IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Norfolk Division

NANSEMOND INDIAN NATION, a federally recognized Indian Tribe, *et al.*

Plaintiffs,

v.

COMMONWEALTH OF VIRGINIA; *et al*.

Defendants.

Civil Action No. 2:25-cv-00195

DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

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Introduction

In just two years, Plaintiff Fishing Point Healthcare has billed taxpayers hundreds of millions of dollars to serve roughly 2,000 Medicaid members. *See* Ex. 1, Declaration of J. Lunardi ("Lunardi Decl.") ¶¶ 37, 138. Fishing Point's Medicaid bills for this small group outstrip those of Virginia hospitals serving ten times more people. *See id.* ¶ 139. Nearly all of the millions stem from Fishing Point's use of what appear to be subcontracted providers to perform "personal care services" and "home health services"—things like bathing, dressing, and toileting, along with physical or speech therapy—in members' homes, at the federal "all-inclusive rate" ("AIR") of $801. *Id.* ¶¶ 31, 73–75. It appears that most of these non-clinic services were provided without a physician's authorization or oversight—contrary to federal regulations. *Id.* ¶¶ 82–93. And though the AIR is meant to be "inclusive" of all services provided in one outpatient visit, Fishing Point appears to have billed that rate for multiple services within one visit—and sometimes over the five-visit limit in one day. *Id.* ¶¶ 101–03. Fishing Point has also racked up millions more in bills by charging the $801 AIR to provide over-the-counter medications—meaning it has (repeatedly) billed taxpayers $801 to provide an $11 bottle of ibuprofen. *Id.* ¶¶ 106–07.

In short, there appears to be potential fraud or abuse happening at Fishing Point. Virginia's Department of Medical Assistance Services ("DMAS") has thus referred Fishing Point to the Medicaid Fraud Control Unit ("MFCU") and, as federal law requires, suspended all payments to Fishing Point while the credible allegation of fraud is investigated. *Id.* ¶¶ 110–15. This suspension did not come out of nowhere: it follows six months during which DMAS withheld payment on Fishing Point's personal services claims. Yet Fishing Point and its operator, Plaintiff the Nansemond Indian Nation, only came to court this month. They seek an extraordinary laundry list of relief and assert a freestanding right to operate their healthcare facilities as they please, "free

from state interference." Compl. ¶ 358(e). Their motion for preliminary injunction is unjustifiably delayed, lacks any basis in law or fact, and is inappropriately clothed in invective and inflammatory accusation.

This action is not about tribal sovereignty. It is about Virginia's authority to manage its Medicaid program and eradicate fraud and abuse in the same. Granting the overreaching relief Plaintiffs seek would place this Court "in the role of Medicaid payment processor[]" when Congress intended the Commonwealth to play that role. *Saint Anthony Hosp. v. Whitehorn*, 132 F.4th 962, 979 (7th Cir. 2025). It would also undermine an ongoing fraud investigation and contravene the federal directive requiring Virginia to suspend claims during its pendency.

Nothing justifies that course. Plaintiffs will not succeed on the merits: most of the defendants are immune from suit, and each claim is more deficient and unsupported than the next. Plaintiffs also establish no immediate threat of irreparable harm, especially when they have done nothing in the six months since DMAS began pending personal care services claims. And the equities and public interest weigh strongly against granting Plaintiffs' requested relief, given what appears to be a massive fraudulent misuse of taxpayer dollars. The Court should deny the Motion.

Background

Something concerning was happening: the Medicaid billings for Fishing Point Healthcare were skyrocketing. That healthcare service provider, founded in 2023 by the Nansemond Indian Nation and operating a clinic in Portsmouth, had billed roughly $2,675,514 that year for personal care services—meaning support services "furnished to an individual" enrolled in Medicaid ("Medicaid member" or "member") "in a home or other location" outside a clinic. 42 U.S.C. § 1396d(24); Lunardi Decl. ¶¶ 19–21, 66. These services, provided by aides or attendants rather than clinicians, can include assistance with things like bathing, dressing, and toileting. Lunardi

Decl. ¶¶ 39–40, 149. In 2024, Fishing Point's billings for these services had suddenly surged. They now totaled $96,167,628: a 3,594.4% increase. Lunardi Decl. ¶¶ 66–67. This number reflected services provided to 520 of the 1,267 members Fishing Point billed DMAS for—meaning 41.04% of the Medicaid members that Fishing Point served had received personal care services, when just 2.3% of the overall Medicaid population did so in 2024. *Id.* ¶¶ 73, 75.

Similarly eye-popping were Fishing Point's billings for home health services—things like in-home skilled nursing, speech therapy, occupational therapy, and physical therapy. *Id.* ¶¶ 48–49. Those bills had also ballooned, from $164,808 for the month of July 2023 to $820,379 in July 2024. *Id.* ¶¶ 76–79. And 75.61% of the members Fishing Point billed for were receiving these services, in contrast to 4.98% of Virginia's total Medicaid population. *Id.* ¶¶ 80–81. Even more staggering: *only 1.62%* of Fishing Point's 2024 billings stemmed from services other than personal care or home health—all services provided outside Fishing Point's physical clinic by what DMAS understands to be subcontracted, non-tribal providers. *Id.* ¶¶ 75, 87, 89.

In fact, Fishing Point patients had very few office visits during 2024, and *none* during 2023—Fishing Point did not even bill for an office visit until January 2024.[1] *Id.*¶¶ 90–91. This disparity between office visits and non-clinic services was striking, because personal care and home health services must be "authorized . . . by a physician in accordance with a plan of treatment." 42 C.F.R. § 440.167(a). Indeed, any non-clinic service "received through" a tribal clinic must be provided pursuant to a written care coordination agreement between the clinic and non-clinic provider, and there must be an established relationship between the patient and a clinic practitioner. ECF No. 1-2. But how could a physician be authorizing these services when it was

[1] Lance Johnson indicates that Fishing Point's clinic was not even open until "a year ago," despite Fishing Point billing for services in April 2023. ECF No. 22-1 ¶ 10; Lunardi Decl. ¶ 20.

likely that most of their recipients had never stepped foot within Fishing Point's clinic? It appears that none was: of the 2,086 Medicaid members for whom Fishing Point has billed for non-clinic services, *only 90* ever had an evaluation and management visit with a physician that Fishing Point billed to Medicaid. Lunardi Decl. ¶ 92.

DMAS, the "single state agency" responsible for administering Virginia's Medicaid program, was paying attention. *Id.* ¶ 3. So was the Centers for Medicare & Medicaid Services ("CMS"). Fishing Point's drastic spike in billings raised multiple red flags, leading CMS to contact DMAS in June 2024 about the issue.[2] *Id.* ¶ 55. The spike also raised concerns at DMAS as to whether personal claims services were being appropriately reimbursed. *Id.* ¶¶ 56–58.

On October 10, 2024, DMAS notified Fishing Point that it would "pend"—meaning, hold without paying—any future claims for personal care services while it sought guidance from CMS on how those claims should be handled. *Id.* ¶¶ 60, 62. DMAS also told Fishing Point it planned to seek CMS's approval of an amendment (or "SPA") to Virginia's Medicaid state plan—the CMS-approved document in which States describe their Medicaid programs—clarifying reimbursement practices for tribal health providers. ECF No. 1-45; 42 C.F.R. § 430.10.

Fishing Point refused to stop providing personal care services during this process. Instead, Fishing Point continued to rack up stratospheric bills: since October 10, Fishing Point has sought reimbursement for $228.5 million in pended personal care services claims. Lunardi Decl. ¶¶ 63,

[2] Contrary to Plaintiffs' assertions, CMS has not sanctioned Plaintiffs' billing practices by conducting a standard payment error rate measurement ("PERM") audit. That audit simply assesses DMAS's "error rate" in paying out claims that do not meet federal requirements—it does not evaluate any one provider's billing practices or look for potential fraud. Lunardi Decl. ¶¶ 119-31. And it certainly has not done so for Fishing Point, as the audit has reviewed only 0.018% of Fishing Point's personal care services claims. *Id.* ¶¶ 126, 130. In any event, CMS recently reopened the Fishing Point claims to re-evaluate medical necessity, so its audit remains ongoing. *Id.* ¶ 131.

135. The sums Fishing Point has billed outstrip total Medicaid billing by large medical institutions. In 2024, for example, DMAS reimbursed Norfolk's Sentara Princess Anne Hospital $79,407,496 to service 16,816 Medicaid members—versus the over $91 million it reimbursed Fishing Point to serve just 1,150 members, mainly through personal care services. *Id.* ¶¶ 138–40.

Meanwhile, DMAS has uncovered other problematic practices, including what appears to be double billing and over-billing. *Id.* ¶¶ 94–103. The current state plan authorizes paying tribal providers the $801 AIR for up to five outpatient visits per member per day, meant to cover all services provided within a single visit to the clinic. *Id.* ¶¶ 31–35. But Fishing Point has been billing for multiple services in one visit—and has frequently billed for more than 5 (and sometimes as many as 10) in one day. *Id.* ¶¶ 102–03. Fishing Point is also billing at the AIR for over-the-counter drugs—one time billing Medicaid *$801 for a jar of Vaseline*. *Id.* ¶ 107. In 11 months, Fishing Point has billed taxpayers roughly $3,066,535 for such medications. *Id.*

These facts support a credible allegation of fraud. DMAS has thus declined to process Fishing Point's application to provide dental services while investigating further. *Id.* at 26 n.6. DMAS has also referred Fishing Point to MFCU for investigation and possible prosecution. *Id.* ¶¶ 109–11. And as of April 29, 2025, as federal law requires, DMAS suspended all payments to Fishing Point while the credible allegations of fraud are being investigated. *Id.* ¶¶ 112–14; *see* 42 C.F.R. § 455.23(a); 42 U.S.C. § 1396b(i)(2)(C). Plaintiffs now have 30 days to appeal that suspension. Va. Code § 32.1-325.1; 12 VAC 30-20-500 *et seq.*

Plaintiffs appear undeterred. They just opened a second clinic in Newport News and plan to open another one in Norfolk soon. *See* VPM News, *Nansemond Indian Nation Set To Open Second Health Clinic*, https://tinyurl.com/nansemond (Feb. 27, 2025). They continue to serve over 1,100 Medicaid beneficiaries monthly, Lunardi Decl. ¶ 145—though the Nansemond tribe itself

includes only about 550 tribal members, meaning most of those serviced are likely not American Indian/Alaskan Native People ("AI/AN"), *id.* ¶ 36. Yet Plaintiffs claim they are in dire straits and suffering deprivations of rights that are nowhere to be found in federal law. They are wrong.

Standard of Review

"A preliminary injunction is an extraordinary remedy never awarded as of right." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 24 (2008). To obtain this extraordinary relief, Plaintiffs must "demonstrate that (1) they are likely to succeed on the merits; (2) they will likely suffer irreparable harm absent an injunction; (3) the balance of hardships weighs in their favor; and (4) the injunction is in the public interest." *League of Women Voters of N.C. v. N.C.*, 769 F.3d 224, 236 (4th Cir. 2014). "Although no single factor is dispositive, the first *Winter* factor is most important." *N. Virginia Hemp & Agric. LLC v. Virginia*, 700 F. Supp. 3d 407, 416 (E.D. Va. 2023), *aff'd in part, vacated in part, remanded*, 125 F.4th 472 (4th Cir. 2025).

Argument

Plaintiffs support their injunction request with a four-count complaint that reads more like a political or policy speech than a lawsuit. Untethered to binding precedent, Plaintiffs allege (1) violations of the Supremacy Clause, (2) interference with their Indian Self-Determination and Education Assistance Act ("ISDEAA") contract, (3) infringement of tribal sovereignty, and (4) violation of 42 U.S.C. § 1983. None of these claims are viable, and Plaintiffs do not satisfy any of the requirements for a preliminary injunction.

I. Plaintiffs cannot succeed on their claims because Defendants are almost entirely immune from suit.

Immunity bars this entire case except for the official capacity claims against Defendants Roberts and Lunardi (which are due to be dismissed for failure to state a claim).

A. Sovereign immunity bars the claims against Virginia and its agencies.

The Eleventh Amendment's grant of sovereign immunity means that, "[a]bsent waiver, neither a State nor agencies acting under its control may be subject to suit in federal court." *Puerto Rico Aqueduct & Sewer Auth. v. Metcalf & Eddy, Inc.*, 506 U.S. 139, 144 (1993) (citations omitted). This protection applies to the Commonwealth. It also covers the Office of the Secretary of Health and Human Resources ("OSHHR") and DMAS as "arms of the state," because the State would be responsible for any judgment against those entities. *Hutto v. S.C. Ret. Sys.*, 773 F.3d 536, 543 (4th Cir. 2014).

Plaintiffs are wrong to assert that any defendant waived sovereign immunity merely "[b]y electing to participate in the federal Medicaid program." Compl. ¶ 316. The Supreme Court has directly rejected that proposition: "[n]either . . . participation in [Medicaid] itself, nor a concomitant agreement to obey federal law, is sufficient to waive the protection of the Eleventh Amendment." *Florida Dep't of Health & Rehab. Servs. v. Florida Nursing Home Ass'n*, 450 U.S. 147, 150 (1981) (per curiam); *see also Madison v. Virginia*, 474 F.3d 118, 130 (4th Cir. 2006) ("[G]eneral participation in a federal program or the receipt of federal funds is insufficient to waive sovereign immunity.").

Nothing Plaintiffs cite provides differently. *Arlington Central School District Board of Education v. Murphy* says nothing about sovereign immunity. 548 U.S. 291, 295–96 (2001). And *Papasan v. Allain* merely discusses *Ex parte Young*'s limited exception to sovereign immunity, *see* 478 U.S. 265, 277–78 (1986)—it does not stand for the idea that any alleged violation of federal law exposes a State to suit, *contra* Compl. ¶ 316. Nor do Plaintiffs point to any express waiver of immunity. *See Madison*, 474 F.3d at 130 ("A waiver must be unequivocally expressed in statutory

text." (citations omitted)). Sovereign immunity thus bars Plaintiffs' suit against the Commonwealth, OSHHR, and DMAS and does not permit injunctive relief against them.

B. The Governor is immune in all respects.

Three forms of immunity bar Plaintiffs' official-capacity and personal-capacity claims against Governor Youngkin. First, no exception to sovereign immunity permits suit against him in his official capacity. "The *Ex parte Young* exception" that Plaintiffs invoke "is directed at officers of the state who are clothed with some duty in regard to the enforcement of the laws of the state, and who threaten and are about to commence proceedings to enforce against parties affected by an unconstitutional act." *McBurney v. Cuccinelli*, 616 F.3d 393, 399 (4th Cir. 2010) (cleaned up). Thus, "[f]or a state officer to be sued under the *Ex parte Young* doctrine, general authority to enforce the laws of the state is not sufficient." *King v. Youngkin*, 122 F.4th 539, 548 (4th Cir. 2024) (citation omitted). Plaintiffs must point to "a special relation between the officer being sued and the challenged" state action—meaning they must show the state official has both "*proximity to* and *responsibility for*" that conduct. *McBurney*, 616 F.3d at 399 (citation omitted).

Most of what Plaintiffs complain about has nothing to do with any specific duty of or conduct involving the Governor, much less his enforcement of any state law. Plaintiffs allege that Governor Youngkin generally "exercises authority over the agencies responsible for administering Virginia's Medicaid program" and "endorsed" a proposed budget amendment, Compl. ¶ 38—not that he has any enforcement duty relevant to any aspect of the program, the bill, or the agency conduct Plaintiffs challenge. Indeed, even if Plaintiffs plausibly alleged that he had "publicly endorsed and defended the challenged" conduct—which they do not—the Governor would still lack the "direct[] involve[ment] in enforce[ment]" required. *Waste Mgmt. Holdings, Inc. v.*

Gilmore, 252 F.3d 316, 331 (4th Cir. 2001). The official-capacity claims against the Governor must be dismissed.

Second, absolute legislative immunity bars the personal-capacity claims against the Governor as to the only direct conduct he allegedly took: "endors[ing] a state budget amendment" that Plaintiffs assert is unlawful. Compl. ¶¶ 38, 277–88, 363(a). The Governor has absolute legislative immunity for what Plaintiffs unambiguously describe as "legislative action." *Id.* ¶ 38. Executive officials "are entitled to legislative immunity when they perform legislative functions," including by approving or disapproving bills or otherwise performing an "integral step[] in the legislative process." *Bogan v. Scott-Harris*, 523 U.S. 44, 55 (1998). That is exactly what Plaintiffs assert the Governor did. *See* Compl. ¶¶ 277–81. Absolute legislative immunity thus requires dismissing the personal-capacity claims against the Governor related to that conduct.

Third, qualified immunity bars any remaining personal-capacity claims. Plaintiffs' conclusory allegations that the Governor allowed purported violations of federal rights do not clear the hurdle of qualified immunity, because they do not (1) identify any clearly established right that (2) a reasonable person in the Governor's position would have known he was violating through his alleged actions. *Love-Lane v. Martin*, 355 F.3d 766, 783 (4th Cir. 2004). Courts "must identify the specific right the plaintiff alleges was infringed at a high level of particularity." *Atkinson v. Godfrey*, 100 F.4th 498, 505 (4th Cir. 2024) (citation omitted). For the right to be clearly established, "existing precedent must have placed the statutory or constitutional question beyond debate[,]" as "viewed with reference to the particular facts of the case." *Id.* at 505–06 (citations omitted).

Plaintiffs' remaining allegations against Governor Youngkin boil down to (unsupported) assertions that: (1) he "failed to intervene in DMAS's efforts to divert Medicaid beneficiaries" into

managed care organizations ("MCOs"), in violation of 42 U.S.C. § 1396a(a)(23) and 42 C.F.R. § 438.14, and (2) he authorized DMAS to "pend" claims for personal care services, in violation of 42 U.S.C. § 1396a(a)(8) and several regulations. Compl. ¶¶ 363(b)–(c). No court has held that these provisions convey personally enforceable rights to providers and tribes like Plaintiffs. *See infra* at 24. Nor has any court held that what the Governor is alleged to have done—permit DMAS to rework its approach to tribal healthcare and authorize DMAS to pend reimbursement claims—violates those (nonexistent) rights. Because "[n]either the Supreme Court, [the Fourth Circuit], the highest court of the state where the conduct occurred nor a consensus of other circuit courts of appeals have determined that conduct similar to that of the [Governor]" violates federal rights, "the right[s] alleged to be violated w[ere] not clearly established." *Atkinson*, 100 F.4th at 501. Governor Youngkin is thus immune from suit and cannot be enjoined. *Id.*

C. Sovereign immunity bars the official-capacity claims against Secretary Kelly.

Secretary Kelly, named only in her official capacity, is also entitled to sovereign immunity. Plaintiffs allege that she exercises "supervisory authority over the implementation and enforcement of state Medicaid policies and practices." Compl. ¶ 35. Again, such "general authority" does not suffice. *King*, 122 F.4th at 548. Plaintiffs also fault her for allowing or failing to remedy purported violations of federal law, *see* Compl. ¶ 35, but do not allege she has any specific enforcement authority over state law or direct involvement in the conduct alleged.

Indeed, Plaintiffs' conclusive assertions that Secretary Kelly's "failure to act" and "inaction" allowed alleged violations to occur, Compl. ¶¶ 364(a)–(b), do not support the view that she had specific authority over any relevant conduct. And their own framing makes clear that Secretary Kelly merely had high-level oversight of Virginia's Medicaid program rather than direct participation in any state action. *See id.* ¶ 364(c) (alleging that "Defendant Kelly, *in his [sic]*

leadership role overseeing DMAS and the state's broader Medicaid program, directly participated in the decision to maintain the pended status of Fishing Point's claims and failed to take corrective action." (emphasis added)). Secretary Kelly cannot be enjoined.

D. Defendants Roberts and Lunardi are entitled to qualified immunity as to the personal-capacity claims against them.

Plaintiffs cannot pursue their personal-capacity claims against Director Roberts and Chief Deputy Director Lunardi, as qualified immunity protects each from suit. Nowhere do Plaintiffs identify any clearly established federal rights a reasonable officer in Roberts' or Lunardi's position would have known they were violating by taking the alleged actions at issue. Indeed, Plaintiffs do not identify *any* personally enforceable federal rights at all, *see infra* at 22–26, much less ones that the Supreme Court, Fourth Circuit, or other federal courts of appeals recognized at the time of the alleged conduct, *Atkinson*, 100 F.4th at 501. There was simply no "existing precedent . . . plac[ing] the statutory or constitutional question beyond debate," especially not as to the "particular facts of this case." *Id.* at 505–06 (citations omitted). Qualified immunity thus bars the personal-capacity claims against these defendants, and they cannot support any injunction.

II. Plaintiffs are otherwise unlikely to succeed on the merits.

Plaintiffs can only pursue their remaining claims against Director Roberts and Chief Deputy Director Lunardi in their official capacities for prospective relief—but they remain unlikely to succeed on the merits of any such claims.

A. The Supremacy Clause claim fails.

Plaintiffs' first cause of action asserts that pending their personal care services claims, not processing their dental clinic application, and "endors[ing] Virginia's biennial budget amendment" are "state actions" that conflict with federal law. Compl. ¶ 306. They cast this claim as one for "Violation of the Supremacy Clause." *Id.* No such claim exists. *See Armstrong v. Exceptional*

Child Ctr., Inc., 575 U.S. 320, 327 (2015). "[T]he Supremacy Clause is not the source of any federal rights, and certainly does not create a cause of action." *Id.* at 324–25. Nor does the Declaratory Judgment Act, which Plaintiffs apparently invoke, Compl. ¶ 317, supply a cause of action where federal law gives none—it "is remedial only and neither extends federal courts' jurisdiction nor creates any substantive rights." *CGM, LLC v. BellSouth Telecomm. Inc.*, 664 F.3d 46, 55–56 (4th Cir. 2011). Plaintiffs' claim thus fails from the start.

Even if Plaintiffs could properly frame the preemption claim they apparently wish to pursue, it would also fail because Plaintiffs do not identify any state *law* that conflicts with federal law. *See Armstrong*, 575 U.S. at 324 (Courts "must not give effect to state laws that conflict with federal laws."). What they complain of are simply alleged violations of federal law by state actors. *See* Compl. ¶ 306 (alleging "conflicting state *actions*," including "intentional violation of federal law" (emphasis added)); ECF No. 22 at 14 (complaining of "state conduct that obstructs federal law"). That is not the stuff of preemption.

Indeed, Plaintiffs do not identify any state statute that this Court could line up against a federal law to "determin[e] the constitutional question of whether they are in conflict." *N. Virginia Hemp*, 125 F.4th at 492. The only potential state law Plaintiffs point to is an unenacted budget amendment they complain wrongly allows DMAS to reimburse tribal health programs at different rates for AI/AN versus non-AI/AN patients.[3] That amendment does not conflict with federal law because it does not authorize the State to take any action without first obtaining federal approval. The bill simply directs DMAS to "seek all necessary federal authority . . . to implement" its proposed reimbursement parameters. H.B.1600, Item 288, TTTTT, Reg. Sess. (Va. 2025). It

[3] Any challenge to this proposed bill is not ripe. *See Doe v. Virginia Dep't of State Police*, 713 F.3d 745, 758 (4th Cir. 2013).

provides that DMAS "shall implement this reimbursement change" only "consistent with the effective date of the appropriate federal authority." *Id.* And it contemplates that if the change is "*not* approved by [CMS], then DMAS shall seek approval" for a different reimbursement structure. *Id.* (emphasis added). Under the bill, DMAS cannot do more than ask CMS for approval to act—approval CMS cannot give unless the proposed reimbursement change would comport with federal law.[4] *Cf. Douglas v. Indep. Living Ctr. of S. California, Inc.*, 565 U.S. 606, 614 (2012) (remanding challenge to state SPA after approved by CMS). Thus, the bill does not require any action contrary to federal law. The opposite: it directs DMAS to seek federal approval.

And nothing about the proposed reimbursement policy would violate federal law, because nothing in federal law mandates the "one facility, one rate" principle Plaintiffs say should control. Plaintiffs locate that principle in (1) CMS guidance and (2) Virginia's "Tribal Reimbursement SPA." Compl. ¶ 101. Neither qualifies as federal law with preemptive effect. (And the SPA's reimbursement provisions are exactly what the budget amendment seeks permission to change).

Agency "interpretations contained in policy statements, agency manuals, and enforcement guidelines . . . lack the force of law." *Christensen v. Harris Cnty.*, 529 U.S. 576, 587 (2000); *Fellner v. Tri-Union Seafoods, LLC*, 539 F.3d 237, 243 (3d Cir. 2008) ("[I]t is federal *law* which preempts contrary state law; nothing short of federal law can have that effect." (emphasis in original)). So the (1) CMS letter with its "policy interpretation" of when services are "received through" an Indian Health Service facility, and (2) FAQ about the same, have no preemptive effect. *See* ECF No. 1-2, 1-3.

[4] And federal law expressly provides for such approval procedures, meaning it cannot present a conflict with federal law merely to direct DMAS to seek approval of a SPA or waiver. 42 U.S.C. §§ 1396a(a)(1), (b); C.F.R. §§ 430.10, 430.12(c)(2)(i).

Virginia's state plan falls further short. A Medicaid state plan is just a "written statement submitted by [the state] agency [to CMS] describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with" applicable law and regulations. 42 C.F.R. § 430.10. It is not federal law. Nor does "[t]he fact that federal law conditions State participation in the Medicaid program on the State's adoption of a Medicaid plan . . . thereby transform provisions of a State's plan into federal law." *Concourse Rehab. & Nursing Ctr., Inc. v. DeBuono*, 179 F.3d 38, 44 (2d Cir. 1999). Plaintiffs' Supremacy Clause claim thus fails on multiple fronts and cannot support the injunctive relief Plaintiffs request.

B. The interference with ISDEAA contract claim fails.

Plaintiffs also lack a viable cause of action for their second claim, in which they contend that Defendants have interfered with their ISDEAA contract with the federal government. ISDEAA "authorizes the [federal] Government and Indian tribes to enter into contracts in which the tribes promise to supply federally funded services, for example tribal health services, that a Government agency would otherwise provide," with the government paying "contract support costs." *Cherokee Nation of Oklahoma v. Leavitt*, 543 U.S. 631, 634 (2005). Plaintiffs assert that this basic transfer of operating authority somehow gives them a right to participate in Medicaid "independently of state control" or preempts the field of "Indian healthcare" when read together with the Indian Health Care Improvement Act ("IHCIA"). Compl. ¶¶ 323, 328. They also allege that defendants are impeding their execution of their contract "by taking actions that directly conflict with" federal law. *Id.* ¶ 332. They are wrong on all counts.

To start, Plaintiffs identify no right of action available against third-party States or state actors for purported "interference" with an ISDEAA contract. Indeed, that ISDEAA authorizes actions against the *federal* government for claims arising under the statute suggests that no other

enforcement mechanism exists. *See* 25 U.S.C. § 5331(a); *Alexander v. Sandoval*, 532 U.S. 275, 290 (2001) ("The express provision of one method of enforcing a substantive rule suggests that Congress intended to preclude others."). This limitation makes sense: ISDEAA focuses on contracts between the federal government and tribes governing transfers of services, not on a freewheeling tribal right to offer Medicaid services without state oversight. Disputes under ISDEAA thus center on parties' compliance with their contractual obligations—not on the separate issue of a third-party State's administration of its Medicaid program. *See, e.g.*, *Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 185–86 (2012) (dispute over contract support costs).

Nor do Plaintiffs properly frame any claim for preemption in the field of "Indian healthcare." *Contra* Compl. ¶ 328. The idea that Congress barred state regulation of a tribe's Medicaid billing practices by enacting ISDEAA and IHCIA ignores Medicaid's operation as "a cooperative federal and state program." *Pharm. Rsch. & Mfrs. of Am. v. Concannon*, 249 F.3d 66, 74 n.6 (1st Cir. 2001) (rejecting field preemption as inapplicable in this context), *aff'd sub nom. Pharm. Rsch. & Mfrs. of Am. v. Walsh*, 538 U.S. 644 (2003). It especially overlooks Medicaid's provisions giving States broad authority and oversight obligations in administering their programs—including by requiring them, as Virginia has done here, to suspend claims subject to a credible allegation of fraud. 42 C.F.R. § 455.23.

Plaintiffs' argument also reads preemptive intent into statutes that lack any. ISDEAA allows tribes (instead of the federal government) to administer tribal healthcare programs, while IHCIA aims to promote quality health care for tribal members. *See, e.g.*, 25 U.S.C. § 1602. Though both broadly address "Indian healthcare," neither reflects any intent to limit a State's authority to administer its Medicaid program when a tribe chooses to participate in it. Nor do the cases Plaintiffs cite have to do with healthcare, much less with ISDEAA or IHCIA. They address

state regulation—mainly, taxation—of commercial activities on tribal reservations. *Ramah Navajo Sch. Bd., Inc. v. Bureau of Revenue of New Mexico*, 458 U.S. 832, 834, 837–38 (1982); *White Mountain Apache Tribe v. Bracker*, 448 U.S. 136, 138–39 (1980). This action does not involve state taxation of reservation activities, so those cases' preemption analysis has no bearing.[5]

What Plaintiffs really complain about are alleged violations of federal law—not preemption of state law. *See* Compl. ¶ 332. But these grievances still do not give rise to an "interference with ISDEAA contract" claim when Congress has not authorized any such cause of action. Underscoring this conclusion is Plaintiffs' consistent citation to (and mischaracterization of) inapplicable authorities, some of which actually validate Defendants' alleged actions.

Timely reimbursement. Plaintiffs complain that the pending of personal care services claims over the last six months is unlawful. Compl. ¶¶ 332(a), (d). The regulation they cite says the opposite: claims from providers like Plaintiffs need be paid within 12 months of receipt, and only then if they are not "under investigation for fraud or abuse." 42 C.F.R. § 447.45(d)(4), (d)(4)(iii); *see also United Cerebral Palsy Ass'ns of New York State, Inc. v. Cuomo*, 966 F.2d 743, 746 (2d Cir. 1992) (State payments to providers were appropriately made "well within the 12 month statutory requirement"). *Practitioners'* claims must be paid sooner—but Plaintiffs are not practitioners. 42 C.F.R. §§ 447.45(d)(2)–(3) (discussing claims from "practitioners" and "providers" separately); *see also id.* § 489.2(b) (describing "providers" to include "clinics").

None of the other provisions Plaintiffs cite even speak to reimbursement timing:

- 25 U.S.C. § 1621e provides for recovery of health services costs against a State when services were provided under "workers' compensation laws; or a no-fault automobile accident insurance plan or program." *Id.* § 1621e(b).

[5] And to the extent Plaintiffs mean to assert another conflict preemption claim, that claim also fails because Plaintiffs again identify no state *law* in conflict with federal law. *Supra* at 12–13.

- 42 U.S.C. § 1396j(d) cross-references 25 U.S.C. § 1645, which requires certain *federal* agencies to reimburse tribes for servicing specified beneficiaries.

- 42 U.S.C. § 1396a(a)(13)(A) is a notice and comment provision that "merely requires that states determine their reimbursement rates via a 'public process'" but does not require specific reimbursement methodologies or speak to the pending of claims. *HCMF Corp. v. Allen*, 238 F.3d 273, 276 (4th Cir. 2001).

- The other regulations Plaintiffs reference just define "clinic services," 42 C.F.R. § 440.90(c), and require "disclosure[s] by Medicaid providers," *id.* § 455.104.

- The CMS guidance on reimbursement amounts both lacks force of law and does not provide a right to reimbursement within a set time. *Supra* at 13.

Dental clinic application. Plaintiffs' objections about the dental clinic application also rest on provisions that do not say what Plaintiffs claim they do. Compl. ¶ 332(b). Nothing in these provisions mandates processing a provider application on any timeline.

- 42 U.S.C. § 1396a(a)(8) provides that *individual* applicants for Medicaid benefits must receive reasonably prompt assistance—it does not set out any timeline by which to process a *provider*'s application to provide services.

- 42 C.F.R. § 431.107 requires provider recordkeeping and "furnishing of information."

- 42 C.F.R. § 455.104 and § 440.90(c), again, deal with provider disclosures and define "clinic services."

- 25 U.S.C. § 1621t allows tribal health programs to employ professionals licensed by other States.

- 25 U.S.C. § 1642 allows tribes to buy health benefits coverage.

Tribal consultation. Plaintiffs' claim that Defendants violated tribal consultation requirements is also unfounded. Compl. ¶¶ 322(c), (e). The Medicaid Act requires state plans to "provide for a process under which the State seeks advice on a regular, ongoing basis" from tribal health programs on relevant issues and that "includes solicitation of advice prior to submission of any plan amendments [or] waiver requests." 42 U.S.C. § 1396a(a)(73)(A). CMS regulations say this process must "be conducted in accordance with [either] the consultation process outlined in

the [CMS] July 17, 2001 letter or the State's formal tribal consultation agreement or process." 42 C.F.R. § 431.408(b)(2). Virginia's state plan contains its formal process: DMAS must provide "written communication" about SPAs or waivers before submitting them to CMS, and must offer a 30-day period for tribes to request additional information or offer comments. Compl., Ex. 4. This consultation process does not, contrary to Plaintiffs' implication, require some kind of ongoing negotiation before the State even *decides* to seek a SPA.

Plaintiffs do not allege any failure to follow this process. Indeed, DMAS has met or exceeded its consultation obligations. It has held frequent calls with Fishing Point since 2023. Lunardi Decl. ¶ 162. It sent Fishing Point the required notices of its intent to seek the SPA and a related waiver. *Id.* ¶¶ 157–60. It extended the consultation period to give the tribe more time to engage. *Id.* ¶¶ 159–60. DMAS also agreed to hold an in-person consultation meeting during this period, even though it had no obligation to do so. *Id.* ¶ 165. That is more than what is required. Plaintiffs' nit-picking that they received DMAS's notices at the wrong email address does not reflect any substantive violation of this process, especially when they were aware of the ongoing consultation window but refused to engage. Rather than meet with DMAS, they chose to file suit.

In sum, nothing in Plaintiffs' allegations reflects any violation of federal law. And nothing about any of this impacts Plaintiffs' ISDEAA contract.

C. The infringement of tribal sovereignty claim fails.

Plaintiffs' third claim—that Defendants' conduct infringes on their "inherent sovereignty" and "authority to independently govern" their healthcare program, Compl. ¶ 341—fails for many of the same reasons as their first and second. No cause of action for "infringement of tribal sovereignty" exists. The tribal sovereignty doctrine operates instead as a defensive "barrier[] to

the assertion of state regulatory authority over tribal reservations and members." *Bracker*, 448 U.S. at 142.

Even if such a claim existed, tribal sovereignty is not some blanket prohibition on state regulation of tribal healthcare providers. Far from it. The doctrine once had broader import but is now a "backdrop" principle focused on "the right of reservation Indians to make their own laws and be ruled by them." *Id.* at 142–43. It rarely preempts state law itself: "[t]he trend has been away from the idea of inherent Indian sovereignty as a bar to state jurisdiction and toward reliance on federal pre-emption." *McClanahan v. State Tax Comm'n of Arizona*, 411 U.S. 164, 172 (1973); *see E. Band of Cherokee Indians v. N.C. Wildlife Res. Comm'n*, 588 F.2d 75, 77 (4th Cir. 1978) ("[M]ost controversies are settled by reliance on federal preemption principles."). So given that Plaintiffs have no valid preemption claim, *supra* at 11–13, their tribal sovereignty claim fails from the start.

Either way, tribal sovereignty only pertains to "what is necessary to protect tribal self-government or to control internal relations." *Montana v. United States*, 450 U.S. 544, 564 (1981). It simply means that "tribes retain sovereign interests in activities" on their reservations, *Nevada v. Hicks*, 533 U.S. 353, 392 (2001) (O'Connor, J., concurring in part and dissenting in part), as well as "inherent power to determine tribal membership, to regulate domestic relations among members, and to prescribe rules of inheritance for members," *Montana*, 450 U.S. at 564. It is not, as Plaintiffs imply, a field preemption rule that extends beyond tribal lands or internal relations to bar state regulation of anything remotely tribe-affiliated. *Contra* Compl. ¶¶ 344–45. And it does *not* mean that tribes are free from state regulation in all respects, *see Eastern Band of Cherokee Indians*, 588 F.2d at 77—especially not when they voluntarily participate in Medicaid's cooperative federalism program to service thousands of non-tribal members using taxpayer dollars.

ISDEAA and IHCIA do not change this conclusion. *See supra* at 15. Neither do the authorities Plaintiffs rely on, which address the distinct scenario of state taxation of commercial activities on reservations. *Supra* at 15–16. Indeed, nothing supports Plaintiffs' fundamental premise: a State is not stripped of its authority to administer its Medicaid program when a tribal healthcare provider chooses to participate.

Once again, though, Plaintiffs do not assert a sovereignty claim so much as they assert that Defendants violated federal law. *See* Compl. ¶ 347. And once again, Plaintiffs identify no such violation. Their contentions about (1) the pended claims, *id.* ¶¶ 347(b), (d); and (2) the dental clinic application, *id.* ¶ 347(a), which basically repeat those made in Count 2, remain unavailing. *See supra* at 16–17. And their assertion that the unenacted budget amendment violates federal law remains incorrect. *See* Compl. ¶ 347(c); *supra* at 12–14. Nothing else they cite reflects any violation (or says what Plaintiffs claim):

- 25 U.S.C. § 1680c(c)(2) allows tribes to decide to serve non-AI/AN beneficiaries but does not require any specific reimbursement structure if tribes do so.
- 42 U.S.C. § 1396j(d), again, cross-references a requirement for federal agencies to reimburse tribes for specific beneficiaries—it says nothing about "eligibility criteria," *contra* Compl. ¶ 347(c).
- CMS policy interpretations do not have force of law and cannot be violated by a state budget amendment (that authorizes seeking CMS approval of a SPA). *Supra* at 13.
- Tribal consultation is required before a SPA is submitted to CMS for approval—not before a budget amendment authorizing a state agency to seek approval of that SPA is "endorsed" by a Governor. *Supra* at 17–18.

This claim, like the three before it, cannot justify injunctive relief.

D. The Section 1983 claim fails.

Finally, Plaintiffs' § 1983 claim also lacks merit. Plaintiffs identify no enforceable federal rights they may pursue in a § 1983 action, much less any they plausibly allege were violated.

A § 1983 plaintiff must show a deprivation of "rights, privileges, or immunities secured by the Constitution and laws" of the United States. 42 U.S.C. § 1983. That is, "a plaintiff must assert the violation of a federal *right*, not merely a violation of federal *law*." *Planned Parenthood S. Atl. v. Kerr*, 95 F.4th 152, 160 (4th Cir. 2024), *cert. granted in part*, 220 L. Ed. 2d 372 (Dec. 18, 2024) (citations omitted). Doing so requires showing that "Congress has unambiguously conferred individual rights upon a class of beneficiaries to which the plaintiff belongs." *Health & Hosp. Corp. of Marion Cnty. v. Talevski*, 599 U.S. 166, 183 (2023) (citation omitted).

This "demanding bar" is especially important in actions involving Spending Clause legislation like the Medicaid Act, *id.* at 180, where a plaintiff's request to recognize an enforceable right "often implicates separation-of-powers and federalism concerns," *Saint Anthony Hosp.*, 132 F.4th at 977. Thus, "§ 1983 actions are the exception—not the rule—for violations of Spending Clause statutes." *Talevski*, 599 U.S. at 193–94, (Barrett, J., concurring). To prove this is the "atypical case," the statutory provision must be "phrased in terms of the persons benefited and contain[] rights-creating, individual-centric language with an unmistakable focus on the benefited class." *Id.* at 183. Even if a statute contains the necessary right-conferring language, a defendant can still "demonstrate[e] that Congress did not intend that § 1983 be available to enforce those rights," including because Congress designed a "comprehensive enforcement scheme that is incompatible with individual enforcement under § 1983." *Id.* at 186 (citations omitted).

Plaintiffs do not identify any statutes conferring rights that they, as a tribal entity and Medicaid provider, may enforce under § 1983. Indeed, the Supreme Court has expressed doubt

that providers can *ever* be the "intended beneficiaries (as opposed to mere incidental beneficiaries)" of a Medicaid Act provision, as "the Medicaid agreement . . . was concluded for the benefit of the infirm whom the providers were to serve, rather than for the benefit of the providers themselves." *Armstrong*, 575 U.S. at 332. And as to many of Medicaid's provisions, "the explicitly conferred means of enforcing compliance . . . by the Secretary's withholding funding, § 1396c, suggests that other means of enforcement [against a State] are precluded." *Id.* at 331–32. Unsurprisingly, then, none of the provisions (or other sources) at issue reflect Congress's unambiguous intent to convey enforceable rights to Plaintiffs.

Right to "operate as a distinct provider . . and to receive Medicaid reimbursement for services furnished outside the physical clinic," Compl. ¶ 358(a). Plaintiffs base this purported right on 42 C.F.R. § 440.90(c). But "[a]n administrative regulation [] cannot create an enforceable § 1983 interest not already implicit in the enforcing statute." *Smith v. Kirk*, 821 F.2d 980, 984 (4th Cir. 1987). Plaintiffs do not point to any statutory provision giving them this purported right. And the regulation itself simply defines the scope of "clinic services"—it does not contain any rights-creating language. *See* 42 C.F.R. § 440.90(c).

Right to receive Medicaid reimbursement at the Federal AIR for covered services, Compl. ¶ 358(b). Plaintiffs point to three statutory provisions and Virginia's SPA # 21-007 as the sources for this purported right. None supply it.

As discussed, a SPA is not codified or otherwise incorporated into federal law. *Supra* at 13–14. It therefore cannot confer federal rights.

And the Medicaid provisions cannot be read to unambiguously confer enforceable rights on providers like Plaintiffs. 42 U.S.C. § 1396a(a)(8) directs that a state plan "provide that all *individuals* wishing to make application for medical assistance . . . shall have opportunity to do so,

and that such assistance shall be furnished with reasonable promptness to all eligible *individuals*." *Id.* (emphasis added). This provision "is expressly intended to benefit 'all' individuals eligible for Medicaid assistance." *Doe v. Kidd*, 501 F.3d 348, 356 (4th Cir. 2007). Because it "is not unmistakably focused on providers like" Plaintiffs, it does not confer enforceable rights on them. *Saint Anthony Hosp.*, 132 F.4th at 973; *see Virginia Hosp. & Healthcare Ass'n v. Roberts*, 671 F. Supp. 3d 633, 653 (E.D. Va. 2023) (no enforceable right when Medicaid "provisions are phrased in terms of beneficiaries, not providers"); *Prestera Ctr. for Mental Health Servs., Inc. v. Lawton*, 111 F. Supp. 2d 768, 775 (S.D.W. Va. 2000) ("Cases that have found § 1983 enforceable rights for Medicaid beneficiaries are clearly inapposite" in case involving providers.).

Meanwhile, 42 U.S.C. § 1396a(a)(13)(A) does not convey enforceable rights on anyone. "[Section] 1396a(a)(13)(A) contains no substantive mandate; it merely requires that states determine their reimbursement rates via a 'public process' that allows providers notice and an opportunity to comment on the proposed rates." *HCMF Corp.*, 238 F.3d at 276; *see Armstrong*, 575 U.S. at 331 (Section 1396a(a) is "phrased as a directive to the federal agency charged with approving state Medicaid plans, not as a conferral of the right to sue upon the beneficiaries of the State's decision to participate in Medicaid."). Thus, it is not enforceable through § 1983.

Finally, 42 U.S.C. § 1396j(d) simply cross-references IHCIA "[f]or provisions relating to the authority of certain Indian tribes . . . to elect to directly bill for, and receive payment for, health care services[.]" It has no rights-conferring language, nor does it set out an "entitlement to reimbursement" from the State, *contra* Compl. ¶ 358(b). Similarly, the IHCIA provision it points to, 25 U.S.C. § 1645, requires specific federal agencies to reimburse tribes for servicing people the agencies would typically service. It does not confer a universal right on the tribes to be reimbursed by States. Plaintiffs thus locate no source for this right.

Right to freedom from enrollment delays and discriminatory participation criteria, Compl. ¶ 358(c). Plaintiffs base this alleged right on three regulations—42 C.F.R. §§ 431.107, 431.110(b), 455.104—none of which, again, may convey individual rights. *Kirk*, 821 F.2d at 984.

They also point to 42 U.S.C. § 1396a(a)(5)'s requirement that state plans identify "a single State agency to administer" them. Like other provisions of § 1396a, this "directive to the federal agency" does not confer personally enforceable rights on Medicaid providers. *Armstrong*, 575 U.S. at 331; *see San Lazaro Ass'n, Inc. v. Connell*, 286 F.3d 1088, 1099 (9th Cir. 2002) ("the single state agency requirement is a structural programmatic requirement" that "does not create individual entitlements.").

42 U.S.C. §§ 1396a(a)(8) and (23), which Plaintiffs also cite, have been read to convey rights to individual beneficiaries—again, not to providers or tribes like Plaintiffs. *Kidd*, 501 F.3d at 356; *Kerr*, 95 F.4th at 155. Because their exclusive focus is on Medicaid beneficiaries, not providers, they do not support Plaintiffs' § 1983 claim.

Right to enforce the terms of Virginia's SPA, Compl. ¶ 358(d). Again, a state plan confers no privately enforceable rights. Nothing in *Wilder v. Virginia Hospital Association*, 496 U.S. 498 (1990), *Antrican v. Odom*, 290 F.3d 178 (4th Cir. 2002), or *Talveski* changes this conclusion, as those cases involved rights conferred by statutory provisions, not a state plan.

Right to operate Fishing Point free from state interference, Compl. ¶ 358(e). Plaintiffs source this "right" in 25 U.S.C. § 1642, which they characterize as governing "state preemption in licensure," Compl. ¶ 358(e). That provision just says that tribes "may" elect to use federal funds to buy health benefits coverage. 25 U.S.C. § 1642(a). Its general, precatory language does not convey an expansive "right to operate Fishing Point free from state interference." *Contra* Compl. ¶ 358(e); *see Blessing v. Freestone*, 520 U.S. 329, 341 (1997).

Similarly, 25 U.S.C. § 1680c(c)(2) empowers tribes "to determine whether" they should provide health services to individuals not otherwise made "eligible" under IHCA. *Id.* It does not "unambiguously impose a binding obligation on the States" that tribes may then enforce through § 1983. *Blessing*, 520 U.S. at 341.

Neither does 42 U.S.C. § 1396j(d), which Plaintiffs characterize as a "prohibition on additional conditions imposed on ISDEAA programs," Compl. ¶ 358(f)—despite this provision simply cross-referencing statutes without addressing that issue whatsoever.

Right to tribal consultation, Compl. ¶ 358(f). Plaintiffs base this right on a state plan that gives no enforceable rights. *Supra* at 13. Neither does CMS's Tribal Consultation Policy: "[a] policy letter has even less legal stature than a regulation" in terms of its (in)ability to create rights enforceable under § 1983. *HCMF Corp.*, 238 F.3d at 277. And the regulation Plaintiffs point to, 42 C.F.R. § 431.408(b), also cannot create rights beyond any conferred by statute. *Supra* at 22. Plaintiffs are left with 42 U.S.C. § 1396a(a)(73), which directs CMS to ensure that state plans "provide for a process" for tribal consultation and advice. *Id.* Like the rest of § 1396a, this provision is "a directive" to CMS and not "a conferral of the right to sue upon" Medicaid providers or tribes. *Armstrong*, 575 U.S. at 331.

Right to provide healthcare services and be free from conflicting state regulation, Compl. ¶ 358(g). Plaintiffs locate this expansive "right" in ISDEAA provisions including 25 U.S.C. § 5302, a "congressional declaration of policy" aimed at facilitating tribal control over tribal education and healthcare. That provision reflects the federal government's effort to transition its control of such matters over to the tribes, *see Salazar*, 567 U.S. at 185—it does not reflect any congressional intent to grant the tribes amorphous and unqualified rights "to provide healthcare" that they may enforce against the States through § 1983.

25 U.S.C. § 5321(a)(1), meanwhile, directs the federal government to "enter into a self-determination contract or contracts with a tribal organization" to conduct covered programs. It lacks rights-creating language focused on tribal healthcare providers. Even if it could be read to convey some right, moreover, it would not be an expansive right to provide healthcare without state involvement—especially when state involvement is critical to Medicaid's cooperative federalism. *Supra* at 15.

And 25 U.S.C. § 5331(a) gives the federal courts jurisdiction over claims brought by tribes against the *federal* government under ISDEAA. This framework reflects that ISDEAA disputes are generally contractual ones between the tribe and the federal government and "suggests that other means of enforcement are precluded." *Armstrong*, 575 U.S. at 332.

In sum, because Plaintiffs identify no personal rights they may enforce against Virginia or its officials under § 1983, this claim cannot succeed. And even if Plaintiffs somehow overcame this hurdle, their allegations do not reflect any violation of the provisions on which they rely.

III. Plaintiffs will not suffer any imminent irreparable harm without an injunction.

"[P]laintiffs' failure to show a likelihood of success on the merits dooms their request for a preliminary injunction" and obviates the need to assess the remaining factors. *N. Virginia Hemp*, 125 F.4th at 497. But Plaintiffs also fail to make the necessary showing on those fronts.

Plaintiffs do not show any imminent, non-speculative threat of irreparable harm. A preliminary injunction movant "must make a 'clear showing' that it will suffer harm that is neither remote nor speculative, but actual and imminent." *Mountain Valley Pipeline, LLC v. 6.56 Acres of Land, Owned by Sandra Townes Powell*, 915 F.3d 197, 216 (4th Cir. 2019) (citations omitted). Plaintiffs do not meet this standard.

First, because "an application for preliminary injunction is based upon an urgent need for the protection of [a] Plaintiff's rights, a long delay in seeking relief indicates that speedy action is not required." *Quince Orchard Valley Citizens Ass'n, Inc. v. Hodel*, 872 F.2d 75, 80 (4th Cir. 1989) (citations omitted); *see also N. Virginia Hemp*, 700 F. Supp. 3d at 427 ("allegations of harm [were] undercut by [a 5-6 month] delay" in filing). Plaintiffs waited six months to do anything about the pended (now suspended) claims. Lunardi Decl. ¶ 132. That unjustified delay shows they have no "urgent need" for protection. They can wait for this Court to resolve this action on the merits—which should not take long, given there is no merit to their claims.

Second, Plaintiffs' assertions of potential harm are speculative and unsupported. They gesture at potentially stopping services or closing shop at some point. But they supply no specifics. This scenario contrasts sharply with that in *Children's Hospital of the King's Daughters, Inc. v. Price*, 258 F. Supp. 3d 672 (E.D. Va. 2017), *aff'd in part, vacated in part sub nom. Children's Hosp. of the King's Daughters, Inc. v. Azar*, 896 F.3d 615 (4th Cir. 2018). There, the plaintiff hospital supplied this Court with concrete facts and numbers about its operating margins and debts as well as the "financial catastrophe" and number of employee layoffs that could occur in the short term were state law enforced. *Id.* at 690. Plaintiffs make no such effort here.

Nor could they. Plaintiffs continue to operate at full force. *See* ECF No. 22 at 21, ECF No. 22-1 ¶ 24. They even opened a new clinic a month ago and plan to open more. *Supra* at 5. That is not a business on the verge of bankruptcy. No surprise: Virginia has paid out roughly $194,472,403 in Medicaid claims to Fishing Point since 2023. Lunardi Decl. ¶ 135. And these payments far exceed the actual costs of providing services. *Id.* ¶ 142. Plaintiffs are doing just fine.

This case is also unlike *Pashby v. Delia*, where *beneficiaries* of public assistance showed irreparable harm because 2,405 of them had already "lost needed medical care." 709 F.3d 307, 329–30 (4th Cir. 2013). Even if providers like Plaintiffs could assert such harm on behalf of beneficiaries they serve—which is doubtful—Plaintiffs do not identify an imminent risk that they will terminate services or identify any beneficiaries that have already lost services, as in *Pashby*.

Moreover, Plaintiffs make no showing that the people they serve—largely through non-tribal subcontractors—could not get care before 2023 or would be unable to get care in the densely populated Portsmouth/Newport News metropolitan areas without Fishing Point. In fact, their claim that they are "the only available facility for underserved populations, including the unhoused," in Newport News is simply untrue. ECF No. 22-1 ¶ 9. Most of Fishing Point's 1,197 Medicaid members are already enrolled in an MCO with a local provider network, which can provide care coordination and ensure continuity of care. Lunardi Decl. ¶ 145. Virginia also has 1,400 personal care providers and 300 home health agencies. *Id.* ¶ 148. These providers existed before Fishing Point and can continue to operate regardless of Fishing Point. And most of the subcontractors Fishing Point appears to be using are already enrolled with DMAS as Medicaid providers, and could likely continue providing services to the same members Fishing Point serves if billing for those services were transferred to the members' MCOs. *Id.* ¶ 149. That is, Fishing Point is not the "unique facility" at issue in *Rodde v. Bonta*, and the State is not outright shutting them down like in that case. 357 F.3d 988, 991 (9th Cir. 2004); Lunardi Decl. ¶¶ 150–52.

Plaintiffs' other cited cases also fail to suggest irreparable harm here, where there are no constitutional claims. To be sure, "[t]he loss of First Amendment freedoms, for even minimal periods of time, unquestionably constitutes irreparable injury." *Elrod v. Burns*, 427 U.S. 347, 373 (1976). But, contrary to Plaintiffs' assertions in their motion, *see* ECF No. 22 at 26, Plaintiffs

allege no such constitutional injuries in their Complaint. These decisions are thus inapt. Indeed, this dispute boils down to money. And a dispute about money typically does not permit the award of extraordinary, equitable relief. *See Hughes Network Sys., Inc. v. InterDigital Commc'ns Corp.*, 17 F.3d 691, 694 (4th Cir. 1994).

IV. The balance of equities and public interest weigh strongly against relief because DMAS must protect the public fisc and combat fraud.

These final factors "merge" when relief is sought against government actors. *Nken v. Holder*, 556 U.S. 418, 435 (2009). Here, they tip heavily against a preliminary injunction.

Plaintiffs' arguments on these elements effectively repeat their merits and irreparable harm arguments. But arguing that conduct "is against the public interest because it is unlawful" is "circular reasoning" that does not advance the equities/public interest argument. *USA Farm Lab., Inc. v. Micone*, No. 23-2108, 2025 WL 586339, at *4 (4th Cir. Feb. 24, 2025). And, of course, Plaintiffs fail to show any unlawful conduct or identify concrete, imminent harm.

Instead, it is Plaintiffs who appear to be acting unlawfully. Plaintiffs are correct that there is a strong public interest in ensuring the Medicaid program's "integrity," ECF No. 22 at 28—but that interest cuts against an injunction here. There is a strong public interest in preventing the fraudulent or incorrect use of taxpayer dollars in the Medicaid program as well as in ensuring that Virginia Medicaid members are receiving the appropriate level of service in accordance with federal and state requirements. *See Victoria Transcultural Clinical Ctr. VTCC, LLC v. Kimsey*, 477 F. Supp. 3d 457, 466 (E.D. Va. 2020) ("The public deserves the utmost diligence in the protection of its financial resources." (citations omitted)); *Prestera Ctr.*, 111 F. Supp. 2d at 782 ("[T]he Medicaid statutes and regulations at issue clearly were intended by Congress to benefit the public, prevent fraud, and provide for efficient use of public resources"). This interest is especially strong here, where DMAS has referred Fishing Point to MFCU for investigation and, as it is

required to do, suspended all payments to Fishing Point during the investigation. *Supra* at 5. The public interest weighs strongly against this Court's intervention in this process—especially because Plaintiffs may pursue their right to appeal the suspension and should be required to exhaust that administrative remedy before seeking any judicial relief. *Supra* at 5; *cf. ABA, Inc. v. D.C.*, 40 F. Supp. 3d 153, 172 (D.D.C. 2014) (no likelihood of success in challenge to credible fraud suspension when administrative appeal was ongoing).

These issues also reflect the strong public interest in recognizing Virginia's broad authority to administer its Medicaid program. Medicaid is "designed to advance cooperative federalism," *Wisconsin Dep't of Health & Fam. Servs. v. Blumer*, 534 U.S. 473, 495 (2002), and States should enjoy "considerable autonomy . . . under the [Medicaid] Act," *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 629 (2012) (Ginsburg, J., concurring in part). Plaintiffs ask this Court to commandeer the State's authority and step in as the arbiter of what claims should be paid when. Nothing in the Medicaid Act or other federal law permits this intrusion. *See Saint Anthony Hosp.*, 132 F.4th 978–79. Especially not when a credible allegation of fraud is being investigated.

Conclusion

For these reasons, the motion for preliminary injunction should be denied.

Dated: April 29, 2025

Respectfully submitted,

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