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

MELISSA WILSON., *et al.*, individually and on behalf of all others similarly situated,	)	
Plaintiffs,	)	**Civil Action No. 3:14-CV-01492**
v.	)	**Judge William L. Campbell, Jr.**
	)	**Magistrate Judge Newbern**
WENDY LONG, *et al*.,	)	
***Defendants*.**	)	

DEFENDANTS' PRETRIAL BRIEF

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October 3, 2018

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Cases **Page**

Statutes

Other

The problem that gave rise to this lawsuit in 2014 was resolved by the middle of 2015, and for the past three years, Defendants (the State) have operated the TennCare program in full compliance with all applicable provisions of the Medicaid Statute. Plaintiffs are not entitled to any relief on either of their claims. The preliminary injunction should be vacated, and judgment should be entered in favor of the State dismissing this case.

STATEMENT

This action was filed more than four years ago during the initial months following the effective date of the Affordable Care Act. The named Plaintiffs all alleged that they had submitted Medicaid applications to the Federal Exchange months earlier and had received no response. They further alleged that the State refused to accept appeals challenging the Federal Exchange's failure to resolve their Medicaid applications with reasonable promptness. *See generally* Complaint (July 23, 2014), D.E. 1. The problems experienced by the named Plaintiffs arose from the confluence of three extraordinary developments, all beyond the control of TennCare officials, all three of which were necessary to produce the delays in adjudicating TennCare applications and TennCare's inability to consider appeals arising from those delays.

First, the Affordable Care Act made many changes to the Medicaid program that became effective January 1, 2014, three of which are particularly significant in this case. First, the ACA provided for the establishment of "Exchanges" through which individuals could apply for health care coverage in a number of different programs, including Medicaid, and instructed the Secretary to establish a federally operated Exchange in all states that choose not to establish their own Exchange. *See* 42 U.S.C. §§ 18031, 18041, 18083(a). Second, the Act required the use of a new methodology, known as Modified Adjusted Gross Income ("MAGI"), for calculating income and financial eligibility for most applicants for Medicaid. *See* 42 U.S.C. § 1396a(e)(14).

Third, the Act required both states and the federal government to verify information provided on Medicaid applications using data that could be queried electronically from agencies such as the Internal Revenue Service ("IRS") and the Social Security Administration ("SSA"). *See* 42 U.S.C. § 18083(c); *see also* 42 C.F.R. § 435.949. To facilitate this process, CMS created the Data Services Hub, which CMS describes as "provid[ing] one connection to the common federal data sources needed to verify consumer application information for income, citizenship, immigration status, access to minimum essential coverage, etc." Kathleen Sebelius, *What's Working in the Marketplace: The Data Services Hub* (Oct. 26, 2013), *available at* https://bit.ly/2IFb5CI.

Second, the computer system (known as ACCENT) the State used to determine Medicaid eligibility prior to 2014 was not capable of performing eligibility determinations under the new ACA-required MAGI rules, and the State has experienced extensive delays in developing its new eligibility computer system (known as Tennessee Eligibility Determination System ("TEDS")).[1] Accordingly, TennCare proposed, and CMS approved, a Mitigation Plan that provides that all TennCare applications requiring MAGI eligibility determinations must be submitted for adjudication to the Federal Exchange.

Third, in July 2014, days before the Complaint was filed, the State learned for the first time that certain Medicaid applications submitted to the Federal Exchange were not being processed by the Federal Exchange. Specifically, the Exchange was unable to timely process Medicaid applications flagged by its computer system for inconsistencies between the application and data from agencies such as the IRS and the SSA. When a discrepancy arises between the data obtained from the Hub and the individual's application (for example, a

[1] The State currently expects TEDS to be fully operational at some point in 2019.

discrepancy concerning the applicant's income as reported on the application versus income as reported in the IRS's database), the Federal Exchange will request that the applicant submit verification documentation (for example, copies of pay stubs). But the Federal Exchange did not have a process for reviewing the supplemental verification documentation submitted by applicants and, as a result, adjudication of those applications was delayed. This problem was not unique to Tennessee; Medicaid applicants in every state that relies on the Federal Exchange to make eligibility determinations faced the same difficulty.

Compounding this problem, the Federal Exchange would not provide the State with any information concerning those individuals' applications. As a result, the State had no idea who or how many people had suffered delays due to the Federal Exchange's failure to timely review supplemental verification materials. This made it impossible for the State to provide meaningful fair hearings to applicants who had applied at the Federal Exchange—without the application file, there was no way for the State to determine whether the Federal Exchange had timely adjudicated the application or not.

On September 2, 2014, the Court issued a preliminary injunction directing the State "to provide the Plaintiff Class with an opportunity for a fair hearing on any delayed adjudication." Preliminary Injunction Order at 8 (Sept. 2, 2014), D.E. 91 ("PI Order") (footnote omitted). Under the terms of the injunction, the State must provide a hearing within 45 days to any class member who requests one and provides proof that he or she submitted a TennCare application more than 45 days earlier (or 90 days in the case of an application based on disability). *Id.* at 8–9. The Court explained that these hearings are "for the purpose of determining the cause of the delay, not to appeal a denial of a claim." Class Certification Order at 4 (Sept. 2, 2014), D.E. 90.

TennCare was able to comply with the preliminary injunction only because CMS began routinely and systematically providing the State with data concerning Medicaid applications it was unable to adjudicate in the Fall of 2014. Using this data, the State developed a manual process to resolve applications with data inconsistencies that had been "pended" at the Federal Exchange as a result of such inconsistencies. In addition, the State established a delayed application appeals process that guarantees a hearing, within 45 days, to any class member who requests one and provides proof (or the State independently finds proof) that he or she submitted a TennCare application more than 45 days earlier (or 90 days in the case of an application based on disability).[2]

As a result of the State's implementation of these processes and the CMS Approved Mitigation Plan, the facts on the ground today bear no resemblance to the facts alleged in the original complaint filed during the summer of 2014. At that time, Medicaid applicants like the named Plaintiffs whose applications had been "pended" indefinitely by the Federal Exchange had no recourse whatsoever with the State—the State literally did not know they existed and had no ability to assist them because it did not have access to any information concerning their Medicaid applications. Medicaid applicants whose applications are "pended" by the Federal Exchange today do receive State assistance because CMS now provides the State with information concerning these applications on a routine and regular basis and the State adjudicates them. As a result, in the last fiscal year, an average of over forty thousand TennCare applications per month were submitted, and over 99 percent were adjudicated on a timely basis.

[2] In the vast majority of delayed application appeals, the hearing on the cause of the delay ends up being unnecessary because the State is able to adjudicate the underlying application before the 45-day deadline, thus mooting the dispute.

In the event of any delay, unlike the named Plaintiffs, Medicaid applicants have access to a State administrative appeal system. While the State was initially required to develop and implement this system by the preliminary injunction, it is now required to maintain the appeal system permanently by TennCare regulations, *see* TENN. COMP. R. & REGS. 1200-13-19 *et seq*., and the State has no intention of eliminating the delayed application administrative process regardless of what happens in this case. It is undisputed that every single TennCare applicant since August 2015 has either received a final eligibility determination in 45 days (or in the case of disability applicants, 90 days) or has been given the opportunity to press an administrative appeal that almost invariably results in the prompt adjudication of the application.

ARGUMENT

I. Plaintiffs Are Entitled to No Relief for Violation of 42 U.S.C. § 1396a(a)(8).

A. Section 1396a(a)(8) Does Not Govern the Timing of Eligibility Determinations.

In their first cause of action, Plaintiffs allege that, by "failing to adhere to their duty to determine Medicaid eligibility with reasonable promptness," Defendants have violated Plaintiffs' "rights under 42 U.S.C. § 1396a(a)(8)." Complaint ¶ 154. This claim fails because the reasonable promptness requirement in Section 1396a(a)(8) applies only to the payment of Medicaid healthcare claims, not to the determination of eligibility for those services.

The provision states that a state's Medicaid plan must "provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals." 42 U.S.C. § 1396a(a)(8). The statute defines "medical assistance" as "payment of part or all of the cost of [covered] care and services." 42 U.S.C. § 1396d(a). Thus, Section 1396a(a)(8) requires that the State must, "with reasonable promptness," pay Medicaid claims

submitted by "eligible individuals." The provision says nothing about how promptly a state must determine anyone's eligibility in the first place. Instead, a different provision—Section 1396a(a)(19)—sets forth the standards governing eligibility determinations, and it does not require "reasonable promptness." *See* 42 U.S.C. § 1396a(a)(19) (State Plan must "provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined . . . in a manner consistent with simplicity of administration and the best interests of the recipients").

Consistent with the clear text of the statute, the Sixth Circuit has confirmed that the State's "duty" under Section 1396a(a)(8) is "*limited to* '*pay*[*ing*] *promptly* . . . for medical services when presented with the bill.' " *Brown v. Tenn. Dep't of Fin. & Admin.*, 561 F.3d 542, 545 (6th Cir. 2009) (emphasis added) (alteration in original) (quoting *Mandy R. v. Owens*, 464 F.3d 1139, 1143 (10th Cir. 2006), and holding that "*Mandy R.* accurately states the law of our circuit"); *see also Westside Mothers v. Olszewski*, 454 F.3d 532, 540 (6th Cir. 2006) ("The most reasonable interpretation of § 1396a(a)(8) is that all eligible individuals should have the opportunity to apply for medical assistance, i.e., financial assistance, and that such medical assistance, i.e., financial assistance, shall be provided to the individual with reasonable promptness."). Based on this interpretation of the statute, the Sixth Circuit held that "a waiting list for waiver services does not violate federal law because the state's duty is to pay for services, not ensure they are provided." *Brown*, 561 F.3d at 545. The reasonable promptness requirement in Section 1396a(a)(8) does not govern Medicaid eligibility determinations.

B. Even if 42 U.S.C. § 1396a(a)(8) Applies to Eligibility Determinations, It Does Not Grant Rights That Are Enforceable Under 42 U.S.C. § 1983.

In *Gonzaga University v. Doe*, 536 U.S. 273, 283 (2002), the Supreme Court held that Section 1983 provides a remedy only for those rights that another statute "unambiguously"

confers. To unambiguously confer a right, the Court explained, the statute must be "phrased in terms of the persons benefited"—rather than the entity regulated (here, the State)—to such an extent that the individual is the statute's "unmistakable focus." *Id*. at 284 (quoting *Cannon v. Univ. of Chicago*, 441 U.S. 677, 691, 692 n.13 (1979)). If a statutory provision instead "focuses on the aggregate services provided by the State," it "confers no individual rights and thus cannot be enforced by § 1983." *Westside Mothers*, 454 F.3d at 542 (quoting *Gonzaga*, 536 U.S. at 282) (internal brackets and quotation marks omitted).

As an initial matter, Plaintiffs unquestionably lack any judicially enforceable right to receive eligibility determinations within 45 days (or 90 days, for those seeking Medicaid based on disability). Those deadlines are set by a regulation, 42 C.F.R. § 435.912(c)(3), and it is settled that regulations cannot serve as the source of a right enforceable under Section 1983. *See Alexander v. Sandoval*, 532 U.S. 275, 291 (2001); *Johnson v. City of Detroit*, 446 F.3d 614, 629 (6th Cir. 2006). Such rights must come from a statute or Constitutional provision.

But Section 1396a(a)(8) itself does not create a judicially enforceable right. First, far from "unambiguously" conferring a right to have Medicaid applications adjudicated with reasonable promptness, there is a strong argument that the provision does not even apply to eligibility. *See supra* Part I.A. At a bare minimum, the statute is ambiguous as to whether the reasonable promptness requirement applies to eligibility, and that ambiguity forecloses a Section 1983 cause of action under *Gonzaga*.

Second, Section 1396a(a)(8) focuses on the entity regulated, not on the "persons benefited." *Gonzaga*, 536 U.S. at 284. This part of the *Gonzaga* inquiry requires attention to statutory "text and structure." *Id*. at 286. The text here focuses on the State's obligations to "all eligible individuals," a formulation that encompasses a group of people "in the aggregate,"

Westside Mothers, 454 F.3d at 542, not a specific individual granted a right. *Compare* 42 U.S.C. § 1396a(a)(3) (requiring the State to "grant[] an opportunity for a fair hearing before the State agency *to any individual* whose claim . . . is denied or is not acted upon with reasonable promptness" (emphasis added)). Thus, the reasonable promptness requirement in Section 1396a(a)(8) "is simply a yardstick" by which "to measure the *systemwide* performance of a State's Medicaid program." *Westside Mothers*, 454 F.3d at 543 (quoting *Blessing v. Freestone*, 520 U.S. 329, 343 (1997)) (internal brackets omitted).

What is clear from the text of Section 1396a(a)(8) is confirmed by the Medicaid Statute's structure. The statute specifies what must be in the State Plan in Section 1396a, and it provides that the State need only "comply substantially" with the provisions of Section 1396a in administering its plan. 42 U.S.C. § 1396c(2) (authorizing the Secretary to withhold Federal payments to a Medicaid program that does not "comply substantially" with the requirements of Section 1396a). Thus, no given individual has the right to a prompt eligibility determination, since a state may substantially comply with a requirement without complying in all cases. *See Does v. Gillespie*, 867 F.3d 1034, 1042 (8th Cir. 2017) ("Focusing on substantial compliance is tantamount to focusing on the aggregate practices of [the] state." (internal quotation marks omitted)); *see also Gonzaga*, 536 U.S. at 288 ("[*Blessing*] found that Title IV-D failed to support a § 1983 suit in part because it only required 'substantial compliance[.]' "). The Sixth Circuit has thus held that the reasonable promptness requirement in Section 1396a(a)(8) is merely a "general policy goal[]" for states to meet—and thus not the kind of requirement that creates rights enforceable under Section 1983. *Cook v. Hairston*, 948 F.2d 1288, 1991 WL 253302, at *5 (6th Cir. 1991) (unpublished).

Moreover, the right Plaintiffs claim to find in Section 1396a(a)(8) is too "vague and amorphous" for courts to enforce. *Gonzaga*, 536 U.S. at 282 (quoting *Blessing*, 520 U.S. at 340). In the context of determining eligibility for Medicaid, it is not at all clear what constitutes "reasonable promptness." CMS clearly understood that states required more guidance, for it promulgated a regulation establishing a default standard of 45 days (90 days in the case of disability applicants) with exceptions for unusual circumstances such as the failure of the applicant or a physician to timely provide necessary information. *See* 42 C.F.R. § 435.912(c) & (e). Again, rights enforceable under Section 1983 must be discernible from the text of the statute and may not be derived from regulation, *Alexander*, 532 U.S. at 291; *Johnson*, 446 F.3d at 629, and the statutory term is not sufficiently clear and concrete to give rise to an enforceable right.

Finally, it is clear that Congress did not intend to confer a judicially enforceable right to have Medicaid applications adjudicated with reasonable promptness because it expressly provided for an *administrative* remedy. Section 1396a(a)(3) requires the State to provide "an opportunity for a fair hearing *before the State agency*" when an application is not adjudicated with reasonable promptness. 42 U.S.C. § 1396a(a)(3) (emphasis added). It is well settled that when Congress specifically provides an administrative "mechanism" as a remedy, Congress intends for parties to use that mechanism—not a Section 1983 lawsuit in federal court. *Gonzaga*, 536 U.S. at 289; *see also id.* at 285 n.4 (Section 1983 is not available where "Congress shut the door to private enforcement either expressly, through 'specific evidence from the statute itself,' or 'impliedly, by creating a comprehensive enforcement scheme that is incompatible with individual enforcement under § 1983.' " (citations omitted)). The Supreme Court has explained that "[t]he express provision of one method of enforcing a substantive rule suggests that Congress intended to preclude others." *Alexander*, 532 U.S. at 290; *see also City of Rancho*

Palos Verdes v. Abrams, 544 U.S. 113, 121 (2005) ("The provision of an express, private means of redress in the statute itself is ordinarily an indication that Congress did not intend to leave open a more expansive remedy under § 1983.").

C. TennCare Substantially Complies with 42 U.S.C. § 1396a(a)(8).

Even if Section 1396a(a)(8) did require reasonably prompt eligibility determinations, and even if it conferred a right that was judicially enforceable under Section 1983, Plaintiffs are still not entitled to any relief because TennCare substantially complies with both Section 1396a(a)(8) and the regulation Plaintiffs rely upon, 42 C.F.R. § 435.912.

More than 99 percent of TennCare applications are adjudicated within the 45 and 90-day periods specified by 42 C.F.R. § 435.912(c). Neither the statute nor the regulation imposes the unrealistic requirement that the State achieve 100 percent perfection on the tens of thousands of TennCare applications it receives each month. The regulation expressly recognizes exceptions to these deadlines, "for example," when the State cannot meet them because the applicant or a physician "fails to take a required action," or because of some other force "beyond the [state] agency's control." *Id.* § 435.912(e)(1) & (2).

Plaintiffs have not provided any evidence suggesting that the relatively few cases where the eligibility determination extends beyond 45 or 90 days fall outside of these exceptions. Similarly, the statute recognizes that perfection is not required, both by limiting the requirement to "*reasonable* promptness," 42 U.S.C. § 1396a(a)(8) (emphasis added), and by limiting the State's obligation to "comply[ing] substantially" with the provisions of Section 1396a—including the requirements of Section 1396a(a)(8)—in administering its plan, 42 U.S.C. § 1396c(2).

D. The Sole Remedy for Any Violation of Section 1396a(a)(8) Is a Fair Hearing Before the Agency Pursuant to Section 1396a(a)(3).

The Medicaid Statute itself provides the remedy for any violation of the reasonable promptness requirement, and it is not federal judicial equitable or declaratory relief. Instead, Congress has instructed the State to provide "an opportunity for a fair hearing *before the State agency*" when an application is not adjudicated with "reasonable promptness." 42 U.S.C. § 1396a(a)(3) (emphasis added). The Supreme Court has repeatedly held that " 'it is an elemental canon of statutory construction that where a statute expressly provides a particular remedy or remedies, a court must be chary of reading others into it.' " *Middlesex County Sewage Auth. v. National Sea Clammers Ass'n*, 453 U.S. 1, 14–15 (1981) (quoting *Transamerica Mortgage Advisors, Inc. v. Lewis*, 444 U.S. 11, 19 (1979)); *see also Touche Ross & Co. v. Redington*, 442 U.S. 560, 571–74 (1979). "In the absence of strong indicia of a contrary congressional intent, we are compelled to conclude that Congress provided precisely the remedies it considered appropriate." *Middlesex County*, 453 U.S. at 15. Here, that remedy is an administrative appeal to the State Medicaid agency. 42 U.S.C. § 1396a(a)(3). In this regard, it is telling that, though Plaintiffs sought declaratory and preliminary injunctive relief addressing their Section 1396a(a)(8) claim, this Court limited the relief to an order requiring "fair hearings" as provided by Section 1396a(a)(3). See Preliminary Injunction Order, D.E. 91, at 8.

II. Plaintiffs Are Entitled to No Relief for Violation of 42 U.S.C. § 1396a(a)(3).

Plaintiffs also seek relief for violation of 42 U.S.C. § 1396a(a)(3), but the parties have stipulated that an appeal process for delayed eligibility determinations is both codified in the TennCare regulations and available to all class members. *See* Agreed Factual and Evidentiary Stipulations ¶ 33, D.E. 244. The continued availability of the administrative appeals process both moots Plaintiffs' Section 1396a(a)(3) claim, and makes declaratory or continued injunctive

relief "not only unnecessary, but improper." *John B. v. Emkes*, 710 F.3d 394, 412 (6th Cir. 2013) (internal quotation marks omitted). Either way, Plaintiffs are entitled to no relief on this claim.

A. Plaintiffs' Section 1396a(a)(3) Claim Is Moot.

The judicial power is limited to "Cases" and "Controversies." U.S. CONST. art. III, § 2, cl. 1. The Supreme Court has "interpreted this requirement to demand that 'an actual controversy . . . be extant at all stages of review, not merely at the time the complaint is filed.' " *Campbell-Ewald Co. v. Gomez*, 136 S. Ct. 663, 669 (2016) (quoting *Arizonans for Official English v. Arizona*, 520 U.S. 43, 67 (1997)). Here, Plaintiffs seek declaratory and injunctive relief for their claim that TennCare lacked the hearing process required by Section 1396a(a)(3). Now that TennCare provides that process, Plaintiffs have no relief left to receive. *See, e.g.*, *Murphy v. Hunt*, 455 U.S. 478, 481–82 (1982) (per curiam). Plaintiffs argue that the case is not moot because the State might abandon its appeal system once the preliminary injunction is vacated and the case dismissed. But this argument fails both legally and factually.

Legally, the Supreme Court has often rejected arguments that moot claims should survive because a defendant may return to its former ways where, as here, there is little if any reason to expect that the Defendant will resume the challenged conduct. *See, e.g.*, *Already, LLC v. Nike, Inc.*, 568 U.S. 85, 93–94 (2013); *SEC v. Med. Comm. for Human Rights*, 404 U.S. 403, 404–06 (1972). And the Sixth Circuit has repeatedly reached the same conclusion in two circumstances, both of which exist here. First, the Court of Appeals presumes good faith on the part of government officials: when they change their conduct, "such self-correction provides a secure foundation for a dismissal based on mootness so long as it appears genuine." *Bench Billboard Co. v. City of Cincinnati*, 675 F.3d 974, 981 (6th Cir. 2012); *see also Rio Grande Silvery*

Minnow v. Bureau of Reclamation, 601 F.3d 1096, 1117 n.15 (10th Cir. 2010) (citing similar cases applying the same presumption). Second, when government officials codify that change in a regulation, the alleged problem "no longer requires judicial resolution." *Meadows v. Hopkins*, 713 F.2d 206, 208 (6th Cir. 1983). In such cases, "there is no reasonable likelihood 'that the wrong will be repeated.' " *Mosley v. Hairston*, 920 F.2d 409, 415 (6th Cir. 1990) (quoting *United States v. W.T. Grant Co.*, 345 U.S. 629, 633 (1953)).

Nothing indicates that Tennessee's change of conduct—embodied in the TennCare appeals process—is anything other than "genuine." *Bench Billboard*, 675 F.3d at 981. Plaintiffs argue that the State only adopted the administrative appeals process after this suit was filed, but the State could not have adopted the process any sooner because the Federal Exchange was not providing the State with any information concerning the TennCare applications it was failing to adjudicate on a timely basis. Indeed, the State failed to provide those hearings in the first place in 2014 only due to a confluence of extraordinary events—the State's ancient computer system, the ACA's new MAGI eligibility requirements, and Federal Exchange's inability to process certain applications and its initial refusal to provide the State with data about those applications—that themselves will not recur. The evidence will show that the State has no intention of abandoning this process, regardless of the outcome of this lawsuit, and Plaintiffs can point to no evidence to the contrary.

Moreover, the delayed application administrative appeal system has been codified in TennCare's regulations, *see* TENN. COMP. R. & REGS. 1200-13-19 *et seq.*, and the State has been administering it for years without complaint from Plaintiffs. There is thus "no reasonable likelihood" that any Medicaid applicants in Tennessee will lack the opportunity for a delayed application appeal. *Mosley*, 920 F.2d at 415; *see also DeFunis v. Odegaard*, 416 U.S. 312, 317

(1974) (reiterating the "settled practice . . . fully to accept representations" that alleged violations will not recur, even when the change in official policy came after the suit). Plaintiffs' claim under Section 1396a(a)(3) must be dismissed as moot.

B. Declaratory or Injunctive Relief Would Be Unnecessary and Improper.

In the alternative, declaratory or injunctive relief would be both unnecessary and improper under settled principles of equity and federalism. Orders that burden government officials "impact on the public's right to the sound and efficient operation of its institutions." *Rufo v. Inmates of Suffolk Cty. Jail*, 502 U.S. 367, 380–81 (1992) (quoting *Heath v. De Courcy*, 888 F.2d 1105, 1109 (6th Cir. 1989)). The Sixth Circuit therefore has held that "injunctive relief after a period of compliance should not extend beyond the time necessary to remedy the violation." *Gonzales v. Galvin*, 151 F.3d 526, 531 (6th Cir. 1998). The Supreme Court likewise has instructed courts to be "flexible" in considering whether prior orders should remain in effect, so that "responsibility for discharging the State's obligations is returned promptly to the State and its officials." *Horne v. Flores*, 557 U.S. 433, 450 (2009) (internal quotation marks omitted).

This flexible approach involves two questions: "first, whether the state has achieved compliance with the federal-law provisions whose violation the decree sought to remedy; and second, whether the State would continue that compliance in the absence of continued judicial supervision." *Emkes*, 710 F.3d at 412. Here, all agree that the State has "achieved compliance" with Section 1396a(a)(3): those few Medicaid applicants whose applications are not processed within 45 or 90 days may bring an appeal pursuant to the TennCare regulations, and the State has provided this opportunity without fail for over three years. And this compliance will continue with or without "continued judicial supervision," since those regulations are not going anywhere.

Thus, not only is the existing injunction subject to vacatur, but any further declaratory or injunctive relief would be both "unnecessary" and "improper." *Id*.

CONCLUSION

At the conclusion of the trial, the Court should vacate all outstanding injunctive relief and dismiss this case with prejudice.

October 3, 2018

Respectfully submitted,

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I hereby certify that a true and accurate copy of Defendants' Pretrial Brief was served upon the following counsel of record on this 3rd day of October, 2018, via the Court's Electronic Case Filing system:

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