IN THE CHANCERY COURT FOR DAVIDSON COUNTY, TENNESSEE

Sean P. Smith,	)	
	)	
Petitioner,	)	
	)	
v.	)	
	)	
TENNESSEE DEPARTMENT OF FINANCE & ADMINISTRATION, DIVISION OF TENNCARE; and	)	**Case No. 24-0074-I**
	)	
	)	**Chancellor Patricia Moskal**
	)	
STEPHEN SMITH, DIRECTOR OF TENNCARE, in his official capacity,	)	
	)	
Respondents.	)	

PETITIONERS RESPONSE IN OPPOSITION TO RESPONDENTS' MOTION TO DISMISS AMENDED COMPLAINT AND PETITION FOR REVIEW

Congress creates legislation in support of the U.S. Constitution. Our Constitutions act to safeguard the common good. The Medicaid Spending clause statutes are congressional directives which are structured to serve the common good and protect the rights of recipients. The Medicaid statutes act as a contract forming a voluntary partnership between the federal government and states. Medicaid statutes afford States a great deal of discretion in how they construct and implement their Medicaid plans so that they can be effective partners in the pursuit of the common good.

States run the risk of abusing their discretion when they do not comply with the directives of Congress provisioned in the Medicaid statutes. Such abuses of discretion come with a substantial risk of commiting actions which unduly deprive recipients of their civil and constitutional rights. When Respondents exercise their discretion to make agency decisions which violate a disabled adult beneficiary's civil and constitutional rights it opens them up to private legal action through multiple laws [42 U.S.C. §§ 1983, 1985, 1986, 12101] [29 U.S.C. § 794] [T.C.A. § 71-6120(b)] [U.S. & TN Constitutions] whose remedies are described as being supplementary or additive to any remedy offered by the state, such as that offered by administrative review [T.C.A. § 4-5-322] [*Infra* pg. 6 ¶ 1, pg. 65 ¶ 4].

defrauding the State and Federal government by getting paid to do a job that they not only do no do, but are taking actions to work against. The voluntary partnership between the federal and state government to operate Tennessee's Medicaid program in accordance with congressional directives is contrasted and circumvented by the partnerships that the state of Tennessee makes with its local partners that actively violate those congressional directives, with what seems to be the Respondents full knowledge and consent.

State agencies and many other organizations throughout Tennessee seem to go the extra mile to discriminate against people with mental disabilities, as my C-A's disclosed in detail, and my Motion for Accessible Justice argued. The court might contest that Justice is Accessible to people with Mental Disabilities, but when we look at actual data about what is really going on in Tennessee with people with mental disabilities, I think it is evident that my side of the argument has a greater weight of the evidence.

> "When a person having knowledge of the law and the power to stop a wrong and the duty to prevent wrong from being done does not act, they are liable for any failure to act [42 USC § 1986]."
>
> "Official oppression has occurred when a public servant, 'Intentionally subjects another to mistreatment...' or; 'Intentionally denies or impedes another in the exercise or enjoyment of any right, privilege, power or immunity, when the public servant knows the conduct is unlawful' [TCA § 39-16-403]."
>
> "Official misconduct has occurred when a public servant 'with intent to obtain a benefit or to harm another, intentionally or knowingly:'
>
> '3) Refrains from performing a duty that is imposed by law or **that is clearly inherent in the nature of the public servant's office** or employment;
>
> (4) Violates a law relating to the public servant's office or employment" (emphasis added) [TCA § 39-16-402].' [Am. Pet. pg. 12 ¶ 2-4]

The same logical analysis I applied to Dr. Martinez and his fiduciary obligation applies to the Respondents [Am. Pet. Ex. B pg. 67-68]. It's practically interchangeable, which was the intention and was disclosed as such [*Supra* pg. 3 ¶ 2]. Some minor changes and viola:

(1) If Respondents possess the "appropriate training and experience" to "perform functions within its special competence" [*Supra pg. 49 ¶ 1 "I think that..."]* then:

(A) Respondents would be familiar with or fully able to comprehend the information which has been communicated in Mr. Smith's verbal and written submissions and;

(B) Respondents would possess an even greater depth of knowledge and comprehension of the information which was presented in Mr. Smith's verbal and written submissions, for Mr. Smith is not a Deputy Director of TennCare and an expert within this field of State Medicaid Managed Care Health Plan Administration, and Respondents must, by default, possess greater knowledge and comprehension than those the plan fiduciary designates as a layman who does not have possession of the "appropriate training and experience".

(i) that "greater knowledge and comprehension" would include already being aware of the additional information contained in the materials referenced in this letter which were not included in the appeal;

(C) pursuant to (1)(A);(B), Respondents acted in the manner they did in full knowledge of the harm their actions would cause Mr. Smith and other plan beneficiaries.

Alternatively;

(2) If Respondents did not possess the "appropriate training and experience" to "perform functions within its special competence" then:

(A) it would only be prudent to have conceded and disclosed their ignorance to the State and other plan administrators.

(B) failing to declare their ignorance and despite their ignorance then act in a capacity where they make Agency Decisions would be unlawful.

Additionally:

(3) If the State and other plan administrators knowingly allow Respondents or another to violate their obligations and harm plan beneficiaries they then become accomplices to the misconduct.

(A) allowing misconduct to occur can be defined as having knowledge that it will occur or is likely to occur and then permitting it to occur unopposed.

(B) Mr. Smith's medical appeal, email, complaints, grievances, call notes, and other documentation in the possession of Respondents demonstrate that they possess knowledge of misconduct that has occurred and is likely to continue to occur.

(C) Due to having foreknowledge that this misconduct had occurred and was likely to continue occurring, allowing it to occur can be asserted as gross incompetence or a conspiracy to commit the offense.

Not only do Respondents have knowledge their misconduct harming me has occurred, will occur, is occuring, and will continue to occur if unopposed, but Respondents stand before the court actively opposing actions seeking to curtail that misconduct.

In my communications, verbally and in writing, I've consistently explained to Respondents how their actions cause their disabled adult plan beneficiary(ies) to want to kill themselves:

"At discharge I viewed suicide as being a more likely outcome than I did at intake. Contempt. Frustration. Trauma. I do need mental health services. Ironically, I need them to figure out how to deal with the trauma of being mistreated by physicians, insurers, officers, and other figures in the community who are 'supposed to help' but are instead causing harm to myself and others. Yet, step one of achieving 'get help' has been, and remains: fix sleep, fix pain, fix eating and digesting issues, return to exercise - address medical needs, then go talk about the psychological struggles."

"The current medical system, especially third party payers, is so antagonistic to meeting the needs of patients that I honestly wonder if it would be better for me at this point to focus my efforts on determining the value of continuing to exist with this limitation. I really am tired of this circus I'm being put through and one way or another it would be a relief

to permanently divorce myself from it. These contemplations have been going on a long time, and are not an ill-conceived consideration - I need help and in the absence of being able to receive that help I have to choose from the options available to me."

[Am. Pet. Ex. B file:(2019 C-A) pg. 36 ¶ 2, pg. 33 ¶ 2].]

Then there's the part about how the other leading causes of death and disability also seem to be related to jaws, airways, sleep, and breathing, as I communicated in my 2019 C-A [Am. Pet. Ex. B file:(2019 C-A) pg. 12 ¶ 3]. Since the Respondents seem to have not reviewed that, or any of the other C-A references, here it is again:

Appeal Reference 39. Foundation for Airway Health. (May 22, 2019) Bed Waldman: Policy Implications of Treating Sleep & Airway Pathology | GNYDM 2018 Airway Summit. [web video]. Accessed: July 2, 2019. Retrieved from: https://vimeo.com/337890092/1655efbe59 segment time at: 13:00:00-18:00:00.

Watch the 5 minute segment, or the whole video, but in either event, it should become quite obvious that the Respondents' failures for my care and needs is just the tip of the iceberg. Their misconduct has been ruinous to all of Tennessee, and it is in the public interest to intervene.

It's also another layer of disability discrimination and rights violations, as it is those health conditions which are understood to cause people with severe psychiatric illness to die 10-25 years earlier than their peers, which psychiatric medications not only do not effectively treat but can in fact increase the severity of, as I communicated in both of my C-A's [Am. Pet. Ex. B pg 16 ¶ 1-4]. Meaning, if people like me don't outright kill ourselves, but somehow manage to stay alive, the Respondents' misconduct is nevertheless going to cut our lives short by 10-25 years. I think that qualifies as being deprived and destroyed of life [TN Const. Art 1 Sec 8]. That is, assuming one believes the lives of disabled adults matter, and we are more than just a "commodity, like livestock on a farm" to be exploited [*Supra* pg. 29 ¶ 2 "livestock"], that we are not "three fifths" of a person [U.S. Const. Art. 1 Sec. 2 Cl. 3].

Maybe my ire and anger and passion is beginning to be more understandable, and relatable. That when I describe Respondents actions as contributing to and causing atrocity, it

becomes clear that I am not exaggerating. That I have been one who "with due study and preparation, thinks for himself" [*Supra* pg. 15 ¶ 2 (*On Liberty* quote)].

Were that Respondents had reviewed my Tennessee block grant public comments and my 2019 and 2023 C-A's fully and fairly, and had taken my Averments to be true, then we might have been able to Avert these public health disasters.

> "Insurers and employers have an opportunity to own this problem, fix it, and provide benefit to themselves and their beneficiaries before matters escalate further. Yet, my past experiences breed a cynicism that expects insurers and plan administrators to double-down on committing misdeeds and dig an even deeper hole for themselves rather than trying to turn a new leaf and fix what's broken."
>
> "People with intense struggles are presented with an obstacle course that even the most able individuals have a limited ability to navigate. It's wrong. It's wrong in a way that is indefensible. Yet, insurers, employers, and many of their staff are perfectly content to engage in activities which uphold the operation of a system focused on commoditizing the suffering of these vulnerable people." [Am. Pet. Ex. B. file:(2019 C-A) pg. 39 ¶ 2-3]. [*Supra* pg. 15 ¶ 1 (Milgram study quote)]
>
> "It feels a little like a Noah's Flood situation. I tell everyone 'you do that and this will happen, so instead act in a way that leads to a favorable outcome', and instead of listening, everyone insists on continuing in actions that will lead everyone to drown." [Am. Pet. Ex. B. file:(2019 C-A) pg. 36 ¶ 4].

I don't think now is a good time for Respondents, for the State of Tennessee, to double-down on doing disaster by dismissing my dispute. But bad habits are hard to break and Tennessee has habitually made it their mission to abuse and exploit it's disabled citizens:

> "Tennessee has among the highest denial rates for disability applicants in the nation, rejecting 72 percent of all claims in 2017.
>
> Doctors are paid a flat rate for each application file they review. How much they earn depends on how fast they work.

One doctor, a felon, earned $420,000 in one year for reviewing the applications of 9,088 Tennesseans applying for disability.

State and federal offices review a tiny percentage of denied disability claims for accuracy. In the last fiscal year, 7,400 people died waiting for their disability appeals to be heard."[18].

The state of Tennessee's modus operandi is to wrongfully deny people who are disabled their benefits and wait for their unmet medical needs to kill them, or they kill themselves. It seems the state even contracts felons to help do their dirty work. And their contracted MCO partner UnitedHealth Group seems to be an aspiring felon:

"Two reports and one lawsuit for violating patient privacy;

Seven reports and three lawsuits for upcoding and overbilling the federal government;

Seven reports and five lawsuits for denying patient care based on cost instead of medical necessity, and

Eight reports and seven lawsuits for steering patients and providers toward UHG owned subsidiaries in order to increase company profits.".[19]

The above report seems to barely scratch the surface, with this violation tracker listing 388 offenses by UnitedHealthgroup and its subsidiaries.[20]

Tennessee has been hard at work, and disability advocacy groups have taken notice, and accordingly awarded Tennessee a D on their 2023 Disability Scorecard[21]. Which I think is a fitting grade because the first letter in disaster is D.

"This is a state and federal fiscal disaster - finding a better way to fund TennCare won't change the nightmare patients like me are being abandoned to nor mitigate the colossal

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[18] The Tennessean. (Jan 13, 2019). Denied: How some Tennessee doctors earn big money denying disability claims. Retrieved: https://www.tennessean.com/story/news/2019/01/06/tennessee-doctors-disability-claims/1077220002/

[19] https://www.economicliberties.us/data-tools/unitedhealth-group-abuse-tracker/

[20] https://violationtracker.goodjobsfirst.org/prog.php?parent=unitedhealth-group&order=pen_year&sort=desc

[21] https://www.tndisability.org/tennessee-disability-scorecard

waste of public resources that is taking place." [Am. Pet. Ex. B file: "TNCARE Public Comments 10.3.19 10.15.19.pdf" pg. 14 ¶ 4].

A Disgraceful Discriminatory Deadly Disaster from Deliberate Dereliction of Duty Depriving the Disabled of their Due. I think I can hear echoing in the background a narrator saying: Perhaps there is a "set of facts in support of his complaint that will entitle him to relief.".

9 - Tennessee's Disabled Adults Are or Are Not Protected?

I would prefer to have gone through this entire case without a detailed discussion about the Tennessee Adult Protection Act. But the Respondents' Motion to Dismiss makes it seem necessary that I explain matters which I thought should have been obvious in my Petition and its Exhibits. One might note that T.C.A. § 71-6-101–126 isn't directly mentioned in my Petition. But I clearly reported and thereby gave others cause "to suspect" the "Abuse" "Neglect" "and Exploitation of disabled adult plan beneficiaries", which triggers T.C.A. Title 71 chapter 6 [T.C.A. § 71-6-103(b)(1)] [Am. Pet. pg. 4 ¶ 6, pg. 10 ¶ 1, pg.11 ¶ 1-2].

In my 2023 C-A I repeatedly make direct mention to the disabled adult protection statutes and how they apply to my health plans [Am. Pet. Ex. B pg. 6 ¶ 5, pg. 24 ¶¶ 2-3, pg. 25 ¶ 1, pg. 26 ¶ 3-4, pg. 37 ¶ 2]. My Petition and my 2023 C-A make an indirect yet still formal complaint of multiple parties, including the Respondents, committing disabled adult neglect, abuse, and exploitation, and nobody bothering to report it. Although, maybe they did try to report it and like me found out that Adult Protective Services (APS) won't allow people to make such verbal reports [Reply Resp. Opp. Mot. Accom. pg. 6-7].

The entire point of the statute is to protect those that can't function well enough to protect and advocate for themselves. Which is why reporting is mandatory for all citizens of Tennessee [T.C.A. § 71-6-103(b)] and violation of the duty to report is a Class A Misdemeanor [T.C.A. § 71-6-110]. Not that I've ever seen or heard of this statute being enforced against Medicaid plan fiduciaries engaged in fraud and generalized misconduct which neglects, abuses, and exploits their Medicaid beneficiaries.

Many of the people at state agencies that I tried to get help from told me they believe these vulnerable adult protection laws don't apply to health plan fiduciaries, without being able to articulate much of a reason as to why. Which is typically how prejudiced and discriminatory views deprive people of equal protection of the laws. Focusing on that part of my case also

brings up past traumatic events and triggers my PTSD [Am. Pet. Ex. B pg. 12-13]. So I try to avoid thinking about it if I can.

In my Petition I explained, "The TennCare plan administrators act as trustees of this account of funds that is the collective property of the beneficiaries" [Am. Pet. pg. 10 ¶ 2]. Which I believe means that the Tennessee Adult Protection Act does apply to the Respondents and their MCO's [T.C.A. § 71-6-102(5), 39-15-501(4)].

The Social Security Administration is an institution that manages the provision of social welfare benefits to qualifying individuals. TennCare is an institution providing qualified individuals access to Medicaid health plan benefits. These health plan benefits are the property-asset of the disabled adults who are qualified individuals [Am. Pet. (pg. 9 ¶ 4)--(pg. 10 ¶ 2)]. By contract and agreement TennCare's plan administrators and MCOs operate in a fiduciary capacity "to act as a trustee of such property" so that we may get medically necessary care to "attain or retain the capability for independence" and be able to exercise our "right to fully participate in all aspects of society" [42 U.S.C. §§ 1396-1, 12101].

Respondents act as trustees of a property-asset which is "necessary to maintain the health and welfare of an adult" in "a situation in which an adult is unable to provide or obtain the services that are necessary to maintain that person's health or welfare" [T.C.A. § 71-6-102(1)(A)]. A property-asset that Respondents have seized through "deception" and withheld proper access to by "exercising control over" the property-asset for their own "appropriation" [T.C.A. § 39-15-501(7)] [*Supra* pg. (31 ¶ 1)--(35 ¶ 3)]. A property-asset that a reasonable person would consider essential for the well-being of an elderly or vulnerable adult" [Id. (8)(A)(ii)]. And have thereby caused me, a vulnerable disabled adult, to suffer "prolonged pain", "suffering", and "incapacity" from the "infliction" of "serious" "physical harm" and "psychological injury" which normally requires "medical treatment" [T.C.A. 39-15-501(2);(9);(11-12). A property-asset which is "very important" to a disabled adult as without it they can "never hope to integrate themselves into the community" City of Cleburne v. Cleburne Living Center, Inc., 473 U.S. 438 (1985)] [Am. Pet. pg. 10 ¶ 1].

There is also a "right of recovery in civil action" which is "In addition to other remedies provided by law" [T.C.A. § 71-6-120(b-c)]. This seems particularly relevant due to how Respondents' fraud and violation of my civil and constitutional rights is part of my claim for damages [T.C.A. § 39-15-501(7), 71-6-102(8)] and that, "the §1983 remedy . . . is, in all events, supplementary", not substitutional, "to any remedy any State might have." [*Supra* pg. 6 ¶ 1, FN 2].

As much as I think it's important to acknowledge the applicability of the Tennessee Adult Protection Act to my situation, I think focusing my case on it could hurt me. I am afraid that someone from APS might try to insert themselves into my life acting under the misguided notion that they know what's best for me, and thereby further deprive me of my rights. Hence I elected to refrain from directly mentioning the Tennessee Adult Protection Act statutes in my Petition, despite its most obvious and explicit inclusion in my 2023 C-A and the "conspicuous absence" [*Supra* pg. 21 ¶ 1] of UHCCP-TennCare making any effort whatsoever to acknowledge, address, or in any way deal with this problem related to disabled adult neglect, abuse, and exploitation being perpetrated by them.

Dated May 29th 2024.

Sincerely,

Sean Smith
6402 Baird lane
Bartlett TN, 38135
(901) 522-5775
TheLastQuery@gmail.com
DefendTheDisabled.org

Affidavit of Informational Accuracy of Petitioners' Response in Opposition to Motion to Dismiss

I Sean Smith, duly sworn, do hereby affirm that the information I present in my *Response in Opposition to Respondents Motion to Dismiss* and it's Exhibits is to the best of my knowledge and ability true and correct per my records, memory of past events, and/or documentation of those events, and submit my Response in Opposition as both a legal Argument and a Testimony.

Dated May 29th 2024.

Sincerely,

Sean P. Smith 5.29.2024

Sean Smith
6402 Baird lane
Bartlett TN, 38135
(901) 522-5775
TheLastQuery@gmail.com
DefendTheDisabled.org

ROBERT H BROWN
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF SHELBY
My Commission Expires May 17, 2026

State of Tennessee County of Shelby

I certify this to be a copy of the original document

this 29th day of May, 2024

Robert H Brown

Notary

My Commission Expires May 17, 2026

Certificate of Service

I Sean Smith hereby certify that a true and correct copy of *Petitioners' Response in Opposition to Respondnets' Motion to Dismiss Amended Complaint and Petition for Review,* and, *Affidavit of Informational Accuracy of Petitioners' Response in Opposition to Motion to Dismiss* is being forwarded via email and USPS certified mail to the following:

Respondents Counsel
HAYLIE C. ROBBINS (BPR# 038980)
Assistant Attorney General
Office of the Tennessee Attorney General
Haylie.Robbins@ag.tn.gov

Dated May 29th 2024.
Sincerely,
Sean Smith
6402 Baird Lane
Bartlett TN, 38135
(901) 522-5775
TheLastQuery@gmail.com
DefendTheDisabled.org

Index of Exhibits for Petitioners' Response in Opposition to Respondents' Motion to Dismiss Amended Complaint And Petition for Review

Exhibit A5 - Proof of Service of PHI Request to UHCCP via Email and USPS Certified Mail provided as digital .pdfs

File Names:

"Resend of Sean Smith's UHC Info Reqs (from 2.6.20) 3.26.20-redacted.pdf"

"Resend of UHC PHI Reqs, Electronic Receipt 4.20.20.pdf"

"Sean Smith's UHC Info Req via Gmail 3.26.2020.pdf"

"UHC Info Req Packet Envelope.pdf"

Exhibit B5 - Call Recordings and Partial Transcript of Calls as digital files.

File Names:

"Calls, TennCare Appeals, Transcript 12.7-18.2023.odt"

"2023-12-07 10-53-29 (TennCare Appeals Ricky M.).mp4"

"2023-12-18 11-23-47 (TennCare Appeals and Advocacy Tiffany & Seattle).mp4"

"2023-12-18 16-06-42 (TennCare Supervisor Java P.).mp4"

These Audio Files (.mp4) contain sensitive information and need to be filed under seal. The other files (.pdf, .odt) can be part of the public record.

"To guarantee the protection of federal rights, 'the §1983 remedy . . . is, in all events, supplementary to any remedy any State might have.'" [Health and Hospital Corp. of Marion County v. Talevski, 599 U.S. ___ (2023)].

When those civil and constitutional rights violations occur as a result of Respondents engaging in illegal activities which neglected, abused, exploited, repeatedly injured, defrauded, and discriminated against a beneficiary based upon disability, this further expands the Respondents liability for damages and the need for punitive penalties, as such "has long been recognized as the proper means for preventing entities from acting unconstitutionally." [Armstrong v. Exceptional Child Ctr., Inc., 575 U.S. 320, 338 (2015)].

If judicial review at the Davidson County Chancery Court is too "narrow in scope" [Order Deny Mot. Acc. Just. pg. 3 ¶ 1] to fully or partially adjudicate my case in a manner in which my case can be "construed so as to do substantial justice" [Tenn. R. Civ. P. 8.01] and provide the injunctive and equitable relief so required by that justice, then a transfer of venue or directing me to refile my case would seem indicated. It is beginning to become clearer to me that the scope of my case's fraud and civil and constitutional rights claims and the need for a court appointed attorney may require refiling in federal court for it to be possible for any amount of substantive justice to be done. But to dismiss my case for failure to state a claim or lack of subject-matter jurisdiction seems like it would be another inappropriate decision and action in a long line of inappropriate decisions and actions made by the State of Tennessee.

Contents:

RULES AND METHODS

My Amended Complaint and Petition for Judicial Review includes in its Exhibit B my 2019 and 2023 Complaint-Appeal (C-A). I specified that I retain "call recordings and other records" I can present to the court as part of my case [Am. Pet. pg. 5 ¶ 3]. In December 2023 I made phone calls to TennCare Appeals where I complained about my C-A not getting full and fair review and requested further administrative remedy. Those calls are events and records that both I and Respondents are aware of and are immediately material to evaluating the Respondents' claim that I did not exhaust administrative remedies. Pursuant to Tenn. R. Civ. P. Rule 10.03 these records are part of my pleading and I will include these records in my arguments and analysis.

The sections of my 2023 C-A focused on Cigna-Fedex were intended and declared to be representative of Respondents misconduct, and should be ready as such when cited [Am. Pet. pg. 6 ¶ 3, ("detailed accounts" of respondents misconduct, "would end up being quite similar to that which is demonstrated in this letter.").

I am also going to include the UHCCP-TennCare Member Handbook in my arguments and analysis as if it were directly included with my pleading. The Member Handbook is an essential tool to navigate the UHCCP-TennCare health plan. As essential as a dictionary is to navigating the English language, or the Rules of Civil Procedure are to civil litigation. In the same way the court would not fault me for citing a dictionary definition to prove a point, I believe the court won't fault me for citing the UHCCP-TennCare Member Handbook.

Sources cited and included in my arguments and analysis which were not in my pleading and are not obviously "essential" will be included to assuage any doubt that there is a "set of facts in support of his complaint that will entitle him to relief.". However, many of these sources of information are facts that are within the "special competence" of the Respondents [Memo Sup. Mot. Dismiss pg. 4 ¶ 4], and thus Respondents 'should' know them, in the same way that they 'should' know their statutory obligations, or a beneficiary should know their rights and responsibilities as outlined by the Member Handbook, and could be construed to also being 'essential' to any discussion about my claims.

"D. Rule 12.02(6). FAILURE TO STATE A CLAIM"

"Certain general principles govern the disposition of motions to dismiss for failure to state a claim. The motion is determined on the face of the complaint. The court must treat the allegations of the complaint as true and construe averments liberally in favor of the pleader. The court must further give the nonmoving party the benefit of all reasonable inferences. The court must not grant the motion unless it appears beyond doubt that the plaintiff can prove no set of facts in support of his complaint that will entitle him to relief. Pemberton v. American Distilled Spirits, 664 S.W.2d 690 (Tenn. 1984)."

[Robert Childers & John Maddox. (Aug 21, 2014). Civil Rules 12 65 handout. See pg. 4. https://www.tncourts.gov/sites/default/files/docs/civil_rules_12__65-handouts.pdf]

"a complaint should not be dismissed, no matter how poorly drafted, if it states a cause of action" [Dobbs v. Guenther, 846 S.W.2d 270, 273 (Tenn. Ct. App. 1992)]

ARGUMENTS AND ANALYSIS

1 - As to What Type of Suit Has Been Brought

1.1 - My Core Claims and Rights of Action More Clearly Asserted

Respondents' wonder "as to what type of suit Petitioner has brought, if any." [Memo Sup. Mot. Dismiss pg. 1 ¶ 1] Is it an appeal or an original action, or both, and how does it fit into Tennessee's court system?

Perhaps clarity may be offered by simply stating matters for what they are. This is a suit brought by a physically and mentally disabled adult who has been neglected, abused, exploited, repeatedly injured, defrauded, and had his rights deprived by Respondents for over six years and who has tried and failed to find anyone in Tennessee to intervene and in desperation now pleads pro se with the court for relief, in much the same way a wild animal might struggle and flail about seeking release from a hunter's snare.

That so much time, effort, energy, and resources have been and are being expended by the State of Tennessee to limit and prevent disabled adults like me from getting the medically necessary rehabilitative care we need to be made 'able' to fully participate in society, demonstrates the nonsensical and irrational nature of the States actions, through which one can

see the totality of their failure as administrators of the TennCare program [42 U.S.C. §§ 1396-1, 1396a(a)(19)] and the absolute necessity of a lawsuit against them.

One of the reasons I did not try to list every offending action and law broken by TennCare and it's Managed Care Organization (MCO) Unitedhealthcare Community Plan (UHCCP) in my Petition is that doing so would not only be an "undue hardship" [Am. Pet. pg. 5 ¶ 1] but it would have prevented my Petition from being "simple, concise, and direct" [Tenn. R. Civ. P. 8.05]. I figured I'd have an opportunity to list out all the finer details of my case later, even though I was confused about when or how that would transpire [Mot. Accom. pg. 10 ¶ 4].

The 60 day deadline to file my Petition didn't offer me much time to do legal research. Most of my time was and is spent trying to manage my disabilities while deprived of needed care [Am. Pet. pg. 6 ¶ 5]. My mental disabilities also made it hard for me to learn and understand my rights, what a right of action was and how it relates to my claims, the importance of each to a case, and how and when to assert them. Then more time was used up trying and failing to find attorneys who would help litigate against TennCare, all while trying to keep my mind from giving up and surrendering to suicide.

I have spent almost all day everyday of this entire year performing legal research and study and trying to litigate this case. In order to promote function I have implemented cyclic ketosis, as I warned would be harmful to require me to do in my Motion for Accomodations. In the past month and a half my weight has gone from ~192-188 lbs to ~180-174 lbs despite trying to eat enough. I understand and can better explain my case now than I did in January.

In my interactions with the Respondents and their MCO UHCCP they have made decisions and taken actions which violated civil and criminal federal and state statutes [42 U.S.C. §§ 1396-1, 1396a(a)(3);(8);(10)(A);(19);(30)(A), 12101, 1983, 1985(2-3), 1986] [29 U.S.C. 794] [42 CFR §§ 431.200;205(d-f);220;221, 438.68;100(b);206;207;208(b);210;214(C);224, 438.406(b)(2)(iii);(b)(5), 440.230;240;260;262, 440.50;168-169, 441.18(a)] [45 CFR §§ 164.502, 164.512(j)(1)(i)(A), (Am. Pet. Pg. 12 ¶ 6)] [T.C.A. §§ 39-16-402;403, 39-15-501(2);(4);(7-9);(11-12);(14), T.C.A. 71-6-101(1-2);(5)] and my Constitutional rights [U.S. Const. Amend. 1st, 5th, 9th, 14th; TN Const. art. 1. sec. 8].

It's a long list that's been getting longer and I'm probably missing or forgetting a few. As I dig deeper into my case I turn over rocks and keep finding more snakes [*Infra* (pg. 15 ¶ 4)--(pg. 16 ¶ 1)]. There are even some laws relevant to my case that I intentionally omitted from my Petition as I had concerns that I might be harmed If I had included them. [*Infra* pg. 64-66 (Sec. 9 - Tennessee's Disabled...)].

The Respondents assert that my "allegations seem to rely upon what [Petitioner] believes to be enforcement of these statutes" [Memo. Sup. Mot. Dismiss. Pg. 6 ¶ 3]. While I dearly hope my case will lead to greater oversight and prejudicial enforcement of the law against the Respondents, it is my understanding that the scope of my right of action to directly enforce federal and state statutes against the Respondents' is limited[1] [Armstrong v. Exceptional Child Ctr., Inc., 575 U.S. 320, 135 S. Ct. 1378, 191 L. Ed. 2d 471 (2015)], but still quite established[2] [Health and Hospital Corp. of Marion County v. Talevski, 599 U.S. ___ (2023)].

My case does not seek to privately enforce most of these statutes that I have frequently cited and asserted that the Respondents' have violated, such as 42 U.S.C. §§ 1396-1, 1396a(a)(19);(30)(A). Respondents seem to have not understood the purpose of my citing and alleging violations of many of these statutes. For clarification consider the wording of 42 U.S.C. § 1396a(a)(19) which mandates that "care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients;". Providing care and services in a manner which injures, defrauds, and violates the civil and constitutional rights of plan beneficiaries does not act "in the best interests of the recipients". That stipulated fact then stipulates many other conclusions about my allegations, claims, and right of action.

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[1] "The sheer complexity associated with enforcing §30(A), coupled with the express provision of an administrative remedy, §1396c, shows that the Medicaid Act precludes private enforcement of §30(A) in the courts."
Although Sotomayor in dissent noted that, "We expressed no hesitation in concluding that federal courts could require compliance with this obligation, explaining: 'It is . . . peculiarly part of the duty of this tribunal, no less in the welfare field than in other areas of the law, to resolve disputes as to whether federal funds allocated to the States are being expended in consonance with the conditions that Congress has attached to their use.'" "...a faithful application of our precedents would have led to a contrary result, I respectfully dissent." [Armstrong v. Exceptional Child Ctr., Inc., 575 U.S. 320, 329 (2015)]

[2] "§1983 can presumptively be used to enforce unambiguously conferred federal individual rights, unless a private right of action under §1983 would thwart any enforcement mechanism that the rights-creating statute contains for protection of the rights it has created."
"To guarantee the protection of federal rights, 'the §1983 remedy . . . is, in all events, supplementary to any remedy any State might have.'" (emphasis added) [which I think means, administrative remedies, if there are still some left to exhaust, are 'supplementary' and not substitutional]
"*Gonzaga* sets forth our established method for ascertaining" "whether Congress has "unambiguously conferred" "individual rights upon a class of beneficiaries" to which the plaintiff belongs." "We have held that the *Gonzaga* test is satisfied where the provision in question is " 'phrased in terms of the persons benefited' " and contains "rights-creating," individual-centric language with an " 'unmistakable focus on the benefited class.' "."

It is stipulated that I have a privately enforceable right of action against Respondents for their violation of many of these statutory provisions when their actions would or did deprive me of my civil or constitutional rights.

Additionally, were respondents to provide "care and services" in a manner serving "the best interests of the recipients"[42 U.S.C. § 1396a(a)(19)] it becomes stipulated that their actions would then prioritize and facilitate rehabilitative care - as it is their inherent duty to do and I directly requested of them in 2023 [Am. Pet. Ex. B pg. 7 ¶ 2] [Am. Pet. pg. 12 ¶ 2-3, TCA § 39-16-402;403]. Prioritizing beneficiaries rehabilitation would further serve the "simplicity of administration" by drastically reducing the amount of administrative staff, providers, and costs needed to operate the health plan [Am. Pet. pg. 11 ¶ 4].

I had explained throughout my 2019 and 2023 C-A's how Respondents actions and decisions are preventing and limiting my access to "medical assistance", to the point it is often inaccessible, which is illegal [42 U.S.C. § 1396a(a)(10)(A)] [Am. Pet. pg. 3 ¶ 1] [*Infra* (pg. 22 ¶ 1)--(pg. 26 ¶ 2)] [Am. Pet. Ex. B pg. 4 ¶ 2, pg. 24 ¶ 2, pg. 26 ¶ 4, pg. 42 ¶ 3, pg. 68 ¶ 5] [[Am. Pet. Ex. B file: "Sean Smith's 2019 Medical Appeal (redacted for court 2024).pdf" hereafter cited as (2019 C-A) pg. 4 ¶ 1-4, pg. 18 ¶ 2-3, pg. 19-28, pg. 27 ¶ 2, pg. 32 ¶ 3-4].

That I cannot access the "medical assistance" whose statutory definition is "'rehabilitative services' that provide 'for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level' [42 U.S.C. § 1396d(a)(13)(C)]." [Am. Pet. pg. 9 ¶ 2]. That such actions deprive me of my civil and constitutional rights [Am. Pet. pg. 3 ¶ 1, pg. 9 ¶ 2-4, pg. 10 ¶ 1-2, pg. 11 ¶ 1-3, pg. 12 ¶ 4-6, pg. 13 ¶ 1; Ex. B pg. 8 ¶ 2-3, pg. 65 ¶ 1; file: (2019 C-A) pg. 4 ¶ 2 & 4, pg. Pg. 5 ¶ 3, 18 ¶ 1, pg. 30 ¶ 3, pg. 32 ¶ 1-3, pg 36 ¶ 2-3, pg. 37 ¶ 3, pg. 38 ¶ 1 & 4, pg. 39 ¶ 2-3, pg. 53-59].

Which includes violating many of my rights as a beneficiary [42 CFR § 438.100(b)(2)(iii-iv);(3);(c);(d)], including my rights to receive "such" "rehabilitative services" to "attain or retain capability for independence" with "reasonable promptness" [42 U.S.C. §§ 1396-1, 1396a(a)(8);(10)(A), 1396d(a)(14)(C)] [Am. Pet. pg. 2 ¶ a-k, pg. 3 ¶ 1, pg. 4 ¶ 1-5, pg. 5 ¶ 2 & 4, pg. 6 ¶ 1-5, pg. 9 ¶ 1-2,] [Am. Pet. Ex. B pg. 2 ¶ 1, pg. 5 ¶ 3, pg. 28 ¶ 3-4, pg. 33 ¶ 3, pg. 42 ¶ 1, pg. 60-62, pg. 67 ¶ 4, pg. 74 ¶ 1; file: (2019 C-A) pg. 29 ¶ 2, pg. 53-58] [Infra (pg. 22 ¶ 1)--(pg. 26 ¶ 2)] which are rights I can privately enforce[3].

UHCCP-TennCare have intentionally represented to me that by entrusting my property-asset 'medicaid health plans benefits' to them and investing my time, effort, and energy

[3] National Health Law Program. (2022). Fact Sheet: Private Enforcement of the Medicaid Act Under 42 U.S.C. § 1983 pg. 7

in exercising my rights and fulfilling my responsibilities as a health plan beneficiary, I would in turn receive medically necessary rehabilitative care and services with "reasonable promptness". Tenncare has been making unlawful agency decisions which have limited and prevented me from receiving rehabilitative care and services with "reasonable promptness". UHCCP-TennCare have effectively seized my property-asset 'Medicaid health plan benefits' without due process or just compensation, and reappropriated it for their own ends, and this has caused me to sustain numerous physical, mental, financial, and social injuries. These injuries impose physical, mental, and financial restraints upon my ability to function and perform my activities of daily living and integrate into my community. Respondents' unlawful seizure of my property-asset, and the injuries, restraints, disability, and communal displacement it imposes upon me have caused me to be deprived of "being 'able' to Live Life, Exercise Liberty, and Pursue Happiness; to have a chance to have Independence and Declare oneself to society as a participant of society." [Am. Pet. pg. 10 ¶ 1].

TennCare knowingly and illegally makes the agency decision to operate an inadequate provider network that cannot provide the required PCP and Specialist services for my disabilities which are caused by or related to my jaws-airway [Am. Pet. pg. 3 ¶ 1; pg. 4 ¶ 3-5; pg. 7 ¶ 2 & 4; *Infra* pg. 21-*30* (Sec. 5 - Provider Network Inadequacy)]. This prevents plan beneficiaries from getting their jaws-airway issues diagnosed and being provided information about their health condition and the treatments for it.

This inadequate provider network made me ignorant of my health condition and the treatments for it, whereby Respondents' had effectively decided for me what decisions I could make about my health and body, causing me "to become injured and experience more severe disability" [Am. Pet. pg. 9 ¶ 2].

Respondents' illegal inadequate provider network violated my constitutional rights "to acquire useful knowledge" as a medicaid plan beneficiary and make decisions about my health and body [42 CFR § 438.100(b)(2)(iii-iv), U.S. Const. Amend. 9] [Meyer v. Nebraska, 262 U.S. 399 (1923)] [Am. Pet. pg. 2 ¶ a-k, pg. 3 ¶ 1, pg. 4 ¶ 3-4, pg. 6 ¶ 3-5, pg. 9 ¶ 1-2; Ex. B. Pg. 68 ¶ 3-4; file: (2019 C-A) pg. 4 ¶ 4, pg. 12 ¶ 2].

This is also an agency decision to operate an illegally inadequate provider network which discriminates against my jaws-airway and related disabilities [Am. Pet. pg. 10 ¶ 1-2, pg. 11 ¶ 1-3] [Am. Pet. Ex. B pg. 4 ¶ 2, pg. 24 ¶ 2, pg. 26 ¶ 4, pg. 42 ¶ 3, pg. 68 ¶ 5] [Am. Pet. Ex. B file: (2019 C-A) pg. 27 ¶ 2, pg. 32 ¶ 4].

UHCCP-TennCare have been and are engaged in a fraudulent scheme which violates my civil and constitutional rights and has caused me to sustain several years of physical,

mental, financial, and social injuries "in the knowledge" that doing so would place my "health in jeopardy." [Am. Pet. Ex. B pg. 68 ¶ 4, Mot. Acc. Just. Ex. B4 file:"Dr. Rice Vivos Dx Tx.pdf"]. The knowledge that in order to "defend himself against the misconduct of the [Respondents]" "He must complete difficult tasks while burdened by" "his unmet health needs" which "greatly impair him" "and do so while knowing the circumstances he is subjected to will worsen his medical conditions and disability and thereby cause him even further impairment. And also while knowing that this path he is forced upon endangers what possibility there is for him to benefit from rehabilitative treatments. Mr. Smith is placed in jeopardy now and in the future irrespective of the timeliness and quality of the care he receives." [Am. Pet. Ex. B pg. 73 ¶ 4] [Am. Pet. pg. 12 ¶ 6].

Tick...

Tock...

1.2 - The Interrelationship Between Medicaid Statutes And Beneficiaries Civil And Constitutional Rights

I admit that sometimes it may require some 'critical thinking' to understand the explanations I have offered in my pleading and its exhibits. For example I explained how by being disabled I and others require rehabilitative care so that we "may return to useful employment" [Am. Pet. pg. 7 ¶ 1; see also pg. 10 ¶ 2]. I thought it was evident how a benefit to disabled adults is "very important" when without it they can "never hope to integrate themselves into the community" City of Cleburne v. Cleburne Living Center, Inc., 473 U.S. 438 (1985)] [Am. Pet. pg. 10 ¶ 1].

That I would not have to be so obvious as to declare that in order to integrate myself into my community I need to be 'able' to work and in order to work I need rehabilitative care [42 U.S.C.§ 1396d(q)(2)(C)]. I thought my citation of The Nation's Proper Goals for people with disabilities from the Americans with Disabilities Act (ADA) was a more than adequate explanation on that front [Am. Pet. pg. 11 ¶ 3]. I thought that since Congress understood this point well enough to enact the ADA and make the rehabilitation of disabled adults amongst Respondents inherent obligatory duties, and Eisenhower outright stated matters as such in 1956, and the Social Security Administration quoted Eisenhower for over a decade, that

respondents were on the down low with this obviously not secret knowledge that their job includes helping me get rehabilitated so I can be able to have a job. I thought this because the Respondents represented to me that, "Working helps people earn money, learn new skills, meet new people, and play an important role in their communities. Work can also help people stay healthy and build self-confidence." [UHCCP-TennCare Member Handbook 2023 pg. 91 ¶ 4].

There's an interrelationship between the various statutes I cite and allege violation of and the civil and constitutional rights of disabled adult Medicaid plan beneficiaries. Respondents' failure to fulfill their statutory obligations has a propensity, not a guarantee, to violate the rights of their plan beneficiaries. The pursuit of The Nation's Proper Goals for people with disabilities is a general mandate to all parties, but is one for which Medicaid plan administrators must be diligently observant and adherent to. For it is those proper goals which serve to protect the fundamental civil and constitutional rights of their disabled adult plan beneficiaries for which they serve as fiduciaries and trustees to [Am. Pet. pg. 3 ¶ 1, pg. 10 ¶ 1-2].

There is no policy, procedure, or rule which Medicaid plan administrators can make or implement to work against the Nation's Proper Goals without it also working to defeat the purpose and mission of the Medicaid program. For Respondents to work against the Nation's Proper Goals is "repugnant" to federal laws and "to the Constitution." [Marbury v. Madison, 5 U.S. 137, 181, 2 L. Ed. 60, 2 L. Ed. 2d 60 (1803).]. Respondents must seek Prior Authorization from federal statutes and our Constitutions for their agency decisions, and when denied there is no administrative remedy to exhaust and their only option of appeal must be "directed to Congress" [Health and Hospital Corp. of Marion County v. Talevski, 599 U.S. ___ (2023)]. To attempt to maneuver around that restriction under the color of law is to rob beneficiaries of our fundamental rights by defrauding our Constitutions which hold in trust the common good [42 U.S.C. §§ 1983, 1985(3),1986].

While "the State's "breach" of the Spending Clause contract" is a matter for the Secretary of HHS to directly enforce [Armstrong v. Exceptional Child Ctr., Inc., 575 U.S. 320,

328 (2015)], there is a pact that all parties must comply with which is our Constitutions. The State's breach of that pact further opens them to private legal actions.

2 - Injunctive And Equitable Relief Is Proper Justice For My Case

Respondents asserted that, "Petitioner has made no claim against TennCare or the State of Tennessee that can be redressed by this Court; instead, Petitioner's only avenue of recourse is with the agency itself." [Memo Supp. Mot. Dismiss pg. 6 ¶ 3].

In explaining Respondents violations of laws related to Medicaid statutes in my Petition and 2023 C-A, I sought to demonstrate that their misconduct is not incidental or accidental but a purposeful act of "deliberate indifference" to the civil and constitutional rights of myself and other beneficiaries. That the respondents misconduct cannot somehow be construed to be in pursuit of a proper governmental purpose or objective. Their conduct has been misconduct; their agency decisions have been 1) "in violation of constitutional and statutory provision[s]", 2) "in excess of statutory authority of the agency", 3) "Made upon unlawful procedure", 4) "capricious" and an "abuse of" and "clearly unwarranted exercise of discretion", 5) "Unsupported by evidence that is both substantial and material in the light of the entire record" [T.C.A. § 4-5-322(h)].

My petition has sought the Chancery Court's review of TennCare's agency decisions and actions and asks for injunctive and equitable relief that "has long been recognized as the proper means for preventing entities from acting unconstitutionally.":

> "as we have long recognized, if an individual claims federal law immunizes him from state regulation, the court may issue an injunction upon finding the state regulatory actions preempted."
>
> "...courts may in some circumstances grant injunctive relief against state officers who are violating, or planning to violate, federal law." [id..at 326]
>
> "What our cases demonstrate is that, "in a proper case, relief may be given in a court of equity ... to prevent an injurious act by a public officer." Carroll v. Safford, 3 How. 441, 463, 11 L.Ed. 671 (1845).".
>
> "The ability to sue to enjoin unconstitutional actions by state and federal officers is the creation of courts of equity, and reflects a long history of judicial review of illegal executive action, tracing back to England." [Id. at 327]
>
> "concluding that the case was "cognizable in a Court of equity," and holding it to be "proper" to grant equitable relief insofar as the state tax was "repugnant" to the federal

law creating the national bank". [Armstrong v. Exceptional Child Ctr., Inc., 575 U.S. 320, 338 (2015)]

The Respondents' agency decisions have been "repugnant" to the federal laws creating the TennCare program [42 U.S.C. §§ 1396-1, 1396a(a)(3);(8);(10)(A);(19);(30)(A)] and to the Constitution and common good that Congress enacted those laws in support of.

As my Petition had already explained, "The SSA's purpose and mission preempts its policies and procedures. While I understand and appreciate the Davidson County Chancery Court's review of petitions often has a focus on the policies and procedures specific to a dispute with TennCare and it's MCC's, I would submit that the mission of the Medicaid program, its purpose, should garner consideration, particularly as it pertains to deciding what is proper conduct for plan administrators." [Am. Pet. pg. 7 ¶ 2] I explained how it is the Respondents' "duty" to act "in accordance with recognized standards of conduct which preempted policy and procedure." [Id. pg. 7 ¶ 3]. And in defining what proper conduct is, we arrive at a standard by which misconduct can be both defined and determined to have occurred [Memo. Sup. Mot. Dismiss pg. 5 ¶ 2 ("Petitioner's complaint makes vague allegations about unspecified 'misconduct,'")]. Whereby we can evaluate Respondents' conduct based upon "how they are implementing policy and procedure and the impact that their implementation has upon a beneficiary, their community, our State, and our Nation.". [Am. Pet. pg. 7 ¶ 4].

This standard isn't new information to the Respondents and their MCO UHCCP. In my 2019 C-A (pg. 18 ¶ 1) I communicated to them that "Denying coverage of procedures that can drastically improve or resolve the medical issues leading to disability is entirely antithetical to the mission statement of Medicaid programs...'to assist the disabled' [99]".

The Respondents have been and continue to ignore standards of "good conduct for Medicaid plan administrators" as described by "politicians" such as Eisenhower did singularly [Am. Pet. pg. 7 ¶ 1] or that groups of "politicians" did as the body known as Congress through its legislation [Id. pg 10 ¶ 2] [42 USC 1396-1, 1396a(a)(19)], or as the Social Security Administration has communicated in its publications since at least 2005.[4] Respondents "interpret and apply policy and procedure to work against the purpose and mission of the Medicaid program" [Am. Pet. pg. 7 ¶ 4] "...for which they are employed to achieve." and "Their actions betray their position of trust" [Id. pg 9 ¶ 3].

[4] this quote from Eisenhowser has been used in multiple SSA documents. My Petition references a 2021 SSA document, and my 2019 C-A references a 2005 SSA document. One can safely say the SSA has long recognized Eisenhowser's statement as an established mandate codifying a standard of conduct for medicaid plan administrators. Respondents seemed dismissive of Eisenhowsers statement in the Memo. Sup. Mot. Dismiss pg. 6 ¶ 3.

The Chancery Court of Davidson County as a court of equity seems to have the jurisdiction to provide relief in my case, and this jurisdiction seems to extend beyond the strict confines of the UAPA. Though perhaps the Court and Respondents will disagree and require I seek relief in a different Tennessee or federal court. I'm beginning to think my suit requires that I refile it. Though I don't fully understand what that really means or how to do it, or in what court I need to refile, or how I can function well enough and long enough to reinitiate and finance a lawsuit even more demanding than this Petition for Judicial Review. How would it affect my due process violation claim from being denied a fair hearing? Can I refile that or do I have to try to deal with it here first?

The state of Tennessee has deprived me of my civil and constitutional rights and without an attorney will likely continue to do so. Maybe I need to go to federal court just so that I can get appointed an attorney. Maybe the state of Tennessee has become a place so inimical to the rights of disabled adults that the federal courts are the only place I can hope to obtain protection and justice.

3 - The Matter of Subject-Matter Jurisdiction

The Respondents argue that "TennCare's denial of outpatient physical therapy services" "is the only agency decision this Court presently has jurisdiction to review" and that "the Court does not have proper jurisdiction to grant Petitioner relief, and this action must be Dismissed." [Memo Sup. Mot. Dismiss pg. 5 ¶ 2]. That the Chancery Court cannot order Respondents' to follow the law and provide full and fair review to plan beneficiaries [Am. Pet. pg. 14 ¶ 1-2]. That the Chancery Court as a court of equity cannot "grant equitable" and "injunctive relief against state officers who are violating, or planning to violate, federal law." despite such actions being "the creation of courts of equity" [*Supra* pg. 6 ¶ 1 FN1].

Respondents have convinced themselves it's not their job or responsibility to help me get rehabilitative jaws-airway-disability care. In response to Respondents misconduct their MCO UHCCP and their provider network has by and large concluded it is not their job and responsibility to help me get rehabilitative jaws-airway-disability care. And now Respondents wish to convince the court it is not your job and not your responsibility to adjudicate the issues I describe and plead for relief from.

If such is so, then I wonder whose job and responsibility it is, and why it is necessary to further delay and obfuscate a resolution to the issues I complain of by completely dismissing my suit. Each moment we linger in court is a moment longer respondents work to subvert the

mission and purpose of the Medicaid program by limiting and preventing rehabilitate care, and intentionally placing myself and those like me under conditions that guarantee injury [Am. Pet. Ex. B pg. 51-63] and violate my rights.

Even were the court to review the agency decisions I have contested and issue an order to reverse them, the number of laws broken by Respondents is so extensive it's unclear to me what the court must enjoin to effectively intervene. By itself, reversing Respondents' agency decisions or ordering an injunction seems incapable of providing relief for the violation of my civil and constitutional rights in the past, or stopping such future occurrences of violations from occurring in the future. It also seems incapable of providing relief which penalizes Respondents enough to de-incentivize them from harming the other plan beneficiaries like me. Even as a very socially isolated individual I know of two such TennCare beneficiaries in my own neighborhood. That for Justice to be done such that it is fully supportive of our Constitutions and the common good requires more relief than I have asked for, or even know how to ask for, and perhaps more than the UAPA can afford.

These are atypical circumstances and it would seem appropriate for an atypical response to be supplied inasfar as the court has discretion to supply it. If the Chancery Court can't do that, or agrees with Respondents' assessment that it lacks the competence and jurisdiction necessary to fully adjudicate my suit/plea-for-equitable-injunctive-relief, then transferring my case to a venue that can and will deal with it [T.C.A §§ 16-1-116, 16-11-102] [Local Rule 3.04][5] or directing me to refile my suit seems more appropriate than continuing this abusive game of kick-the-can that UHCCP, TennCare, and the State of Tennessee have required me to endure for over six years, and show every indication of trying to continue until the can breaks apart and scatters into the earth to be forgotten and trod upon by everyone as they attend to what they are told and believe to be their jobs and responsibilities.

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[5] "and such court determines that it lacks jurisdiction, the ccurt shall, if it is in the interest of justice, transfer the action or appeal to any other such court in which the action or appeal could have been brought at the time it was originally filed." (TCA 16-1-116)
"The chancery court has concurrent jurisdiction, with the circuit court, of all civil causes of action, triable in the circuit court" [TCA 16-11-102]
"3.04 - Transfer of Cases
The Presiding Judge may transfer a case from one court to another or from one division to another. The Judges and Chancellors of the 20th Judicial District may transfer cases among themselves by mutual consent except in cases of recusal. It is not necessary that the parties or their counsel consent to such a transfer." [Local Rules 3.04]]

In my Petition I presented the Nuremberg trials as a well-known real-world example of this type of 'not my job not my responsibility I just follow rules' mindset [Am. Pet. pg. 7 ¶ 3]. Stanley Milgram's psychological studies at Yale in the 1960s sought to better understand the societal psychology of the Holocaust and famously demonstrated how, "Ordinary people, simply doing their jobs, and without any particular hostility on their part, can become agents in a terrible destructive process. Moreover, even when the destructive effects of their work become patently clear, and they are asked to carry out actions incompatible with fundamental standards of morality, relatively few people have the resources needed to resist authority."[6]
With a more recent study finding, "acting under orders caused participants to perceive a distance from outcomes that they themselves caused" and "people actually feel disconnected from their actions when they comply with orders, even though they're the ones committing the act."[7].

Milgrims experiment demonstrates a concept that was observed much earlier by John Stewart Mill in his 1859 publication *On Liberty,* "Truth gains more even by the errors of one who, with due study and preparation, thinks for himself, than by the true opinions of those who only hold them because they do not suffer themselves to think…".

4 - Respondents Complaint-Appeal Determinations Have Been Invalidated

For my pleading I focused on trying to provide a summary that gave the 'general idea' of my case. I had believed that legal professionals whose practice of law was focused upon medicaid and disability, would be able to understand my situation from my general claims. I thought that after having read my 2023 C-A, TennCare's denial letter, and my Petition that the Chancellor and Attorney General would have all they'd need to see the Respondents' misconduct and understand the statutory and constitutional provisions which had been violated.

Instead what has happened is that Respondents' Motion to Dismiss asserts that my "appeal was denied as untimely because it was not filed within 40 days of any agency notice.

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[6] Milgram, Stanley (1974). "The Perils of Obedience". Harper's Magazine. Archived from the original on December 16, 2010. Abridged and adapted from Obedience to Authority.]
See Also: https://en.wikipedia.org/wiki/Milgram_experiment

[7] And: Joshua Barajas. (Feb 20, 2016). How Nazi's Defense of "Just Following Orders" Plays Out in the Mind.

See Ex. A to Am. Pet.; see also Tenn.R. & Regs. 1200-13-19-.06(3). Nowhere in the Amended Complaint does Petitioner challenge this determination". [Memo Sup. Mot. Dismiss. pg. 6 ¶ 1].

The correct time limit to appeal is 60 days [42 CFR §§ 431.221(d), 438.402(2)(ii)], making Tenn. R. & Regs. 1200-13-19-.06(3) when applied to an MCO beneficiary's appeal to be in violation of federal law. Given the federal statutory requirement to afford 60 days[8] Tenn. R. & Regs. 1200-13-19-.06(3) if applied to appeals would violate the beneficiaries right to due process, making it a facially unconstitutional rule. It could be further argued that it is "unreasonable" [§ 431.221(d)] to afford 40 days for a fair hearing request when it is federally required to afford 60 days for appeals. The rule being facially unreasonable is made all the more offensive by the fact it is illegal [42 CFR § 438.408(f)(2)], thus making Tenn. R. & Regs. 1200-13-19-.06(3) facially unconstitutional for both appeals and fair hearings. This is yet another example of the Respondents "Weaponizing policy and procedure against disabled adult plan beneficiaries" [Am. Pet. pg. 11 ¶ 2] in order to "work against the purpose and mission of the Medicaid program" [Id. pg. 7 ¶ 4] and "betray their position of trust" in "violation of...the U.S. Constitution" [Id. pg. 9 ¶ 3-4].

Contrary to Respondents' assertion, in my [Am. Pet. pg. 4 ¶ 2] I had directly challenged TennCare's determination by completely invalidating it with the statement "In his Nov 2023 C-A Mr. Smith did not state he was appealing a denied request for Outpatient Physical Therapy." It is a reasonable inference that my having not stated a request for Outpatient Physical Therapy in my 2023 C-A means I did not request that service, means my C-A was not for that service, means that no such request was made and thus no 'untimely' request exists. Therefore, my "complaints and requests" "have not even been acknowledged...let alone acted upon, which precludes the possibility of any promptness even being possible with respect to a review and determination..." [Id. pg. 9 ¶ 1]. Per the Respondents' failure to work any of my actual requests, let alone do so in a timely manner, and my having made a request for a fair hearing, "a hearing is required" [42 CFR §§ 431.200, 431.220(1), 431.221] [Am. Pet. pg. 8 ¶ 5] which TennCare denied and thereby deprived me of my constitutional rights to "due process", "petition the Government for a redress of grievances", "just compensation", and other rights, "privileges or immunities" [U.S. Const. Amend. 1st, 5th, 14th; TN Const. art. 1 sec. 8]. Somehow "equal protection of the laws" applies here too, but my mental disabilities are keeping me from understanding that well enough to articulate matters. Which is among the many reasons I thought I should be appointed an attorney.

[8] see also https://www.macpac.gov/publication/federal-requirements-and-state-options-appeals/

I even specified why the information related to physical therapy was present in the 2023 C-A explaining that: "...Mr. Smith presented Examples of Misconduct committed by his health plans." "...to substantiate his allegations of health plan misconduct and other forms of abuse, neglect, and exploitation that have caused harm to Mr. Smith. The information related to past disputes about physical therapy was presented as Evidence of health plan misconduct." [Am. Pet. pg. 4 ¶ 6].

It is reasonable to infer that the information related to physical therapy was presented to provide examples of UHCCP-TennCare misconduct which neglected, abused, exploited, and injured me, in the hope that the health plans would recognize they had hurt me and then understand how to stop hurting me. Much like how it is reasonable to infer that a child who exclaims to a caregiver, "Ow, you're hurting me." intends for the caregiver to cease the act of harm. And indeed I verified that to be the case while explaining what my health plans need to do so I can get help, "I just want it all [the misconduct] to end." "I want to stop being abused and exploited". "I want the misbehavior to stop so patients will be able to access medically necessary care." [Am. Pet. Ex. B pg 71 ¶ 1, file:(2019 C-A) pg. 39 ¶ 2].

I further clarified that "Mr. Smith would not write 88 pages over the course of several months at great detriment to his physical and mental well-being simply to appeal for "outpatient physical therapy"."[Am. Pet. pg. 5 ¶ 4].

My 2023 C-A was 88 pages long and contained 38,650 words. It's title is, "An Example Of The Misconduct Committed By Plan Fiduciaries And Their Contracted Partners & An Appeal For Rehabilitative Treatment". Word search within the text body shows the term "physical therapy" is used only 4 times, "temporomandibular" 8 times, "jaw" 10 times, "discriminat(e)(ion)(ory)" 12 times, "rehabilitat(e)(ive)(ion)" is used 19 times, "abuse" 38 times, "injury" 38 times, "suicide" 38 times, "TMD"/"TMJ" 43 times, "airway" 43 times, "legal" 56 times, "breathing" 71 times, "law" 84 times, "disab(led)(ility)" 85 times, "misconduct" 94 times, "sleep" 249 times; the word "hope" is used 6 times.

I explained in exhaustive detail how my jaws-airway issues cause a variety of health conditions that cause my disabilities and requires an interdisciplinary team of physicians that are highly specialized in each health condition, particularly understanding how jaws and airways relate to each condition [Am. Pet. Ex. B. pg 43-62, file:(2019 C-A) pg. 1, pg. 13 ¶ 2 ("...my struggles, although medical issues, would require a dentist to treat them, and that medical doctors would need to be involved in demonstrating this and coordinating my care in an interdisciplinary fashion with the dentist functioning as the 'quarterback'.")].

It would be a reasonable inference that I would need and would request access to interdisciplinary "Rehabilitative Treatment" for the health conditions causing my disabilities. Googles definition of "Interdisciplinary" is "relating to more than one branch of knowledge.". It is therefore stipulated that interdisciplinary rehabilitative treatment requires more than one branch of knowledge. It is, and has been argued and explained as being, an unreasonable, unlawful, and an unwarranted exercise of discretion - "nothing could be further from the truth" - to assert my 2019 and 2023 C-A inferred that outpatient physical therapy could provide rehabilitation for my disabilities which were explained as requiring interdisciplinary care to diagnose and treat [Am. Pet. pg. 4 ¶ 2 & 6, pg. 5 ¶ 4, pg.12 ¶ 5; Ex. B file:(2019 C-A) pg. 4 ¶ 1-4, pg. 13 ¶ 3-4, pg. 16 ¶ 3, pg. 31 ¶ 5, pg. 32 ¶ 1]. My 2019 C-A emphatically and explicitly stated the opposite of Respondents 2019 and 2023 agency decisions:

> "[Specialized Physical Therapy] Treatment with Dr. Mcmahon has helped me more than anything else, but it's like treading water. My head bobs above water, but I can still expect to drown absent appropriate intervention."
>
> "...it's benefits are limited and do not provide lasting relief as it does not directly address the etiology of my TMD..."
>
> "Even with Dr. Mcmahon's help I had experienced declines in overall function." [Am. Pet. Ex. B file:(2019 C-A) pg. 24 ¶ 5, pg. 25 ¶ 1].

From the analysis of my C-A's it becomes reasonable not only to infer, but to stipulate it as fact, that Respondents did not perform full and fair review of my 2019 and 2023 C-A's. That their 'review' was performed in bad faith and involved an agency decision to refuse to work any of the complaints and requests my C-A made, and as a result they violated numerous constitutional and statutory provisions.

Indeed, we can find further evidence of this from Respondents filings. Respondents stated, "Petitioner's Appeal form listed "rehabilitative treatment of disabilities" as the requested care needed, however he did not specify what doctor, if any, had prescribed this treatment, or any other details related to the care he was seeking. (Ex. D to Am. Pet.)" [Memo Sup. Mot. Dismiss pg. 2 ¶ 1].

The TennCare Appeal Form did not provide enough space on it to even write "rehabilitative treatment of the health conditions causing my disabilities" so I wrote "rehabilitation of disabilities" and didn't even have enough room for that with "disabilities" cut off at "disab". My health conditions cause the disability of paresthesia and ataxia of my hands causing me to struggle to write [Am. Pet. pg. 2 ¶ f], which means I can't squeeze things into a really tiny form. One could say it is a stipulated fact that TennCare has a disabled medical appeals form limiting

their disabled adult plan members capability to appeal for "rehabilitative treatment of the health conditions causing my disabilities".

If respondents require plan members to provide more detail, then they ought to provide a form which would reasonably afford the space to provide that detail [42 CFR § 438.406(a)]. Respondents' criticism further demonstrates the arbitrary, capricious, and discriminatory nature of how they interpret and implement policy and procedure to work against the purpose and mission of their organization.

It is also very frustrating to me, and further demonstrative of their arbitrary and capricious nature, that only now while seeking to dismiss my suit do Respondents' ask "what doctor, if any, had prescribed this treatment". Had Respondents' provided a full and fair review of my C-A's they would have asked that same question years ago, and per their statutory requirements, have then requested further information from myself and my doctors. Which would have allowed a dialogue about my care needs and how to meet them to transpire.

TennCare is required to review plan members appeals and to make "an individualized determination of medical necessity based upon the need of each TennCare enrollee and his or her medical history." and "...an evaluation of pertinent medical evidence. TennCare and the MCCs shall elicit from enrollees and their treating providers all pertinent medical records that support an appeal". "Medical opinions shall be evaluated pursuant to TennCare Medical Necessity Rule 1200-13-16." [Tenn. Comp. R. & Regs. 1200-13-13-.11(3)(a-b)]. UHCCP-TennCare did not, to my knowledge, seek to elicit anything from me or my doctors.

I believe the veracity of the stipulated fact that the Respondents did not provide full-fair review is further demonstrated when we think back to our years of formative education during grade school. I think most people generally understand what full and fair review is because education in this country has required children to learn how to read books and write reports on books and then have their reports graded by teachers. I think any jury of my peers will unanimously agree that TennCare and its adult staff who have had many years of higher education and are funded by $14 billion tax dollars a year must provide a full and fair review of complaints and appeals that is better than that offered by a grade school level book report. When Respondents' denial letter can't pass a grade school standard for a review and report, one must logically conclude that they engaged in misconduct. That, "Indeed, if one authored a review of a movie or a book without having seen or read the material they would be the subject of dismissal, ridicule, and scorn." [Am. Pet. pg. 65 ¶ 3].

My petition stated, "Tenncare 'must grant an opportunity for a hearing to the following: (1) Any individual who requests it because he or she believes the agency has taken an action

erroneously.' [42 CFR § 431.220]. I submit that to engage in misconduct is to act in error. Therefore, a C-A about health plan misconduct is a document whose primary focus is upon 'erroneous actions'." [Am. Pet. pg. 8 ¶ 3].

In my 2023 C-A I asserted that, "those who dare to review Sean Smith's 2019 medical appeal first-hand [will] see with their own eyes how absurd it is to assert that the appeal was about denied physical therapy bills. The position adopted by UnitedHealthcare's denial demonstrates a willful disregard of how their past actions have caused physical and psychological injury to Mr. Smith." [Am. Pet. Ex. B (pg. 31 ¶ 6)--(pg. 32 ¶ 1)].

It is a reasonable inference that if I challenged the notion that my 2019 C-A was about physical therapy, and then used that example in my 2023 C-A as an example of TennCare misconduct neglecting, abusing, and exploiting me, then I would challenge any notion that my 2023 C-A was for physical therapy, as it would also then be an example of misconduct neglecting, abusing, and exploiting me. It would, therefore, be reasonable to infer that an agency decision to assert my 2023 C-A was about physical therapy would be an unwarranted exercise of discretion in violation of constitutional and statutory provisions. Especially when one considers that my 2023 C-A comprehensively reviews the contents of my 2019 C-A, even having one section titled "A Full & Fair Review Provides Evidence of Illegal Activity And Injury Done to the Beneficiary", in which I quote excerpts from the research articles I referenced throughout my 2019 C-A in order to demonstrate that full and fair review was not performed by UHCCP-TennCare and when such review is done one will then understand how the health plans conduct is misconduct that injures me and violates my rights [Am. Pet. Ex. B pg. 37-63].

My challenge to TennCare's "determination" that my 2023 C-A was a request for Outpatient Physical Therapy is contained within the C-A itself. Moreover, in my 2019 C-A I predicted, "I would go so far as to say the way patients with needs such as mine are handled by third-party payers is so broken that I can easily repeat the outcomes I've described and generate more evidence to corroborate the presence and impact of these problems. At this point, I have full confidence that despite stating this in my appeal nothing will change within these organizations. That, in fact, this appeal will most likely be reviewed with a similar degree of ignorance and inattention to detail that has been present throughout my interactions with Cigna and Unitedhealthcare to get medical diagnostics and treatment approved" [Am. Pet. Ex. B file: (2019 C-A) pg. 32 ¶ 3].

With my 2023 C-A mentioning the "law" over 80 times and "misconduct" over 90 times you would think it'd be a prudent and rational response from the plan administrators acting in a fiduciary capacity to contact me and ask for more information. To reasonably infer that

something has gone terribly wrong and I as a plan member really need their help. To try to form a line of communication between myself and plan administrators that can address the problems I am encountering. That way I could get the medically necessary rehabilitative care I need and is an inherent duty of TennCare's Plan administrators to facilitate access to.

You know what's not in Tenncare's denial letter or any of their communications to me? Any such outreach. Sometimes it's not what's said or how it is said that is most important. But it's what is inherently evident or entirely absent that offers the greatest clarity. "Its conspicuous absence militates strongly against their position." [Armstrong v. Exceptional Child Ctr., Inc., 135 S. Ct. 1378, 1383 (2015)]. Analysis of my Petition, 2019 and 2023 C-A's, and TennCares denial letter illustrate numerous specific instances of misconduct that Respondents have refused to acknowledge or address.

TennCare's agency decision to make the "false assertion" my C-A was a request for Outpatient Physical Therapy and deny it for that reason, in order "to deprive Mr. Smith from receiving the due process of a fair hearing" [Am. Pet. pg 12 ¶ 5] was a "willful and unreasonable action without consideration or regard for the facts and circumstances.". [Boothe v. Roofing Supply, Inc. Of Monroe, 893 So. 2d 123, 126 (La. Ct. App. 2005)].

5 - Provider Network Inadequacy Prevents Communicating Care Needs And Facilitates Respondents Fraud

I'm a disabled adult Medicaid beneficiary who is a plan member of Unitedhealthcare Community Plan (UHCCP) who is a contracted Managed Care Organization (MCO) of Tennessee's Medicaid Plan TennCare. According to the UHCCP TennCare Member Handbook for 2023, I have "Rights and Responsibilities", which include, "the responsibility to:" "Understand the information in your member handbook and other papers that we send you" [UHCCP-TENNCARE Member Handbook 2023 pg. 164][9].

The member handbook instructs that I "have the responsibility to:", "Go to your PCP for all your medical care unless: Your PCP sends you to a specialist for care. You must get a referral from your PCP to go to a specialist." [Id. pg 163] "If the specialist is not in our Provider Network, your PCP must get an OK from us first." [Id. pg. 22]. I'm informed that I "have a right to:" "Be told in an easy-to-understand way about your care and all the different kinds of

[9] https://www.uhc.com/communityplan/assets/plandocuments/handbook/en/TN-MemberHandbook-EN.pdf

treatment that could work for you, no matter what they cost or even if they aren't covered." [Id. Pg. 161-162]

And that I "have the responsibility to:" "Work with your PCP so that you can understand your health problems" and "come up with a treatment plan that you both say will help you." [Id. pg. 163].

While attempting to exercise and uphold those rights and responsibilities from 2012-2016 I discovered in-network doctors didn't understand my symptoms or have many answers for my identified health problems [Am. Pet. Ex. B file:(2019 C-A) pg. 54 ¶ 3]. My general dentist Dr. Stephen Williams, who was not in-network with UHCCP-TennCare, referred me to see an out-of-network jaw specialist, Dr. Melody Barron. I had to pay out-of-pocket to see Dr. Barron to get my jaws-airway issues diagnosed and receive basic patient education about [Id. pg. 18 ¶ 3].

Even after my diagnosis and basic patient education and bringing this matter to my doctors attention, UHCCP-TennCare's PCPs and Specialists could not tell me much of anything about my jaws-airway issues and how they cause or contribute to my other health conditions which cause my disabilities. Nor could they tell me how to effectively treat my jaws-airway-disability, let alone work with me "to come up with a treatment plan that [my PCP and I] both say will help [me]." [2023 Member Handbook pg. 163]. For years UHCCP-TennCare PCPs told me I needed to see specialists because my symptoms can't be explained as jaws-airway problems. And for years I got referred to and saw many specialists [Am. Pet. Ex. B file:(2019 C-A) pg. 58 ¶ 1]. I discovered the UHCCP-TennCare provider network to be inadequate with an extreme deficit in education, expertise, and experience related to jaws-airways and the health conditions and disabilities that they cause and contribute to and could offer "very little insight" [Id. (pg. 20 ¶ 2)--(pg. 21 ¶ 2)].

Almost no UHCCP-TennCare specialists know jaws-airway issues any better than the PCPs, and often told me that finding a jaws-airway specialist and getting the health plan to let me see them is a problem for my PCP. Many times over the phone UHCCP-TennCare told me that getting me access to jaws-airway care is the responsibility of my doctors. Even though I explained to UHCCP-TennCare over and over that my doctors either don't know how to or won't try to because they believe the health plan won't let them help me get the jaws-airway care I need. [Am. Pet. pg. 3 ¶ 1, pg. 4 ¶ 6; Ex. B pg. 68 ¶ 2-3; Ex. B digital file:(2019 C-A) pg. 4 ¶ 1-4, pg. 13 ¶ 3-4, Pg. 15 ¶ 4, pg. 18 ¶ 2, pg. 19 ¶ 1-3, (pg. 13 ¶ 3)--(pg. 14 ¶ 3), pg. 15 ¶ 4, pg. 21-22, pg. 23 ¶ 1, pg. 27 ¶ 3, pg. 31-32 ¶ 4 & 1, pg. 54 ¶ 6, pg. 59 ¶ 1-2, pg. 66 ¶ 2].

"As a patient I need a primary care physician who is not constrained in their ability to assess and coordinate my care because a service which is necessary is exceedingly difficult or impossible to get approved. It is disconcertingly common to find doctors so discouraged by past interactions with third-party payers they believe efforts to appeal third-party payers to assist them in the care of their patient would be nothing more than a waste of their time that would detract from servicing the needs of their patients. Sadly enough, some of these services that are poorly incentivized in the current reimbursement provided by insurers are things as fundamental as taking the time needed to seek out the educational resources necessary to understand a patient's needs, to communicate with the patient so as to gather a detailed history, or to collaborate with other physicians involved in the patients care so as to better understand or meet patient needs." [Id. pg. 4 ¶ 1-4].

"I also learned, unfortunately, that most physicians (including specialists) did not have the training to fully understand the complaints I was reporting, let alone how these are medically necessary to treat and which treatment options are the most appropriate to explore."

"The tethers third-party payers attach to physicians impede or outright disallow doctors from doing what is necessary to achieve favorable patient outcomes in the TMD population. To be frank, physicians treating this patient population find it difficult to fulfill even their hippocratic oath when it comes to the treatment of patients whose financial status makes them reliant upon medical insurance to access care. Therefore, despite the fact that care is medically necessary, the predominant practice in this field of medicine has been that patients figure out how to pay out of pocket for treatment. This is as much for the practicalities of being in practice as it is the ethical dilemma of avoiding being in a position in which a patient experiences a continued decline in their health because the third-party payer denies coverage; this would place the treating physician in a position in which they would then be unable to fulfill even the most basic standards of care. I would go so far as to state that physicians currently (2019) contracted on an in-network basis to Cigna and UnitedHealthcare are severely constrained in their ability to provide ethical and efficacious care to patients with TMD and disordered breathing in a manner that is sustainable to their medical practice. For pragmatic reasons, financial sustainability often takes precedence over patient outcomes. This reality leaves many basic needs unmet and has been particularly harmful to TMD patients. It is quite disagreeable for Cigna and United Healthcare to claim current in-network physicians can

provide comparable care to the physicians I have sought to attain out-of-network adequacies for." [Id. pg. 13 ¶ 3-4].

"That so many specialists from various fields are observing the behaviors of third-party payers impede patients access to medically necessary services illustrates this is not an isolated matter subject to the nuances of medical professionals holding differences of opinion. It has become increasingly clear that certain patient populations are not having their needs met primarily due to the behavior of third-party payers and the unwillingness of clinicians to fight with the payer system to facilitate care to those patients in need. This situation harms patients, and in many instances - especially within the population I am apart of - ends up costing third-party payers more in the long-run as patients get sent to one specialist after another having 'covered procedures' performed and reimbursed to physicians which do little to nothing to address the medical issues causing the patient's primary complaints." [Id. Pg. 18. ¶ 2].

"Fighting the same battles that never win the war and being instructed to perform tasks that even the doctors refuse to do because they believe them worthless in the long-run. Medical professionals seem to predominantly be of the opinion that the denial of request for care and reimbursement for procedures by third-party payers is based upon criteria unconcerned with the patients welfare - this is beyond upsetting." [Id. pg. 27 ¶ 3].

"There are many other instances that have occurred" "that illustrate how medical insurers are wrongfully denying coverage" such as "Primary Care Physicians that stop trying to figure out what's wrong and how to fix it because they believe insurance won't approve the diagnostics." [Id. pg. 59 ¶ 1-2]

"The behavior of Cigna and other third-party payers has served as an impediment that has obfuscated access to appropriate care for myself and others. This behavior has led to a substantial amount of waste in time and resources. It is bad for patients, it is bad for third-party administrators..." "In my observation, the behavior of UnitedHealthcare and TennCare do not at all seem to be geared to trying to rehabilitate people who are disabled by chronic medical conditions." [Id. (pg. 31 ¶ 4)--(pg. 32 ¶ 1)]

Many times I had asked UHCCP-TennCare over the phone for help to find a PCP who would help me get my health plan to allow me to see specialists who could help with my jaws-airway-disability. UHCCP-TennCare would direct me to a generic list of providers I had to cold call and attend 'blind date' appointments with. "Need to find a doctor or change your doctors?" "We want to make sure that you get good care" [2023 UHCCP-TennCare Member Handbook pg. 144]. For years I found the majority, nearly all, UHCCP-TennCare providers

cannot or will not provide effective care for my jaws-airway issues or help get me to a specialist who could. And those few who can or would help, get prevented or limited from helping by UHCCP-TennCare misconduct and other factors outside of my control.

Throughout all of this many physicians tried to blame my symptoms and psychological struggles on psychiatric issues. In doing so they discriminated against both my mental and physical disabilities and limited my access to medically necessary care [Am. Pet. Ex. B pg. 8 ¶ 2, pg. 22 ¶ 1, pg. 41 ¶ 5, pg. 61 ¶ 2]. Despite my psychiatrist writing a letter in 2017 asserting that my symptoms were not "a psychiatric manifestation of his chronic mood disorder" to try to get them to stop doing that, I continued to encounter discrimination which limited my access to care [Am. Pet. pg. 38 ¶ 3].

"If you are not happy with the care that you are getting, call us...Tell us that you need to make a complaint." [2020 Member Handbook pg. 145]. That "If you still can't get the care you need, you can call TennCare member Medical Appeals" [Id. pg. 150]. I called and complained and reasoned and pleaded and begged and grievanced and escalated and case managed many times over many years, and I found myself unable to "get good care" for my jaws-airway-disability needs despite all of my efforts [Am. Pet. pg. 5 ¶ 2].

The member handbook instructs that I "have a right to:" "Ask TennCare and Unitedhealthcare Community Plan to look" "at any mistake you think they made about" "getting your health care", and, that I "have a responsibility to:" "Give information to the UnitedHealthcare Community Plan and to your health care providers so that they can care for you" [2023 Member Handbook pg. 163]. After everything I've told my health plans and the doctors in their provider network, what more can I communicate so that they can understand how to care for me?

I more intensively educated myself and spent years trying unsuccessfully to find UHCCP-TennCare PCPs and Specialists who were willing to receive and review educational materials about jaws-airways. I offered to directly provide educational materials to them or to refer them to educators so that they could become educated enough to be able to communicate the medical necessity of my jaws-airway-disability care needs to other doctors and my health plans. I asked specialists for help, including those outside of UHCCP-TennCare's network, asking them for referrals to a jaws-airway specialist or a PCP who can and will help me.

In 2018 I found Dr. Gillespie, an ENT specialized in sleep medicine. Dr. Gillespie wrote a letter acknowledging my sleep breathing issues and recommending orthognathic surgery mediated palate expansion, but didn't know of any in-network physician to refer me to for

diagnostics and treatment planning. UHCCP-TennCare refused to review and respond to Dr. Gillespie's recommendation which was submitted with my 2019 C-A [Mot. Acc. Just. Ex. B4].

Further complicating Dr. Gillespie's recommendation and UHCCP-TennCares refusal to even consider it, is that my education then and now lets me understand that by itself that orthognathic procedure would not adequately treat my case. A critical component of effectively treating my jaws and airway relies upon expanding and remodeling my nasomaxillary complex. There was and yet remains substantive clinical and research evidence indicating there were and are treatment modalities for expanding and remodeling the nasomaxillary complex which provide substantive benefits that orthognathic procedures do not. I and my doctors needed access to the specialists in non-surgical jaws-airway treatment modalities in order to create an actionable treatment plan.

A constant problem throughout all of this is I couldn't figure out on my own which of the many jaws-airway specialists I should see. My PCPs and Specialists similarly didn't know either, and weren't volunteering to figure it out on my behalf or to submit PA's so that I could consult with, learn from, and assess my long list of out of network jaws-airway specialists. A few specialists and PCPs made suggestions on who I could consult with, and I'd add them to my long list, but they offered no solution as to how to get my health plans to allow me to see them.

I reasoned that if my health plans will not help me, and my UHCCP-TennCare doctors will not or can not help me, and I am going to have to have my parents pay out of pocket to try to get help, then I should do a thorough job figuring out which out-of-network jaws-airway specialists I needed to consult with to help me "understand [my] health problems" and "come up with a treatment plan that...will help [me]." as best as I could by myself. [2023 Member Handbook pg. 163].

I gathered an extensive amount of information from research publications, continuing education materials, patient support groups, long-form podcast interviews, and consultations. I reached a point where I needed help making sense of the data I had accumulated. The UHCCP-TennCare provider network did not have such help.

What else can I do?

The member handbook instructs I "have a right to:"

"Get medically necessary care that is right for you, when you need it." and;

Get "Help to make decisions about your health care".

But How? And From Who?

I also have a right to, "Make appeals and complaints about UnitedHealthcare Community Plan or your care." The Handbook asserts that, "An Appeal is one way to fix mistakes in TennCare."

[Id. pg 153] and that, "You have the right to get an answer from your health plan when you or your doctor asks for care" [Id. pg. 164]. (emphasis added).

Per the member handbook I have rights I cannot exercise because the provider networks PCPs and specialists will not or can not provide the information, education, or assistance required to assess and address my jaws-airway issues and related disabilities. Per the Member Handbook, I have a responsibility to provide this information to UHCCP-TennCare and a right to complain and appeal for the care that I need.

I explain to UHCCP the hardship it would be for me to write my C-A and ask for help and am told there is no one who can help me. [Am. Pet. pg. 6 ¶ 4 & 6] [Am. Pet. Ex. B file: (2019 C-A) pg. 32 ¶ 4]. I spent several months drafting and then finally submitting my 2019 C-A. UHCCP-TennCare refuses to provide full and fair review of it, and makes the agency decision to falsely assert my appeal was about physical therapy. I complained to TennCare via phone calls that they did not properly review my C-A and demanded that they provide a fair-full review. TennCare responds with a letter denying any such improper conduct occurred and reaffirms their unsubstantiated fallacious assertion that my C-A was about physical therapy [Am. Pet. pg. 32 ¶ 2, Ex. B file:"TennCare Grievance of Appeal Rev & PHI Req Misconduct, Denies Wrongdoing 5.27.20.pdf"]. [Am. Pet. pg. 6 ¶ 1-2]

In 2020 I began drafting and had almost completed a followup C-A, but due to not getting "medically necessary care that is right" for me when I needed it, I got too injured to complete it until Nov 2023, at which time I submitted it to my health plans. UHCCP-TennCare refused to provide full and fair review and, again, denied my C-A saying it was about physical therapy [Am. Pet. pg. 4 ¶ 2, pg. 6 ¶ 1-2, pg. 8 ¶ 2]. I was denied a fair hearing despite preemptively requesting a fair hearing on my appeal form [Am. Pet. Ex. D]. I called TennCare Appeals in December 2023 and complained I had not received full and fair review, was denied a fair hearing, and demanded an explanation and remedy [*Infra* pg. 43-47 (Sec. 7.2 - Respondents Have Denied...)]. TennCare refused to provide either and reiterated their letter's "outpatient physical therapy" denial determination and directions for me to file a Petition for Judicial Review [*Infra* pg. 47 ¶ 1]. I filed a Petition for Judicial Review Jan 26th 2024. Now TennCare, as Respondent, claims I did not exhaust all administrative remedies and have no claim upon which relief may be granted and my Petition should be dismissed, because if my appeal wasn't about physical therapy, then the court has no jurisdiction to provide review and relief.

I and other TennCare beneficiaries are led to believe by Respondents intentional representations that by entrusting our property-asset 'health plan benefits' to UHCCP-TennCare

and investing our time and resources in exercising our rights and fulfilling our responsibilities as medicaid beneficiaries we will in exchange be "furnished" with "medical assistance" which is medically necessary rehabilitative care with "reasonable promptness" [42 U.S.C. 1396a(a)(8);(10)(A)]. That our role as plan members will be "to participate as beneficiaries of a legally compliant good faith Medicaid program" [Am. Pet. pg. 10 ¶ 1, Ex. A (TennCare's denial letter) pg. 4 ¶ "We do not allow unfair treatment in our program", pg. 6 ¶ "we obey federal and state civil rights laws"].

That it is our right and our role to, "Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand." [42 CFR § 438.100(b)], not to instruct and educate Respondents and their inadequate provider network about our jaws-airway condition so that they understand our need for treatment and can properly supply basic services like PCP case management and receiving diagnostics and care from specialists [42 CFR §§ 438.68;206;208(b);210, 440.230(b-c); 440.168-169;240] [42 U.S.C. 1396a(30)(A)]. Let alone have to self-educate ourselves in order to provide such instruction and education despite the impairments caused by our mental and physical disabilities [42 CFR § 440.262].

> "It is my hope that members will be provided the resources that will enable us to access the physicians and procedures appropriate to our cases. However, step one in accomplishing that requires first that Cigna and United Healthcare cease acting in bad faith and fulfill what they are, supposedly, obligated to do: one example of many I could provide being, third-party payers are obligated to fairly and competently assess and review claims, network adequacies, appeals, and otherwise interact with members and physicians in a manner which does not place unreasonable burdens upon them; such as forcing someone as myself into a situation which requires one spend years of their life to gather enough information that they can write their own medical appeal rather than using those efforts to seek and receive care for their condition from physicians specialized to meet their needs." [Am. Pet. Ex. B file:(2019 C-A) pg. 4 ¶ 2].

It is the Respondent's role and responsibility to create methods and standards which get "<u>used</u> to assure that services are of high quality." [42 CFR § 440.260] (emphasis added), in order "to deliver care to and coordinate services for..enrollees" such that "each enrollee has an ongoing source of care appropriate to his or her needs" [42 CFR § 438.208(b)(1)] and will be afforded the opportunity to be "'able' to Live Life, Exercise Liberty, Pursue Happiness, to have a

chance to have Independence and fully participate in society." [Am. Pet. pg. 10 ¶ 1]] [42 U.S.C. 1396-1, 12101, U.S. & TN Constitution].[10]

Respondents knowingly deprive me of those rights and prevent me from fulfilling those responsibilities, and thereby deny to me without due process the role and benefits that I am entitled to as a medicaid beneficiary which would afford me the opportunity to be a full participant in society [Am. Pet. pg. 9 ¶ 4].

Perhaps saying I had such rights is just another false claim, and my role has never been that of a beneficiary, a person, a citizen, a human being with rights, but has been and is that of a commodity, like livestock on a farm [Am. Pet. Ex. B file: "TNCARE Public Comments 10.3.19 10.15.19.pdf" pg. 4 ¶ 4 ("To say that people in these situations are being commoditized like livestock is, to me and others, not an exaggeration, it is a literal description."), file: (2019 C-A) pg. 32 ¶ 1-3 ("people who are disabled and reliant upon Medicaid are treated like cattle" "commodities that fill up offices and allow providers and third-party payers to profit while not meeting the medical needs of those patients" "Medicaid isn't a program to support and rehabilitate, it's a trap that allows others in society to profit through the exploitation of a vulnerable population in need of assistance.") pg. 38 ¶ 1 & 4,]

Does the account of events I relay speak to TennCare pursuing a 'proper governmental purpose or objective'? Does it sound indicative of agency decisions which are "arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion"? Does it perhaps sound like Fraud?

> "It is a situation wherein the resources one is supposed to have access to are being withheld - a cookie jar, full of cookies, with the people in stewardship of the cookies saying they want to give you cookies, but the cookies are locked in a safe. How does it open? What's the combination? Submit a request. Get denied or receive no response and upon confrontation with the cookie-stewards receive more declarations about how they have so many cookies and they want to give them to you. All while one slowly

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[10](Mot. Acc. Just. pg. 11 ¶ 2): "It is difficult to find a justification for it to be the burden of disabled adults to educate a health insurance plans administrators and its doctors or the Court and its staff so that they can comprehend our disabilities well enough to avoid discriminating against us and depriving us of our fundamental rights. Yet, that burden is imposed upon me by health plan misconduct, by the Respondents, the Courts requirements, and societies inattention and inaction to the plight of disabled adults in their community. This is a full-time job that I don't receive compensation for doing. A job that when I do it I am often subjected to more abuse, discrimination, and injuries that I receive no workers comp for. It is a burden in addition to already overwhelming burdens. I've had to try harder in the last decade than most people have to during their entire lifetime, and despite trying so hard, and gaining the hard-won experience that comes with such persistent diligent effort, I still fail and get injured because I am a disabled adult - Because I Am Not Able."

starves and becomes emaciated while trying to get the cookies." [Am. Pet. Ex. B pg. 70 ¶ 3].

UHCCP-TennCare have been and are engaged in a fraudulent scheme which violates my civil and constitutional rights and whose injuries are not merely financial, but physical, mental, and social.

Let's consider for a moment a different and more common standard of review. Would you like to be treated like I described? Would you want those you love and care for to be treated like that? Under what conditions would you deem it appropriate to treat someone like I've been treated? What exercise of discretion is warranted to correct this injustice caused by a series of Agency Decisions made in Deliberate Indifference to my health, safety, and fundamental rights?

As complicated as this all can be, my case and my pleading can be simplified to:
Disabled Adult Needs And Has Right To Medically Necessary Rehabilitative Care, But Instead Gets Neglected, Abused, Exploited, Injured, And Deprived of His Civil And Constitutional Rights For Years Because People Didn't Do The Job They Represented That They Would Do And Receive Federal And State Funding To Do.

6 - Petitioner's Claim of UHCCP-TennCare's Fraud:

"Thus, fraud claims will survive a Tenn.R.Civ.P. 12.02(6) motion to dismiss if they demonstrate that a claimant would be entitled to relief under some set of facts." [*Dobbs v. Guenther*, 846 S.W.2d 270, 274 (Tenn. Ct. App. 1993)]

I attempted to communicate in my Pleading and 2019 and 2023 C-A's my understanding that Respondents are defrauding beneficiaries and taxpayers and damaging their communities. I have a private right of action to sue for this fraud due to personal injuries and civil and constitutional rights violations [42 U.S.C. §§ 1396a(a)(8), 1983, 1985(2-3), 1986] [29 U.S.C. § 794] [T.C.A. § 71-6-120(b)] [Am. Pet. pg. 3 ¶ 1, pg. 9 ¶ 2 & 4, pg. 12 ¶ 4-6, pg. 13 ¶ 1].
In my 2019 and 2023 C-A's I stated:

"One may even more broadly assert fraud is occurring within UnitedHealthcare and TennCare by noting that the duty to curb costs and assist beneficiaries [42 U.S.C. §

1396a(19);(30)] cannot be fulfilled when the program's operations prevent beneficiaries from receiving medical care for conditions that if not properly treated are known to lead to a high rate of medical utilization for a variety of services and cause injury to communities, the State, and the Nation. This fact was demonstrated in the references in Mr. Smith's [2019] medical appeal [S.S. 2019 M.A. Ref 40, 41, 42, 43, 44, 45, 52, 139, 140]. It's puzzling why the misconduct of these organizations is allowed to antagonize vulnerable persons, injuring them and their communities, all while defrauding taxpayers. The individuals facilitating this misconduct have betrayed the plan beneficiaries, their communities, and their country. They honor neither Oath nor Law and they prey upon the most vulnerable among us while claiming, and perhaps even believing, they are providing a service to others.".

I explained in my Petition [Am. Pet. pg. 9-11], that the State of Tennessee Department of Finance and Administration is required to make certain that their division TennCare and its plan administrators and MCOs are aware of and fulfill their duties and obligations. Respondents' official positions require them to be aware that they receive funding for the purpose and mission of providing to disabled adult beneficiaries like myself "rehabilitative services" "for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level" [42 U.S.C. § 1396d(a)(13)(C)] "in a manner consistent with simplicity of administration and the best interests of the recipients" [42 U.S.C. § 1396a(a)(19)] "to help such families and individuals attain or retain capability for independence or self-care" [42 U.S.C. § 1396-1]. That they are "to enlist enough providers so that care and services are available under the plan *at least to the extent* that such care and services are available to the general population in the geographic area" (emphasis added) [42 U.S.C. § 1396a(a)(30)(A)] so as to "ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished" and "May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary". [42 CFR § 438.210] (emphasis added).

Pursuant to 42 CFR § 438.207, UHCCP must represent to TennCare at each contract

As a qualified individual [42 U.S.C. § 1396d(p);(q)] my property-asset 'medicaid health plan benefits' [Am. Pet. pg. 9-10, ¶ 4 & 1-2] were provided to Respondents to be held in trust by UHCCP-TennCare based upon their "intentional misrepresentation" of material facts [*Dobbs v. Guenther*, 846 S.W.2d 270, 274 (Tenn. Ct. App. 1993)]. Respondents represented to me that I had rights [UHCCP-TennCare Member Handbook 2023 pg. 161-162] [42 CFR § 438.100(b)]. Particularly a right to: 1) get rehabilitative "medically necessary care that is right for you, when you need it.", 2) "Be told in an easy-to-understand way about your care and all the different kinds of treatment that could work for you, no matter what they cost or even if they aren't covered.", 3) get "Help to make decisions about your health care".

Respondents have intentionally represented to myself and others that they would construct, implement, operate, and maintain a health plan which will manage and coordinate care via Managed Care Organizations to facilitate rehabilitation with reasonable promptness [42 U.S.C. §§ 1396-1, 1396d(a)(13)(C), 1396a(a)(8);(10)(A), 1396d(t)(2-3), 42 CFR §§ 440.50;168-169, 441.18(a)] in a manner that serves the best interests of recipients and the simplicity of administration [42 U.S.C. § 1396a(a)(19)] by providing full and fair review of complaints and appeals and affording due process via fair hearings [42 U.S.C. §§ 1396a(a)(3);(19), 42 CFR §§ 431.200-250, 438.210(b-d);228;406(b)(2)(iii)], operating an adequate provider network [42 U.S.C. § 1396a(a)(30)(A); 1396d(t)(3)(C), 42 CFR §§ 431.200;205;220;221, 438.68;206;207;210, 440.230(b-c)];240;260;262,], use and protect our health information lawfully [*Infra* (pg. 37 ¶ 1)--(pg. 40 ¶ 2)], identify and stop abuse [T.C.A. § 71-6-101], and will assist their beneficiaries pursuit of the Nation's Proper Goals for people with disabilities [42 U.S.C. § 12101] [29 U.S.C. § 794] [Am. Pet. Ex. A (Ex. A is TennCare's denial letter) pg. 4 ¶ "We do not allow unfair treatment in our program", pg. 6 ¶ "we obey federal and state civil rights laws"], and otherwise fulfill their duties and obligations "faithfully" with "fidelity" "in support" of our Constitutions [Am. Pet. Ex. C (Ex. C is TennCare's Deputy Directors' Oath of Office)].

"I go back to [Sleep Medicine Specialist] Dr. Wise, frustrated, exhausted, tired, in pain, and after asking for options and receiving non-committal responses I ask him, "How do people in my position, people who are on disability and reliant upon insurance, get access to care for their disordered breathing" and he told me "in my experience, they don't." They don't. They don't get care. No willingness to appeal, or to try to work something out, just a collective, 'sorry, but insurers won't make it easy for doctors to treat you; you don't have a problem physicians are willing to acknowledge professionally in their practice because of the payer system'. Despite my attempts to find a way to access care Dr. Wise records in the medical record that "the patient elected not to proceed with an oral appliance.", effectively excusing himself and others. And so, active disease processes are left to fester." [Am. Pet. Ex. B file:(2019 C-A) Pg. 19 ¶ 2]

"On August 30th, 2019 I receive a letter from Dr. Wise. It's essentially a 'termination letter that isn't a termination letter'. The doctor states he is not going to do a peer-to-peer or apply any further effort to try to get a sleep study approved. He believes that no insurance would approve an in-lab study for my care. He tells a narrative in this letter which does not reflect what was communicated during office visits. To me, it seems like he gives up on me, directing me to find care elsewhere or pay out-of-pocket for the sleep study. How does one pay for a PSG under the financial limitations imposed by a lifetime of disability? I suppose in his mind I will have 'elected' not the have the PSG." [Id. pg. 23 ¶ 1]

"Sleep physicians engage in these behaviors mostly because they believe the behavior of insurers makes it impossible to get the needed studies approved and treatment provided. This behavior being tolerated also relies upon patient ignorance regarding the care they're receiving." [Id. pg. 54 ¶ 6].

UHCCP-TennCare were made aware that their provider networks inadequacy had resulted in their providers repeatedly discriminating against my mental and physical disabilities, subjecting me to physical and psychological injury, and generally compromising my health and safety [Am. Pet. Ex B pg. 4 ¶ 1-2, pg. 8 ¶ 3, pg. 22-23].

That for people with jaws-airway disability the UHCCP-TennCare provider network has proved itself 'unsafe' due to its inadequacy, and remains a hazardous obstacle which prevents needed rehabilitative care [Id. pg. 8 ¶ 3]. Put another way, UHCCP-TennCare puts out a sign claiming 'Floor Is Dry' despite being told repeatedly verbally and in writing 'Floor Is Wet With Guests Slipping and Falling and Getting Injured'.

UHCCP-TennCare's deficit in jaws-airway care within their provider network prevents plan members like me from being properly diagnosed and told about their care options. UHCCP-TennCare incentivizes, reinforces, and uses the ignorance and indifference of their providers and plan members as an instrument of control to prevent needed specialized care. [Id. pg. 4 ¶ 1-2]. Thereby they try to reduce care costs by implementing this short-sighted and destructive strategy to maximize profit through the capitated payments received through their contract with TennCare. The more beneficiaries UHCCP has, the greater their total payment. The MCO attempts to profit and TennCare attempts to reduce costs by maintaining provider and plan member ignorance of the rehabilitative therapies available from specialized physicians for their health conditions [Am. Pet. Ex. B file:(2019 C-A) pg. 2 ("constrained by what insurers covered and thus what physicians would make me aware of was an option.)]. This ignorance of one's health condition also leads to ignorance about ones disabilities and as a result ones disability related civil rights.

In the event that one is liberated from Respondents' ignorance-based instrument of control, one remains subjugated. Relegated to the torment that leads to here, now, at this Chancery Court. To being abused, injured, without care and with every cause to believe care will remain inaccessible, with more abuse forthcoming, and not the court nor any other party will intervene, will Defend The Disabled, and that the surest and sanest path to reducing one's prolonged and senseless suffering is to accept, as one accepts the nature of gravity, that Respondents have made suicide the only accessible solution. And if you try to get help with finding such acceptance, Respondents have made sure that their provider network will properly reinforce that conclusion and speed you on your journey to oblivion [*Infra* (pg. 52 ¶ 3)--(pg. 57 ¶ 4)].

One might better appreciate now, after these explanations, how the things I tried to explain in my Petition were meant to communicate that there is a provider network inadequacy caused by UHCCP-TennCare misconduct which is discriminating against and injuring me and those like me based upon our disabilities.

Throughout 2017-2024 I communicated over the phone to Respondents the problems I was encountering trying to get the care I needed and the injuries not getting that care was causing me. I recorded almost all of those calls and have offered to provide them to the court even though it will be a "hardship" to review and present this evidence [Am. Pet. pg. 5 ¶ 1-3].

My 2019 C-A further communicated Respondents' failures and the injuries they have caused to me, and I also exhorted the Respondents to fulfill their duties and assist me so that I could receive needed care. TennCare denied my 2019 C-A asserting it was about physical therapy. I complained over the phone on multiple calls to UHCCP-TennCare of their misconduct preventing full and fair review of my C-A and their general non-compliance with federal and state statutes. To which TennCare replied with a letter dated 5.7.2020 claiming I had not "provided any specific information for TennCare to investigate" [Am. Pet. Ex. B pg. 32 ¶ 2-4], which the call recordings would prove exceedingly false (I have run out of time to include them here).

By 2019 Respondents' had been provided "knowledge of the resprenstation's falsity" [*Dobbs v. Guenther*, 846 S.W.2d 270, 274 (Tenn. Ct. App. 1993); see *Supra* pg. 32 ¶ 1]. Respondents purposefully persisted in their misconduct and fraud; their abuse and exploitation of a disabled adult plan beneficiary they held a fiduciary responsibility to.

> "To claim to prioritize members mental health while purposefully engaging in a business model that compromises their mental health, thereby positioning oneself to utilize their mental anguish as a means to increase profits." [Am. Pet. Ex. B file:(2019 C-A) pg. 38 ¶ 4].
>
> "As I understand things now, if a member is given false information regarding coverage then the care organization is usually required to honor the information provided to the member through member services. No such accommodation was extended to me when I

called in complaining about how I had been misled over the course of several months to believe that Unitedhealthcare would process and reimburse claims as a secondary insurance from providers who are in-network with my primary insurance. Worse yet, even as I was on the phone complaining about this matter representatives would continue to provide me with false information regarding how they function as a secondary insurance." [Id. pg. 26 ¶ 2]

And then there's the many pages about the provider network being inadequate [*Supra* (pg. 22 ¶ 1)--(pg. 26 ¶ 2)].

I had also made requests for my Protected Health Information to be released from TennCare and it's MCO so that I could review in detail the records of events surrounding my 2019 C-A denial which I had a statutory right to not just in terms of requesting PHI [45 CFR § 164.524] but also as a Medicaid beneficiary [42 CFR §§ 438.224;406(b)(5)]. UHCCP and TennCare both refused to work on my PHI requests.

On 1.31.2020 a UHCCP Supervisor named Alton instructed me to send my PHI request to Privacy.TennCare@tn.gov. I sent my PHI request to that address on 2.6.2020. I also mailed a hard copy of my PHI request to UHCCP via their prepaid envelope [Ex. A5 file: "UHC Info Req Packet Envelope.pdf"]. I did not receive any response to either PHI request submission, so I emailed again on 3.4.2020 asking for acknowledgement. TennCare responded "We have received your requests." and TennCare explained "These documents would have to be produced by United Healthcare." [Ex. A5 file:"Resend of Sean Smith's UHC Info Reqs (from 2.6.20) 3.26.20-redacted.pdf" pg. 4-5].

My email reply sent on 3.10.2020 included information such as: "I was provided conflicting information on where to send the request.", "More than one representative asserted I had to contact TennCare", "As UHC:CP is an MCO of TennCare I believe their misconduct is TennCare's responsibility to remedy.", "I am not to be burdened with performing duties outside of the scope of my responsibilities as a plan member. Requiring me to do so is illegal. You don't get to use me to do a job that is yours to perform. I am tired of the exploitation!", "I'm tired of being led around on a wild goose chase.", "I need medical care. I have made requests for

disclosure of information as part of trying to access that medical care...", "Trying to find a way to get...UHC or TennCare to actually help me per the law is" "breaking my mental health apart, while my unmet medical needs ravage both mental and physical. I can't even get a PHI request sent in and fulfilled so I can get the information needed to fully communicate to TennCare why my needs remain unmet." [Id. pg. 6 (B2)].

> "This 'knowledge of likely injury' comes from Mr. Smith's complaint-appeal [Exhibit B, pg 6] and other past verbal and written disclosures of information he made to Unitedhealthcare and TennCare, which are Protected Health Information (PHI) [45 CFR § 160.103]. Plan administrators are not permitted to use PHI to cause harm to or deprive the rights of their plan beneficiaries [45 CFR § 164.502]." [Am. Pet. pg. 12 ¶ 6]. [*Supra* pg. 7 ¶ 6 "UHCCP-TennCare have..."].

TennCare did not respond to my reply. On 3.24.2024 I replied once more to the email chain with "Hello? Are you there? I still need a way to make my PHI request. If you want to claim it's not your responsibility, as United Healthcare Community Plan has asserted, then provide directions which allow me to make that request of United Healthcare. Ignoring my pleas for assistance and direction is neglectful and abusive." (emphasis added). (Id. pg. 7).

No such directions or instructions were provided, which violated the general statutes for medicaid and privacy law I have already discussed, as well as specific medicaid-disability related civil rights protection laws [42 CFR § 438.406(a), 440.462] which then trigger the protections of other laws a few of which are, [42 CFR § 440.230;240;260], and general disability civil rights protections [42 U.S.C. § 12101; 29 U.S.C. § 794], as well as 42 U.S.C. § 1983 because "...and laws".

> "TennCare Appeals & Grievances refuses to investigate allegations of misconduct of their MCO and their organization and engages in misdirection and the use of lies in order to dismiss grievances. TennCare Oversight refuses to exert regulatory action over the MCO's. The MCO's engage in misconduct while claiming that they're just following TennCare's directions. The word "Collusion" seems fitting. What letters and reports one could write exploring that subject." [Am. Pet. Ex. B pg. 35 ¶ 3].

I set about to figure out how to send my PHI request to UHCCP on my own. I emailed my PHI request to UHCCP on 3.26.2020 with a second copy delivered via USPS certified mail on 4.20.2020 [Exhibit A5 files:"Sean Smith's UHC Info Req via Gmail 3.26.2020.pdf" & "Resend of UHC PHI Reqs, Electronic Receipt 4.20.20.pdf"]. Some excerpts from my PHI Request include:

"UHC:CP and TennCare have both refused to provide the assistance required for me to realize such a [PHI] request".

"In many instances I have been provided misinformation." and then "abandoned to figuring things out of [my] own."

"Requests have already been submitted in written format over 30 days ago per directions provided by the covered entity United HealthCare Community Plan."

"...verbal [PHI] requests have repeatedly been made prior to this..."

"...so many laws have been broken throughout these interactions [with UHCCP-TennCare] it seems silly to even bother pointing out HIPAA obligations. In short, what has occurred is a clear case of Abuse, Exploitation, and Neglect."

"Because matters have only continued to escalate - and I expect no change in that trend, as instead of admitting wrong and seeking to protect me, the efforts to cause me harm have persisted - I am also placing forth in this letter a request for the generation of a grievance regarding these proceedings and any other forms of investigation which could be implemented to provide protection to myself, the plan member, against the abuses of UHC:CP, Tenncare, and the persons contracted in their employ." (emphasis as in original)

"Further delays may cause documentation and information that should be regarded as evidence in future litigation to be destroyed. I would extend that anything but prompt and immediate action would be neglectful and unlawful. Act immediately to acquire, preserve, and disclose the requested Protected Health Information." (emphasis added)

TennCare sent me a letter on 5.7.2020 denying any wrongdoing [Am. Pet. Ex. B digital file: "TennCare Grievance of Appeal Rev & PHI Req Misconduct, Denies Wrongdoing 5.27.20.pdf"]. It's unclear which grievance or complaint the letter was responding to. I deem it most likely it is one of my many verbal complaints over the phone which the letter responds to. TennCare's letter makes reference to my 2.6.2020 communications to TennCare. "As you requested on February 6th, 2020, we have provided below the information for requesting your medical records from United Healthcare." [Id. pg. 1 ¶ 4]. As if I hadn't already submitted that request in February, March, and April, which UHCCP had in each instance decided to ignore and was disclosed in my communications [Exhibit A5 file: "Resend of Sean Smith's UHC Info Reqs (from 2.6.20) 3.26.20-redacted.pdf" pg. 1, pg. 18 (D4); file:"Resend of UHC PHI Reqs, Electronic Receipt 4.20.20.pdf"].

This is all yet another example of very "specific information for TennCare to investigate" regarding how "UHC and TennCare are not in compliance with federal and state laws" [Am. Pet. Exhibit B pg. 32 ¶ 2-4] which Respondents did not investigate; perform full and fair review of; do the job they are paid to do; had instead engaged in misconduct and abused and exploited me further.

In response to the 2019 C-A denial and withholding of PHI, in 2020 I began drafting my 2023 C-A. I put everything I had into drafting the 2023 C-A to the neglect and detriment of everything else. As explained in the 2023 C-A, I became so injured by Respondents' misconduct, the neglect, abuse, exploitation, and injuries that occur as part of their fraud, that I could not finish and submit the document until November 2023.

In the 2023 C-A I explained their statutory violations and fraudulent actions. Respondents' response to my 2023 C-A demonstrates that they continued to deny full and fair review and limit and prevent rehabilitative care and otherwise acted to subvert the purpose and mission of the medicaid program and are engaged in willful fraud. They have continued to intentionally misrepresent the fact their health plan will not provide rehabilitative "medically necessary care" to me and others like me and I continue(d) to suffer "physical, psychological, financial, and social damages" [Am. Pet. pg 14 ¶ 1].

I have suffered those damages for over six years. I have suffered the damage of not having full and proper access to my property-assets 'medicaid health plan benefits'. I have been directly defrauded of my property-assets, time, resources, health, rights, and denied any administrative remedy to indemnify me of this fraud and its injuries. Myself and beneficiaries like me have been defrauded by the Respondents. From the beginning of my being a plan beneficiary and to date UHCCP-TennCare have provided "a promise of future action with no present intent to perform" [*Dobbs v. Guenther*, 846 S.W.2d 270, 274 (Tenn. Ct. App. 1993)]] [Am. Pet. Ex. B pg. 70 ¶ 3].

7 - What Administrative Remedies Remain?

7.1 - What Remedies Were Made Accessible Were Exhausted

The Respondent's assert that "Until Petitioner demonstrates that his available administrative remedies have been exhausted for the relief he is requesting beyond outpatient physical therapy, the Court does not have proper jurisdiction to grant Petitioner relief" [Memo Supp. Mot. Dismiss pg. 5 ¶ 2] and that "generally, all remedies and relief must be exhausted with the agency prior to seeking review" [Id. pg. 6 ¶ 2]. That Petitioner has made no claim against TennCare or the State of Tennessee that can be redressed by this Court; instead, Petitioner's only avenue of recourse is with the agency itself." [Id. pg. 6 ¶ 3].

There is and never was an appeal for outpatient physical therapy in 2019 or in 2023, making TennCare's determinations that there was inherently invalid and illegal [*Supra* pg. 16 ¶ 2]. The administrative process for submitting care requests begins with and requires an adequate provider network which allows beneficiaries to exercise their rights and fulfill their responsibilities, which Respondents illegally and fraudulently deprive me of [*Supra* pg. 21-30 (Sec. 5 - Provider Network Inadequacy)]

It's the Respondents responsibility, their state-federally funded job, to fully and fairly review my C-A, which they did not do [*Supra* (pg. 16 ¶ 2)--(pg. 21 ¶ 2)]. The proper administrative process is that if upon such full-fair review Respondents then determined there was no "valid factual dispute" [Tenn. R. & Regs. 1200-13-13-.01(141)] it was their administrative duty to supply a notice to me which directed me to "provide additional information as identified in the Notice." [Tenn. R. & Regs. 1200-13-13-.11(d)]. Respondents did not serve any such notice to me.

Asking such basic questions as "what doctor, if any, had prescribed this treatment" [Memo Sup. Mot. Dismiss pg. 2 ¶ 1] is one of the initial steps to assessing whether or not there is a "valid factual dispute" which is part of performing "an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his or her medical history." . Which Respondents did not do [*Supra* (pg. 17 ¶ 5)--(pg. 18 ¶ 1)].

Moreover, UHCCP-TennCare have created and operate a health plan in which the provider network predominantly cannot or will not submit competent Prior Authorization requests (PA) or provide substantive assistance with Appeals for my jaws-airway needs and related disabilities [42 CFR § 440.168-169]. UHCCP-TennCare do this while also prohibiting plan beneficiaries from submitting PAs on our own behalf [42 CFR § 441.18(a)(2)]. The plan services required to allow these basic administrative tasks to properly transpire are fundamental to the administrative process, as evidenced by 42 CFR § 438.210 and 440.230. Which provides the "Requirements" that the "Medicaid agency" must "ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished" and "May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary".

Severely limiting and/or preventing myself and other beneficiaries with jaws-airway related health conditions and disability from being able to have access to PCPs and Specialists who are capable of and enabled to fulfill their roles within the structure of an MCO health plan violates statutory requirements [42 U.S.C. § 1396a(a)(8);(10);(19);(30)(A), 42 CFR § 438.68;206;208(b);210, 440.214;230;240;260;262, 441.18(a)(2)].

I cannot exhaust administrative remedies that are unavailable and inaccessible because Respondents engage in illegal activities which prevent the proper administrative processes from occurring. That I should have to explain that fact, yet again, goes to further demonstrate how irrational, arbitrary, capricious, incompetent, and illegal the TennCare program really is. Respondents seem to work harder to find reasons, excuses, or ways to avoid admitting fault for failing in their responsibilities than they do to actually do their job.

Preventing PAs, appeals, fair hearings, and due process by operating an inadequate provider network is inappropriate, illegal, and discriminates against the disabilities of multiple classes of persons, as jaw-airway issues cause disabilities of various types, including but not limited to psychiatric, neurological, immunologic, respiratory, gastrointestinal, cardiovascular, and many more. Conditions as wide-ranging as Crohn's to Bipolar Disorder to Epilepsy to Diabetes to Obesity to Chronic Back and Neck Pain can each be caused or significantly contributed to by jaws and airway issues.

Respondents denying me full and fair review of my C-A's and illegally depriving me of due process by denying me a fair hearing has fully exhausted the available and accessible administrative processes for the administrative agency to review and provide remedy. And as I will next demonstrate, the Respondents upon being made aware of this refused to afford me any other administrative remedy, opting to reaffirm their November 30th 2023 determination and its explicit direction to me that my only recourse is to file a Petition for Judicial Review. Respondents claiming that I did not exhaust administrative remedies is just more abusive nonsense. This Petition for Judicial Review was made at their direction, their requirement, their denial of my many requests to be supplied an administrative remedy made over a period of literally years.

7.2 - Respondents Have Denied Petitioners Requests for Administrative Remedy

My 2023 C-A was mailed on November 20th 2023. I received TennCares denial letter dated November 30th 2023 on December 7th 2023. TennCare's denial letter stated "We have worked all of the requests related to your appeal" and "You won't get a hearing." That if "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." [Am. Pet. Ex. A]

In my view TennCare had not worked any of the requests related to my appeal, let alone all of them. I called TennCare Appeals on Dec 7th 2023 and I explained to TennCare Appeals representative Ricky M. that my C-A did not receive full and fair review because TennCare's letter had denied it claiming I had appealed a request for outpatient physical therapy and my C-A was most definitely not appealing a denied request for outpatient physical therapy.

Ricky told me that he was not the right person for me to discuss this matter with, and he would "put in a call back request for the review team to call you" and that this task would be reviewed "within 48 hours" [Exhibit B5 Transcript ~00:11:15, ~ 00:12:06]. Rick M. told me that they will "re-review" my appeal and "reach out to you" to either "reiterate their decision" or if "provided with any additional information they may readdress their decision" [Exhibit B5 Transcript 00:12:28]. Ricky told me "the task will be worked and they will put that call out. If you do not hear a call within the next 48 business hours please call back" [Exhibit B5 Transcript 00:15:14].

No one from TennCare tried to contact me and so I called TennCare Appeals again on Dec 18th 2023 and explained to TennCare Appeal representative Tiffany G. my call with Ricky M. on the 7th and that no one from TennCare had since contacted me.

Tiffany told me that she was "notified [by my plan member records] to reach out to someone from a different department" and that she has "emailed that person letting them know that you have called back" and gave this person my phone number. [Exhibit B5 Transcript 00:12:40]. Tiffany said the person's name was Tyler D., but she cannot tell what position Tyler D. has or what department they're in. I asked "Whoever Rick sent this issue to, their response was to simply notify them if I call back?" Tiffany said, "that is the only note that I see on the file". [Exhibit B5 Transcript 00:13:22]. I told Tiffany I wasn't sure what I should do next that "if they're just going to ignore me, then all I can do is maybe try to figure out how to file the court thing" and I asked if Tiffany was supposed to help me with that. Tiffany told me I should contact the TennCare Advocacy Program, and transferred my call to them.

I told TennCare Advocacy rep Seattle B. about my Nov 30th 2023 denial letter, that it says all I can do is "file a petition for review", that "I have no idea what they're talking about" or who is supposed to "help me do that" [Exhibit B5 Transcript 00:24:51.74]. That TennCare Appeals said I should talk to TennCare Advocacy. Seattle told me "We don't handle appeals in this department, so I'm not understanding why they directed you to us. They handle that." She suggested that I "make a complaint on the appeal department for all the situation that you have going on." Tiffany told me that both she and her manager advised that I call the TennCare Appeals department back and immediately request to speak with a supervisor.

I called TennCare Appeals and requested to speak with a Supervisor. I was transferred to Java P. and I proceeded to explain that "Tenncare Advocacy told me that I needed to talk with a supervisor like yourself to file a complaint against Tenncare Appeals over what I've been dealing with", to which Java replied that "There's no complaint to file in this department. We file appeals.". Confused, I asked "Why would advocates tell me to file a complaint by talking to you then?" and Java says, "I have no idea, sir. And I'm so sorry for that." [Exhibit B5 Transcript 00:14:57.42].

I had a 1 hr 35 min long phone call with Java explaining my situation. In this call Java explains to me that "If we don't have a PA [Prior Authorization Request] for what you're telling me you need I don't know what to do because that's out of the parameters of anything that I can help you with." [Exhibit B5 Transcript 00:51:36.45]. I try to explain how I believe TennCare could help this situation. That when a "plan beneficiary spends 10 months writing a letter explaining things in detail" that the health plan reads and responds to it, acknowledging that "We need to find a solution" to the issues described in the letter and as part of that solution "prove you're gonna work in good faith" to my in-network and out-of-network doctors [Exhibit B5 Transcript 01:09:41.27]. That were TennCare to respond to my letter in that manner, then "I'd be like hey

jaw doctor dude, see they're actually gonna try to help me. They're gonna let you help me. It's worth your time to submit a request to them". That these jaw doctors "would be very interested in working with a health plan that was going to work in good faith" [Id.].

It was a long call, aggravating my jaws-head-neck issues, and related neurological and psychiatric issues, while also triggering my PTSD, but I managed to communicate to TennCare Appeals Supervisor Java P. that:

"I need to get to specialists. I can't do more than describe the problem as I have and if there's no one to help me overcome this barrier, there is logically only one conclusion and that's... It's going to be a fatal situation. And that's what I'm perplexed about. Is I'm in a situation that leads to death but there's no... There's nothing in place to seem to allow an intervention. There's no way for you to escalate this to get your senior leadership to know 'our current activities are going to kill our plan beneficiary'. Like it doesn't make any sense to me." "...like isn't there a senior operations analyst that needs to analyze this?" [Exhibit B5 Transcript 01:22:05.67].

To which Java tells me that they:

"Don't have a senior operations analyst. I don't know what they would do, but we have an appeals processing unit. Like I said you're in a department that's very much specialized, right. We file appeals. That is what we do. If the health plan is not doing what they need to do, our people will reach out on your behalf. It's called care coordination. They do that, often. But you've given me a lot of information, sir. And the first step is getting doctors that will assist you. You're saying they won't help you. And I don't know how you how you want us to fix that, because they're not in network. They can't check a doctor. You know, when you have United Healthcare if the doctor's not treating you right that's in their network, there's checks and balances for that. You can report that grievance in United Healthcare and say this doctor is not giving me adequate care. I'd like to report, you know, how I feel. I had a lady report that she felt she's been discriminated against for whatever reason. That doctor's in network with UHC. She can report that to UHC. Unfortunately you are telling me that the doctors you're trying to work with are not in network with us or Cigna. So I don't know how we're supposed, you think we're supposed to check, have checks and balances on a doctor who is not in contract with United Healthcare. How is United Healthcare supposed to do that? They cannot." [Exhibit B5 Transcript 01:24:00.13].

Despite the exhaustive information I communicated in my 2019 and 2023 C-A's, and on this call to Java P., I am told there is no administrative remedy to be supplied to my situation, which it's unclear if Java didn't fully understand my situation or what. At one point during the call Java told me she knows I'm mistaken about TennCare making it impossible to get access to

out-of-network jaws-airway doctors because she has often seen Vanderbilt refer plan members to a children's hospital in Cincinnati for gastrointestinal diseases and the doctors there get approved to deliver care [Exhibit B5 Transcript 00:44:10.46]. Then later on during the call Java tells me the health plan can't help me work with doctors who "are not in network with us". Which seems more like Java's is trying to invalidate and dismiss my complaints, rather than seek a resolution that lets me get the medically necessary rehabilitative care I need. I explained things exhaustively in my C-A's and tried to do the same on this call, but for whatever reason, people at TennCare don't seem to form entirely coherent responses to what I explain.

> "What I am sure of is that my case has been mishandled repeatedly and I have suffered immensely because of this and I hear similar stories from other patients. When I have voiced my unmet needs to representatives of the various organizations involved in this, the response I have grown accustomed to is one that dominates with an inability to facilitate solutions. I have been made to jump through one hoop after another, each hurdle greatly delaying or impeding access to care, at times even preventing access entirely." [Am. Pet. Ex. B. file: (2019 C-A) pg. 32 ¶ 3].

In my pleading I communicated that I retain "call recordings and other records" which can "substantiate his allegations that he did make multiple reports and complaints to UnitedHealthcare Community Plan and TennCare that health plan misconduct was occurring and harming Mr. Smith." [Am. Pet. pg. 5 ¶ 3]. This December 2023 call is one such call. I have many more such calls going back years. The assertion that I have not exhausted administrative remedies is one that is "Unsupported by evidence that is both substantial and material in the light of the entire record." [T.C.A. § 4-5-322(h)(5)(A)].

I submitted exhaustive C-A's that the doctors in the UHCCP-TennCare provider network aren't doing what's required to properly manage my care. That UHCCP and TennCare Appeals have refused to fully and fairly review my C-A's. This refusal to fully and fairly review the C-A's then stipulates that they are refusing to supply these checks to their in-network physicians. If UHCCP-TennCare did attempt to supply such checks, they would have to directly confront the fact that these physicians behave in this manner because they have been conditioned to do so by UHCCP-TennCare's misconduct. That these in-network doctors "believe the health plan won't let them help me get the jaws-airway care I need. [Am. Pet. pg. 3 ¶ 1, pg. 4 ¶ 6]" [*Supra* pg. 22 ¶ 4]. As explained in my 2023 C-A:

> "the misconduct of the Named Entities has permitted, incentivized, and at times even coerced many of the physicians and healthcare facilities comprising their provider network to engage in activities that work against the best interests of and cause harm to

their plan beneficiaries. And when made aware of this the Named Entities have failed to take action which curtails or puts a stop to the misconduct and harm that the Named Entities and their physicians and facilities in their health plan network are perpetrating against their plan beneficiaries" [Am. Pet. Ex. B. Pg. 4 ¶ 1].

"The Named Entities misconduct creates a situation in which a majority of their in-network physicians are conditioned by the health plans illegal activities to provide suboptimal care, and in so doing the clinical experience physicians gain is similarly lacking. Alongside which their efforts to seek and acquire continuing education become constrained by the direction in which their medical practice has gone. This in turn prevents plan beneficiaries from receiving services which inform them as to what their medical needs really are and then communicating the medical needs with accuracy to the health plan.

As a result of the Named Entities misconduct their in-network physicians tend to lack the "training and experience" required to understand the medical needs of Mr. Smith and other patients with similar health needs. Even amongst those with sufficient training to understand those medical needs, most do not wish to become actively involved in advocating for the patient to the health plan as their clinical experience causes them to expect to encounter wrongful denials of requests for care which will waste their time, this then further undermining the quality of care they can deliver to their patients." [Am. Pet. Ex. B Pg. 68 ¶ 3-4].

Ultimately, the synoptic agency determination to my 1hr 20min call with TennCare Appeals Supervisor Java P. was that Java believed, "You've done what you could do which was file an appeal. Our appeals unit looked at the appeal. Said it was more than 60 days since the denial. It was closed as untimely. The next steps on the letter says file a petition with the chancery court. That is all that I can give you. Sir, we've been on the phone for over an hour and I don't want to keep taking up your time. And I can't give you any other solution except for what is, what is there, was placed in front of you, which is the chancery court." [Exhibit B5 Transcript 00:24:51.74].

7.3 - Respondents Have Had Over Six Years to Supply an Administrative Remedy

Respondents are the ones who have determined I have exhausted all administrative remedies. In their denial letter, their response or lack thereof to my initial December 7th outreach and complaint, and on December 18th when I pressed my issue and tried to file a

complaint, but was told I could not. No, even long before then. Before I even submitted my 2019 C-A. Respondents had this opportunity on October 3rd and 10th of 2019 at the TennCare Block Grant Meetings at Jackson TN and Memphis TN where I submitted in writing and orally presented my complaints:

> "This is a problem that desperately needs solving and the solution isn't to be found in a block grant. It's not to be found in 'efficiencies' that prevent people from receiving the care they need to treat the conditions which disable them. I and others need help that we're not receiving because the people tasked with operating the programs we are now dependent upon for assistance do so with priorities that are anathema to caring for patients. If we really want to provide fiscal benefits to Tennessee and care to its vulnerable citizens the problem we need to tackle is the behaviors of the parties operating these organizations as well as the physicians participating in the programs. We need to make it so that it's no longer acceptable to discriminate and abuse people who are vulnerable and in need of medical care. So that it's no longer okay for physicians to stand by in learned helplessness as 'victims of a system'. That prior to trying to improve the efficiency of a program we first must make certain it is fulfilling its mission. We need to have outrage and act on that outrage when we hear the review process insurers are implementing lack integrity and are wrongfully denying care to those in desperate Need. We need to no longer be so accustomed to our medical system exploiting and killing people that hearing about another dead body is casually dismissed as meaningless anecdote." [Am. Pet. Ex. B file:"TNCARE Public Comments 10.3.19 10.15.19.pdf" pg. 5 ¶ 1].

Or perhaps, being dismissed as not being "competent evidence" [Order 4.22.2024 Deny Mot. Accom. pg. 3 ¶ 2]. I'm unsure how fair my criticism is, but it seems applicable. For a myriad of reasons.

> "UnitedHealthcare and TennCare claim Mr. Smith's 2019 medical appeal was entirely about denied physical therapy claims - nothing could be further from the truth [UnitedHealthcare, 2019, UHC, Med Appeal Denial] [TennCare, 2019, Med Appeal Denial]. That these determinations occurred proves, beyond a doubt, UnitedHealthcare and TennCare's noncompliance pursuant to 42 CFR § 438.406. Another letter like this one would have to be written to go into the details required to speak fully on that matter. I would hope that readers of this letter would by now hold a desire that the writing of such a letter not be made necessary. Especially those who dare to review Sean Smith's 2019

medical appeal first-hand and see with their own eyes how absurd it is to assert that the appeal was about denied physical therapy Bills." [Am. Pet. Ex. B pg. 31 ¶ 5]

I guess this is that letter. Should I dare to hope the readers of this letter will be any different?

I think that the Respondents have had ample opportunity to provide an administrative remedy for my dispute by "perform[ing] functions within its special competence — to make a factual record, to apply its expertise, and to correct its own errors so as to moot judicial controversies." [Parisi v. Davidson, 405 U.S. 34, 37 (1972)] [Memo Sup. Mot. Dismiss pg. 4 ¶ 4]. Having had that opportunity Respondents have shown themselves not simply unable but unwilling to "perform functions within its special competence" or "correct its own errors" [*Supra* pg. 18 ¶ 2 "From the analysis...", pg. 45 ¶ 3 "...like Java's is trying to invalidate"].

Moreover, promoting "judicial efficiency" and protecting "administrative authority" can not take priority over the civil and constitutional rights of myself and other TennCare plan beneficiaries, nor fulfilling the mission and purpose of the Medicaid program.

And "administrative remedies need not be pursued if the litigant's interests in immediate judicial review outweigh the government's interests in the efficiency or administrative autonomy that the exhaustion doctrine is designed to further." [West v. Bergland, 611 F.2d 710, 715 (8th Cir.1979)]. When exhausting an administrative remedy requires one to be unduly and unreasonably destroyed or deprived of life, liberty, property, and other fundamental rights, it is unconstitutional to require them to exhaust that remedy.

Respondents are tasked to further the interest of providing rehabilitative care to disabled adults such that they are in pursuit of The Nations Proper Goals for people with disabilities. They have had their chance to do that, six years of chances, and here now they prove themselves to still yet be enemies of that interest to rehabilitate disabled adults by their refusal to provide full and fair review, or perform reconsideration of their refusal, and then depriving me of due process by denying a fair hearing, and now seeking to deprive the adjudication of judicial review through a motion to dismiss. I pursue the interest of rehabilitating disabled adults, of Defending the Disabled, while Respondents' seek to oppose it and exploit us like cattle. My interest as a litigant is the legitimate interest for myself, those like me, TennCare itself, the State of Tennessee, and The Nation.

TennCare's violation of my civil and constitutional rights, the injuries from their fraud, the discrimination against my disabilities, and their dereliction of their duties as plan administrators to myself and other beneficiaries, has occurred due the Respondents making decisions and taking actions that are well "in excess of the statutory authority of the agency" [T.C.A. § 4-5-322(h)(2)].

"We recognize that an exhaustion decision requires attention to the particular administrative scheme involved'. "claiming the agency is operating *ultra vires."* "has justified early judicial review, however, in those cases in which agencies have transgressed clearly marked boundaries to their jurisdiction." ." [West v. Bergland, 611 F.2d 710, 715 (8th Cir.1979)].

Respondents' have undermined the proper prescribing of administrative remedy, and in so doing have made it necessary for the Courts to intervene and judicially reprimand the Respondents for neglecting their duties, abusing their discretion, and exceeding the bounds of their authority. "This is not a case where remedies lie unused in the past." and "a grant of judicial review under the present circumstances would not encourage individuals" like me who need jaws-airway rehabilitative care "to sidestep agency process." as Respondents' illegal activities have made such process ineffective or inaccessible [Id. 716]. Respondents have also caused and continue to cause me "irreparable injury" for which without judicial intervention there will be "inadequate remedy". [Id. 718]

The "Exhaustion of administrative remedies is not an absolute prerequisite for relief,". [Colonial v. Morgan, 263 S.W.3d 827, 839 (Tenn. 2008)]. Being a disabled adult without legal counsel, and a beneficiary of a medicaid plan that prevents the proper prescription of administrative remedies, I am uncertain whether my claims under 42 U.S.C. 1396a(a)(8);(10) might require the exhaustion of administrative remedies. But if they do I think it is by now clear that what remedies were made accessible were exhausted. My actions under 42 U.S.C. § 1983 and those based upon the violation of my constitutional rights do not require the exhaustion of administrative remedies.[11]

I think the burden is upon the Respondents to demonstrate that there remains specific administrative remedies yet to be exhausted and how it is in the "best interests of the recipients" and conducive to the "simplicity of administration" [42 U.S.C. § 1396a(a)(19)] for me to try to exhaust them. Or put more plainly, the respondents need to demonstrate that their administrative remedy offers equal or greater protection to and equitable relief for the violation of the civil and constitutional rights of myself and other recipients than would be provided by

[11] Patsy v. Board of Regents, 457 U.S. 496 (1982) (exhaustion not a prerequisite to § 1983 enforcement action). See also, e.g., Wilder , 496 U.S. at 523 (1990) ("availability of state administrative procedures ordinarily does not foreclose resort to § 1983"); Felder v. Casey, 487 U.S. 131 (1988); Skubel v. Fuoroli, 113 F.3d 330 (3rd Cir. 1997) (exhaustion of Medicaid administrative rule making process would be futile). But see Arden House, Inc. v. Heinz, 612 F. Supp. 81 (D. Conn. 1985) (holding provider should take rate claims through state processes). Salas v. Grancare, Inc., 22 P.3d 568, 573 (Colo. App. 2001) (exhausting administrative processes cannot be a precondition for a suit whose sought remedy is not provided for by administrative remedies).

adjudication, and do so in a manner that is, for the State, administratively simpler than that process provided by the Court's adjudication.

Even were Respondents to now supply information on these unspecified administrative remedies I may not have yet exhausted, I don't believe I have to exhaust them now, as when I called and requested further administrative remedy Respondents withheld this information from me, directing me to file a Petition for Judicial Review, and thereby necessitating I file a Petition for Judicial Review.

At this point the last administratively provided remedy I think I might be 'able' to exhaust would be to ask Respondents to settle this matter out of court. Which I technically already did in my 2023 C-A [Am. Pet. Ex. B pg. 5 ¶ 1, pg. 7]. So I think whether or not that or any other administrative remedy gets accessed now would be at my discretion, and for Respondents to assert otherwise would be another instance of an "unwarranted exercise of discretion" on their part. I'm still willing to discuss how the Respondents' may administratively provide my suits requested relief, but my experience so far indicates they will operate in bad faith and so it would be a challenge for me to entertain any offer or promises that they might make in private. I would need assurances that Respondents were not making yet another "promise of future action with no present intent to perform" [*Supra* pg. 41 ¶ 1].

8 - Tennessee's Proper Governmental Objectives Requires the Integrity of Beneficiaries Decisional Autonomy and Access to Rehabilitative Care

The case law around the right to make decisions about one's health and body is difficult for me to find, review, understand, and apply directly to my situation, because much of it seems to center upon abortion. With abortion there are typically two sides of the argument. Those being, that "state action 'encouraging childbirth except in the most urgent circumstances' is 'rationally related to the legitimate governmental objective of protecting potential life.'" [Thornburgh v. Amer. Coll. of Obstetricians, 476 U.S. 747, 785 (1986)] and that "a law that forbids abortion would condemn many American women to lives that lack dignity, depriving them of equal liberty and leading those with least resources to undergo illegal abortions with the attendant risks of death and suffering." [Stenberg v. Carhart, 530 U.S. 914, 920 (2000)] and would fundamentally

impinge upon a "woman's decisional autonomy regarding their own well-being" [*Allegheny Reprod. Health Ctr. v. Pa. Dep't of Human Servs.*, 26 MAP 2021, 233 (Pa. Jan. 29, 2024)]

For my situation, the *proper* governmental objective for Tennessee's medicaid program is to provide medical assistance which rehabilitates and protects the lives of disabled adults. The state cannot effectively pursue that objective by keeping beneficiaries such as myself ignorant of the health conditions causing our disabilities and making us unable to make these important decisions about our health and bodies. Such knowledge and decision-making in turn determines if I remain "alienated from 'Life, Liberty, and the pursuit of happiness' by fully treatable, even curable, health conditions." [Am. Pet. pg. 3 ¶ 1]. The state making this decision for myself and others like me violates that right to make this important decision for ourselves and thereby also determines whether or not I and others are 'able' to exercise our fundamental rights as full participants of society.

This state-mediated deprivation of rights discriminates against our disabilities and occurs without the due process which is constitutionally guaranteed. The state perpetrates this offense while acting in a fiduciary capacity whose obligations include an inherent duty to provide rehabilitative care. My situation is that of a one-sided State mediated deprivation of rights, liberties, privileges, and immunities without any proper governmental objective being cognizable. It is one in which the cognizable proper governmental objectives are being worked against by the Respondents' misconduct.

This has been occurring for years, with Responders made aware of it in writing in 2019, "I was bounced between specialists for four years with negative findings, and those findings being negative in part because the diagnostics used were constrained by what insurers covered and thus what physicians would make me aware of was an option." which is "...a common story amongst patients with Temporomandibular Disorders (TMDs) and/or disordered breathing..." aka jaws-airway-disability. [Am. Pet. Ex. B file: (2019 C-A) pg. 2 ¶ 2)]

Throughout these past several years that I have been seeking and unable to get rehabilitative care due to the misconduct of the Respondents, I have often contemplated how strange it seems that people argue against abortion based upon the premise that they must

protect unborn life that cannot protect itself, while at the same time are allowing through their inaction and inattention and facilitating through their direct and indirect participation the destructive State mediated abuse and exploitation of the lives of disabled adults whose existence is in no way shape or form a matter of debate. If life is so precious, why do you seek to protect the unborn at the expense of neglecting the living? Does my life not matter? Does that unborn child's life stop mattering to you once born? Or is it just the lives of those with disabilities that are unworthy of protection?

It would seem a more proper and rational governmental objective, and use of resources, to make certain that our State is a place worth being birthed into prior to requiring people to be born into it. I think that is a sound prerequisite. Put more directly, due to the deprivation of my rights, the physical and psychological torture I am being subjected to, I often wish I was dead, which is more commonly expressed with the sentiment, "I wish I'd never been born".

In the United States suicide is "the second leading cause of death for people ages 10-14 and 20-34."[12] In Tennessee, we rank as being on the mid to high end of suicide rates year after year.[13] The State with the lowest rate of suicide in 2021 was 7.1 in New Jersey, and the highest was 32.2 in Wyoming. The rate of suicide in Tennessee was 17.0 in 2021. The rate of suicide has been steadily climbing in Tennessee, with it being 14.1 in 2014, 15.7 in 2015, 16.3 in 2016, 16.8 in 2017, and 17.2 in 2019-2020.

Respondents have been doing such a great job making sure people like me are supplied a surplus of reasons to want to kill ourselves. Including not being able to get proper care for our psychiatric disabilities that are caused by health conditions which are caused by our jaws-airway issues. Which my 2019 and 2023 C-A's explained in exhaustive detail [Am. Pet. Ex. B pg. 42-62 (just scan threw), file: (2019 C-A) pg. 53-58].

All of which Respondents compound by abusing and exploiting us until it induces PTSD [Am. Pet. Ex. B pg. 2 ¶ 2, pg. 68 ¶ 5], while knowing that, "...among more recent reviews, there

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[12] Centers for Disease Control. (2024). Facts About Suicide. Retrieved: https://www.cdc.gov/suicide/facts/index.html

[13] https://www.cdc.gov/suicide/facts/rates-by-state.html

is a growing indication that individuals with PTSD suffer a disproportionately higher rate of SDB compared to the general population." [Id. pg. 84].

> "The psychologist, Tiffany Taft, said McNaughton was not an unusual case. About 1 in 3 patients with diseases like colitis suffer from medical trauma or PTSD related to it, she said, often the result of issues related to getting appropriate treatment approved by insurers."[14]

My Averments included that the Respondents' misconduct has created "conditions" in which I cannot get care for my disabilities and they know this injures and traumatizes me as I "fight and advocate for [myself] against misconduct" [Am. Pet. pg. 12 ¶ 6; Ex. B file:(2019 C-A) pg. 17 ¶ 1, pg. 34 ¶ 1-4, pg. 37 ¶ 3, pg. 38 ¶ 1] [*Supra* (pg. 37 ¶ 3)--(pg. 38 ¶ 1)].

From Mental Health America's 2022 report titled, "The State of Mental Health in America"[15], out of the 52 states Tennessee ranked 34th in terms of an "Overall Ranking" [Id. pg. 9]. Right where the CDC's suicide statistics would lead one to expect it to be. For "Youth Rankings" Tennessee Ranks 40th, at the bottom of the barrel, which makes sense when Respondents are being not just allowed, but rewarded, to engage in illegal activity which compromises care for children, mothers, and disabled adults [Id. pg. 12]. In terms of "Access to Care" Tennessee ranks 45th in the nation [Id. pg. 14]. One might think that Tennessee's failure has to do with an overwhelming demand for limited resources, but Tennessee is ranked at 13th in terms of the "Prevalence of Mental Illness", making us amongst the Nation's lowest in prevalence [Id. pg. 13].

However, it would be reasonable to infer that people aren't getting diagnosed because they're not able to access proper care. Or when they do access care they access the type of negligent, abusive, injurious, fraudulent 'care' I described in my C-A's [Am. Pet. Ex. B pg. 22-23]. Which Respondents and other arms of Tennessee's government have not made a priority to curtail. I mean, just look at the Google Reviews for Lakeside Behavioral Health

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[14] [David Armstrong, Patrick Rucker, May Miller. (Feb 2, 2023). UnitedHealthcare Tried to Deny Coverage to a Chronically Ill Patient. He Fought Back, Exposing the Insurer's Inner Workings. Retrieved: https://www.propublica.org/article/unitedhealth-healthcare-insurance-denial-ulcerative-colitis

[15] https://mhanational.org/issues/2022/ranking-states

System (LBHS), which has an overall rating of 2.1 out of 5 stars. Just 4 days ago, on May 23rd 2024, was a Review by Stephen B. (https://g.co/kgs/KiCZNRY) where he says:

> "This is supposed to be a mental health treatment facility but it is jail (punishment for mentally ill people)."
>
> "This is a physically/mentally unhealthy and abusive environment."
>
> "This place needs to be shut down and some folks are gonna have to become inmates for a change."
>
> "Lakeside lies about everything, and they even lied in their response to this review. They are not willing to talk to me. I have tried contacting them several times and they do not cooperate."

Stephen's comparison of LBHS to a prison seems particularly apt, as for several years I have personally heard mental health professionals describe LBHS and other psychiatric facilities in Memphis with words such as "holding tanks".

When you're a person with mental health needs, or a provider with a patient with such needs, and you see many such reviews, and hear such corroborations directly from physicians and patients, one would be reasonable to infer that it's probably best to not seek care there, and thus not get diagnosed or treated. That the best way to be 'safe' is to stay at home to self-treat one's depression and suicidal ideation, because That's Tennessee Ya'll.

Much like how people with mental disabilities need to avoid the police because "people affected by serious mental illness are 11.6 times more likely to experience police use of force, and 10.7 times more likely to experience police-related injury than those unaffected by mental illness.".[16] It's on our todo list, and the recommendations of advocates list of things to do [Am. Pet. B pg. 10 ¶ 4, pg. 11 ¶ 1].

However, that study's findings can't be reflective of Tennessee, let alone where I live in Memphis. It just can't. Because in Tennessee "30 out of Tennessee's 95 counties have [Crisis Intervention Team] CIT-trained officers", a "40-hour, Memphis-born program" which "has a

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[16] Chaplain, Madeline. (2023). Inefficacy of the Crisis Intervention Team Model. SUURJ: Seattle Univ. Undergraduate Res. Jour.: Vol. 7, Art. 8. Retrieved: https://scholarworks.seattleu.edu/suurj/vol7/iss1/8

proven history of success in improving the safety of both officers and people experiencing mental health crisis.".[17] It can even "save a tremendous amount of taxpayer dollars".

Or maybe not?

> "Despite national CIT popularity, larger system and policy-level challenges undermine the model's successful implementation."
>
> "Systematic analyses of the CIT support officer-level outcomes, including officer satisfaction and self-perception of a reduction in use of force. But the CIT model is not intended to appease its police officers. The CIT's foundation seeks to reduce lethality in police response with individuals experiencing mental health crises; the CIT model is meant to protect its citizens (Dupont et al., 2007)." [*Supra* pg. 55 ¶ 3, FN16]

Oh, right. That thing. CIT's mission and purpose is to "protect its citizens". Kind of like, Police are supposed to Serve and Protect Its Citizens, and not disproportionately injure and kill the most vulnerable citizens. Still, CIT might not be perfect but it should help and we can make it better. Progress right? We can make CIT version 2.0, and get the Police in Tennessee to stop unnecessarily harming mentally ill and disabled persons and instead deescalate encounters and as needed detain and transport to a psychiatric facility that will..oh right, engage in illegal activity which neglects, abuses, exploits and serves to otherwise endanger the health and safety of the individual in need [Am. Pet. Ex B pg. 21-22]. That must be part of how "larger system and policy-level challenges undermine the model's successful implementation." [*Supra* pg. 55 ¶ 3, FN16].

I guess it's better than getting beaten or shot by cops. TennCare ought to revise the UHCCP-TennCare Member Handbook to reflect this so that it is no longer a fraudulent intentional misrepresentation. That the TennCare health plan doesn't provide mental health services [2023 Member Handbook pg. 36, 38]. It provides a holding tank that is less dangerous

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[17] Jerfrey Daley. (Sept 14, 2022). How we can transform the way police responds to mental health encounters. Retrieved: https://www.tennessean.com/story/opinion/2022/09/14/transforming-how-police-respond-to-mental-health-crisis/7943461001/].

than prison and better than getting beaten and/or shot by cops, but probably more dangerous and harmful than if you were left entirely and completely alone to sit and ponder suicide.

All this talk about the jobs of the state arm "Police" reminds me that I should ask, whose job is it to make sure that the State of Tennessee Department of Finance and Administration, Division of TennCare doesn't contract with providers and facilities that are "physically/mentally" "abusive" [*Supra* pg. 54 ¶ 3]. It's the Respondent's job. Maybe Respondents just didn't understand they were supposed to do that job. Oh wait, I already told them they were supposed to in 2019 [Am. Pet. Ex. B file:(2019 C-A) pg. 36 ¶ 1] and in 2023:

> "These mandates" [42 U.S.C. §§ 1396a(a)(19);(30)] "require plan fiduciaries to make certain that the health plan avoids forming contractual relationships with facilities that engage in misconduct, especially when this misconduct harms plan beneficiaries. And upon being made aware one of their contracted partners is engaged in misconduct, take all actions possible to prevent the contracted partner from being in a position which would allow them to cause further harm to plan beneficiaries and the health plan. Included in which would be fulfilling their legal duty to report the ongoing abuse, neglect, exploitation, and discrimination of a disabled adult [TCA 71-6-103(b)]."
>
> [Am. Pet. Ex. B pg. 25 ¶ 2-3, pg. 26 ¶ 4].

I wonder, what Respondents Reply to my Response in Opposition will be? Will they refuse to acknowledge these issues, or try to dismiss them as mere "vague allegations about unspecified 'misconduct'" [Memo Sup. Mot. Dismiss pg. 5 ¶ 2].

Maybe the Respondents and the Court can clarify in their forthcoming responses for myself and all the other people with mental disabilities in Tennessee. Are our circumstances "exceptional" [Order Deny Mot. Acc. Just. pg. 3 ¶ 1] before, during, or after the Respondents' misconduct kills us or causes us to kill ourselves? As matters currently stand it seems like the answer is none of the above, but surely that can't be the case.

Respondents have known for years that they have an illegally inadequate provider network and not only refused to rectify this, but maintain a relationship with these facilities which rewards these facilities for abusing and exploiting their plan members, and in doing so,