testify that if she indicated she sent a "missing information letter" and no further response is recorded, that indicates she received no response and closed the case.[237]

There is also a lack of clarity regarding whether a particular form is required for an individual to request an accommodation. TennCare has not created a form that is clearly identified as for requesting a reasonable accommodation.[238] Ms. Olson testified that "to make a reasonable accommodation request . . . you have to make a complaint of discrimination to TennCare," and the only form that is available is the complaint form; however, she also suggested that individuals could make requests over the phone.[239] At another point, she testified that only persons with disabilities can make complaints orally, although all individuals can call TennCare Connect for help filling out the form.[240] Ms. Olson's log suggests that in response to requests for assistance she sends a "missing information letter" asking individuals to complete paperwork associated with the discrimination complaint form, including the form itself and an information release.[241] Steering individuals to complex formal procedures to request a reasonable

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[235] *Id.* at 126; *see Id.* at 128-29.
[236] *See* TC-AMC-245007; AHS Depo Fields, Ex. 13; Olson Depo 244.
[237] Olson Depo 133-35; *see* TC-AMC-0000648149 (Investigation Summary & Results Column Rows 3, 4, 10, 11, 12, 20, 21, and 22, among others, with references to "sending a missing information letter" with a closing date listed).
[238] Olson Depo 71-72.
[239] *Id.* at 52, 71-72.
[240] *Id.* at 139.
[241] *Id.* at 130-33; Olson Depo, Ex. 45 ("If you would like to request a reasonable accommodation for more time to complete the application, please complete and return the forms that are included with this letter."); *see also, e.g.*, Olson Complaint Log, TC-AMC-0000648149 (rows 206 and 207) (sending missing information letters related to inquiries based on "possibly sex and disability") (row 212) (sending a

accommodation is counter to my experience and problematic for several reasons, including the burden to individuals to complete such processes, reluctance to disclose requested information, and the overall chilling effect of a formal versus informal, easy to complete process.[242]

Requests for accommodations that make it through the referral process to Ms. Olson face additional barriers. In response to requests, Ms. Olson commonly sends letters requesting additional information to determine if the individual wants to file a complaint.[243] If the individual does not respond to the letter, she does not move forward.[244] Further, according to Ms. Olson, "the burden is on the complainant to provide [her] with the evidence . . . that proof" of her disability.[245] For instance, one notation on Ms. Olson's log indicates the individual "did not report having a disability or discriminaiton [sic]," and that she was sending a missing information letter, even though the individual "reported needing TC [TennCare] for one year because legally blind, has stomach issues, and anixety [sic]."[246]

In this case, even if Ms. Olson believed that she needed proof of disability, it seems there would be no need to demand it from the beneficiary in instances where TennCare has records of the person's disability. For individuals eligible on the basis of disability, that proof can be found in TEDS or potentially in information from the Social Security Administration, or information

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missing information letter related to inquiry based on "not sure possibly disability") (row 335) (sending a missing information letter related to inquiry based on "[p]ossibly race and disability").

[242] *See* Shengli Dong et al., *Accommodation Request Strategies Among Employees with Disabilities: Impacts and Associated Factors*, 63 *Rehab. Counseling Bull.* 168, 168-169 (2020) (discussing the negative effects associated with formal requests for accommodation versus informal requests).

[243] Olson Depo 130-34; *see also* Olson Complaint Log, TC-AMC-245007 (row 235) (sending a missing information letter in response to individual "claiming never received redetermination packet and may need help completing the packet" along with forwarding to response unit).

[244] *See* Olson Depo 134-35.

[245] Olson Depo 251.

[246] TC-AMC-245007 (row 434). I understand that an individual who is legally blind may not be eligible for TennCare on that basis. However, TennCare may have other information about an individual's status to determine whether a person has a disability.

provided by beneficiaries in the application or redetermination processes. Further, medical claims data could contain information on a beneficiary's diagnoses or treatments that document his disability. TennCare, however, has not provided the OCRC with access to TEDS or Interchange.[247]

TennCare further lacks policies or procedures regarding how the OCRC reviews and evaluates requests for accommodation. Ms. Olson testified that there are no policies outlining timelines for review of accommodation requests.[248] Also, there appear to be no written policies discussing who has authority to grant or deny requests or outline criteria for decision making in response to accommodation requests.[249]

Ms. Olson's log also seems to provide inconsistent documentation of the resolution of issues coming in. For instance, one note identifies an individual who "Needs assistance in gathering information and completing forms for QMB reauthorization - eye disease," but no resolution is documented.[250] Another entry indicates an individual who was "Claiming failing to get assistance with elig/redeterm."[251] The log notes that Ms. Olson determined that there was "no evidence of discrimination. Closed and mailed letter on January 9, 2019," without indicating whether the individual was ever provided the assistance with the redetermination process.

The absence of effective policies provides individual decision makers broad discretion and creates substantial risk of unreliable and inconsistent responses to requests for

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[247] Olson Depo 64.
[248] *Id.* 190-91.
[249] During the 2002 renewal process the state acknowledged the need for clear, comprehensive written policies by instituting such policies as part of its proactive strategy to provide accommodation as needed. *Rosen* Appendix, AMC-ALL-0125 – AMC-ALL-0134.
[250] Olson Complaint Log, TC-AMC-245007 (row 410).
[251] Olson Complaint Log, TC-AMC-245007 (row 109).

accommodation. Ms. Olson expressed that when an individual is offered an alternative form of assistance, that is not the person's stated preference, that does not constitute a denial of an accommodation, because the individual was offered something else that Ms. Olson believes is equivalent.[252] There is limited opportunity for individuals to seek review of Ms. Olson's determinations. Ms. Olson testified that if an individual disagrees with her decision about her accommodation the person can ask her to review her own decision.[253] The only other option is to file a complaint with the federal Department of Health and Human Services.[254] A reasonable accommodation process with unbounded discretion creates substantial barrier risks for individuals with disabilities. Moreover, individuals are required to go through this cumbersome process anew, even if they require ongoing accommodations, such as consistently receiving letters in large print.[255]

The experience of named Plaintiff William Monroe is also illustrative of the barriers an individual with disabilities encounters in obtaining the assistance needed to navigate the eligibility redetermination process, even when those requests make their way to Talley Olson in the OCRC. On September 30, 2019, an advocate from the Tennessee Justice Center (TJC) sent a letter to TennCare that asserted that Mr. Monroe did not have the resources TennCare was

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[252] Olson Depo 77-81.
[253] *Id.* at 75, 78-79.
[254] *See* Olson Depo 75, 78-79.
[255] *See* Olson Depo 87 (stating that requests for Braille, large print, and audio format are provided only on an ad hoc basis), 166 (Q: "If reasonable accommodations are granted to enrollees, does AHS or TennCare reach out at the next redetermination process to those enrollees to inquire whether or not they still need those reasonable accommodations?" A: "So TennCare on their own -- or AHS certainly would have probably no knowledge of members who receive reasonable accommodations, probably." Q: "Why is that?" A: "Because they're my individual cases that are kept as confidential as possible."), 167 (also stating that TennCare has never granted a reasonable accommodation concerning a renewal packet so there is no need for TennCare to reach out the next renewal period).

requesting information about and described his disabilities and need for accommodation.[256] The letter explicitly described Mr. Monroe's limited use of his hands due to a spinal cord injury, inability to sign and return documents, ability to give verbal authorization but difficulty hearing such that he needed for a person to speak slowly and clearly, that he lived alone and could no longer drive, and that TJC had been unable to find someone to come visit him in person to provide assistance.[257] Ms. Olson could not recall receiving the letter but testified that she became aware of Mr. Monroe's situation at the time.[258] She testified that she was told that he may need an accommodation, but she was not sure he in fact needed an accommodation.[259]

In response, Ms. Olson sent Mr. Monroe a letter dated October 9, 2019 stating:

> The Tennessee Justice Center told us you may want to ask us for reasonable accommodation. They thought you may need more time to complete your CHOICES application. If you would like to request a reasonable accommodation for more time to complete the application, please complete and return the forms that are included with this letter.[260]

The letter stated that he had six days from the date of the letter to send in the needed CHOICES application information.[261] The letter stated that complaints must be in writing and TennCare did not accept verbal complaints for investigation except from a person with a disability who could not send a written complaint. However, TennCare already knew that Mr. Monroe could not send a written complaint and would need to communicate verbally with the speaker speaking slowly and loudly. Nonetheless, TennCare sent him additional paperwork to complete.[262] Ultimately,

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[256] Olson Depo, Ex. 46, TC-AMC-000003465 to -66.
[257] Olson Depo, Ex. 46, TC-AMC-000003465 to -66.
[258] Olson Depo 214-17.
[259] *Id.* at 217, 219.
[260] Olson Depo, Ex. 45, TC-AMC-0000003707 to -08.
[261] Olson Depo, Ex. 45, TC-AMC-0000003707 to -08.
[262] Olson Depo, Ex. 45.

Ms. Olson testified that although she was unsure, "[her] understanding [was] that he did not actually need an accommodation."[263] At the time that she sent Mr. Monroe the October 9, 2019 letter, she did not consider whether he was able to collect and provide the required documents listed because "we were not at the level of him needing a reasonable accommodation."[264] Ms. Olson testified that she communicated with TennCare's Office of General Counsel about Mr. Monroe's case and understood that they would work with TJC, meaning "there wasn't anything for [her] to do because they were all going to handle it."[265]

Mr. Monroe's request for accommodation does not appear in Talley Olson's complaint log, although two other examples similarly indicate Ms. Olson found no accommodation was needed in response to requests to "help . . . navigate redetermination process."[266] I understand that Mr. Monroe's request was resolved not by OCRC or TennCare's reasonable accommodation process, but through the involvement of the parties' lawyers.

4. TennCare's Failure to Use TEDS or Other Tracking Mechanisms Inhibits Access.

In my experience evaluating and reviewing entities serving individuals with disabilities, I have found that the entity should have a mechanism for tracking accommodation requests, but also for ensuring that a person receives those accommodations effectively, including on an ongoing and timely basis. To the extent this process can be automated reliably and to the benefit of individuals with a disability, it should be.

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[263] Olson Depo 215. Ms. Olson recalled that he "wanted maybe some in-person assistance with his application" and that he had questions, and "Member Services was able to assist with all that" and "he did get in-person assistance." *Id.*
[264] *Id.* 220.
[265] *Id.* at 220.
[266] TC-AMC-245007 (rows 83-84).

For example, if a person has requested large print notices, the processes may estimate the time necessary to prepare such documents before the notices are sent so the alternate format notices will be sent timely. Similarly, if a person has requested that notices be read to them, part of the work flow may be the creation of a task that when a notice is sent for such an individual, a worker will call the individual within a set timeframe to provide that information orally, and to be able to mark the task as completed or outstanding.

TennCare does not have such processes and mechanisms: it does not track requests for accommodations from the point they are made; if assistance is granted, it is not consistently recorded in the individual's TEDS file;[267] a granted accommodation is not provided on an ongoing basis, even if the person's need for accommodation is predictable and continuing.[268]

In addition, when a worker enters information into TEDS indicating a client has a disability, it does not appropriately prompt inquiry into, or notation of, whether the person needs accommodations. The result is that people with disabilities often are not screened adequately for the need for accommodations. The failure to implement an option to track disability in TEDS has the operational result of workers being unaware the person they are interacting with has a disability or has known needs for assistance. This likely causes the person to have to go through

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[267] TEDS does not contain a set place for accommodations requested to be designated. Flener Depo 249. Although case notes may contain information on accommodation requests, the requests are referred to OCRC. Flener Depo 249-50. TennCare's methods for tracking the existence of an accommodation or disability in a specific client's case note or an overall case note in TEDS are inadequate. *See* Flener Depo 247-50. Both disability and any accommodation notes are not aggregated or placed in a dataset, depend on manual entry by the TennCare caseworker, and, for known physical and disabilities other than blindness, depend on the "possibility a worker might make a note in a case." Flener Depo 247, 249-50.

[268] *See, e.g.*, Brooks Depo 209-10. If a person requested an accommodation at application, that person would likely have to request an accommodation anew during the redetermination processes. *See* Brooks Depo 209-10; *see also* Olson Depo 157-58.

the process again to request assistance or try to complete the redetermination process without needed help.

C. TennCare's Structures & Systems Provide Insufficient Oversight.

In my research and experience working with and reviewing public entities serving individuals with disabilities, I have found that maintaining systems for monitoring and oversight is critical to ensure individuals with disabilities have access to the offered program. There are well-recognized elements to an effective monitoring and compliance system, including proactive procedures and reactive policies (such as to complaints) with appropriate organizational leadership and structures.

First, monitoring and oversight should include quality assurance measures. For instance, supervisors of frontline call center staff should identify calls with people with disabilities so they can include a sample, random or otherwise, of disability-related calls as part of their monitoring of calls to check for adherence to training and policies. Likewise, designated ADA coordinators should have as part of their routine procedures the ability to pull sample calls as well as conduct testing of workers at all beneficiary interaction points.[269] In addition, when issues arise in one individual's case that could be impacting other like individuals with disabilities, an effective quality assurance system should take steps to evaluate the scope of the problem.

Second, entities must devote enough personnel and resources to conduct effective oversight and monitoring. Although some agencies have singular ADA coordinators, in my experience an effective compliance system should reflect the levels and needs of the overall

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[269] *See* U.S. Dep't of Justice, *Access for 9-1-1 and Telephone Emergency Services* (July 15, 1998), https://archive.ada.gov/911ta.htm (recommending frequent unannounced testing of call centers, such as for 911, including call takers at each type and level of position, their equipment, and adequacy of training).

system. For organizational function purposes, more effective systems for large programs develop interconnected levels. More than one person should fulfill these duties where necessary based on the number of people served, staff, and the need for accommodations. The person designated as an ADA coordinator may fill other functions within an organization, but needs to have sufficient capacity for the ADA coordinator functions. ADA coordinators play an important function in identifying methods to use available data and systems to proactively identify access issues and monitor for compliance.[270]

Third, effective entities typically have monitoring processes to understand the needs of the population served and measure whether access is being appropriately provided to people with disabilities. Public programs such as TennCare have wide ranges of data available to identify the prevalence of disability within a program. The ability to identify prevalence of disability in a program allows an entity to design methods of administration that will provide effective access to the program, given the needs of the participants, and should allow measurement tools to monitor whether access is provided.

TennCare's monitoring and oversight is not adequate, largely because it relies on the OCRC and primarily a singular person, Ms. Olson, for disability discrimination compliance.[271] Although Ms. Olson has had conversations about getting additional help, it appears that none has

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[270] *See, e.g.*, New England ADA Ctr., ADA Title II Action Guide for State and Local Governments (2017), https://www.adaactionguide.org/, "Step 2: Appoint an ADA Coordinator" (discussing the role and qualifications of ADA coordinators).

[271] Olson Depo 28 ("I work solo."), 40 ("I'm a solo, independent office. I work on my own."); 73 ("I'm the sole decisionmaker in that area."), 103 ("I am the sole decisionmaker for TennCare services programs about reasonable accommodations."); *see* Hagan Depo 25, 235-36.

been provided.[272] TennCare thus does not have a structure that creates reasonable layers of compliance with reporting mechanisms to identify access issues for enrollees with disabilities.

TennCare thus does not funnel and share data and other information in a coordinated way that can be aggregated and analyzed by TennCare or shared with other compliance officers throughout the TennCare system that are associated with redeterminations. OCRC seems not to have regular, ongoing interaction with TennCare leadership to report on compliance issues, inform monitoring activities, and ensure civil rights compliance.[273] OCRC does not monitor the prevalence of disabilities among the TennCare population, nor assess the potential need for accommodations among TennCare enrollees.[274] OCRC does not have access to TEDS to monitor or evaluate issues related to redeterminations.[275]

TennCare does not track what Ms. Olson characterizes as "mitigating measures," namely assistance provided by frontline staff.[276] This means that, even if OCRC chose to address prevalence and assessed need for disabilities, OCRC would not have data regarding the actual assistance provided by call center or other frontline staff. For instance, TennCare cannot determine whether, given the large prevalence of recipients having cognitive and mental

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[272] Olson Depo 26-27.
[273] *See* Olson Depo 31 ("So, like, once a month I go to [TennCare] senior staff [meetings], and we talk about what's going on in the agency. But I don't normally talk at those."); Hagan Depo 24-25.
[274] Olson Depo 54-55.
[275] Olson Depo 64.
[276] Olson Depo 108 (testifying that there is no tracking of time extensions or offers to explain forms and that tracking is limited to language and communication assistance reports). Some TennCare contractors do provide Language and Communication Assistance Reports. Plaintiffs counsel provided me with a summary of those reports. Report Attachment C, 2023.05.05 TennCare LCAS Reports Summary. Those reports only appear to track auxiliary aids and services, such as language interpreters and use of VRI. *See, e.g.*, TC-AMC-0000252532 (TNCSA report showing fields for VRI, TTY, TRS, ASL, Large Print, SRS, and "list other auxiliary aids or services if provided"). The reports appear somewhat unreliable: several do not contain any tracking of disability-related communication assistance at all. Moreover, the numbers are low relative to the anticipated need of the TennCare population. *See* TC-AMC-0000263630 (row 41).

disabilities, staff are providing commonly needed assistance for this population, such as orally reading and explaining notices and other written materials to the client. Even where OCRC does track individual issues, it does not seem to evaluate whether issues raised on behalf of individuals might be systematically impacting others. For instance, one note on Ms. Olson's log states that an "applicant reported needing help with applying for MSP [Medicare Savings Program] is hard of hearing and is having trouble hearing TennCare Connect."[277] The log notes she left a message referring the individual to the AAADs. But there is no indication that Ms. Olson evaluated why the TennCare Connect CSR was hard to hear or why communication assistance was not used. Ms. Olson testified that, with respect to redeterminations, there has "not been a need to" look for similarly situated individuals.[278] Ms. Olson appears not to have much knowledge about the functionality of TEDS as it relates to ADA compliance, and she had no involvement in planning for the resumption of redeterminations with respect to ADA compliance.[279]

TennCare has chosen not to collect disability-related or accommodation data that could be used during the redetermination process or to monitor TennCare's accommodation system. TEDS contains a "data dictionary," which represents the back-end tables of the eligibility determination system,[280] evidently from the Georgia eligibility determination system from which TEDS was built.[281] The TEDS data dictionary contains fields for "has a disability that will require accommodation," "type of accommodation," "the applicant is hearing impaired." "the

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[277] TC-AMC-245007 (row 429).
[278] Olson Depo 144.
[279] Olson Depo 156-57, 181-82.
[280] TennCare Depo Hagan 15-16.
[281] TennCare Depo Hagan 19-20.

nature of the disability," and the "physical disability of an individual."[282] TennCare stated that the fields are not used because "[i]t's not something that we needed for our business" and "[i]t's not a data element needed to make a[n] eligibility determination"[283] but stated that it could collect this data.[284]

Oversight of contractors appears to rely significantly on the annual completion of a "Nondiscrimination Compliance Questionnaire."[285] This questionnaire relies on attestations from the contractor, including trainings provided to new employees, with attached documents for paper review.[286] The compliance officers at the TennCare beneficiary-facing entities are largely focused on tasks other than overseeing disability access for beneficiary services provided by the entity.[287] Despite AHS having a compliance officer and completing these questionnaires and

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[282] TennCare Depo Hagan 19-26. These fields were present in the Georgia eligibility determination system upon which TEDS was built. TennCare Depo Hagan 19-20. At least one of the fields originated from a system created by Deloitte that predated Georgia's system and was not implemented by Georgia. TennCare Depo Hagan 19-21.

[283] TennCare Depo Hagan 19, 22-26.

[284] TennCare Depo Hagan 22.

[285] *See* Olson Depo 15 (describing quarterly and annual reports and policies and procedures from contractors as being part of her case files), 240-41 (describing that, since the completion of the CAP, she has monitored calls and engaged in the quarterly and annual review process to ensure AHS compliance); *see, e.g.*, TC-AMC-0000263807 (Completed Nondiscrimination Compliance Questionnaire 2021-2022 for AHS).

[286] *See, e.g.*, TC-AMC-0000263807 (Completed Nondiscrimination Compliance Questionnaire 2021-2022 for AHS).

[287] AHS Depo Fields 29, 110, 164 (Kim Conner is in Pittsburgh and oversees HR for AHS); TNCSA Depo Whitfield 87-89 (TNCSA's ADA coordinator is also the agency's human resources manager, a role in which she answers employee questions regarding "TNCSA policies, procedures, payroll, benefits, you name it."); 105-107 (conducts new hire nondiscrimination training); 117 (reporting to TennCare regarding civil rights compliance); TNCSA Depo Patterson 13-22(["Ms. Bruner] wears many hats as well. Certainly onboarding, maintaining benefits, maintaining..." and working on nondiscrimination reports; estimates about 50% of time spent on HR matters, with 20% on reporting LEP calls.)

TennCare accepting them, no problems were identified until OCRC instituted a one-time CAP process.[288]

TennCare's failure to collect robust data examining the needs of its enrollee population causes its processes to fail at the first step: without understanding the needs of the population, TennCare cannot engage in the kind of planning necessary to ensure individuals with disabilities maintain adequate access to the program. It also cannot measure program access and assistance offered when TennCare lacks a clear policy for offering and providing assistance, including notice to beneficiaries, the roles of each entity engaging with beneficiaries in the redetermination process, training for staff, tracking of assistance, and monitoring. System-level organizational processes of TennCare have resulted in beneficiaries with disabilities struggling to get the help they need, often being pointed in another direction repeatedly, and facing numerous barriers to their efforts to access the program.

VI. Conclusion

The opinions herein reflect my views to date and may be supplemented by additional information presented to me through this matter's discovery and litigation process. I respectfully

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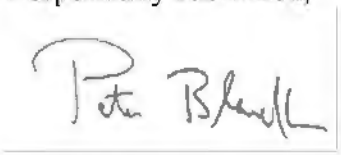
[288] *See* TC-AMC-0000252712 (emails regarding absence of desk reference sheet and script) (email from AHS staff, "I myself would ask, what all is included in reasonable accommodations?"); TC-AMC-0000252541 (outlining call center staff not recognizing requests for reasonable accommodation); *see also* TC-AMC-0000647463 (call in which the caregiver for N.F., an individual with cancer, spoke with an AHS customer service representative about N.F.'s need for help in obtaining third-party verification documents of his citizenship or immigration status. In talking with the CSR, the caretaker repeatedly referenced the ADA and the right to receive reasonable accommodations. The CSR did not acknowledge these statements in any way. At one point, the CSR inexplicably stated that AHS doesn't "do outreach."). Although thereafter the CAP was required for AHS, there does not appear to be follow up monitoring specific to that issue or general ADA-related monitoring procedures implemented to measure the ongoing impact of the CAP, or whether other remedial measures should be taken. This CAP appears to be reactionary rather than a mix of reaction to a problem and proactive measures to monitor compliance as I would expect in my experience of system-level organizational processes and remedying identified problems in the short and longer terms.

reserve the right to amend and supplement this declaration based on such new information. I state the views contained herein are true and correct to the best of my knowledge and belief.

Respectfully submitted,



Peter Blanck, Ph.D., J.D.

May 9, 2023